Improve Elder Abuse Communication by Utilizing an Evidence-Based Screening Guideline in a Gerontology Clinic: A Quality Improvement Project

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Abstract

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One in six older adults are affected by abuse yet only 1.4% cases of abuse are reported by physicians.
Purpose: This DNP Project aimed to utilize an evidence-based screening tool for early detection and appropriate management of elder abuse to reduce adverse outcomes, care for and protect vulnerable older individuals.
Methods: The population of interest for this quality improvement process were patients 65 years and older, staff, and providers at the project site. Exclusion criteria were patients less than 65 years of age. Interventions included an educational presentation provided to staff and providers about abuse risk factors and clinical manifestations, the evidence based EASI screening tool, and management of patients who screen positive for abuse.
Results: Data were collected from 100 random chart audits over a five-week period. Data were analyzed using descriptive statistics and Chi-Square test. Findings indicated 54% were screened, 46% were screened negative, and 2 individuals were screened positive for abuse. Findings showed 35% of providers and staff were compliant with use of the EASI screening tool. A Chi-Square Test for Independence indicated a significant association between elder abuse screening and positive abuse cases, $n = 100$, $p = <0.001$, $phi = 1.000$.
Conclusion: Education and the use of an evidence-based screening tool are effective approaches in screening and recognizing elder abuse. Healthcare professionals have legal and ethical obligations to appropriately diagnose, report, and refer to individuals who are abused.
The primary care setting can provide a valuable opportunity in recognizing and caring for abused elders to care and protect elders.

NOTE: *This poster was originally presented at the Touro University Nevada – Primary Care, Gerontology, and Rheumatology Health Center on October 25th, 2022, and February 16th, 2023, to Touro University Nevada School of Nursing faculty and colleagues.*

Keywords: abuse; EASI tool; elder; interventions; screening

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Improve Communication for Elder Abuse Screening in a Local Gerontology Clinic

There is an estimated 962 million people who are aged 60 and older worldwide, comprising of approximately 13% of the global population (Van Royen et al., 2020). There is a concern of the risk of abuse and violence occurring in the elderly population. As the populations ages, there is an increased rate of abuse in older adults as one in every six older adults are affected (Van Royen et al., 2020). Van Royen et al., (2020) defined elder abuse as, "A single or repeated act that occurs within any relationship where there is an expectation of trust which causes harm or distress to an older person" (pp.1793-1807). Abuse can occur in the older adult' population between family members, informal and formal caregivers, or acquaintances (Yon et al., 2018). Some older adults may or may not disclose abuse to their providers for fear of retaliation and dependence on the abusers.

Primary care settings provide a valuable opportunity for elder abuse screening (National Center on Elder Abuse, 2016). Healthcare providers are mandated to report suspected abuse of minor children and the elderly. This becomes a difficult situation as there are some healthcare providers who are hesitant about reporting experiences of abuse (Simmons et al., 2020). There is hesitancy of older adults reporting to clinicians and the lack of available resources for individuals seeking assistance related to abuse (Simmons et al., 2020). Therefore, reports of abuse are missed or underreported in the clinical settings.

Doctor of Nursing Practice (DNP)-prepared nurses have an essential role in the early recognition and management of older adults who are victims of elder abuse. Healthcare professionals have legal and ethical obligations to appropriately diagnose, report, initiate the conversation, and refer individuals who have been abused (Hoover & Polson, 2014). This DNP project will focus on addressing elder abuse through the implementation of an evidence-based

screening guideline to be used at the project site to improve communication, identification, and management of elderly abuse.

Background

The effects of elder abuse have adversely influenced the physical, emotional, spiritual, and social lives of this population. The quality of life is affected by the impact of abuse. There are six different types of elder abuse and is categorized by physical, psychological, sexual, financial, neglect, and violation of personal rights (Van Royen et al., 2020). The physical form is among the most common types of abuse. Factors that increase the risk of abuse include the presence of psychological disorders such as Alzheimer's Disease, people who have impaired disabilities including physical and mental disabilities, and those individuals who are unable to provide self-care due to chronic illnesses/diseases (Feltner et al., 2018). Other risk factors are being female, presence of having cognitive deficits, and being older than 74 years old (Yon et al., 2018).

Primary prevention for elder abuse includes elimination of risk factors, utilization of risk assessment tools, and caregivers support programs for assistance (Van Royen et al., 2020). Prevention of elder abuse is the key to protecting the health, safety, and lives of older adults in this vulnerable population. Secondary prevention includes performing screening assessments, providing resources for victims and families, and offering legal counseling if appropriate (Van Royen et al., 2020). Referral to local community resources including the Adult Protective Services is initiated upon assessment. Early recognition, intervention, and management through screening tools will reduce adverse effects by averting further harm for older individuals who are suspected to be abused and those who are at-risk for abuse. Providing awareness and education on elder abuse screening to providers, staff, and stakeholders is essential to promote a safe

environment for the older adults' population in the clinic (K. Mecham, personal communication, April 14, 2022).

Secondary prevention includes screening tools to provide early detection and serve as a valuable tool in the assessment and management of older adults who are at-risk and suspected of experiencing abuse. Adverse health effects can be reduced and/or prevented using screening tools in place (Van Royen et al., 2020). An example of a screening tool includes the Elder Abuse Suspicion Index (EASI), which is utilized to identify victims of elder abuse through an interview using a questionnaire (Van Royen et al., 2020). This screening tool uses a five-to-six item indicators in a yes-no format (Van Royen et al., 2020). There is a sensitivity of 0.47 and a specificity of 0.75, respectively (Van Royen et al., 2020). Another screening tool is the Brief Abuse Screen for Elderly (BASE) and is used to assess the risk of elder abuse through a telephone interview, followed by a home visit and evaluation from the multidisciplinary team (Van Royen et al., 2020). This screening tool uses a five-item questionnaire and evaluates the presence or absence of physical, psychosocial, financial abuse, or neglect (Van Royen et al., 2020). The reliability of this screening tool is 0.91 and the predictive validity of 0.89-0.91 (Van Royen et al., 2020).

Cases of elder abuse may be undetected, underreported, or missed especially without the use of screening tools in practice. Recent research suggests that only 1.4% cases of elder abuse are reported to the Adult Protective Services by physicians (National Center on Elder Abuse, 2016). There are also limited studies that assess the use of screening or effective treatments for elderly abuse (Feltner et al., 2018). The gap in research regarding the prevalence of elder abuse poses challenges in addressing elder abuse (Yon et al., 2018). Factors associated with the limited research are associated with healthcare professionals having lack of or insufficient training, lack

of understanding in the detection of clinical manifestations, risk factors, and insufficient knowledge on proper management associated with elder abuse (Van Royen et al., 2020). There also remains a significant lack of validated assessment tools and interventions for elder abuse (Van Royen et al., 2020). Currently, there are no standardized guidelines in place for providers and staff to utilize for elder abuse screening. There is currently no elder abuse policy in place at the project site. Providers and staff have limited knowledge and training regarding screening for abuse and management.

Project Question

The DNP project will focus on improving communication for elderly abuse and violence through an implementation of an evidence-based national guideline into the practice setting. The project question was designed using the PICOT format, "Will implementing an evidence-based elder abuse screening tool in a primary care clinic improve identification of victims, risks, communication, and management for abuse victims within 5-weeks' timeframe of the project?"

Search Methods

Implementation of an elder abuse screening tool in a primary care clinic requires appraisal of evidence-based research findings to support its relevance and reliability through peer-reviewed literature and national guidelines prior to implementation into practice. The search methods utilized for the project proposal include terms related to "elder," "abuse," "screening," "tool/tools," "prevention," "interventions," "primary care," "clinic," "evidence-based," and "national guidelines."

Searching databases were verified by resources that are exclusive to peer-reviewed journal articles with full text and citations available. The results derived from online databases including Google Scholar, Elton B. Stephens Company (EBSCO), Cumulated Index to Nursing

and Allied Health Literature (CINAHL), Jay Sexter Library at Touro University Nevada, and state or national guidelines. National centers related to elder abuse, academic institutions, National Library of Congress, American Medical Association, local community departments/divisions, state and national agencies, and national legislature were included. National resources include the Centers for Disease Control and Prevention (CDC), Administration for Community Living (ACL), National Library of Medicine (NIH), Office of the Justice Programs of the National Criminal Justice Reference Service (NCJRS), The Elder Justice Act of the Congressional Research Service (CRS), and the National Aging Research Institute (NARI).

The key "impact of elder abuse" was also included in the literature search. The search methods yielded results that were only within five years of publication and listed in ascending order of relevancy. The inclusion criteria consisted of the relevant search terms, peer-reviewed articles, and primary and secondary prevention strategies. Exclusion criteria include articles published more than five years prior, expert opinions, and case studies that were not relevant to the development of the proposal. A review of abstracts was further conducted also narrowed the results irrelevant to elder abuse screening and intervention measures. Articles unrelated to elder abuse screening measures and interventions were also excluded. Duplicate articles were further excluded.

National guidelines and federal/state/local resources were utilized in the search for best practices and standards of care that are helpful for the project proposal. Based on these search terms, the literature review yields approximately 17,300 findings related to search criteria upon initial retrieval. Additional inclusion parameters focusing on primary and secondary preventative strategies were applied and further yielded 18 results on EBSCO and 50 results on PubMed. The

results were then further narrowed based on relevancy to elder abuse screening and interventions. The search was applicable to specifically within 5 years of publication. After reviewing the abstracts, peer-reviewed journal articles were selected, and duplicates of articles removed. There were 13 articles remain after the criteria were applied.

Review of Study Methods

The studies evaluated in this literature review included both qualitative and quantitative literature. The research designs include descriptive, correlative, predictive, and pilot studies. The literature discussed include random controlled trials, meta-analysis, qualitative studies, systematic, scoping review of peer-reviewed journal articles and published books. Peer-reviewed journals and systematic reviews yields the most common types of results. Upon reviewing the literature, relevant themes of the studies emerged and were related to screening tool implementation utilizing several national guidelines to address management for elder abuse. The search methods and emerging themes are relevant to the development and aim of the studies performed for the DNP proposal project.

Review Synthesis

The literature review indicates elder abuse can have a devastating impact on the victim and the families involved. The abuse can be pervasive as it can be perpetrated by the people the victim knows such as family members, caretakers, and even strangers. The impact of the elder abuse may leave the victims feeling as if the abuse was their fault and experience guilt. Elder abuse has many ramifications including devastating financial losses (Institute of Aging [IOA], 2020; Hussemann & Yahner, 2019).

There are strategies that are utilized to prevent and manage elder abuse. The best place to address this issue with the population would be in a trusting environment. The primary care

provider is considered the most trusting relationships people have. Therefore, it is obvious to offer prevention for the elderly patients and management of the ramifications of abuse if needed. Literature discusses the prevention measures as performing screening to identify elder abuse and educating the patient of the risk factors to raise awareness of their vulnerability (University of California San Francisco [UCSF] Division of Geriatrics [DOG], 2016; Hussemann & Yahner, 2019; Centers for Disease Control and Prevention, n.d; Joosten et al., 2017).

Healthcare providers are in a key position and in many states, have legal obligations to report suspected elder abuse. Many states do have penalties for the failure to report abuse; for instance, in California, the failure to report neglect or abuse of an elderly person or a dependent adult is considered a misdemeanor that is punishable with jail time up to six months and fines (Bureau of Medi-Cal Fraud and Elder Abuse [BMFES], n.d.).

Theme Development

The search methods are relevant to the DNP proposal as it provides results for justifying supporting evidence to assist in implementing an evidence-based screening tool into the clinical setting for quality improvement. Themes identified include national hotlines and state and community assistance for victims and caregivers, the identification of risk factors and preventive strategies for elder abuse, impact of elder abuse, primary and secondary prevention strategies, screening tools such as the EASI tool, as well as best practices (Hussemann & Yahner, 2019; Baker et al., 2017; NAMR, 2022; Geiderman & Marco, 2020; Van Royen et al., 2020; Centers for Disease Control and Prevention, n.d.; Nguyen et al., 2015; Simmons et al., 2020; Pond et al., 2019; Estebsari et al., 2018; Centers for Disease Control and Prevention, 2021; Joosten et al., 2017).

The best practices were comprised of recent, relevant, and helpful nursing practices, methods, interventions, procedures, or techniques that are based on high-quality evidence to improve health outcomes (Ham-Baloyi et al., 2020). Best practices assist in providing guidelines to be used in the clinical settings and in practice to deliver the highest standard of care and delivery of healthcare.

Impact of Elder Abuse

The effect on elder abuse influences the quality of life and health outcomes of the older population. Elder abuse not only affects the individual, but also the family as well. The United States Department of Justice indicated that there is an increase of more than 30% on the number of elder abuse cases reported over the past decade (Hussemann & Yahner, 2019). Abuse increases the likelihood of developing mental health issues including depression and anxiety, physical health issues such as bone or joint problems, hypertension, and cardiac problems (Baker et al., 2017; Hussemann & Yahner, 2019).

Research demonstrated that older adults also have insufficient funds available to access services related to abuse, neglect, and financial exploitation (Hussemann & Yahner, 2019). Abuse has caused significant financial consequences in the society as it is associated with $5.3 billion in the national annual health expenditures (Hussemann & Yahner, 2019). The tragic implication of elder abuse has significant consequences on the costs of providing health, social, legal, police, and other services as a result (Baker et al., 2017). There is a direct correlation of abuse in older individuals associated with longer hospital stays, higher rates of accessing emergency services, and dependent on social welfare for the provision of care and security (Baker et al., 2017; Hussemann & Yahner, 2019).

Mandatory Reporting

Healthcare providers and personnel have legal responsibilities to report suspected cases of abuse in the elderly population. Healthcare workers are held to a level of standard under state and federal laws to evaluate and report abuse when abuse is identified or suspected (NAMR, 2022). Identifying abuse victims and reporting the abuse to appropriate authorities has been a requirement to practice. Providers have legal obligations to initiate screening in the practice settings to assess for at risk and suspected individuals of abuse. It is mandatory for providers to report abuse to the appropriate authorities governed by law. Reporting should be reasonably and in good faith believing that such reporting of a patient will benefit or serve the public interest (Geiderman & Marco, 2020). The provider has a duty to protect the public from harm.

Screening

Preventative measures are focused on preventing abuse or further harm through early detection and management of abuse (Van Royen et al., 2020). Secondary prevention is defined as screening to identify diseases/conditions in the earliest stages, before the onset of signs and symptoms using testing, and preventing further harm (Centers for Disease Control and Prevention, n.d.). Key components of prevention focus on meeting the overall environmental health issues in the society, promoting awareness and education regarding health to the public, monitor environmental risks and situations, and implementing widespread surveillance to assist in the identification of health concerns (Centers for Disease Control and Prevention, n.d.). Examples of a secondary prevention measure are to initiate screening tools, programs aimed for counseling victims and caregivers regarding abuse, and providing legal protection and consultation (Van Royen et al., 2020).

Several healthcare settings have initiated a variety of tools to assist in the identification process. Current national guidelines such as the CDC, NARI, NIH, and the National Association

of Mandatory Reporters are considered for the implementation of an elder abuse screening measure at clinical settings. These screening tools have been successfully utilized for early detection and assessment of elder abuse (Nguyen et al., 2015; Simmons et al., 2020; Van Royen et al., 2020). Screening assist in the identification of risk factors, assessment of risks and harms, and to recognize the impact of abuse occurring in the elderly population (Pond et al., 2019).

Tools

EASI Screening Tool

Van Royen et al. (2020) performed systematic reviews using published articles derived from PubMed database, Cochrane, CINAHL, and Canada's Web of Science in identifying assessment tools used for elder abuse. Elder Abuse Suspicion Index (EASI) is a screening tool utilized by healthcare providers conducted as an interview process with a five to six item questionnaire to identify victims of elder abuse (Van Royen et al., 2020). The five items consist of identifying the level of general dependence of caregivers that are reported by the older individuals and the different types of abuse (Van Royen et al., 2020). One of the questions from the questionnaire are to be completed by the clinician in a yes/no format response (Van Royen et al., 2020). There is a sensitivity of 47% and specificity of 75% respectively (Van Royen et al., 2020). According to Van Royen et al. (2020), the study emphasizes the importance of developing and implementing effective interventions focusing on preventing and managing elder abuse. Limitations of the study includes the unavailability of EMBASE and Scopus databases to be utilized for the study and the need for more validated interventions for addressing elder abuse (Van Royen et al., 2020).

Nguyen et al. (2015) conducted 81,681 investigations of suspected cases in Texas related to abuse, neglect, and exploitation in elders 65 and older and has identified victims as being

white and female gender as risk factors. The main purpose of the study was to utilize the EASI tool in the primary care settings, to develop and implement elder abuse interventions, report characteristics of the findings on victims and perpetrators for those who are at-risk and abused, and to evaluate outcomes (Nguyen et al., 2015). Trained specialists assist with the training, provide technical support, facilitate communication, and educate individuals on increasing screening on elder abuse as preventative measures (Nguyen et al., 2015). Limitations of the study include time constraints and occasional clinicians' discomfort with Adult Protective Services as barriers to reporting (Nguyen et al., 2015).

Brief Abuse Screen for Elderly (BASE) Screening Tool

The Brief Abuse Screen for the Elderly (BASE) is a screening tool used to assess the risk of elder abuse that is conducted by telephone interview followed by home visit and evaluation by the multidisciplinary team in Canada (Van Royen et al., 2020). Health professionals must be trained to complete this tool in evaluating for the presence or absence of physical, psychosocial, financial abuse, or neglect (Van Royen et al., 2020). The validity of the tool was supported by significant correlations measurements and has a reliability of 0.91 and predictive validity from 0.89-0.91 (Van Royen et al., 2020).

Hwalek-Sengstock Elder Abuse Screening Tool

The Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST) is an instrument tool that is used to identify people who are at high risk and have a need for protective services (Van Royen et al., 2020). The tool is conducted by service providers through an interview using a five-item questionnaire measuring three forms of abuse including violations of personal rights or direct abuse, characteristics of vulnerability, and potential abusive situations (Van Royen et al.,

2020). The content and validity were conducted in the United States with reliability of 0.29 (Van Royen et al., 2020).

REAGERA-S Screening Tool

A qualitative study examined the effectiveness of administering a screening tool called REAGERA-S, which is a self-administered screening instrument used to identify elder abuse and experiences of abuse in acute hospital settings (Simmons et al., 2020). This tool consists of nine questions focusing on physical, emotional, sexual, financial, and neglect aspects of elder abuse (Simmons et al., 2020). The screening tool is conducted by providers (Simmons et al., 2020). Exclusion criteria were participants who have insufficient physical, cognitive, or language capacities to complete the instrument (Simmons et al., 2020). Sensitivity was 87.5% and specificity was 92.3% (Simmons et al., 2020). The study focused on improving healthcare responses to older victims of abuse and was conducted in Sweden (Simmons et al., 2020). Simmons et al. (2020) concluded that the REAGERA-S is recommended to be utilize in hospitals in the identification of elder abuse among the older adults. Limitation of the study includes the screening tool was conducted in the acute hospital settings and further evaluation on effectiveness of such tool to be incorporated into the primary care settings.

Best Practices

Interventions are essential in the management in reducing harm and complications related to abuse. Interventions should be designed to prevent elder abuse, neglect, and exploitation (Nguyen et al., 2015). Interventions were related to the knowledge of elder abuse, self-efficacy, social support, and health promotion (Estebsari et al., 2018). Educational interventions were effective in preventing elder abuse through empowering the staff and organization, promoting

social support services, self-efficacy, health promoting lifestyles, methods for removing barriers, and raising knowledge in elder abuse (Estebsari et al., 2018).

Preventative Strategies

The Centers for Disease Control and Prevention (2021) indicated interventions to prevent elder abuse which includes developing an understanding of factors that would places older individuals at risk for abuse and interceding to protect them from violence (Centers for Disease Control and Prevention, 2021). These interventions include clinicians providing active listening to older adults and their caregivers regarding their challenges and provide support and/or community resources, report suspected or abuse to local adult protective services (APS) or to law enforcement, utilize the National Center on Elder Abuse for assistance in locating state's reporting information, government agencies, and state laws, educate oneself and others on how to recognize and report elder abuse, learn how to identify the signs of abuse versus the normal aging process, provide caregivers support with referrals for respite care and adult day care programs, and encourage caregivers to seek help when needed (Centers for Disease Control and Prevention, 2021). Providing adequate education on elder abuse prevention such as the identification of risk factors will allow the providers to make informed decisions on care and management.

A scoping study conducted by the National Aging Research Institute found that many of the interventions aimed at preventing elder abuse were focused on establishing educational programs for staff (Joosten et al., 2017). Findings indicated strong evidence for interventions involving psychological and social support to older individuals who are at risk and abused (Joosten et al., 2017). The study concluded that interventions should take an individualized, tailored approach that targets the risk factors for abuse and the specific types of abuse

encountered by the individuals (Joosten et al., 2017). It should be individualized and centered on the specific needs of the older adult. Interventions include collaborating with members of the multidisciplinary team such as support services, provide legal counseling, assessment of individuals' needs, case management and advocacy, and motivational interviewing (Joosten et al., 2017). Nurse Practitioners provide comprehensive, holistically approach to meeting the patient's individual needs through advanced nursing theoretical frameworks, knowledge, and skills. Other interventions include embedding an APS specialist in the clinic settings to serve as an ongoing resource, train clinicians in screening and identification of abuse, administer the screening tools such as EASI into the workplace, follow appropriate protocols for reporting cases of actual or suspected abuse to APS, and refer caregivers to community programs like support groups (Nguyen et al., 2015).

Secondary Prevention

Secondary prevention focuses on thwarting further abuse or harm through early detection of abuse (Van Royen et al., 2020). Secondary prevention is defined as screening to identify diseases in the earliest stages, before the onset of signs and symptoms using testing and harm prevention (Centers for Disease Control and Prevention, n.d.). Key components of secondary prevention focus on meeting the overall environmental health issues in the society, promoting awareness and education regarding public health to the communities, monitor environmental risks and situations, and implementing widespread surveillance to assist in the identification of health concerns (Centers for Disease Control and Prevention, n.d.). Examples of a secondary prevention initiatives are measures to implement screening tools, programs aimed for counseling victims and caregivers regarding abuse, providing legal protection and consultation (Van Royen et al., 2020).

Barriers to Screening

A barrier for primary prevention is the lack of or insufficient education on the clinicians regarding the assessment and management of abuse. An important barrier to screening is the limited access and funding for in home services, which has decreased over the past five years due to state budget cuts and federal sequestration, reports of abuse to APS have increased (Hussemann & Yahner, 2019). Standardized screening tools have not been established across clinical settings. Staff compliance and costs are considered as challenges for the implementation of screening tools in practice. Although there may be local, state, and national resources established to assist the elderly population, there is limited services including legal assistance and consultations for at risk and abused older individuals available. The barriers presented challenges for the provider to provide the best quality of care for patients, limit restrictions to practice fully within the scope of practice, delayed in care and initiation of prompt interventions to manage elder abuse.

Evidence Gaps & Controversies

There is a gap in research related to the limitations of available high-quality synthesis evidence to assist decision-makers on the occurrence of abuse and the implementation of best practice models into clinical settings (Baker et al., 2017). Baker et al. (2017) conducted a Cochrane literature review on 12 platforms between 2015-2016 that included randomized controlled trials and have found that some of the study designs were yielding low quality evidence in its research regarding the effectiveness of proposed interventions associated with elder abuse (Baker et al., 2017). High-quality research in the prevention of elder abuse is in critical need and must be addressed to narrow the knowledge gap in practice (Baker et al., 2017;

Hussemann & Yahner, 2019). The diversity of screening tools also varies in the type of environment as some of the screening tools being utilized in acute versus primary care settings.

Project Aims

The DNP project is focused on implementing an evidence-based guideline for elder abuse screening at the project site. The overarching aim of this DNP project is to improve identification of victims of elder abuse, mitigate risks through education, improve communication between the patient and provider regarding this topic, and manage the abused victim within the timeframe of the project. Participants of the project include the nursing staff and providers in the gerontological clinic. National guidelines, state and local resources will be examined during the implementation process for best practices and standards of care. Evaluation will be measured for effectiveness and efficiency within 5 weeks after implementation of the screening guidelines.

Project Objectives

The following objectives will be met within the timeframe of the DNP project:

1. Implement an evidence-based screening protocol for elder abuse based on national guidelines to be introduced to the participants of this project through an educational presentation.
2. Participants will comply with the elder abuse screening protocol 100% during the implementation phase as measured through chart audit review.
3. Improve provider knowledge regarding elder abuse, risks, professional/legal obligations regarding abuse, and mandatory reporting process to be measured through feedback and reflection.

Implementation Theoretical Framework

Theories are utilized to provide holistic care, impacting the person's physiological and psychological wellbeing, and the quality of life (Dwyer et al., 2017). The Donabedian method is

a quality improvement framework that is commonly used in the healthcare settings. The model uses complex, multi-dimension aspects of health services that focuses on the structure, process, and outcomes (Dwyer et al., 2017). These components of structure, process, and outcomes represents the aspects of the healthcare supply chain in which it has been extensively used to evaluate the quality of care delivered and performance (Dwyer et al., 2017). The Structural element examines how the care is organized and characteristics that impact the ability of the healthcare system to meet the needs of delivery of care (Dwyer et al., 2017). Process refers to analyzing the character of the practice environment and the nature of the activities that is providing care (Dwyer et al., 2017). The Outcome described the impact of the nursing care on health (Dwyer et al., 2017).

The Donabedian model described that good structure increases the chance of good processes, which will lead to increase in good outcomes (Dwyer et al., 2017). Each of the elements demonstrates having a synergistic relationship in the evaluation of healthcare quality as one system affects the effectiveness of the whole system (Binder et al., 2021). This framework was chosen for the explanation, justification, and guidance for implementation of interventions for the proposed project on quality improvement in the healthcare system. The model will be utilized for the research design, data collection, and analysis on the evaluation of the relationships between structure, process, and outcomes specifically for the project related to the assessment, screening, and management of elder abuse in practice (Dwyer et al., 2017).

Historical Development of the Theories

The Donabedian framework was created by Avedis Donabedian, a medical doctor and professor emeritus at the University of Michigan (Berwick & Fox, 2016). He addresses methodology and governance during his professional career that began in 1948 at the American

University of Beirut (Berwick & Fox, 2016). The Donabedian model was introduced in his seminal 1966 article in *The Milbank Quarterly*, for prioritizing governance and management, supported by measurement as determining the causes on the effectiveness and efficiency of healthcare services (Berwick & Fox, 2016). The framework focuses on patient-centeredness, impact on both risks and possibilities for care and health, seeing the healthcare as a system, and an understanding the medical care process itself (Berwick & Fox, 2016). He proposed a conceptual framework for an 'epidemiology of quality' that would assess populations of providers and clients using 'time, place, and person' (Berwick & Fox, 2016). He stated that governance matters to measuring and improving the quality for populations because structural attributes affects how and by whom the care is delivered and will become the measurements of the quality of care (Berwick & Fox, 2016). The Donabedian's work is still significantly relevant for healthcare quality movement on the organizational concepts involving structure, process, and outcomes (Berwick & Fox, 2016).

Application of Major Tenets to the DNP Project

Structure

The structural element of the framework can assist in the implementation and its impact on the provision of healthcare services to implement a screening protocol that is timely, responsive, and acceptable through early detection, assessment, and intervention for the suspected individuals of abuse (Dwyer et al., 2017). Structural measures described the characteristics of space where the care occurs such as the architecture and available of equipment (Binder et al., 2021). Measures include the presence of an elder abuse hotline available at the site (Binder et al., 2021).

For the Structural dimension of the framework, when the elderly individual is screen positive, suspected, or at risk of abuse in the organization, the Donabedian model supports the provider to intervene early and facilitate referrals in the clinic through contacting local resources (Dwyer et al., 2017). This will guide the provider to promptly report the suspected or at-risk individual for further assessment and evaluation of the abuse to the proper authorities. Structural measures include providing clear communication on the assessment findings, related diagnosis, plan of care, treatments initiated, and referrals to the authorities (Dwyer et al., 2017). Providers can also liaise with the senior leadership team or other clinicians for immediate directions of treatment and recommendations especially in emergency situations where safety poses a concern for the victim (Dwyer et al., 2017). The elder abuse prevention hotline serves as a valuable resource to provide for a reference for patients and caregivers to seek assistance related to abuse.

Process

The Process framework described how the staff and providers will respond and intervene early through equipped knowledge with the ability to detect abuse and coordination of care (Dwyer et al., 2017). Process measures include the delivery of care to patients, practice referrals, and clinical reasoning and decision making (Binder et al., 2021; Oostendorp et al., 2020). Measures include initiating screening in place for patients and staff to be implemented at the site for detecting abuse (Binder et al., 2021). Mandatory reporting process will be considered for those who are screen positive and suspected of abuse. The provider will choose who to refer the victim to once she or he has been identified. Having the knowledge on what and when to refer individuals and developing interpersonal trust between staff and providers will influence the decision for the referral to appropriate authorities (Dwyer et al., 2017).

The Process components of the model consists of the referral procedure by the staff and providers (Dwyer et al., 2017). Providers will decide to make the referral or transfer the individual directly to other community resources including transferring to the nearest emergency department (Dwyer et al., 2017). The referral process focuses on timely referral and response based on the identified needs of the individual (Dwyer et al., 2017). During this process, contacting the appropriate authorities such as law enforcement or Adult Protective Services is mandated (Dwyer et al., 2017). Establishing priorities are evidently relevant by the staff to triage the referral process by bringing the attention to the providers when the abuse is suspected (Dwyer et al., 2017). Concerns regarding the health and safety of the abused individuals is the main priority in seeking immediate interventions. This is an important consideration as to not delay care to the individual seeking care and treatments (Dwyer et al., 2017).

Outcomes

Outcomes represent the consequences of the healthcare services provided and the impacts on the individual's health, family, and the quality of life (Dwyer et al., 2017). Outcome measures describe the effects of healthcare on populations (Binder et al., 2021). Abuse affects the quality of health in abused individuals as well as the relationships between family members and caregivers. Measures include the number of patients being evaluated in the clinic, return visits, complications resulting from the abuse, and patient's level of functioning (Binder et al., 2021; Oostendorp et al., 2020). Level of satisfaction can be evaluated from the individual, providers, and staff related to the perceptions of the quality of care provided and the timely manner to respond to the needs of the victimized individual (Dwyer et al., 2017). The level of satisfaction is measured based on the time taken to conduct a thorough assessment of the abuse on the victim, collaboration or consultation with other staff and clinicians, and developing a collaborative plan

of care/action (Dwyer et al., 2017). The desired outcomes can also be influenced by the impact on responding, service delivery, and the availability of healthcare resources to manage abuse in the setting (Dwyer et al., 2017).

Providers have the advanced assessment skills and the legal obligations to report abuse to the appropriate authorities and initiate referrals once the abuse is screen positive or suspected. The facilitation on early assessment and prompt response will influence the level of quality of care (Dwyer et al., 2017). Increasing the knowledge and emphasizing interprofessional collaborations are essentials for the implementation process at the project site to improve the quality of life regarding abuse.

Population of Interest

The direct population of interest that will be involved in the implementation process for the project at the site includes four medical assistants, two front desk receptionists, a clinic manager, four primary care providers which includes a doctoral-prepared advanced nurse provider, two Medical Doctors (MD) and a Doctor of Osteopathic Medicine (DO), two gerontologists consist of a MD and DO, and four rheumatologists consists of a MD, a DO, and two Physician Assistants (PA) ("About Us," n.d.).

Inclusion criteria of the direct population of interest includes the staff and providers in primary care, gerontology, and rheumatology departments at the site. Full-time and part-time staff and providers will participate in the project. Exclusion criteria includes the scheduler and medical and nursing students.

The indirect population of interest includes the elderly population being seen in the clinic. Inclusion criteria includes patients who are at least 65 years old and older. Exclusion criteria includes patients who are less than 65 years of age.

Project Setting

The project will take place in a local health clinic that specializes in primary care, geriatrics, and rheumatology. The health center is located within a private educational institution in Henderson, Nevada. The clinic also has affiliations with local hospitals and clinics in the surrounding valley.

The practice site is a not-for-profit organization, meets the healthcare needs of the community, and provides training for future healthcare professionals. Staff includes medical assistants, front desk receptionists, the clinic manager, primary care providers, gerontologists, and rheumatologists. The practice is focused on providing primary and family care with other specialties in gerontology and rheumatology. The project will take place in the primary care department with gerontologists for expert consultation if needed. Providers generally see two to four patients in an hour and work five to eight hours per day. The site utilizes an electronic medical record (EMR) called Allscripts.

Stakeholders

Stakeholders play a vital role involving the development and implementation process of the project interventions and can provide overall support for the proposed changes. For this DNP project, stakeholders include the clinic manager, staff, healthcare providers, and the leadership/administrative team of the organization. The clinic manager handles the financial data and day-to-day administrative tasks for the clinic. The clinic manager will assist in approving the resources involving the needs of the DNP project. Staff and providers will be participating in the implementation of interventions at the project site. Leadership and the administrative team approved the DNP project as well as aiding in meeting the learning objectives of the project at the site.

This project will impact the stakeholders and the organization as the project will assist in the identification and management of at risk and suspected individuals of abuse, provide safety, and promote the quality of care to the geriatric population at the site. The evidence-based screenings for elder abuse performed will provide early recognition and appropriate referrals, which will assist in promoting positive outcomes for this population. The staff and providers will also improve the knowledge and skills in conducting assessment and management of at risk and suspected individuals experiencing abuse. The project will promote the care and services to assist those at risk and abused victims of abuse in the elderly population.

Interventions

Educational Presentation

An educational teaching presentation will be provided for the staff and providers at the clinic site. The educational session will focus on the prevalence, types of abuse, the risk factors, clinical manifestations, management, and current practices and regulations regarding elder abuse and violence prevention. The level of knowledge of the staff and providers are evaluated after the educational presentation through feedback and reflection. The educational presentation will be presented on the first day of the implementation process (Appendix A). The presentation will be handed out on printed flyers (Appendix B) and a scheduled discussion session. The Elder Abuse Suspicion Index (EASI) tool will also be presented to the staff and providers during the educational presentation. Staff and providers will be provided instructions on when and how to administer the tool at the clinic site.

The details of how to administer the tool includes instruction regarding a positive screening and the referral process for community resources available will be discussed. Should the patient answered, ‘Yes’ for the question, “Are you in danger either from yourself or someone

else?" during the clinic visit, the staff will alert the providers to complete the EASI screening tool for the next step of the implementation process. This question is in the patient's charts with every doctor's visit regardless of the chief complaint or main reason for the visit. If the patient answered, "No" to the question, "Are you in danger either from yourself or someone else?" during the clinic visit, the EASI tool can still be utilized based on the discretion and clinical judgment of the provider, especially if there is suspicion of abuse and violence.

Planning Project Team

The Doctor of Nursing Practice (DNP) Project Team includes the DNP student as project lead, who will facilitate and present the educational training to staff and providers, Project Mentor will oversee, recruit staff/providers, and provide support, the clinic manager will provide support if needed such as scheduling a meeting with stakeholders, medical assistants from the departments who will provide the screening tool for the patients to complete, and providers including gerontologists, primary care providers, and rheumatologists at the clinic will review the EASI screening tool and refer to appropriate authorities. The project lead and Project Mentor will carry out the functions of the project. The Project Mentor and the clinic manager will be coordinating the functional operations of the project at the clinic. Specialty providers will be experts for consultation if necessary.

Project Resources

National guidelines and local, state, and national guidelines and regulations will be utilized for the implementing the educational presentation. The clinic site's policies and procedures manual will be reviewed as reference. The DNP Project Lead will establish the educational presentation utilizing online Microsoft database and provide printed materials including pamphlets and flyers to be distribute to the staff and providers. The DNP student and

the Project Mentor will be providing the educational materials to the staff and providers. The health center's informational department may be consulted for the screening tool to be implemented into the electronic health record if the clinic site decided to implement into practice after the completion of the implementation of the DNP project. There is no cost at the clinic site for the implementation process of the project.

Implementation Timeline

The implementation process of the project will take place over 5 weeks (Appendix C). The first week will consist of a presentation on elder abuse on identification, risk factors, and management to staff and providers and begin to use the EASI screening tool. Chart audits will be performed randomly on 100 patients prior to the implementation for obtaining baseline data for comparison. There will be weekly site visits to assist, address any questions, and provide support to the staff and providers as needed.

Week 1 (10/31/22-11/06/22)

- Day 1: Present educational presentation on elder abuse on identification, risk factors, and management to staff and providers. Flyers/pamphlets will be distributed.
- Day 1: Introduce the utilization of EASI tool.

Week 2 (11/07/22-11/13/22)

- Day 1-7: Continue implementing the EASI tool.

Week 3 (11/14/22-11/20/22)

- Day 1-7: Continue implementing the EASI tool.

Week 4 (11/21/22-11/27/22)

- Day 1-7: Continue implementing the EASI tool.

Week 5 (11/28/22-12/06/22)

- Day 1-7: Continue implementing the EASI tool.
- Day 7: Chart audits will be performed randomly on 100 patients after intervention for data collection.
- Day 7: Obtain feedback, self-reflections, and any future recommendations from stakeholders, staff, and providers regarding implementation.

Tools

Elder Abuse Suspicion Index (EASI) Screening

Preventative measures including training personnel to report elder abuse characteristics for those who are at-risk and abused, provide technical support, facilitate communication, and educate on screening measures of abuse (Nguyen et al., 2015). The Elder Abuse Suspicion Index (EASI) tool is an established tool that has been utilized for screening for elder abuse. It has been validated in previous study and expert consultations ("Development of Best Practice Protocols," n.d.). This tool assists in the early detection/identification of at risk and suspected abuse and violence in the older adults' populations. It was developed to bring awareness about a clinician's suspicion about elder abuse and to assist in the clinical decision making on initiating the referral for further evaluation by social services or adult protective services ("Development of Best Practice Protocols," n.d.). The tool serves as a guide for clinical decision making for the clinician. The tool allows the clinician to assess for concerns related to safety and abuse in cognitively intact older adults commonly seen in the ambulatory settings ("Development of Best Practice Protocols," n.d.) (Appendix D).

The EASI tool was validated for face-to-face enquiry by family physicians for patients, who are ages 65 and older, with a Folstein Mini Mental Status Examination score of at least 25 ("Elder Abuse Suspicion Index," n.d.). Yaffe et al. (2008) developed and validated the EASI tool

to improve physician identification of elder abuse (Brijnath et al., 2020). The tool is utilized to raise a healthcare provider's suspicion about elder abuse at a reasonable level to propose referral for further evaluation by social services and adult protective services (Brijnath et al., 2020). The focus is on addressing neglect, coercion, physical abuse, and verbal abuse (Brijnath et al., 2020). Advantages of using this tool are involving the provider into the screening to increase understanding of the context of the abuse and the knowledge of the individual, inclusion on neglect and financial abuse, brief descriptor of elder abuse indicators, and the average time of administration taking less than 2 minutes (Brijnath et al., 2020). Limitations of the tool include the completion of the last question of the tool by the healthcare provider and older adults who have cognitive impairment (Brijnath et al., 2020).

The EASI tool consists of five categories that identifies the different types of abuse and the level of general dependence of the caregivers reported by the older individuals (Van Royen et al., 2020). There is a sensitivity of 47% sensitivity and specificity of 75% (Van Royen et al., 2020). Questions are formatted in a yes/no responses in the first five questions that are self-reported by the older individual. Question six must be completed by the clinician who is reviewing the results of the questionnaire. A "Yes" responses to one or more of the questions should establish concern ("Development of Best Practice Protocols," n.d.). Based on the responses and the clinical discretion of the clinician, referral to appropriate authorities and resources are mandated necessary for the management of elder abuse and violence.

Permission to conduct the DNP project at the project site was approved from site's clinic manager (Appendix E). Since the site is an educational institution, there is no affiliation agreement required between the university and the project site. There is no permission needed to

perform the DNP project at the clinic site. Single copies of the EASI tool may be reproduced for individual practice use ("Elder Abuse Suspicion Index," n.d.).

Chart Audits

Chart audits will be conducted by the project lead and the Project Mentor (PM) utilizing the clinic's electronic health record, Allscripts, for 100 patients after the implementation process (Appendix F). The database will be used to perform data analysis and collection from the primary care clinic, gerontology, and rheumatology departments. The measurements will include the number of patients' charts that screen 'Yes' utilizing the screening tool and the level of compliance from the staff and providers for referral to appropriate community resources.

Plan for Data Collection

The educational presentation will be conducted by the DNP Lead, who will be supervised by the Project Mentor and clinic manager. Staff and providers may consist of primary care providers, gerontologists, rheumatologists, osteopathic medicine providers, medical assistants, and front desk receptionists. The clinic manager will inform the staff through emails and verbal reminders to staff and providers regarding the time and location of the educational presentation. Data collection will be obtained through chart audits review.

Elder Abuse Suspicion Index (EASI) Screening

The Elder Abuse Microsoft PowerPoint Presentation will be recorded by the Project Mentor during the presentation to be distributed through emails to the providers. Brochures will be distributed for staff and providers. The EASI screening tool will be printed out by the clinic manager and distributed by the front desk receptionists to be included with every patient chart during the admission process when checking patients in (Appendix D). Patients will also be informed to complete the EASI tool. Once the patients and providers complete their sections of

the EASI tool, the tool will be scanned into the patients' charts for review. Hard copy of the tool will then be scanned into the patient's individual charts for reference and validation purposes if needed. If patients refused to complete the tool, a documentation is stated on the tool when scanned into the chart.

Chart Reviews

Chart reviews will be completed during the fifth week of the implementation timeline to measure the level of staff compliance on utilizing the EASI screening tool after interventions. Data collected will include the number of patients screened using the EASI tool and if prompt management was initiated including referring to appropriate authorities if screened positive on the screening tool. Meanwhile, to protect privacy and confidentiality, an alpha-numeric code will be used in place of patients' names and health record identification number to avoid direct identification of health information. There will be 100 total chart audits to be completed. The clinic manager and the Project Mentor will randomly select these 100 charts on the Allscripts electronic health records and provide data for the Project Lead to review for analysis. The data collected from the chart review will also be protected by storing in a password protected Excel file.

Participation Privacy

The confidentiality of the participants will be always maintained during the implementation process as no identified markers will be disclosed. The confidentiality of the patients' medical health records will be maintained through designated alpha numerical code indicated for chart audits review starting from 001, 002, 003, etc. as to avoid directly identifying the markers and characteristics of the patient's population. The clinic's Allscripts EHR will be utilized for conducting chart audits review. The plan to protect the participants' privacy is

enforced by placing restrictions on limiting access only by the DNP team project team including the Project Lead, Project Mentor, and clinic manager with secured access to the Allscripts' EHR database. The access will only be accessible during the clinic site to limit unrestricted access from unauthorized users and in unsecured locations.

Data Storage

The plan to secure project data information is in a Microsoft Excel worksheet for documenting the number of chart audits performed. Data storage will require password secured sites to prevent unauthorized user access. The access will only be conducted directly on the clinic's computers at the site to prevent unauthorized access from unsecured locations. The password access is protected by individual's login and will only be assessable by the Project Lead.

Plan for Data Analysis

Screening Compliance

A Chi-Square Test will be utilized to analyze provider compliance utilizing the elder abuse screening protocol. Data are randomly sampled in the Allscripts EHR database. The objective is to compare the staff and providers' level of compliance on the EASI screening guideline after the educational presentation that was implemented by conducting chart audits on the amount of EASI screening tools being utilized.

Chart Audits

Descriptive Statistics Test will be utilized to determine the percent of patients screened using the EASI tool, and if appropriate referrals were initiated if screened positive. Chart audits will be examined by the number of patients being screening using the EASI tool during the implementation process.

The objective is to increase elder abuse screening compliance using the EASI tool by 100%. Assumption will be that of the patients who screened positive, there will be prompt referrals initiated due to the utilization of the EASI tool after the implementation. Referral resources will be initiated to Adult Protective Services, Social Services, and Law Enforcement if in immediate danger. The SPSS software will be utilized for data analysis.

Ethics/Human Subjects Protection

Participants

Participants will be recruited by the Project Mentor and clinic manager. The Project Mentor and clinic manager will initiate collaboration and recruitment measures with at least one medical assistants and providers from the gerontology and rheumatology departments, and front desk. Participants will be required to utilize the EASI screening tool during the five weeks timeframe of the implementation process.

Confidentiality of the participants and patients will be maintained through utilization of designated alpha numerical coding values. Benefits and risks of the participants are disclosed during the initial week of the implementation process. The benefits include the advancement of knowledge and management of elder abuse, improve screening skills, and aiding in making a positive difference in the lives of the older adult's population through early detection, assessment, and intervention. There are no associated risks to the participants and patients. There is no monetary compensation for the participants or patients. Meals will be provided at the expenses of the Project Lead.

Ethics and IRB Process

To maintain compliance with Touro University of Nevada's policy related to ethics and compliance of the Institutional Review Board (IRB), a determination form was submitted for

review and was determined by the project team to be a Quality Improvement (QI) project. Since the project utilizes a QI design based on published best practices and does not involve direct patient care or human subjects, it was determined that the project will not require IRB oversight.

The project site is a health center located within the Touro University institution and does not require an IRB or QI committee for oversight.

Analysis of Results

Data were analyzed using descriptive statistics test and Chi-square testing. Assumptions for the descriptive statistical tests are based on normal distribution and random sampling. Samples are categorized as determined on numerical value of every fourth value out of the 394 total samples to obtain the 100 chart audits. Confidence interval was at 95% with p-value of 0. 005. To ensure violations are prevented and handled accordingly, duplicate counts are excluded through the sampling populations for both statistical tests.

For descriptive statistics testing, 'Positive Cases for Elder Abuse' are determined as 'YES,' 'Nope,' and 'N/A,' categories. Criteria of the EASI tool that is considered for 'Positive' must meet at least 1 out of the 6 questions answered from the questionnaire as demonstrated in the tool. Missing data may include the last question #6, which must be completed by the provider for validity. Based on the analysis using descriptive statistics, there is 54% of the screening for answering 'Yes' and 46% of the screening for answering 'No.' For the 'Positive Cases for Elder Abuse,' there is two positive screening who answered 'YES,' 52% for 'Nope,' and '46% for 'N/A,' (Appendix H). The utilization of the EASI tool was at 35% as compared to the 65% who did not use the EASI tool. There were 100% validation of the statistical data. No missing data were found on the descriptive statistical test.

Chi Square Test for Independence was used to determine the level of providers' compliance with the use of the EASI tool. Assumptions are based on independent observations and random sampling. The variables are categorized based on 'Screening for Elder Abuse (Yes/No)', 'Positive Cases for Elder Abuse (YES/Nope/N/A)', and 'Use of EASI Tool (USED/NOT USE).' There are 54% that were screened, 46% screened as N/A, and 2 individuals who were screened positive. Confidence level was at 95%. Pearson Chi-Square is at 100.00 with n = 100 charts, *phi* = 1.000 and the Cramer's v = 1.000. The significant level (2-sided) was at <0.001, which indicated that there is a significant association between those who were screened and those who were positive (Appendix H). To measure the level of compliance, the results indicated that staff and providers were 35% compliant with using the EASI tool as compared to 65% for those who are not compliant when using the EASI tool (Appendix H). Pearson Chi-Square is at 46.999 with N=100, *phi* = 0.686 and Cramer's v = 0.686. The significant level (2-sided) was at <0.001, which indicated that there is a significant association between those who were screened positive and with the use of the EASI tool (Appendix H). For positive screening, 54% were screened as compared to the 46% were not screened. Out of the 100 chart audits, 2 individuals were screened positive. Statistical values were valid 100% with no missing data values.

Interpretation of Results

The first objective for this DNP project was to implement an evidence-based elder abuse screening tool. This objective was met through an introduction of an educational presentation introduced to staff and providers at the project site. There was an increased in staff and provides' participation of the educational presentation.

The objectives for the percentage of patients who were screened was partially met. The percentage of screening was achieved at 54% who were screened after the implementation process of the project. There were 46% of those who were not screened, for a cumulative percentage of 100%.

The second objective was that participants would be 100% compliant using the EASI screening tool. This objective was not met. The results indicated that only 35% of the staff and providers were compliant with the utilization of the evidence based EASI tool.

The final objective was to improve the staff and providers' knowledge related to elder abuse, risks, professional/legal obligations, and the mandatory reporting process. This objective was met through the staff and providers' feedback as demonstrated. Participants were able to verbalize understanding of their knowledge of elder abuse was increased regarding the identification on the types of abuse, risk factors, and proper management through prompt referrals to appropriate authorities. Additionally, participants were able to access local and national resources on the reporting process of suspected and at risks older individuals with abuse with the flyers that were distributed during the educational presentational session.

The advantages of using this evidence-based tool were the collaboration between the provider and staff when utilizing and integrating the screening tool into the clinical setting and to increase understanding of elder abuse (Brijnath et al., 2020). The next outcome was to identify at least one positive cases of elder abuse using the EASI tool, with results identifying at least two positive screening using the EASI Tool. Prompt referrals were initiated to appropriate authorities (Elder Abuse Protective Services).

The simplicity and feasibility of the EASI tool of the project can be implemented into the project site. Due to positive findings from the utilization of the EASI tool, it would be beneficial

to continue using the evidence-based tool to promote positive outcomes and increased screening for those older individuals who are at risk for elder abuse in the primary care setting. The costs and benefits are both equally distributed. No modifications to the original timeline plan were necessary.

The results for dissemination will be to the DNP Project Team, stakeholders, clinic manager, staff, and providers in March 2023 and as part of Touro University Nevada's Research Day on March 08th, 2023. The DNP project can be considered for local and national submission for research repository and plan for submission for further dissemination at conferences and associations.

Summary of Results

Out of the 100 chart audits reviewed, 54% were screened versus the 46% that were not screened. Out of the 54% sample that were screened, 2 individuals were screened positive. With the use of the EASI tool, 35% of participants were complaint versus 65% of participants were non-complaint. The older adults who screened positive were referred to appropriate authorities for proper management.

The strengths of the project include the several of the staff (front desk receptionists and medical assistants) who were compliant with the implementation process with scanning the EASI screening tool into the clinic's electronic health record for reference, several of the providers who utilized the EASI tool by completing the last question #6 of the questionnaire to complete the elder abuse screening as implemented, and the majority of the patients who completed questions #1-#5 of the EASI tool during the initial admission process by completing the screening questionnaire. Another strength of the implementation project was the ability to identify at least 2 individuals who were screened positive for suspected or at risk of elder abuse

using the evidence-based screening tool. These older individuals were immediately referred to the appropriate authorities for further evaluation and treatment.

The costs benefit to the organization was increased collaboration between the front desk receptionists, medical assistants, and providers during the implementation process. In addition, there is an increased in knowledge and awareness on the identification of the types of abuse, risks, management of local and national resources for elder abuse, and the importance of the EASI tool in the clinic setting after the implementation.

The weaknesses of the project include majority of the providers who were not compliant with completing the last question #6 of the questionnaire as implemented for the project to meet the completion of the EASI screening tool to ensure compliance, validity, and prompt follow up for referrals as anticipated. In addition, medical assistants were not following up with the providers to ensure completion of the EASI tool within the implementation process of the project.

Limitations

Limitations include time constraints of the project timeline with only five weeks for implementation and being employed at the site. The generalizability of the work may include staff have not had to screen appropriately and the workflow in the clinic. Efforts were minimized through having another staff member, the Project Mentor and Project Lead, being available and assist in providing the educational presentation and guidance to the staff.

Conclusion

Abuse of the elderly has increased. Unfortunately, cases of elder abuse are often missed, under-detected and underreported. Healthcare providers are often the first contact for those experiencing abuse and are mandatory reporters if elder abuse is suspected or occurring.

Healthcare professionals have a duty to protect the health and safety of the older adult populations. Preventative measures to address elder abuse include appropriate assessment and identification of risks, the utilization of screening tools for early detection and intervention, and prompt referral to local authorities.

This Doctor of Nursing Practice project integrated the use of an evidence-based screening tool into a health center specializing in primary and gerontology care with the goal to improve the identification, communication, and management of suspected and abused older adults. Post project analysis indicated that provider and staff knowledge regarding the risk factors, the various types, management, and referrals for elder abuse increased. After integration of the evidenced-based screening tool, post project analysis also revealed that assessment and identification of elder abuse increased.

The use of the EASI tool offered a feasible and sustainable process for screening and identifying elder abuse in a busy practice setting without adding significant costs or increasing staff workload. This project achieved improved elder abuse screening, therefore improving the health and safety of the clinic's older adult population.

Suggested next steps for the clinic include encouraging the continued use of the EASI screening tool in identifying and referring suspected and abused older adults. Development of an elder abuse policy is another important next step. This policy should establish mandatory educational updates for staff, clinic screening requirements, interval audit guidelines to follow clinic outcomes, as well as address the management, referrals, and follow-up requirements when elder abuse is suspected or found.

Implications of this project to nursing practice include enhancing the awareness and screening of elder abuse at the local, state, and national level. It also provides further evidence in

identifying which interventions are successful in screening and addressing elder abuse. It is those successful processes that should inform policy and legislation as it relates to elder abuse. Beyond mandatory reporting requirements, integrating mandatory screening processes for various healthcare setting and follow-up processes should be considered. It is these continued efforts, that will improve the health and well-being of our elder population.

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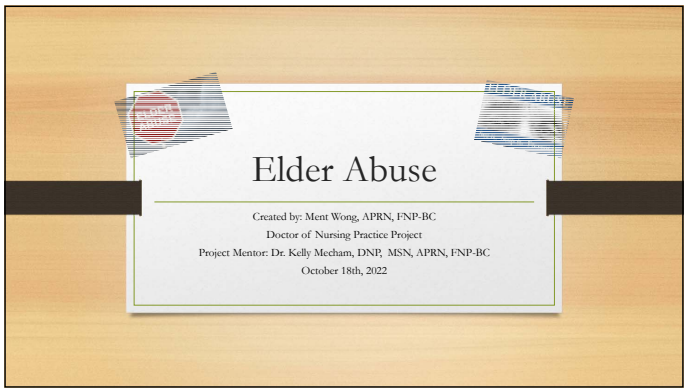
Appendix A

Educational Presentation

10/24/2022



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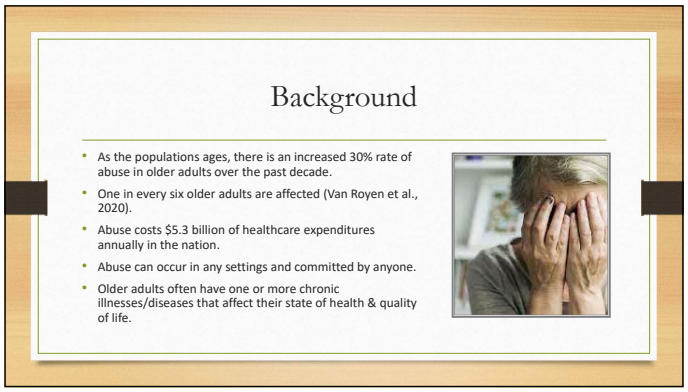

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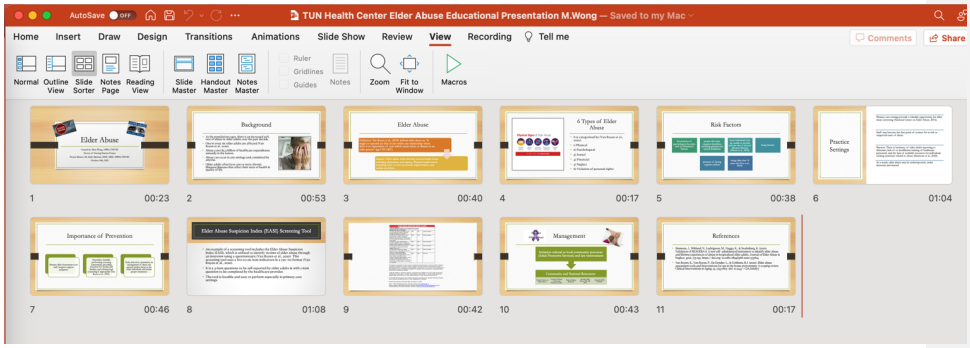
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TUN Health Center Elder Abuse Educational Presentation M.Wong — Saved to my Mac
Home Insert Draw Design Transitions Animations Slide Show Review View Recording Tell me
Comments Share
Normal Outline View Slide Sorter Notes Page Reading View Slide Master Handout Master Notes Master Ruler Gridlines Guides Notes Zoom Fit to Window Macros
Elder Abuse
Background
Elder Abuse
6 Types of Elder Abuse
Risk Factors
Practice Settings
1 00:23
2 00:53
3 00:40
4 00:17
5 00:38
6 01:04
Importance of Prevention
Elder Abuse Suspicion Index (EASI) Screening Tool
Management
References
7 00:46
8 01:08
9 00:42
10 00:43
11 00:17

Appendix B

Educational Presentation Flyer

Risk Factors for Abuse

Psychological disorders, physical and mental disabilities, inability for self-care due to chronic illnesses/diseases, female gender, cognitive deficits, and being older than 74 years old

Impact of Elder Abuse

Affects older individual and family members leading to physical and mental health issues:

- Depression and anxiety
- Bone or joint issues
- Hypertension
- Cardiac problems

6 Types of Elder Abuse

Physical, Psychological, Sexual, Financial, Neglect, & Violation

Project Objective

Improve knowledge of healthcare personnel regarding elder abuse screening

To enhance screening, reporting and management using an evidenced based screening tool.

Prevention Measures

- Risk Assessment tools and Caregiver support programs
- Performing screening assessments, providing

Elder Abuse Suspicion Index (EASI) Screening Tool

- Five Yes/No questions asked of the patient
- One Yes/No question asked of the provider
- Screening Areas:
  - Risk for abuse (1 item)
  - Abusive behaviors (5 items)

"The EASI was developed to raise a doctor's suspicion about elder abuse to a level for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of *Yes* on one or more of the questions 2-6 may establish concern. The EASI was

Reporting Vulnerable Adult Abuse

Nevada's Elder Abuse: (702) 486-6930 or (888) 729-0591

* If a vulnerable adult is in immediate danger, the local police, sheriff's office or emergency medical service should be contacted. If the person is not in immediate danger, the report should be made via one of the designated phone numbers.

Other Resources

National Center on Elder Abuse

National Aging Research

CDC

Created by: Ment Wong, APRN, FNP-BC
Touro University Nevada – Doctor of Nursing Practice (DNP) Program Spring 2022 Cohort
October 18, 2022
DNP Project Team: Project Mentor – Dr. Kelly Mecham, DNP, MSN, APRN, FNP-BC
Project Instructor – Dr. Heidi Johnston, DNP, RN, CNE

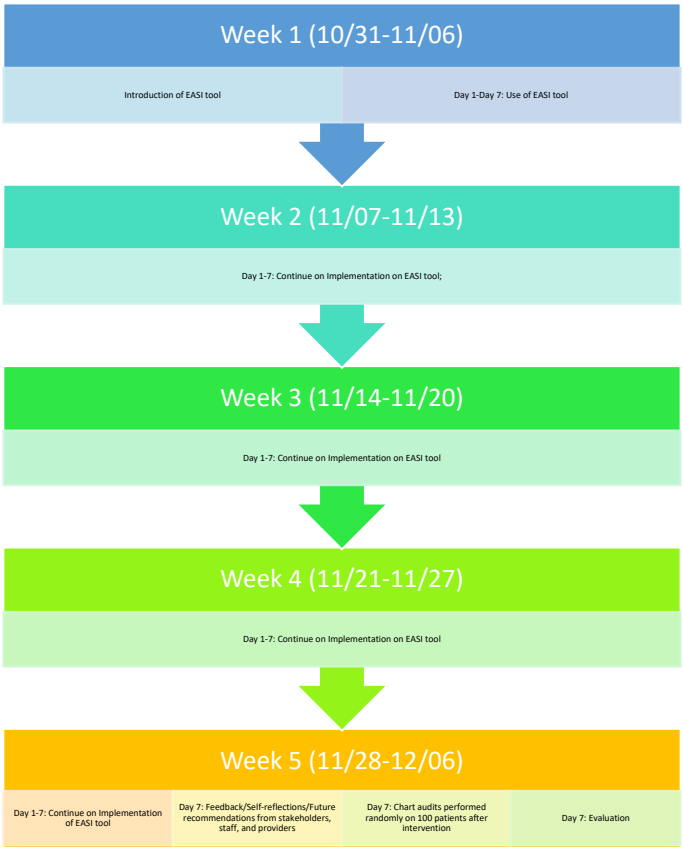
PROTECT SENIORS
Take a stand against **ELDER ABUSE**.
YEAR OF ELDER ABUSE PREVENTION

- An estimated 962 million adults aged 62 and older worldwide experience some form of abuse equaling 13% of the global population.
- Abuse costs $5.3 billion of national health expenditures annually
- Prevalence: 1 in every 6 older adults are affected
- The United States Department of Justice reported an increase in more than 30% of elder abuse cases over the past decade
- Only 1.4% cases of elder abuse are reported to Adult Protective Services by health care personnel
- **Healthcare personnel are mandatory reporters of elder abuse**

Field Code Changed

Appendix C

Implementation Timeframe



Appendix D

Elder Abuse Suspicion Index (EASI) Tool

ELDER ABUSE SUSPICION INDEX © (EASI)			
EASI Questions **Q.1-Q.5 asked of patient; Q.6 answered by doctor** **Within the last 12 months:**			
1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

The EASI was developed* to raise a doctor's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, adult protective services, or equivalents. While all six questions should be asked, a response of "yes" on one or more of questions 2-6 may establish concern. The EASI was validated* for asking by family practitioners of cognitively intact seniors seen in ambulatory settings.

*Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: The Elder Abuse Suspicion Index (EASI) ©. Journal of Elder Abuse and Neglect 2008; 20(3) 000-000. In Press. Haworth Press Inc: http: //www.HaworthPress.com

© The Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada) February 21, 2006. (Registration # 1036459).

Posted with permission from Mark Yaffee, November 17, 2009.

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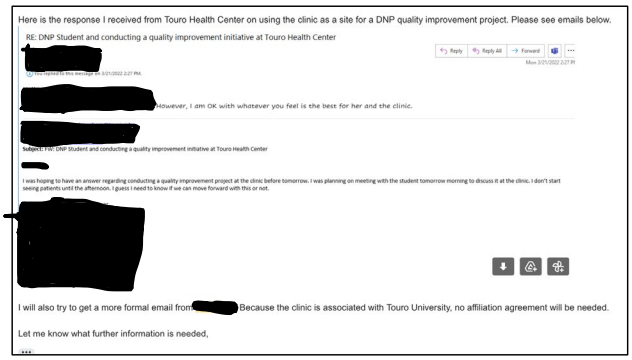
Appendix E

Permission at Site



Here is the response I received from Touro Health Center on using the clinic as a site for a DNP quality improvement project. Please see emails below.

RE: DNP Student and conducting a quality improvement initiative at Touro Health Center

[redacted] Reply Reply All Forward

Mon 3/21/2022 2:27 PM

[redacted] However, I am OK with whatever you feel is the best for her and the clinic.

[redacted]

Subject: FW: DNP Student and conducting a quality improvement initiative at Touro Health Center

[redacted]

I was hoping to have an answer regarding conducting a quality improvement project at the clinic before tomorrow. I was planning on meeting with the student tomorrow morning to discuss it at the clinic. I don't start seeing patients until the afternoon. I guess I need to know if we can move forward with this or not.

[redacted]

I will also try to get a more formal email from [redacted] Because the clinic is associated with Touro University, no affiliation agreement will be needed.

Let me know what further information is needed,

...

Appendix F

Chart Audits

Data Collection (STAFF/PROVIDERS'S COMPLIANCE)

Staff/Provider's Compliance

	Compliant	Not Compliant
Before	N/A	N/A
After	54%	46%

Data Collection: POST-INTERVENTION

Patient #	Screening Rates (Yes/No)	Positive Screening for Elder Abuse (YES/Nope/N/A)	Use of EASI Tool (USED/NOT USE)
001	Yes	Nope	NOT USE
002	No	N/A	NOT USE
003	Yes	Nope	USED
004	No	N/A	NOT USE
005	No	N/A	NOT USE
006	Yes	Nope	USED
007	Yes	Nope	NOT USE
008	Yes	Nope	USED
009	Yes	Nope	USED
010	Yes	Nope	USED
011	No	N/A	NOT USE
012	Yes	Nope	USED
013	No	N/A	NOT USE
014	Yes	Nope	USED
015	No	N/A	NOT USE
016	No	N/A	NOT USE
017	No	N/A	NOT USE
018	No	N/A	NOT USE
019	No	N/A	NOT USE
020	No	N/A	NOT USE
021	Yes	Nope	NOT USE
022	No	N/A	NOT USE
023	Yes	Nope	USED
024	Yes	Nope	NOT USE
025	Yes	Nope	NOT USE
026	No	N/A	NOT USE
027	Yes	Nope	USED
028	No	N/A	NOT USE

029	No	N/A	NOT USE
030	Yes	Nope	NOT USE
031	No	N/A	NOT USE
032	Yes	Nope	USED
033	No	N/A	NOT USE
034	Yes	Nope	NOT USE
035	No	N/A	NOT USE
036	No	N/A	NOT USE
037	Yes	Nope	USED
038	No	N/A	NOT USE
039	No	N/A	NOT USE
040	No	N/A	NOT USE
041	Yes	Nope	USED
042	Yes	Nope	USED
043	Yes	Nope	USED
044	No	N/A	NOT USE
045	Yes	Nope	NOT USE
046	Yes	Nope	USED
047	Yes	Nope	USED
048	No	N/A	NOT USE
049	No	N/A	NOT USE
050	No	N/A	NOT USE
051	Yes	Nope	NOT USE
052	Yes	Nope	NOT USE
053	No	N/A	NOT USE
054	Yes	Nope	USED
055	Yes	Nope	NOT USE
056	Yes	Nope	NOT USE
057	Yes	Nope	NOT USE
058	Yes	Nope	NOT USE
059	Yes	Nope	USED
060	No	N/A	NOT USE
061	No	N/A	NOT USE
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063	No	N/A	NOT USE
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065	No	N/A	NOT USE
066	No	N/A	NOT USE
067	Yes	Nope	NOT USE
068	No	N/A	NOT USE
069	Yes	Nope	USED
070	No	N/A	NOT USE
071	Yes	Nope	USED
072	No	N/A	NOT USE
073	Yes	Nope	USED
074	Yes	Nope	NOT USE

075	Yes	Nope	USED
076	Yes	Nope	USED
077	No	N/A	NOT USE
078	Yes	YES	USED
079	Yes	Nope	USED
080	Yes	Nope	USED
081	Yes	YES	USED
082	No	N/A	NOT USE
083	Yes	Nope	USED
084	Yes	Nope	USED
085	Yes	Nope	USED
086	Yes	Nope	USED
087	Yes	Nope	USED
088	No	N/A	NOT USE
089	No	N/A	NOT USE
090	Yes	Nope	NOT USE
091	Yes	Nope	NOT USE
092	No	N/A	NOT USE
093	Yes	Nope	USED
094	No	N/A	NOT USE
095	No	N/A	NOT USE
096	No	N/A	NOT USE
097	Yes	Nope	NOT USE
098	Yes	Nope	USED
099	No	N/A	NOT USE
100	Yes	Nope	USED

Appendix H

POST IMPLEMENTATION - DESCRIPTIVE STATISTICS TEST

Screening

		Value	Count	Percent
Standard Attributes	Label	<none>		
Valid Values	No		46	46.0%
	Yes		54	54.0%

Positive

		Value	Count	Percent
Standard Attributes	Label	<none>		
Valid Values	N/A		46	46.0%
	Nope		52	52.0%
	YES		2	2.0%

EASITool

		Value	Count	Percent
Standard Attributes	Label	<none>		
Valid Values	NOT USE		65	65.0%
	USED		35	35.0%

FREQUENCIES

Statistics

		Screening	Positive	EASITool
N	Valid	100	100	100
	Missing	0	0	0

Screening

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	46	46.0	46.0	46.0
	Yes	54	54.0	54.0	100.0
	Total	100	100.0	100.0	

Positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	N/A	46	46.0	46.0	46.0
	Nope	52	52.0	52.0	98.0
	YES	2	2.0	2.0	100.0
	Total	100	100.0	100.0	

EASITool

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	NOT USE	65	65.0	65.0	65.0
	USED	35	35.0	35.0	100.0
	Total	100	100.0	100.0	

POST IMPLEMENTATION – CHI SQUARE TEST FOR INDEPENDENCE
CROSSTAB – SCREENING & POSITIVE

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Screening * Positive	100	100.0%	0	0.0%	100	100.0%

Screening * Positive Crosstabulation

			Positive			
			N/A	Nope	YES	Total
Screening	No	Count	46	0	0	46
		% within Screening	100.0%	0.0%	0.0%	100.0%
		Adjusted Residual	10.0	-9.6	-1.3	
	Yes	Count	0	52	2	54
		% within Screening	0.0%	96.3%	3.7%	100.0%
		Adjusted Residual	-10.0	9.6	1.3	
Total		Count	46	52	2	100
		% within Screening	46.0%	52.0%	2.0%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	100.000[a]	2	<.001
Likelihood Ratio	137.989	2	<.001
N of Valid Cases	100		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is .92.

Symmetric Measures

		Value	Approximate Significance
Nominal by Nominal	Phi	1.000	<.001
	Cramer's V	1.000	<.001
N of Valid Cases		100	

CROSSTAB – POSTIVE AND EASITOOL

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Positive * EASITool	100	100.0%	0	0.0%	100	100.0%

Positive * EASITool Crosstabulation

			EASITool		
			NOT USE	USED	Total
Positive	N/A	Count	46	0	46
		% within Positive	100.0%	0.0%	100.0%
		Adjusted Residual	6.8	-6.8	
	Nope	Count	19	33	52
		% within Positive	36.5%	63.5%	100.0%
		Adjusted Residual	-6.2	6.2	
	YES	Count	0	2	2
		% within Positive	0.0%	100.0%	100.0%
		Adjusted Residual	-1.9	1.9	

Total	Count	65	35	100
	% within Positive	65.0%	35.0%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	46.999[a]	2	<.001
Likelihood Ratio	61.218	2	<.001
N of Valid Cases	100		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is .70.

Symmetric Measures

		Value	Approximate Significance
Nominal by Nominal	Phi	.686	<.001
	Cramer's V	.686	<.001
N of Valid Cases		100	