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A Study of emergency department nurses' attitudes toward the elderly and their knowledge of mistreatment

Vicki L. Christensen
San Jose State University

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**A study of emergency department nurses' attitudes toward the
elderly and their knowledge of mistreatment**

Christensen, Vicki Lynn, M.S.

San Jose State University, 1993

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Ann Arbor, MI 48106

A STUDY OF EMERGENCY DEPARTMENT NURSES'
ATTITUDES TOWARD THE ELDERLY AND THEIR
KNOWLEDGE OF MISTREATMENT

A Thesis
Presented to
The Faculty of the Department of Nursing
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

By
Vicki L. Christensen
May, 1993

APPROVED FOR THE DEPARTMENT OF NURSING

Susan Murphy, D.N.Sc., R.N.

Jean Sullivan, Ed.D., R.N.

M. J. Henderson, M.S., R.N.C.S., G.N.P.

APPROVED FOR THE UNIVERSITY

Serena G. Stanford

ABSTRACT

This thesis addresses emergency department nurses' attitudes toward the elderly and their knowledge of elder mistreatment. With the use of a three part questionnaire, a survey was conducted at three hospitals in a northern California community. Part I of the questionnaire established the nurses' demographic characteristics. The respondents' attitudes toward the elderly were measured using the Aging Semantic Differential in Part II. In Part III, five qualitative questions examined the nurses' knowledge of elder mistreatment.

The sample consisted of 21 emergency department nurses. This represented a 37.5% return rate. Results of the Aging Semantic Differential indicated that the emergency department nurses' attitudes toward the elderly were less positive, with a mean score of 109.79, when compared with their attitudes toward other age groups. There was no significant difference in attitudes toward the elderly among nurses from the three different hospital emergency departments.

The majority of emergency department nurses used both caregiver action and neglect of basic needs as criteria for determining abuse. Another finding revealed that suspected cases of elder mistreatment are not always reported. The majority of the respondents claimed to have reported some but not all cases of elder mistreatment; two nurses had never suspected any case of elder mistreatment; and one nurse had suspected numerous cases of elder mistreatment but never reported any victims, due to a lack of knowledge about the county authorities. These findings suggest a need for an intensive, county-wide education of emergency department nurses about elder mistreatment and the mechanisms necessary for reporting victims.

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Chapter 1

INTRODUCTION

For many years psychologists and sociologists have studied the process of human interaction (Martin & Clark, 1990). This process is complex and dynamic involving individual perceptions, evaluations, attitudes, stereotypes, and reactions. Research has documented evidence of societal influence on individual perceptions including attitudes toward the elderly (Block & Sinnott, 1979; Bookin & Dunkle, 1985). Steinmetz (1978) asserted that Americans' ageist attitudes permit the use of selective inattention to ignore the needs and issues that confront this nation's elderly. Research studies suggest that negative, ageist attitudes toward the elderly persist among the American people. Both individual and institutional behaviors tend to reinforce this phenomenon (Ferraro, 1990; Levin, 1988).

Problem

Elder mistreatment has been described as a "national disgrace" (U.S. House, 1985, p. 1). According to Representative Claude Pepper (1985) of Florida, Chairman of the House Select Committee on Aging, the term "elder abuse" did not exist prior to 1981 (p. iii). It is estimated that 2 million elderly individuals in the United States are mistreated each year (National Aging Resource Center on Elder Abuse [NARCEA], 1990a). Nevertheless, reported incidents of elder mistreatment elude enumeration for several reasons, including but not limited to the following: (a) the lack of a universal, conceptually operant definition of elder mistreatment; (b) the limited and exploratory nature of elder mistreatment research; (c) insufficient theoretical explanations of mistreatment; and (e) a complex set of subjective barriers to the reporting of mistreatment (Haviland & O'Brien, 1989; Hickey & Douglass, 1981; NARCEA, 1990b; Sayles-Cross,

1988). Findings from research suggest that negative attitudes among health care professionals toward the elderly may act as a subconscious obstacle toward detecting and reporting mistreatment (Hickey & Douglass, 1981; Phillips, 1983; Phillips & Rempusheski, 1985; Rathbone-McCuan, 1980; Reynolds & Stanton, 1983).

According to Phillips (1983), nurses have difficulty identifying the mistreatment of elders for the following reasons: (a) the lack of an operational definition, and (b) the bias of unacknowledged variables. The process of mistreatment detection is complicated by multiple intervening variables. Although the preferred method of detection is to match case findings to specific variables, Phillips and Rempusheski (1985) found that nurses were not able to ignore perceptual factors. These perceptual variables included: (a) perceptions about the caregiver's strength, knowledge, and health; (b) the elder's personality; and (c) personal attitudes, stereotypes, and values.

Elder mistreatment is a multifactoral phenomenon that includes a wide range of behaviors, situations, and experiences (Ashley & Fulmer, 1988; Haviland & O'Brien, 1989). Butler (1983) affirmed that "Abuse can be perpetrated or even worse, ignored, because of the negative attitudes directed toward the elderly in our society" (p. xi). Consequently, the negative attitudes of Emergency Department (ED) nurses toward the elderly may serve to undermine the identification and reporting of mistreatment.

Research Questions

This study examined the following questions:

1. What are the attitudes of ED nurses in a selected northern California county toward the elderly?
2. Does a significant difference exist in attitudes toward the elderly among the ED nurses employed at three different acute care

hospitals?

3. What are the criteria that ED nurses use to define elder abuse and/or neglect in this northern California community?

Background and Need

Attitudes influence how an individual thinks, feels, and acts toward others. A study by Levin (1988) provided evidence that attitudes toward the elderly remain unfavorable in this country. Negative stereotypes and attitudes have been shown to influence the behaviors of health professionals (Block & Sinnott, 1979; Bookin & Dunkle, 1985; Solomon, 1983). Negative attitudes and stereotypes toward the elderly have created a class system which results in one group being given more status than the other (Solomon).

Negative attitudes and stereotyping results in the practice of professional "distancing." Distancing, in this instance, is when the caregiver spends less time providing elderly patients with physical, emotional, or spritual care that may be required for a meaningful existence. If distancing becomes an acceptable practice, allowing health care professionals to justify spending less time with elderly patients, the patients may receive less nursing care. Moreover, this distancing may have an impact on the quality of nursing care provided for the elderly (English & Morse, 1988; Fulmer, 1989; Reynolds & Stanton, 1983).

Nurses have been found to make decisions based upon the personal characteristics of patients and their past experience with them (Zakay, 1990). English and Morse (1988) found that nurses chose interventions contingent upon labels assigned to the elders' perceived behaviors. Furthermore, Morgan (1985) reported that nurses' decisions about the elderly were dependent upon the individual's age and functional level.

Other researchers have suggested variables that may positively

affect nurses attitudes toward the elderly. Experience and educational level of the nurse appear to be positive factors. Baker (1984) found that routine contact with the elderly had a positive effect on health care professionals' attitudes. According to Bower (1985), advanced nursing education can positively affect nurses' attitudes toward the elderly.

The purpose of this study was to identify the attitudes of ED nurses in a northern California community towards the elderly. Results of this study may be helpful in designing a program to foster positive views of the elderly and to improve emergency department nurses' reporting of suspected elder mistreatment.

Definitions of Terms

The following terms were defined for this study:

1. Attitude is an affective or evaluative predisposition toward the elderly that is related to a belief or truth (Fishbein & Ajzen, 1975). A positive or negative predisposition is defined by the mean scores as determined by the Aging Semantic Differential tool (see Appendix A).
2. Emergency Department Nurse (ED) is a licensed registered nurse who is employed by a hospital and assigned to work in the emergency department.
3. Elderly are individuals age 65 years and older.
4. Level of nursing education is the highest level of academic nursing education achieved by a participant. For this study, these levels were identified as Diploma, Associate Degree, Baccalaureate Degree, and Masters Degree or above.
5. Elder mistreatment is the current terminology used to describe all forms of elder abuse and neglect (Fulmer & Ashley, 1989, p. 21).

6. Elder abuse is the unmet physical, psychological, or social needs that result from a caretaker's action (Fulmer & O'Malley, 1987).

7. Elder neglect is a caretaker's failure to provide adequate care based on established need (Fulmer & O'Malley, 1987). Neglect can be physical, psychological, or social in nature.

The relationship between attitudes of health professionals and effective care of mistreated elderly is complex and raises important concerns for nurses. This study begins to address this relationship, specifically in regard to emergency department nurses. The following chapter provides a more comprehensive review of the literature related to elder mistreatment and the third chapter explains the methodology used for this study.

Chapter 2

CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

The conceptual framework and literature review are presented in this chapter. First, the social psychological perspective of attitude formation and social interaction will be presented as the conceptual framework for this study. The literature review will be discussed in the second section and is divided into the following topics:

(a) Demographics of Aging, (b) Emergency Department Services and the Elderly, and (c) Elder Mistreatment Identification in Emergency Departments.

Conceptual Framework

The conceptual framework for this study is derived from the social psychological theories of attitude formation and social interaction. Attitude formation is a dynamic, fluid, internal process with multiple intervening variables, that predisposes an individual to specific behaviors. Attitudes are learned through the process of socialization and are subject to continuous evaluation and change. Attitudes that are generalized by experience over time can lead to stereotyping (Bem, 1970; Fishbein & Ajzen, 1975; Weatherley, 1973).

Beliefs are the primary cognitive foundation for construction of attitudes. The principle requisite of a belief is the establishment of a relationship between an object and some unique characteristic that is held as a truth. Beliefs, like attitudes, are learned and variable. At any given time, an individual is influenced by numerous unconscious beliefs that act as an internal frame of reference. This internal reference guides the individual's perceptual awareness of reality, which is a pictorial representation of the world. In addition, the individual's internal reference assists in defining and giving meaning to what is perceived. New experiences and information can challenge a

belief which may result in its transformation (Bem, 1970; Fishbein & Ajzen, 1975; Weatherley, 1973).

An attitude is automatically and simultaneously formed by and founded on a belief about an object. Attitudes are affective or evaluative in nature. Affective attitudes produce either positive or negative feelings toward an object. In contrast, a positive or negative analysis by evaluative attitudes determines the worth of an object. Any given attitude predisposes an individual's response toward an object; responses can be positive or negative. These responses are observable individual behaviors that act as a bridge between the cognitive frame of reference and the social environment (Fishbein & Ajzen, 1975; Weatherley, 1973).

Values are internal standards that give meaning to and establish an object's worth. An individual's identity, or self-concept, is defined by a dynamic, complex interrelationship among the personally defined set of beliefs, attitudes, and values. Although a self-concept, once defined, is relatively stable, it can change. It is the self-concept's ability to change that produces defensive behaviors and motivates the individual to use selective inattention or to suppress an uncomfortable or painful experience (Weatherley, 1973).

Human beings live in a social environment. As a result of this, they are required to learn socially acceptable beliefs, attitudes, and behaviors. Socialization is the learning process that is designed to assist in the acquisition of the skills. This learning takes place in the family, schools, organized religion, and work-place, and is further influenced by the mass media. Compliance, identification, and internalization are mechanisms to teach these social skills. Therefore, social groups act as the external frame of reference that is used by individual members for comparing and evaluating their beliefs, attitudes,

and values (Bem, 1970; Weatherley, 1973).

Humans, as social beings, continually interact with the environment and other beings. The sum of beliefs, attitudes, and values is the unique subjective experience which governs an individual's perception, interpretation, and response to a social encounter. Each experience reinforces, or challenges and changes, the individual's frame of reference. This reinforcement of an individual internal frame of reference is the tenet that leads to overgeneralization of a group's attributes. Although generalization provides cognitive order, overgeneralization is stereotyping which allows people to justify their prejudice and treatment of any specified group, such as the elderly (Bem, 1970; Riehl-Sisca, 1989; Weatherley, 1973).

Both nurses and elderly persons have attitudes based upon past personal and professional experiences. These behaviors are contingent upon and congruent with personal attitudes. Emergency Department nurses' assessments of the elderly may be affected by biased attitudes. Yet, before one can identify the relationship between ED nurses' attitudes and quality of nursing care, it is necessary to identify and describe the unique attitudes that influence ED nurses' responses toward the elderly.

Review of Literature

Demographics of Aging

The aging of the American population has been well documented. Since the turn of this century, the population of individuals age 65 and older has dramatically increased in both absolute numbers and in percentages. In 1900, 4.1% of the population was 65 years of age and older. In comparison, 11.9% of this nation's population was 65 years of age or older in 1985. As the mean age of the population increases this percentage will almost double. From the year 2010 to 2040 it is

expected that this group will increase from 13.8% to 21.7% of the total population (Longino, Soldo, & Manton, 1990; Sayles-Cross, 1988; U.S. Senate, 1988).

This aging trend is inversely related to the decline in birth rates and the decrease in both mortality and morbidity rates. Despite advancements in disease prevention and health services, the elderly experience more functional disabilities resulting from the body's aging process and they develop more chronic conditions. Consequently, the elderly tend to utilize more health services. In 1986, 3% of the gross national product was spent on elderly health services. This is projected to double by the year 2020 as the largest increase in the relative numbers of elderly persons, the largest consumers of health services, is expected to rise from 13.8% to 17.3% (Delunas, 1990; Ferraro, 1990; Longino et al., 1990; U.S. Senate, 1988).

The elderly live on fixed incomes and tend to be more impoverished than the younger population. The elderly often live below the established poverty rate. Social Security benefits provided 38% of the elderly's income in 1986. Women have greater longevity and receive less than one half the benefits of men. These data have significant implications for health services, particularly in the area of emergency services. There will be a demographic shift in the mean age of the population seeking emergency services. This shift will affect the delivery of care and refocus the role of the ED nurse (Andreoli & Musser, 1985; Longino et al., 1990; U.S. Senate, 1988).

Emergency Department Services and the Elderly

Research on the use of emergency services by the elderly has revealed several common characteristics. The elderly utilize the emergency department more than the younger population. In addition, the use of ambulance services increases with age (Ettinger, Casani,

Coon, Muller, & Piazza-Appel, 1987; Lowenstein, Crescenzo, Kern, & Steel, 1986). An explanation for this was proffered by Baum and Rubenstein (1987), "Of additional note in our study was the progressively increasing use of ambulance services with age, particularly the very elderly ... It presumably reflects older people's decreased mobility when sick as well as the more severe nature of their illnesses" (p. 403).

Elderly individuals most often present to the emergency department for the following conditions:

1. Medical conditions such as chest pain, respiratory distress, and urinary tract infections (Baum & Rubenstein, 1987; Ettinger et al., 1987).
2. Self-care difficulties such as falls, difficulties with activities of daily living, and poor food and fluid intake (Lowenstein et al., 1986).

During their visits, the elderly receive extensive and costly diagnostic evaluations and the length of stay is usually longer. In contrast to the younger population, the elderly are admitted to the hospital in greater numbers. Furthermore, the elderly tend to return to the emergency department with the same complaint and are misdiagnosed by the ED physician more often than the younger population (Baum & Rubenstein, 1987; Ettinger et al., 1987; Lowenstein et al., 1986).

The elderly who seek care in the emergency department present with multiple symptoms that complicate treatment. Acute medical conditions in the elderly are compounded by a variety of chronic diseases that manifest in this group. Other variables known to complicate emergency treatment of the elderly include economic, psychological, and social factors. The interrelationship of normal aging and disease related variables further complicates the evaluation

and treatment plan for the elderly in the emergency department (Kidd & Murakami, 1987; Lowenstein et al., 1986; Rahman, Salend, Liston, Lee, Dees & Morgan, 1989).

Emergency department nurses are trained to stabilize and transfer, or refer, the acute patient. This is in keeping with the medical model that attends to a patient's presenting illness and in so doing may misidentify, or ignore altogether, other significant factors. Due to multiple and often confounding variables, the elderly client maybe perceived to be difficult, complex, confused, and time consuming (Kidd & Murakami, 1987; Lowenstein et al., 1986; Rahman et al., 1989).

Both physicians and nurses hold attitudes toward the elderly that may influence care. Lowenstein et al. (1986) suggest that costly diagnostic evaluations for the elderly may result from ageist attitudes. Due to age and the complexity of disease processes in the elderly, physicians tend to order numerous, and often unnecessary, laboratory and radiographic procedures. Kidd and Murakami (1987) assert that negative attitudes toward the elderly affect the quality of nursing assessments and significant findings may be overlooked. Research findings revealed that a number of ED nurses acknowledged a personal bias toward the elderly which reflected past experiences with this group or a negative attitude regarding aging (Rahman et al., 1989, p. 315).

The nurses recognized the following variables that create problems for the elderly: multiple chronic health problems, lack of community-based in-home services, lack of family and friends, inadequate housing, inadequate health insurance, and low income. However, the phenomenon of elder mistreatment failed to be identified as a significant variable (Rahman et al., 1989).

Elder Mistreatment Identification in Emergency Departments

The ED has been sited as one of three public agencies most likely

to encounter victims of elder mistreatment. The literature suggests that ED nurses are in a crucial position to assess and report elderly victims of mistreatment (Fulmer, Street, & Carr, 1984; McDonald & Abrahams, 1990).

The nursing assessment of elder mistreatment victims is complicated. There are published profiles of situations and individuals at risk for perpetrating mistreatment of the elderly; however, there is not one specific type of person that can be classified as a perpetrator. Except for the elders with a high level of dependency, there is not one unique type of elder at risk for mistreatment. The situation is further complicated because no single specific familial relationship or caregiving situation has been associated with precipitating mistreatment. Identification of mistreated elderly requires an expanded awareness among nurses of this phenomenon and advanced assessment skills (Ashley & Fulmer, 1988; Delunas, 1990; Fulmer, Street, & Carr, 1984; Hamilton, 1989; Haviland & O'Brien, 1989; Hurst & Miller, 1986; Kosberg, 1988; NARCEA, 1990b; Pillemer & Finklehor, 1988; Podenicks, 1985).

The clinical presentation of mistreated elderly in the ED is subtle because the elderly rarely verbalize the incidence of mistreatment which complicates its detection. Another variable which also makes it difficult for nurses to identify mistreatment is the complex relationship between healthy aging and the disease process (Ashley & Fulmer, 1988; Fulmer & O'Malley, 1987; Hurst & Miller, 1986; Jones, Dougherty, Schelble, & Cunningham, 1988; Steinmetz, 1978). For example, an elderly person who is brought to the emergency department for treatment of a fractured wrist from a fall. If no physical reason for the fall is found, it is easy for the health professional to attribute this to aging and not question if the elder had been pushed, grabbed, or beaten.

Research findings on nurses' attitudes toward the elderly and the phenomenon of mistreatment are contradictory. Reynolds and Stanton (1983) demonstrated that ED nurses were able to recognize mistreatment; however, most of these nurses did not report the cases to authorities. The authors attributed this finding to the prevalence of bias among ED nurses toward the elderly. In contrast to this point of view, Fulmer (1989) suggests that ageist attitudes of ED nurses may cause them to misinterpret the elderly's clinical presentation and attribute clinical findings to the aging process. For whatever reason, lack of victim identification and reporting means that the phenomenon of mistreatment continues to be selectively ignored. This is creating unmet needs for an unknown number of this nation's elderly (Reynolds & Stanton).

In the next three or four decades, the number of elderly in this nation will dramatically increase, while the number of individuals available to care for this group will continue to shrink. The elderly will continue to place increased physical and financial demands on the family and society (Delunas, 1990; U.S. Senate, 1988). Without a major change in the health care system, more of this population will probably seek care in the emergency department for both emergent and routine care. Emergency department nurses will therefore need to develop a greater awareness of the elderly mistreatment phenomenon in order to meet the health care needs of the elderly. This learning process on the part of the ED nurse includes developing an awareness of one's own values and attitudes toward the elderly (Hurst & Miller, 1986; Reynolds & Stanton, 1983).

Chapter 3

METHODOLOGY

The research methodology used for this study is presented in this chapter, including a description of the sample, the instrument used, and the strategies for data collection. A convenience sample of 21 emergency department nurses completed a survey instrument designed to identify their attitudes about the elderly and their understanding of elder mistreatment.

Data Collection

Setting and Subjects

The setting for this study was in a rural northern California county, which is divided into four geographic sections. The north, south, and east areas are dependent upon agriculture for their primary economic base. These areas have a large population of Hispanics and experience seasonal influxes of migrant farm workers. The west or coastal section of the county is dependent on the large military and tourist population for its economic base. Four acute care, non-military hospitals serve the diverse populations. The subjects for this descriptive, exploratory survey were recruited from the population of emergency department nurses in the county's non-military acute care facilities.

The ED head nurses from all four non-military acute care hospitals were contacted by telephone to determine whether there might be an interest in participation in this study. The study was approved by the Human Subjects Institutional Review Board at San Jose State University, after which each hospital was contacted to identify and comply with the institutional research approval process. Three hospitals did not have a formal research approval process and one had a Nursing Research Committee with an established policy. A cover letter

that explained the purpose of the study and the method for collecting the data was sent to the specific approval authority (see Appendix C). These authorities included: one Chief Operating Officer, one Head Nurse, and one Director of Nurses. A copy of the questionnaire and the consent form accompanied the cover letter. A written proposal was submitted to the hospital with the established protocol. Written permission was obtained from three of the county hospitals (see Appendix D). The head nurse from the fourth hospital chose not to have the ED nurses participate.

Data Collection Instrument

A three part questionnaire was used to survey the subjects in this study. Part I was designed to obtain pertinent demographic data about the respondents. The second part of the survey was the Aging Semantic Differential instrument. Part III consisted of five qualitative questions about elder mistreatment.

Part I: Demographic Data Questionnaire

This first part of the questionnaire requested the following demographic information about the respondents: (a) gender, (b) age, (c) ethnic origin, (d) nursing education, (e) specialty education, (f) specialty certification, (g) years of nursing experience, (i) years of gerontological nursing experience, (j) gerontological nursing education, (k) domestic living situation, and (l) personal experience as a caregiver for an elder. In addition, each subject was asked to identify personal and professional experiences with the elderly.

Part II: The Aging Semantic Differential Instrument

The Aging Semantic Differential is an instrument that has been used extensively for over 30 years to quantify attitudes toward others (Osgood, Suci, & Tannenbaum, 1957; Rosencranz & McNevin, 1969). This instrument includes a series of 32 polar adjectives to measure the

individual's attitude toward an object. The polar adjectives used to determine an individual's attitude toward the elderly are:

1. Progressive and Old Fashioned
2. Inconsistent and Consistent
3. Independent and Dependent
4. Poor and Rich
5. Generous and Selfish
6. Productive and Unproductive
7. Busy and Idle
8. Insecure and Secure
9. Strong and Weak
10. Unhealthy and Healthy
11. Active and Passive
12. Ugly and Handsome
13. Cooperative and Uncooperative
14. Pessimistic and Optimistic
15. Satisfied and Unsatisfied
16. Expectant and Resigned
17. Inflexible and Flexible
18. Hopeful and Dejected
19. Organized and Disorganized
20. Sad and Happy
21. Friendly and Unfriendly
22. Untidy and Neat
23. Trustful and Suspicious
24. Self-Reliant and Dependent
25. Conservative and Liberal
26. Certain and Uncertain
27. Intolerant and Tolerant

28. Pleasant and Unpleasant
29. Ordinary and Eccentric
30. Aggressive and Defensive
31. Exciting and Dull
32. Indecisive and Decisive

The participants were asked to complete the instrument for three persons: a 72 year-old, a 42 year-old, and a 22 year-old person. Subjects were asked to mark on the analog scale at the point that best described a person of a given age.

This instrument was designed to measure the range of stereotypical attitudes and to determine the content of these attitudes (Rosencranz & McNevin, 1969). Osgood, Suci, and Tannenbaum (1957) explained that the reliability of this instrument was established by administering the tool twice to 135 subjects, allowing 5 weeks between the test and retest. This study demonstrated the reliability of the Aging Semantic Differential with a coefficient of .91 (Osgood et al.).

Further research demonstrated the validity of the Aging Semantic Differential (Osgood et al., 1957). Using a test-retest format, one investigator gave this instrument and Thurstone's Attitudinal Scale to 50 subjects. This study revealed a correlation of $r = .91$ (Osgood et al.).

Rosencranz and McNevin (1969) sought to refine the Aging Semantic Differential instrument and conducted a factor analysis to establish construct validity. Using 287 undergraduate students, the investigators were able to reduce the number of relative polar adjectives from 100 to 32. Furthermore, the analysis established three major dimensions used by individuals in evaluating other age groups. These dimensions are: Instrumental-Ineffective, Autonomous-Dependent, and Personal Acceptability-Unacceptability. For this study, the Aging Semantic Differential with 32 polar adjectives was used to determine the

community's ED nurses' attitudes toward the elderly.

Part III: Questions about Elder Mistreatment

In the third section, the subjects were asked to respond to five qualitative questions that assessed their knowledge of elder mistreatment. These questions were:

- (1) Define elder abuse.
- (2) What is meant by elder neglect?
- (3) Is there more than one form of abuse or neglect?
If so, what are they?
- (4) In the past five years, how many elderly patients have you cared for that you suspected may have been victims of mistreatment?
- (5) How many of these cases have you reported to Adult Protective Services?

Data Collection Methodology

A mailed survey method was used for data collection which began on March 16, 1992 and concluded April 16, 1992. A total of 56 questionnaires were distributed as follows: 12 to Hospital A, 12 to Hospital B, and 32 to Hospital C. Participation in this study was voluntary. Twenty-one ED nurses responded by returning completed questionnaires. This represented a return rate of 37.5%.

The data collection period was one month in length. On March 16, 1992, packets for each respondent were delivered to the head nurses at each of the participating hospitals. The packet contained two copies of the consent and one questionnaire for each ED nurse employed at Hospital B and Hospital C (see Appendix E). The respondents were asked to sign both consents, forward one consent to the investigator in a designated envelope, and keep one copy for their files. Since the investigator was an ED nurse at Hospital A, consent to participate in

this study was obtained in person (see Appendix F). Therefore, the packet for Hospital A consisted of the questionnaire and a copy of the respondent's signed consent. Each subject signed the consent form with the understanding that participation in this study was voluntary and that the data would be reported as aggregate data, to ensure individual anonymity.

All subjects were asked to sign the consent and complete the questionnaire at home within four days because one head nurse did not want this study to be completed during the nurses' on-duty time. Consents and questionnaires were returned in separate envelopes. On April 1, 1992, a follow-up letter and questionnaire were delivered to each of the participating head nurses for the number of individuals who failed to respond. No questionnaire was opened until the end of the data collection period on April 16, 1992.

Data Analysis

The data were analyzed for the purpose of answering the following questions:

1. What are the attitudes of ED nurse in a selected northern California county toward the elderly?
2. Does a difference in attitudes exist toward the elderly among ED nurses employed at the different acute care hospitals?
3. What are the criteria that ED nurses use to define elder abuse and/or neglect in this northern California community?

Frequency distributions and percentages were derived for all categorical data. The mean, median, and standard deviation were calculated for the subjects' age, years of nursing experience, and years of emergency nursing experience. Frequency distributions and percentages were calculated after analyzing the subjects' responses and establishing categories for the questions about the settings of

professional experience with the elderly and the nurses' gerontological education.

The Aging Semantic Differential Scale was used to determine ageist attitudes. The subjects were asked to place a mark along an analog scale at a point between the adjective that in the subject's judgment best described the person they were rating. The subjects were asked to rate a 72-year-old, a 42-year-old, and a 22-year-old person. Each set of polar adjectives were scaled from one to seven. The score of one was given for the favorable adjective which best described the person versus a score of seven which indicated a less favorable, adjective (Osgood et al., 1957). A score was generated by adding the subject's score for each adjective. The higher the score the more negative the attitude toward the elderly. There was a possible total of 224 points, indicating the most negative attitude; 32 was the lowest score possible, indicating the most positive attitude.

Each hospital's ED nurses mean score and standard deviation were computed for the 72-year-old, 42-year-old, and 22-year-old. The Kruskal-Wallis statistic was used to test for a statistical difference in attitudes among the nurses of the three hospitals. Finally, the respondents ages were grouped and the mean scores were calculated by age of the participants.

To determine the subjects' knowledge of elder mistreatment, the subjects were asked to respond to five qualitative questions. The qualitative data were analyzed and grouped according to categories. A frequency distribution and percentage was tabulated for responses within each category.

Chapter 4

ANALYSIS AND INTERPRETATION OF THE DATA

This chapter presents the findings concerning ED nurses' attitudes toward the elderly and their knowledge of elder mistreatment. This chapter includes a comparison of the descriptive characteristics of the respondents, findings from the study, and a summary of the participants' comments.

Description of the Sample

Fifteen of the twenty-one participants were over 30 years old, with 28.6% of the subjects in the 40-to-49 year range. The mean age was 40.44 years. The majority (76.2%) of respondents were women ($n=16$). Ninety-five percent of this sample listed White ($n=19$) as their ethnic origin. Thirty-three percent of the ED nurses were Catholic ($n=7$) and 25% were Protestant ($n=6$).

In regard to academic nursing education, 43% of this sample had an Associate Degree ($n=9$), 29% were Diploma nurses ($n=6$), and 19% had a Bachelor of Science Degree in Nursing ($n=4$). With the exception of two subjects, the majority of this sample ($n=19$) had taken two or more courses to prepare themselves to work in the emergency environment. In addition, 11 subjects (52%) were certified as Mobile Intensive Care Nurses (MICN); however, 29% of the respondents had not obtained certification in any area ($n=6$). Only four subjects (19%) had received two or more of the pertinent certifications.

Many of these ED nurses had extensive nursing experience: 28% had 16-to-20 years of experience ($n=6$), followed by 19% with 11-to-15 years ($n=4$) and 21-to-25 years ($n=4$) of experience. The years of experience in emergency nursing varied: 33.3% of the subjects had 1-to-5 years ($n=7$), 23.8% had 11-to-15 years, and 19.0% either had 6-to-10 years ($n=4$) or 16-to-20 years ($n=4$) of emergency experience (see Table 1).

Table 1

Demographic Characteristics of Emergency Department Nurses (N=21)

Variable	Classification	<u>n</u>	Percent
Age	20 to 29 years	3	14.3%
	30 to 39 years	5	23.8%
	40 to 49 years	6	28.6%
	50 to 59 years	4	19.0%
	60 years and over	0	0.0%
	No Response	3	14.3%
Gender	Female	16	76.2%
	Male	2	9.5%
	No Response	3	14.3%
Ethnicity	White	19	95%
	Asian or Pacific Islander	1	5%
	No Response	1	5%
Religion	Anglican	1	5%
	Protestant	6	29%
	Agnostic	1	5%
	Catholic	7	33%
	Atheist	1	5%
	Jewish	1	5%
	Other	2	10%
	Prefer not to respond	2	10%
Academic Nursing Education	Diploma	6	29%
	Associate Degree	9	43%
	Bachelor's Degree	4	19%
	Master's Degree	1	5%
	Doctorate	0	0.0%
	Other	1	5%
Emergency Nursing Education	Arrhythmia Recognition	1	5%
	ACLS	0	0.0%
	ATLS	0	0.0%
	TNCC	1	5%
	Emergency Internship	0	0.0%
	Two or more above courses	19	90%
Specialty Certification	MICN	11	52%
	CEN	0	0.0%
	CCRN	0	0.0%
	Med/Surg	0	0.0%
	None	6	29%
	Two or more above	4	19%
<u>table continues</u>			

Table 1 (continued)

Variable	Classification	n	Percent
Years of Nursing Experience	1 to 5 years	3	14.3%
	6 to 10 years	2	9.5%
	11 to 15 years	4	19.0%
	16 to 20 years	6	28.6%
	21 to 25 years	4	19.0%
	26 to 30 years	0	0.0%
	31 years and over	2	9.5%
Years of Emergency Experience	1 to 5 years	7	33.3%
	6 to 10 years	4	19.0%
	11 to 15 years	5	23.8%
	16 to 20 years	4	19.0%
	No Response	1	4.8%
Setting of Professional Experience with Elderly	Emergency Department	4	19.0%
	Visiting Nurse	3	14.3%
	Intensive Care	2	9.5%
	Acute Care Hospital	1	4.8%
	Student	2	9.5%
	None	15	71.4%
	No Response	1	4.8%
Gerontological	Undergraduate		
	Nurse or Psychology	2	9.5%
	Taught Gerontology to		
	LVN Students	1	4.8%
	Inservice Classes	2	9.5%
	None	15	71.4%
Living Situation	No Response	1	4.8%
	Alone	1	5%
	Spouse	4	19%
	Spouse and Child	12	57%
	Alone with Child	1	5%
	Significant Other	2	10%
Personal Care for Elderly	Roommates	1	5%
	Yes	3	14%
Experience of Elderly	No	18	86%
	Positive	16	75%
	Negative	0	0.0%
	Not Sure	5	24%

The respondents had listed a variety of professional settings in which they gained experience working with the elderly. Their responses were as follows: 23.8% listed no previous experience; 19.0% listed

experience caring for the elderly in the emergency department ($n=4$); 14.3% worked with the elderly as a visiting nurse ($n=3$); 14.2% had worked on a medical-surgical unit ($n=3$) in an acute care hospital; and, 9.5% ($n=2$) had experience with the elderly in ICU.

In regard to special gerontological education, the majority of this sample ($n=15$) had not received gerontological education of any kind. However, 9.5% of the nurses had gerontological nursing education in undergraduate school ($n=2$) or attended inservices ($n=2$) that focused on the issues of caring for the elderly. Eighty six percent of the nurses in this study had no personal experience as a caregiver to an elder person ($n=18$). The majority of the ED nurses (75%) classified both personal and professional experiences with the elderly as positive. Twenty-four percent of the subjects ($n=5$) were not sure whether their experiences were positive or negative.

Emergency Department Nurses' Attitudes

Toward the Elderly

Part 2 of the survey questionnaire used the Aging Semantic Differential to measure ED nurses' attitudes toward the elderly. The respondents were instructed to place a mark along an analog scale between two polar adjectives that in the judgment best described three individuals, a 72-year-old, a 42-year-old, and a 22-year-old. The scale gave a score of one to the most favorable adjective and a score of seven was given to the least favored adjective. Scores were then totaled. The higher the score, the more negative the attitude.

The mean scores ($\bar{M}$) and standard deviations (SD) in attitudes toward the 72-year-old, 42-year-old, and 22-year-old are reported in Table 2 (see page 25). Nurses at Hospital B ($n=2$) had the least positive attitude toward the elderly ($\bar{M}=121.0$). The nurses employed by Hospital A ($n=8$) were marked second in the less positive attitude category ($\bar{M}=109.71$). By

Table 2

Aging Semantic Differential Scores by Hospital

Age	Hospital A	Hospital B	Hospital C	
	<u>n</u> =8	<u>n</u> =2	<u>n</u> =11	<u>N</u> =21
72-year-old	<u>M</u> 109.71 <u>SD</u> 16.32	<u>M</u> 121.0 <u>SD</u> 8.46	<u>M</u> 107.64 <u>SD</u> 22.83	<u>M</u> 109.70 <u>SD</u> 19.46
42-year-old	<u>M</u> 112.5 <u>SD</u> 17.95	<u>M</u> 115.0 <u>SD</u> 2.83	<u>M</u> 92.6 <u>SD</u> 20.70	<u>M</u> 102.80 <u>SD</u> 20.79
22-year-old	<u>M</u> 107.4 <u>SD</u> 34.57	<u>M</u> 91.5 <u>SD</u> 21.92	<u>M</u> 111.0 <u>SD</u> 17.05	<u>M</u> 107.65 <u>SD</u> 23.01

comparison, the attitudes toward the elderly by the nurses at Hospital C (n=11) were the most favorable (M=107.64). However, these nurses' attitudes demonstrated the most variability (SD=22.83).

Emergency Department nurses at Hospital C had the most positive attitude toward the middle-aged individual (M=92.36), followed by Hospital A (M=112.5), and Hospital B (M=115.0).

The attitude of ED nurses at Hospital B toward the 22-year-old were the most favorable (M=91.5). Hospital A nurses were the next most favorable toward the young (M=107.4) and their attitudes were extremely variable (SD=34.57). When compared to the other hospitals, nurses at Hospital C held the least favorable attitude toward this age group (M=111.0) and the least variable (SD=17.05).

Table 3 presents the mean scores by the respondents' age groups. Nurses in the age range of 20-to-29 year cohort demonstrated the least positive attitude toward the elderly (M=119.33), followed by nurses aged 30-to-39 years (M=107.2) and 50-to-59 years (M=105.5). The nurses in the 40-to-49 years group demonstrated the most favorable attitude toward the elderly (M=101.33). The same nurses had the most positive attitude toward the middle-aged individual (M=92.8) and the least favorable

Table 3

Aging Semantic Differential Scores by Age Groups of Respondents

Years	<u>n</u>	72-year-old	42-year-old	22-year-old
20-to-29	3	<u>M</u> 119.33	<u>M</u> 114.33	<u>M</u> 109.33
30-to-39	5	<u>M</u> 107.2	<u>M</u> 105.83	<u>M</u> 102.4
40-to-49	6	<u>M</u> 101.33	<u>M</u> 92.8	<u>M</u> 112.83
50-to-59	4	<u>M</u> 105.5	<u>M</u> 96.0	<u>M</u> 88.67
60+	0			
No Response	3			

attitude toward the young (M=112.83). The nurses aged 50-to-59 years highly favored the 22-year-old (M=88.67), followed by the 30-to-39 years (M=102.3) and the 20-to-29 years group (M=109.33).

Emergency Department Nurses' Knowledge of Elder Mistreatment

Table 4 presents the criteria used by the respondents to define elder abuse. About one-third of the sample (33%) included caregiver action toward an elderly, dependent person in the definition. The majority of nurses (52%) used both caregiver action and neglect as criteria for abuse. Only 10% of this sample (n=2) used neglect of basic needs to define elder abuse.

The criteria used by the ED nurses to define neglect are shown in Table 5. Greater than 50% of the ED nurses (n=12) focused on the caregiver not meeting the needs of the elderly. Four subjects used caregiver actions toward the elder as criteria for neglect. Two respondents claimed that neglect and abuse were the same. One nurse recognized that neglect may not be intentional, and 5% of the subjects used abandonment to define neglect.

Table 4

Criteria Used to Define Elder Abuse

<u>n</u>	<u>%</u>	<u>Criteria</u>
7	33	Abuse required action by caregiver toward an elder.
11	52	Both caregiver action and neglect were criteria for abuse.
2	10	Neglect was used to define abuse.
1	5	No Response

The categories of abuse listed by this sample are presented in Table 6. As shown, 80% of the nurses (n=16) recognized both physical and emotional forms of abuse. Only 25% of the nurses (n=5) listed material and financial exploitation as a form of abuse. Another 14% of the subjects (n=3) identified sexual or spiritual criteria for abuse.

Table 5

Criteria Used to Define Neglect

<u>n</u>	<u>%</u>	<u>Criteria</u>
12	57	Basic physical and psychosocial needs not met by caregiver.
4	19	Neglect required caregiver action.
2	10	Neglect and abuse the same.
1	5	Neglect may not be intentional.
1	5	Abandonment.
1	5	No Response.

Table 6

Forms of Abuse

<u>n</u>	<u>%</u>	<u>Form</u>
16	80	Physical and Emotional
5	24	Material or Financial Exploitation
3	14	Spiritual or Sexual

With the exception of two nurses, 90% of the subjects claimed to have recognized elder mistreatment victims; however, the number of cases reported to APS varied. Sixty-three percent of the nurses claimed to have reported all suspected cases to the county Adult Protective Services. Another 27% of the participants reported some of the suspected cases. One nurse claimed to have suspected a large number of mistreatment victims but did not report them because this nurse did not know about Adult Protective Services.

Discussion of Findings Related to Research Questions

The mean and standard deviations were calculated to establish the ED nurses attitudes toward the elderly and have been reported. To test for a significant difference, the Kruskal-Wallis (KW) was used. A p of $< .05$ was used to accept a significant difference. A frequency distribution and percentages were tabulated for the qualitative questions after the main categories were identified.

Question 1: What are the attitudes among ED nurses toward the elderly in a northern California county?

Seventy-five percent of the ED nurses in the specified northern California community rate both their personal and professional experiences with the elderly as positive. The results of the Aging

Semantic Differential indicate that the nurses' attitudes toward the elderly (72-year-old) this group were marginally negative when compared to the other age categories. The mean score was 109.79 with a standard deviation of 19.46.

Question 2: Does a difference exist in ED nurses attitudes toward the elderly employed at the different acute care hospitals?

The results of the Kruskal-Wallis test indicated that there was no significant difference in the subjects' attitudes toward the elderly at a $p < .05$ (see Table 7). According to Shifflett (B. Shifflett, personal communication, January 15, 1993), caution must be used with interpretation of this result due to the variance in the groups size. In fact, one group had a total of two people.

Table 7

Emergency Department Nurses' Attitudes toward the Elderly

Age Group	Chi-Square	<u>P</u>
72-year-old	.48	.79
42-year-old	4.79	.09
22-year-old	1.78	.41

Question 3: What were the criteria that ED nurses used to define elder abuse or neglect in this northern California community?

Fifty-two percent of ED nurses ($n=11$) in the community used both caregiver action and neglect of basic needs as criteria for determining abuse. Another 33% of the respondents ($n=7$) used caregiver actions as the fundamental key element in defining abuse. The ED nurses in this study preferred to use a more global, vague definition of abuse with the criteria of caregiver action and neglect as key indicators.

Summary

The results of the Aging Semantic Differential indicated that ED nurses in this northern California community have a negatively biased attitude toward the elderly. There was no statistical difference in nurses' attitudes based on employment status at three acute care hospitals. The majority of the ED nurses used both caregiver action and neglect as important criteria in defining abuse, here the community's emergency department nurses are aware of both the physical and emotional forms of elder mistreatment. However, many of the subjects did not identify other forms of mistreatment such as sexual or financial exploitation. Finally, the findings also suggest a trend of underreporting by ED nurses of suspected cases of elder mistreatment. (Issues related to underreporting of elder mistreatment will be discussed further in chapter five).

Summary of Participants' Comments

Ten of the nurses took time to add written comments at the end of the questionnaire. Eight of the nurses had positive comments about the elderly. Four commented on American culture and the lack of attention and respect for the nation's elderly:

- H1S3: Old people are too often "in the way" & don't fit in with busy lifestyles of today. They are often sent to SNF or kept at home and ignored. It's too bad we don't honor the experience of age more.
- H3S1: Some of my most rewarding experiences have been with my "elderly patients" [sic]. It is one of the greatest deficiencies of the American culture that we do not respect and provide for our elders. Our medical system is one of the worst in terms of responsiveness to the elderly and reflects the unfortunate attitude of society.
- H3S8: Someone said that the moral fiber of a country is reflected in how it treats its prisoners. I disagree - I think it's how it treats its elders. Too many are thrown away.
- H3S11: I haven't come across any elderly that have been mistreated by caregivers intentionally. I have seen elderly mistreated due to society's incapability to care for our elderly adequately. Other societies demonstrate how elderly should

be cared for and recognize their important value.

One subject was not aware of the county's Adult Protective Services. Another nurse wrote, ". . . a lot of abuse goes undetected, I think because it is not thought of abuse with elders since most is not seen and the elder person doesn't talk about it." A nurse who identified some personal actions toward an elderly family member wrote ". . . I found myself withdrawing as I couldn't stand to see her like this. I could/should have sought counseling to better interact and cope."

Two of the nurses felt that the questionnaire was not objective and that the researcher was trying to find prejudice:

H3S5: Why don't you try something productive instead of trying to find prejudice. These questions appear designed to prove a preconceived idea.

H3S6: I feel the objective portion of this questionnaire would not give a very realistic view of how people view these different ages, as not only are all people vastly different, but as nurses, our experiences is [sic] frequently only with sick people. Particularly the elderly - there is a big difference in the ways people cope with illness - and trauma subject not addressed in this questionnaire.

The majority of written comments recognized the plight of the elderly in America's youth-oriented society. At a minimum, all respondents have had elder mistreatment brought to a conscious awareness by this study. Identification of elder mistreatment victims is difficult for many reasons, including the complex interrelationship of the normal aging process and chronic disease states that may shadow the subtle signs of abuse or neglect. Greater knowledge of Gerontology may enable professionals to better identify victims. Once there is a knowledge base of elder mistreatment and it is incorporated into daily practice ED nurses can then identify elder mistreatment victims and offer alternatives to a violent existence. As a microcosm of the total society, a change in nurse's attitudes may help to modify attitudes of the American Society.

Chapter 5

CONCLUSION AND RECOMMENDATIONS

Conclusion

Elder mistreatment is reaching epidemic proportions in the United States. The National Resource Center on Elder Abuse (1990a) estimates that nearly 2.0 million elderly are mistreated each year. The lack of a clear, concise definition of mistreatment, the subtle clinical presentation of victims, complicated by the interrelationship between chronic diseases and the aging process, the dysfunctional family syndrome predisposing its members to mistreatment, and the negative bias of ED nurses have been known to act as barriers to identification of elder mistreatment victims.

This study of ED nurses' attitudes and their knowledge of elder mistreatment demonstrated several interesting findings. First, the respondents were experienced Caucasian (95%) ED nurses, middle-aged ($M=40.44$), and predominately female (76.2%). If these women had personally experienced the stress and strain as a caregiver to an elderly relative, it might have had an impact on the attitude score. However, 86% of these nurses responded 'no' to the question of personally caring for an elder.

Seventy-two percent of the respondents were Diploma or Associate Degree nurses. This factor may have influenced the groups' attitudes. Bower (1985) found that advanced nursing education can positively affect nurses' attitudes toward the elderly. The respondents' educational preparation and/or valuing of continuing education may also be related to the respondents, lack of attendance at courses addressing the issues of the elderly (71.4%).

Emergency department nurses' attitudes toward the elderly in this study were slightly more negatively biased ($M=109.70$) when compared to

their attitudes toward the other age groups. However, 75% rated their experience of the elderly as positive. Variability in the respondents mean score ($SD=19.46$) may come from the four nurses who were aware of society's negative bias as noted in their written comments. In addition, the nurse who believed that this study was attempting to find prejudice rated all the individuals the same.

The results of the Kruskal-Wallis statistic indicated that there was no significant difference in the attitudes of the ED nurses employed at the three different acute care hospitals in the study. This is not surprising as it is doubtful if statistical significance could be attained in a study of this small size and the limited number of the community's total population of ED nurses. However, the data suggest that ED nurses may have slightly negatively biased attitudes toward the elderly county-wide as evidenced by the lack of formal gerontological education, lack of attendance at gerontological oriented inservice programs, and the inability to clearly differentiate elder abuse and neglect.

The lack of a clear, concise definition of elder abuse and neglect may be an issue that affects case detection and reporting. Seven nurses (33%) recognized that abuse involved caregiver action toward the elder and 52% ($n=11$) used both caregiver action and neglect as criteria for abuse. The inherent problem with the global, vague definition is that often neglect is unintentional. Therefore, many cases of mistreatment may go undetected, creating a life of unmet needs for an elder. Lack of a concise definition of abuse and neglect may explain the trend of underreporting suspected cases of elder mistreatment to the county Adult Protective Services (APS). The ED nurse may be unsure if a case fits the definition of abuse or neglect and chooses not to report the victim to APS.

An overwhelming majority (80%) of the respondents identified physical and emotional forms of abuse and neglect. Sexual, material or financial exploitation, and spiritual abuse were less often identified as forms of mistreatment. This suggests that the majority of ED nurses were unaware of the numerous forms of mistreatment and therefore may misidentify the clinical presentation of the problem. The end result may be that a number of cases go undetected in the county.

The qualitative data revealed that the majority of the respondents identified and reported all suspected cases of elder mistreatment. Twenty-seven percent claimed to have reported some of the cases. Only one nurse did not report any of the suspected cases and two nurses claimed not to have recognized any victims of elder mistreatment. Due to the fact that there were suspected cases of elder mistreatment that were not reported and there were two nurses who had never suspected elder mistreatment based on presenting symptoms, the data suggest a need for intensive education about the mistreatment phenomenon.

Finally, an interesting trend was discovered in the attitude scores according to age of the participants. The 20-to-29 year age group tended to rate the elderly more negatively ($M=119.33$). The attitude scores became more positive in the following age groups, 30-to-39 year ($M=107.2$) and 40-to-49 year ($M=101.33$). The 40-to-49 year group had the most favorable attitude toward the elderly. Interestingly, the 50-to-59 year group tended to score more negatively in their attitude toward the elderly ($M=105.5$). This same age group scored more positively toward the young ($M=88.67$). The investigator cannot account for this result. Personal experience as a caregiver to an elderly relative may have had a direct impact on this cohort's score; yet, only 14% ($n=3$) claimed to have had this personal experience. The 50-to-59 year old ED nurses responses do raise a few questions. First,

is this age cohort experiencing the bias of a youth-oriented society? Is this age cohort closer to the 72 year-old and hence has a more jaded view of life and aging? Finally, is the level of nursing education a variable in their attitude toward the elderly?

Scope and Limitations

The northern California county for this study was primarily an agricultural, resort community with its own unique set of cultural values. Due to the size of this study, the beliefs, attitudes, and values of the ED nurses in this community may not be generalized to other counties and states. Another limitation which affected the results of this study was by the limited cooperation of the local hospitals. One ED head nurse decided to protect the ED nurses by not divulging the names of the staff to the investigator. This limited the investigator's ability to address the follow-up letters to the subjects who had not responded to the initial survey.

Other limitations may include the problems associated with using the Aging Semantic Differential. Polit and Hungler (1987) identified the following limitations of such an instrument:

1. The questionable accuracy with which a scaled score can measure attitudes.
2. The subjects may rate the adjective that is consistent with the current social bias.

Recommendations

1. Since, the county Board of Supervisors has mandated that the Department of Social Services be responsible for investigating the incidence of elder mistreatment and the results of this study indicates a need for educating the county ED nurses about elder mistreatment. The investigator plans to send a copy of this study to both agencies.

2. The literature supports the use of a special assessment form

designed to assist the ED nurse to identify possible mistreatment and the use of a multidisciplinary team to determine if a case is reportable as mistreatment (Fulmer, Street, & Carr, 1984). Hospital administrators, nursing executives, ED head nurses, and the ED medical director might consider this type of form which has been successful in detecting and reporting victims of elder mistreatment. A copy of this study will be given to each of the participating hospitals.

3. Further research investigating nurses' attitudes toward the elderly and their knowledge of elder mistreatment is needed. This study might be replicated in other counties within California and other states. The results of such studies may produce findings and indicate trends that would provide direction for nursing practice and professional education.

4. Further research is needed to explore the possible explanation for the less favorable attitudinal scores found in the 50-to-59 age cohort toward the elderly. As indicated, this was a surprising finding that may be due to this group's reevaluation process, education, or personal experience with prejudice in the youth-oriented society of the United States.

REFERENCES

References

- Andreoli, K. G., & Musser, L. A. (1985). Challenges confronting the future of emergency nursing. Journal of Emergency Nursing, 11, 16-21.
- Ashley, J., & Fulmer, T. T. (1988). No simple way to determine elder abuse. Geriatric Nursing, 9, 286-288.
- Baker, R. R. (1984). Attitudes of health care providers toward elderly patients with normal aging and disease related symptoms. Gerontologist, 24, 543-545.
- Baum, S. A., & Rubenstien, L. Z. (1987). Old people in the emergency room: Age-related differences in emergency department use and care. Journal of the American Geriatric Society, 35, 398-404.
- Bem, D. J. (1970). Beliefs, attitudes, and human affairs. Belmont, CA: Brooks/Cole.
- Block, M. R., & Sinnott, J. D. (1979). The battered elder syndrome: An exploratory study. College Park: University of Maryland, Center on Aging.
- Bower, H. T. (1985). Do nurses stereotype the elderly? Journal of Gerontological Nursing, 11(1), 17-28.
- Bookin, D., & Dunkle, R. E. (1985). Elder abuse: Issues for the practitioner. Social Casework, 66, 3-12.
- Butler, R. N. (1983). Forward. In J. I. Kosberg (Ed.), Elder Abuse and mistreatment of the elderly (p. xi). Boston: John Wright, PSG.
- Delunas, L. R. (1990). Prevention of elder abuse: Betty Neuman health care approach. Clinical Nurse Specialist, 4(1), 54-58.
- English, J., & Morse, J. M. (1988). The 'difficult' elderly patient: Adjustment or maladjustment? International Journal of Nursing Studies, 25(1), 23-29.
- Ettinger, W. H., Casani, J. A., Coon, P. J., Muller, D. C., &

- Piazza-Appel, K. (1987). Patterns of use of the emergency department by elderly patients. Journal of Gerontology, 42, 638-642.
- Ferraro, K. F. (1990). The gerontological imagination. In K. F. Ferraro (Ed.), Gerontology: Perspectives and issues (pp. 3-18). New York: Springer.
- Fishbein, M., & Ajzen, I. (Eds.) (1975). Belief, attitude, intention, and behavior. Reading, MA: Addison-Wesley.
- Fulmer, T. T. (1989). Mistreatment of the elders: Assessment, diagnosis, and intervention. Nursing Clinics of North America, 24, 707-716.
- Fulmer, T. T., & Ashley, J. (1989). Clinical indicators of neglect. Applied Nursing Research, 2(4), 161-167.
- Fulmer, T. T., & O'Malley, T. A. (1987). Inadequate care of the elderly: A health care perspective on abuse and neglect. New York: Springer.
- Fulmer, T. T., Street, S., & Carr, K. (1984). Abuse of the elderly: Screening and detection. Journal of Emergency Nursing, 10, 131-140.
- Hamilton, G. P. (1989). Prevent elder abuse - using a family systems approach. Journal of Gerontological Nursing, 15(3), 21-26.
- Haviland, S., & O'Brien, J. (1989). Physical abuse and neglect of the elderly: Assessment and intervention. Orthopaedic Nursing, 6, 11-19.
- Hickey, T., & Douglass, R. L. (1981). The mistreatment of the elderly in the domestic setting: An exploratory study. American Journal of Public Health, 71, 500-507.
- Hurst, S. P., & Miller, J. (1986). The abused elderly. Journal of Psychological Nursing, 24, 28-34.
- Jones, J., Dougherty, J., Schelble, D., & Cunningham, W. (1988). Emergency department protocol for the diagnosis and evaluation of geriatric abuse. Annals of Emergency Medicine, 17, 1006-1015.

- Kidd, P. S., & Murakami, R. Y. (1987). Common pathologic conditions in the elderly patients. Journal of Emergency Nursing, 13, 27-32.
- Kosberg, J. I. (1988). Preventing elder abuse: Identification of high risk factors prior to placement decisions. Gerontologist, 28, 43-50.
- Levin, W. C. (1988). Age stereotyping. In H. Cox (Ed.), Aging: Annual editions (pp. 60-66). Guilford, CT: Dushkin.
- Longino, C. F., Soldo, B. J., & Manton, K. G. (1990). Demography of aging in the United States. In K. F. Ferraro (Ed.), Gerontology: Perspectives and issues, (pp. 19-41). New York: Springer.
- Lowenstein, S. R., Crescenzo, C. A., Kern, D. C., & Steel, K. (1986). Care of the elderly in the emergency department. Annals of Emergency Medicine, 15, 528-535.
- Martin, L. L., & Clark, L. F. (1990). Social cognition: Exploring the mental process involved in human social interaction. In M. W. Eysenk (Ed.), Cognitive psychology: An international review (pp. 265-303). New York: John Wiley & Sons.
- McDonald, A. J., & Abrahams, S. T. (1990). Social emergencies in the elderly. Emergency Medicine Clinics of North America, 8, 443-459.
- Morgan, D. L. (1985). Nurses' perceptions of mental confusion in the elderly: Influence of resident and setting characteristics. Journal of Health and Social Behavior, 26, 102-112.
- National Aging Resource Center on Elder Abuse (1990a). Suggested state guidelines: For gathering and reporting domestic elder abuse statistics for compiling national data. Washington, DC: National Aging Resource Center on Elder Abuse.
- National Aging Resource Center on Elder Abuse (1990b). Summaries of national elder abuse: An exploratory study of state statistics based on a survey of state adult protection agencies. Washington, DC:

- National Aging Resource Center on Elder Abuse.
- Osgood, C. E., Suci, G. J., & Tannenbaum, P. H. (1957) The measurement of meaning. Urbana: University of Illinois.
- Pepper, C. (1985). Forward. In United States House of Representatives Select Committee on Aging, Elder Abuse: A National Disgrace (Comm. Pub. No. 99-502). Washington, DC: United States Printing Office.
- Phillips, L. R. (1983). Elder Abuse - What is it? Who says so? Geriatric Nursing, 4, 167-170.
- Phillips, L. R., & Rempusheski, V. R. (1985). A decision-making model for diagnosing and intervening in elder abuse and neglect. Nursing Research, 34, 134-139.
- Pillemer, K., & Finkelhor, D. (1988). The prevalence of elder abuse: A random sample survey. The Gerontologist, 28, 51-57.
- Podenicks, E. (1985). Elder abuse: It's time we did something about it. Canadian Nurse, 81, 36-39.
- Polit, D. F., & Hungler, B. P. (1987). Nursing research: Principles and methods (3rd edition). Philadelphia: Lippincott.
- Rahman, A., Salend, E., Liston, M., Lee, G., Dees, G., & Morgan, M. (1989). An educational program to improve geriatric emergency care. Journal of Emergency Nursing, 12, 313-317.
- Rathbone-McCuan, E. (1980). Elderly victims of family violence and neglect. Social Casework, 61, 61-70.
- Riehl-Sisca, J. (1989). The Riehl interaction model. In J. Riehl-Sisca (Ed.), Conceptual models for nursing practice (pp. 383-402). Norwalk, CT: Appleton & Lange.
- Reynolds, E., & Stanton, S. (1983). Elderly abuse in a hospital: A nursing perspective. In J. I. Kosberg (Ed.), Abuse and mistreatment of the Elderly (pp. 391-403). Boston: John Wright, PSG.
- Rosencranz, H. A., & McNevin, T. E. (1969). A factor analysis of

- attitudes toward the aged. Gerontologist, 9, 55-59.
- Sayles-Cross, S. (1988). Profile of familial elder abuse: A selected review of the literature. Journal of Community Health Nursing, 5, 209-219.
- Solomon, K. (1983). Intervention for the victimized elderly and sensitization of health professionals: Therapeutic and educational efforts. In J. I. Kosberg, Abuse and Mistreatment of the Elderly (pp. 404-421). Boston: John Wright, PSG.
- Steinmetz, S. K. (1978). Battered parents. Society, 15(5), 54-55.
- United States House of Representatives, 99th Congress, Select Committee on Aging (1985). Elder Abuse: A national disgrace (Comm. Pub. No. 99-502). Washington, DC: United States Printing Office.
- United States Senate, Special Committee on Aging (1988). Aging America: Trends and projections (S142-6). Washington, DC: United States Department of Health and Human Services.
- Weatherley, D. (1973). Fundamental ideas of social psychology. Publication #149. Boulder, CO: Social Science Education Consortium.
- Zakay, D. (1990). The role of personal tendencies in the selection of decision-making strategies. Psychological Record, 40, 207-213.

APPENDIX A
Questionnaire

Research Questionnaire for Emergency Department Nurses
Attitudes Toward the Elderly and Their Knowledge of
Elder Mistreatment

44

Part I: Demographic Data

1. What is your gender? (Check one):
Female___(1) Male___(2)
2. What is your age? (Specify number of years): _____
3. What is your ethnic origin? (Check one):
 - (1) American Indian or Alaskan Native _____
 - (2) Asian or Pacific Islander _____
 - (3) Hispanic _____
 - (4) Black, not of Hispanic origin _____
 - (5) White _____
 - (6) Other (Please Specify) _____
4. What is your religious preference? (Check one):
 - (1) Anglican _____
 - (2) Protestant _____
 - (3) Agnostic _____
 - (4) Catholic _____
 - (5) Atheist _____
 - (6) Prefer not to respond _____
 - (7) Jewish _____
 - (8) Other (Please Specify) _____
5. What is your highest level of nursing education?
(Check one):
 - (1) Diploma _____
 - (2) Associate Degree in Nursing _____
 - (3) Bachelor Degree in Nursing _____
 - (4) Master Degree in Nursing _____
 - (5) Doctorate in Nursing _____
 - (6) Other (Please Specify) _____
6. What specialty education have you taken to prepare you
for work in the Emergency Department?
 - (1) Arrhythmia Recognition _____
 - (2) Advanced Cardiac Life Support _____
 - (3) Advance Trauma Life Support _____
 - (4) Trauma Nurse Core Curriculum _____
 - (5) Emergency Nursing Internship _____
 - (6) Other (Please Specify) _____
7. What specialty certification do you have?
 - (1) Mobile Intensive Care Nurse _____
 - (2) Certified Emergency Nurse _____
 - (3) Critical Care Registered Nurse _____
 - (4) Med-Surg _____
 - (5) None _____
 - (6) Other (Please Specify) _____
8. How many years of nursing experience do you have?
Please specify number of years: _____

9. How many years have you worked in the Emergency Department? Please specify number of years: _____
10. Have you had any professional experience working with the elderly? Please specify number of years and in what setting: _____

11. Have you had any educational courses that were specifically oriented to the care of the elderly? Please describe: _____

12. What is your present living situation? (Please Check One):
(1) Live alone _____
(2) Live with spouse _____
(3) Live with spouse and children _____
(4) Live alone with children _____
(5) Live with Significant Other _____
(6) Prefer not answer _____
13. Are you responsible for taking care of an elderly individual outside your professional responsibilities?
(1) Yes _____
(2) No _____
(3) Prefer not to answer _____
14. How do you classify your past personal or professional experiences with the elderly?
(1) Positive _____
(2) Negative _____
(3) Not sure _____

46

72-YEAR-OLD PERSON

PROGRESSIVE	—	—	—	—	—	—	OLD FASHIONED
INCONSISTENT	—	—	—	—	—	—	CONSISTENT
INDEPENDENT	—	—	—	—	—	—	DEPENDENT
POOR	—	—	—	—	—	—	RICH
GENEROUS	—	—	—	—	—	—	SELFISH
UNPRODUCTIVE	—	—	—	—	—	—	PRODUCTIVE
BUSY	—	—	—	—	—	—	IDLE
INSECURE	—	—	—	—	—	—	SECURE
STRONG	—	—	—	—	—	—	WEAK
UNHEALTHY	—	—	—	—	—	—	HEALTHY
ACTIVE	—	—	—	—	—	—	PASSIVE
UGLY	—	—	—	—	—	—	HANDSOME
COOPERATIVE	—	—	—	—	—	—	UNCOOPERATIVE
PESSIMISTIC	—	—	—	—	—	—	OPTIMISTIC
SATISFIED	—	—	—	—	—	—	DISSATISFIED
EXPECTANT	—	—	—	—	—	—	RESIGNED
INFLEXIBLE	—	—	—	—	—	—	FLEXIBLE
HOPEFUL	—	—	—	—	—	—	DEJECTED
ORGANIZED	—	—	—	—	—	—	DISORGANIZED
SAD	—	—	—	—	—	—	HAPPY
FRIENDLY	—	—	—	—	—	—	UNFRIENDLY
UNTIDY	—	—	—	—	—	—	NEAT
TRUSTFUL	—	—	—	—	—	—	SUSPICIOUS
SELF-RELIANT	—	—	—	—	—	—	DEPENDENT
CONSERVATIVE	—	—	—	—	—	—	LIBERAL
CERTAIN	—	—	—	—	—	—	UNCERTAIN
INTOLERANT	—	—	—	—	—	—	TOLERANT
PLEASANT	—	—	—	—	—	—	UNPLEASANT
ORDINARY	—	—	—	—	—	—	ECCENTRIC
AGGRESSIVE	—	—	—	—	—	—	DEFENSIVE
EXCITING	—	—	—	—	—	—	DULL
INDECISIVE	—	—	—	—	—	—	DECISIVE

Below are listed a series of polar adjectives with a scale between. 47
Please place a check mark along the scale at a point which, in your
judgment, best describes a 22-year-old-person. Make each item a separate
and independent judgment. Do not try to remember how you marked earlier
items even though they may seem to have been similar. It is your first
impression or immediate feeling about each item that is wanted.

22-YEAR-OLD-PERSON

CONSERVATIVE	—	—	—	—	—	—	LIBERAL
CERTAIN	—	—	—	—	—	—	UNCERTAIN
INTOLERANT	—	—	—	—	—	—	TOLERANT
PLEASANT	—	—	—	—	—	—	UNPLEASANT
ORDINARY	—	—	—	—	—	—	ECCENTRIC
AGGRESSIVE	—	—	—	—	—	—	DEFENSIVE
EXCITING	—	—	—	—	—	—	DULL
INDECISIVE	—	—	—	—	—	—	DECISIVE
PROGRESSIVE	—	—	—	—	—	—	OLD FASHIONED
INCONSISTENT	—	—	—	—	—	—	CONSISTENT
INDEPENDENT	—	—	—	—	—	—	DEPENDENT
POOR	—	—	—	—	—	—	RICH
GENEROUS	—	—	—	—	—	—	SELFISH
UNPRODUCTIVE	—	—	—	—	—	—	PRODUCTIVE
BUSY	—	—	—	—	—	—	IDLE
INSECURE	—	—	—	—	—	—	SECURE
STRONG	—	—	—	—	—	—	WEAK
UNHEALTHY	—	—	—	—	—	—	HEALTHY
ACTIVE	—	—	—	—	—	—	PASSIVE
UGLY	—	—	—	—	—	—	HANDSOME
COOPERATIVE	—	—	—	—	—	—	UNCOOPERATIVE
PESSIMISTIC	—	—	—	—	—	—	OPTIMISTIC
SATISFIED	—	—	—	—	—	—	DISSATISFIED
EXPECTANT	—	—	—	—	—	—	RESIGNED
INFLEXIBLE	—	—	—	—	—	—	FLEXIBLE
HOPEFUL	—	—	—	—	—	—	DEJECTED
ORGANIZED	—	—	—	—	—	—	DISORGANIZED
SAD	—	—	—	—	—	—	HAPPY
FRIENDLY	—	—	—	—	—	—	UNFRIENDLY
UNTIDY	—	—	—	—	—	—	NEAT
TRUSTFUL	—	—	—	—	—	—	SUSPICIOUS
SELF-RELIANT	—	—	—	—	—	—	DEPENDENT

Part III: Please answer in your own words:

48

1. Define Elder Abuse: _____

2. What is meant by the term elder neglect? _____

3. Is there more than one form of abuse or neglect? If so, what are they? _____

4. In the last five years, how many elderly patients have you cared for that you suspected may have been victims of mistreatment? _____

5. How many of these cases did you report to Adult Protective Services? _____

6. COMMENTS _____

APPENDIX B
SJSU Human Subjects Approval

San Jose State University
Human Subjects-Institutional Review Board

Request to Use Human Subjects in Research
Cover Sheet

50

Date Submitted: March 2, 1992 Project Period: From 3-16-92 To 4-16-92

Funded By: _____

Name: Vicki L. Christensen Department: Department of Nursing

Phone Number: Work (408) 755-6268 During S-S 9a Home 408 663-3712 During M-F

Address: 7610 Fallenleaf Lane, Salinas, California 93907

Campus Affiliation: _____ Faculty x Student _____ Staff _____ Non-SJSU (contact) _____

Title of Proposed Project: A Study of Emergency Department Nurses' Attitudes
toward the Elderly and their Knowledge of Elder Mistreatment

Abstract: SEE ATTACHED ABSTRACT

Number of Subjects: 100 Age of Subjects: 23 years and older

Type of Subjects: Emergency Department Registered Nurses

Proposed Research Method: Survey

What Kinds of Data Will Be Collected: Demographic, Aging Semantic Differential, Qualitative

Is a copy or description of each data collection instrument attached: x YES _____ NO

Are procedures to protect confidentiality delineated: x YES _____ NO

Are agreements from participating institutions (on their letterhead) included: x YES _____ NO

Is a consent form attached: x YES _____ NO

Is it on SJSU letterhead? x YES _____ NO

Possible Risks: Possible discomfort during Semantic Differential includes
emotional reaction to comparing three individuals with similar

Category of Risk: adjectives. Also, may experience discomfort answering
questions about abuse.

(A) Research involving only minimal risk to human subjects:

Probability and magnitude of harm or discomfort are no greater than encountered in daily life.

B. Research involving reasonable risk to human subjects:

Risks to the subject are reasonable in relation to anticipated benefits to the subjects and the importance of the knowledge that may reasonably be expected to result.

PLEASE SUBMIT TWO COPIES OF THE COMPLETED PROTOCOL AND SUPPORTING MATERIALS TO:
SAN JOSE STATE UNIVERSITY, HUMAN SUBJECTS-INSTITUTIONAL REVIEW BOARD, ADM. BLDG.,
ROOM 150, SAN JOSE, CA 95192-0025. FOR QUESTIONS CALL THE HS-IRB AT (408) 924-2479.

Comments

The Semantic Differential uses a list of bipolar adjectives which are descriptive of attributes or behavioral characteristics of a person of any age. As a result, the respondent may become aware of personal attitudes toward the elderly and experience discomfort.

Verification of Translation Accuracy

Title of Proposed Project: _____

I, the undersigned, verify that all translated materials related to the above named study reflect the intent and spirit of English text.

Signature _____

Date _____

Phone _____

Mailing Address _____

Responsible Faculty Member Form

Must be submitted with SJSU student research protocols

Title of Proposed Project: A Study of Emergency Department Nurses' Attitudes toward the Elderly and their Knowledge of Elder Mistrreatment.

Student Investigator(s): Vicki Christensen

Responsible Faculty Member(s): Sharon Hogan, Assistant Professor

I (we), the undersigned, have reviewed the above named study and believe the research conforms to federal, state, and SJSU policy for the protection of human subjects in research. Further, I (we) will monitor the course and conduct of the proposed research.

Signature _____

Date 2/25/92

Department Nursing

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

To: Vicki L. Christensen, Nursing
7610 Fallenleaf Lane
Salinas, CA 93907

From: Serena W. Stanford *Serena W. Stanford*
AAVP, Graduate Studies and Research

Date: March 9, 1992

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"A Study of Emergency Department Nurses' Attitudes
toward the Elderly and their Knowledge of Elderly
Mistreatment"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Serena Stanford immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have questions, please contact me at 408-924-2480.

CC: Sharon Hogan, Ph.D.

APPENDIX C
Sample Cover Letter

February 7, 1992

Julia A. Kiefer, RN, BA, MPA
Director of Nursing
Mee Memorial Hospital
300 Canal Street
King City, California 93900

Dear Mrs. Kiefer:

As per our conversation on February 7, 1992, I am writing to obtain the hospital's approval for surveying the Emergency Department Nurses. This survey is part of my research about nurses attitudes toward the elderly and their knowledge of elder mistreatment. The data needed for this study involves the use of a three part questionnaire. Part one is designed to obtain pertinent demographic data. With the use of a scaled instrument, the Aging Semantic Differential, the second section is designed to elicit an individual's attitude toward the elderly. Part three consists of five qualitative questions which is to assess the nurse's knowledge of elder mistreatment. A copy of the questionnaire is enclosed for your review.

I will deliver to Linda Diaz, RN packets for the nurses on March 16, 1992. This packet will include: (1) a letter explaining the study and consent (2) a copy of the questionnaire, and (3) two self-addressed stamped envelopes. Each nurse will be instructed to complete the questionnaire at home and return in the specified envelope within four days. To ensure confidentiality, all questionnaire with remain sealed until the end of the data collection period on April 16, 1992. A copy of the consent is enclosed for your review.

I will monitor the questionnaires returned by opening and filing the consent. On April 1, 1992, I will deliver to Linda Diaz, RN a follow-up letter and questionnaire for those nurses who have failed to return the questionnaire.

It is not expected that participation in this study will harm or in any way cause the nurses' discomfort. The results, however, will benefit the practice of emergency nursing by adding insight into the increasing challenge of providing care for the elderly. Further, it is hoped that the results will demonstrate a county-wide need for specialized education concerning the emergency care of the elderly.

To obtain San Jose State University approval for this study, I need a letter from you, on hospital stationary, that communicates your agreement to participate upon the above stated terms. In addition, on separate piece of

stationary, I need the names of those nurses who are work in the Emergency Department.

I appreciate your consideration with this study. Please feel free to contact me if you have any questions or comments.

Sincerely,

Vicki L. Christensen, B.S.N., R.N.
Graduate Nursing Student
Department Of Nursing
San Jose State University

APPENDIX D
Approval Letters

MEE MEMORIAL HOSPITAL

300 Canal Street

King City, California 93950-3497

(408) 385-5491

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February 25, 1992

Vicki L. Christensen, B.S.N., R.N.
7610 Fallenleaf Lane
Salinas, CA 93907

Dear Ms. Christensen:

This letter is to serve as notification to San Jose State University of the George L. Mee Memorial Hospital Emergency Department's willingness to participate in your research survey process.

Please let me know if there is anything further I can do to assist you. I'll look forward to your results.

Sincerely,

Julia A. Kiefer, R.N., B.A., M.P.A.
Administrator, Patient Services

1330 Natividad Rd.
P.O. Box 81611
Salinas, CA 93912
(408) 755-4111

"A Heritage of Community Care."

February 11, 1992

Vicki L. Christensen, B.S.N., R.N.
7610 Fallenleaf Lane
Salinas, CA 93907

Re: Study of Emergency Department, Nursing Attitudes Toward the Elderly

Dear Ms. Christensen:

Your proposed study outlined in your February 7, 1992 letter and attachment to us has been reviewed by Shirley Algire, Admin. Assist., Nursing Services, and myself. Natividad Medical Center is agreeable to participating by allowing a survey of nurses, etc. as described in your letter.

By copy of this letter, we are asking Ed Zwinge to be your point of contact and to monitor the handling of your study in accordance with the plan you laid out.

We would certainly be interested in the findings arising from your study. Good luck in your project.

Sincerely,

Gordon Thurman
Chief Operating Officer

cc: Howard Classen, Chief Executive Officer
Shirley Algire, Admin. Assist., Nursing Services
Ed Zwinge, ER Clinical Coordinator

Community Hospital of the Monterey Peninsula

February 10, 1992

To Whom it may concern:

Community Hospital of the Monterey Peninsula has agreed to participate in Vicki L. Christensen's research study about nurses' attitudes toward the elderly and their knowledge of elder mistreatment.

Sincerely,

A handwritten signature in cursive script that reads "Shirley Barrett-Sheridan R.N.".

Shirley Barrett-Sheridan, R.N.
Manager, Emergency Department

SBS:rr

APPENDIX E
Consent Letter

School of the Applied Arts and Sciences • Department of Nursing
One Washington Square • San José, California 95192-0057 • 408/924-3130 • FAX: 408/924-3135

Date

E.D. Nurse
Hospital
Monterey County

RE: Agreement to Participate In Research

Dear Nurse:

I am a graduate nursing student presently conducting research on nurses attitudes toward the elderly and perceptions of mistreatment. The results of this study will add insight into the challenge of providing emergency care for the elderly. You will be asked to complete a questionnaire, at home, and return it to me by mail. Your participation in this research will be completely confidential.

Your participation in this study is voluntary. In the event you choose not to participate, it will not affect your professional standing nor your relations with San Jose State University.

It is not expected that participation in this study will harm or in any way cause you discomfort.

The results of this study may be published and aggregate data will be used. Any information that could result in your identification will be confidential.

If you have any questions about this study, please feel free to contact me at (408) 663-3712 to discuss any reservation you might have. Any complaints about this research may be addressed to Sharon Hogan, MS, RN, at (408) 924-3157. Questions or complaints about research, subjects's rights, or research-related injury may be presented to Serena Stanford, PhD, Associate Vice President of Graduate Studies and Research, at (408) 924-2480.

Sincerely,

Vicki L. Christensen, B.S.N., R.N.
Graduate Nursing Student
Department of Nursing
San Jose State University

I understand the risks and agree to participate in this study by completing a questionnaire. My responses will be confidential. I am aware that my participation is voluntary and that I may withdraw at any time.

Signature

Date

APPENDIX F
Consent to Participate

School of the Applied Arts and Sciences • Department of Nursing
One Washington Square • San José, California 95192-0057 • 408/924-3130 • FAX: 408/924-3135

Agreement to Participate in Research

Responsible Investigator: Vicki L. Christensen, B.S.N., R.N.

Title of Protocol: A Study of Emergency Department Nurses
Attitudes Toward the Elderly

1. I have been asked to participate in a research study investigating attitudes toward the elderly and perceptions of mistreatment.
2. I will be asked to complete a questionnaire on March 16, 1992, and return by mail within four days. I will receive a packet from my head nurse that contains the questionnaire and a self-addressed stamped envelope. The questionnaire will be completed at home.
3. It is not expected that participation in this study will harm or in any way cause you discomfort.
4. The results are expected to benefit emergency nursing by adding insight into the challenge of providing care for the elderly.
5. Results of this study may be published but no information that could identify your participation will be included.
6. Should you have any questions about this investigation, you can contact Vicki L. Christensen, BSN, RN at (408) 663-3712. Complaints about this research may be addressed to Sharon Hogan, MS, RN, at (408) 924-3157. Questions or complaints about research subjects' rights, or research-related injury, may be presented to Serena Stanford, PhD, Associate Vice President of Graduate Studies and Research, at (408) 924-2480.
8. Refusing to participate will in no way effect your professional standing or your relations with San Jose State University.
9. Your participation in this study is completely voluntary.

10. I will receive a copy of the dated and signed consent⁶³
with the questionnaire.

Your signature on this document indicates your agreement to
participate in this study.

The signature of the researcher indicates agreement to
include the subject in the research and attestation that the
subject has been fully informed of his or her rights.

Subject

Date

Investigator

Date