



# Health Care's Role in Stopping the Mistreatment of Older Adults

Dr. Lisa Yeh DO, Dr. Robert Anderson MD & Dr. Sarah Hallen MD

# CONFLICTS OF INTEREST

None

# TERMINOLOGY

- **Older adult** - age 60-65 +
- **Elder** – sometimes used as a noun or adjective to define an older adult
- **Vulnerable adult** – an eligible adult, which includes individuals 65 y/o or those protected under the Adult Protective Services Act
- **Caregiver** - broadly refers to relationships with a provision of assistance with daily activities and an expectation of trust.

# OBJECTIVES

- Recognize possible mistreatment in older and vulnerable adults
- Understand the medical provider role and its challenges in identification and management of mistreatment
- Understand gray zones (capacity, self-neglect, caregiver stress)
- Know who to involve and when

# CASE 1

An 85-year-old man is brought to the emergency department because his visiting nurse noted a blood glucose meter reading of 40 mg/dL.

- The patient's medical history includes type 2 diabetes mellitus.
- He has not visited his primary care clinician since his wife's death 6 months ago.
- He now lives alone and has no relatives living nearby. His clothing is soiled and smells of urine.
- His response to questions about his diabetes regimen is, "I don't know, I want to go home now!"

## Physical examination:

- Appears thin with temporal wasting.

# DEFINITION OF ELDER MISTREATMENT

Proposed by US Dept Justice:

“Elder abuse is an intentional or negligent act by any person that causes harm or a serious risk of harm to an older adult.”

# MAINE'S DEFINITION

“Abuse” as, “the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; financial exploitation; or the intentional, knowing or reckless deprivation of essential needs. ‘Abuse’ includes acts and omissions.”

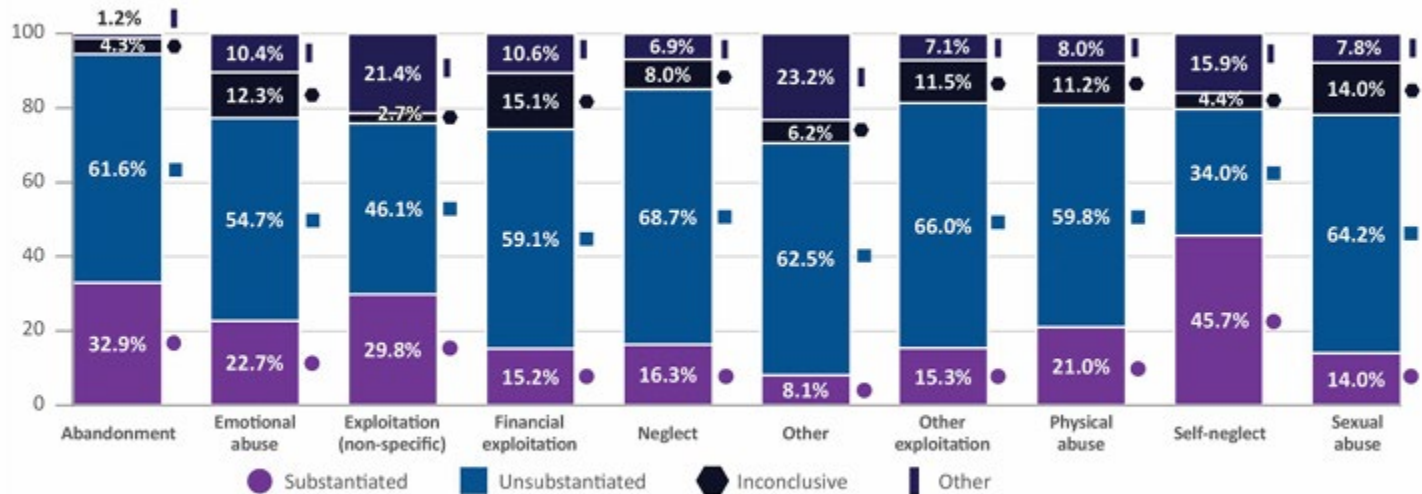
# EPIDEMIOLOGY OF ELDER MISTREATMENT

## Prevalence:

- Up to 10% of community-dwelling older adults each year
  - **Cognitive impairment raises risk to 1 in 2**
  - >20% of nursing home residents
  - Nearly 50% of low-income older adults (associated with fewer resources to meet caregiving demands)
- 
- **As few as 1 in 24 cases are reported to authorities** due to inadequate training, lack of time, desire to avoid involvement with the legal system

# MALTREATMENT TYPE

Exhibit 2.8: Allegations by Disposition and Maltreatment Type



Note: Based on data from 36 states for 699,158 maltreatment types.

# TYPES OF ELDER MISTREATMENT (1 of 3)

| Type           | Definition                                                                                                                           | Examples                                                                                                                                                                                                                                  |
|----------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physical abuse | Intentional use of physical force that may result in bodily injury, physical pain, impairment                                        | <ul style="list-style-type: none"><li>• Slapping, hitting, kicking, pushing, pulling hair</li><li>• Use of physical restraints, force-feeding</li><li>• Burning, use of household objects as weapons, use of firearms or knives</li></ul> |
| Sexual abuse   | Any type of sexual contact with an older adult that is not consensual, or sexual contact with any person incapable of giving consent | <ul style="list-style-type: none"><li>• Sexual assault or battery (eg, rape, penetration, coerced nudity, sexually explicit photographing)</li><li>• Unwanted touching, verbal sexual advances</li><li>• Indecent exposure</li></ul>      |

# TYPES OF ELDER MISTREATMENT (2 of 3)

| Type         | Definition                                                                                                                                          | Examples                                                                                                                                                                                                                                                                                                                                       |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Neglect      | Refusal or failure to fulfill any part of a person's obligations or duties to an older adult that may result in harm (intentional or unintentional) | <ul style="list-style-type: none"> <li>• Withholding of food, water, clothing, shelter, medications</li> <li>• Failure to ensure older adult's hygiene or provide physical aids (eg, walker, cane, glasses, hearing aids, dentures)</li> <li>• Failure to ensure older adult's personal safety and/or appropriate medical follow-up</li> </ul> |
| Self-Neglect | A person's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks                             | <ul style="list-style-type: none"> <li>• Obtaining essential food, clothing, shelter, medical care;</li> <li>• Obtaining goods/services necessary to maintain physical/mental health, or general safety</li> <li>• Hoarding</li> <li>• Managing one's own financial affairs.</li> </ul>                                                        |

# TYPES OF ELDER MISTREATMENT (3 of 3)

| Type                                   | Definition                                                                         | Examples                                                                                                                                                                                                                                                                                                           |
|----------------------------------------|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Financial/<br>material<br>exploitation | Illegal or improper use of an older adult's money, property, assets                | <ul style="list-style-type: none"> <li>Stealing money or belongings</li> <li>Cashing checks without permission/forging a signature</li> <li>Coercing into signing contracts, changing a will, assigning durable power of attorney against wishes, or older adult does not possess the capacity to do so</li> </ul> |
| Emotional/<br>psychological<br>abuse   | Intentional infliction of anguish, pain, distress through verbal or nonverbal acts | <ul style="list-style-type: none"> <li>Verbal berating, harassment, intimidation</li> <li>Threats of punishment/deprivation</li> <li>Treating like an infant</li> <li>Isolating from others</li> </ul>                                                                                                             |



# ROUTINE SCREENING FOR ELDER MISTREATMENT

- Recommended by the American Medical Association (AMA) and Joint Commission
- Not recommended by the US Preventive Services Task Force or American College of Physicians (ACP) – citing concerns about the measure’s specifications and potential overuse of unnecessary elder services referrals.
- The American College of Emergency Physicians, in a policy statement, recommends that emergency personnel assess patients for intimate-partner violence, child and elder maltreatment and neglect.
- The American College of Surgeons recommends considering screening older adults for potential elder abuse
  - Recognizing that trauma-related health encounters provide a unique opportunity to identify this frequently hidden issue.

# Epic Screening Tool

## Outpatient Care Setting

**Fall Risk / Exposure to Violence** ↓

Responsible + Create Note ✎ Macro Manager ▾  Show Row Info  Show Last Filed Value  Show Details  Show All Choices ⚙

---

Exposure to Violence ⤴

Has anyone hurt, frightened, or threatened you recently or in the last year?

Yes No Patient Declined Unable to assess Deferred (companion present) Deferred (clinically not indicated) Deferred (other) ☰ ▾ 📄

Will you discuss this concern with your provider?

Yes No ▾ 📄

## ELDER ABUSE SUSPICION INDEX © (EASI)

| EASI Questions                                                                                                                                                                                                                                                                        |     |    |                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|----------------|
| Q.1-Q.5 asked of patient; Q.6 answered by doctor<br><i>(Within the last 12 months)</i>                                                                                                                                                                                                |     |    |                |
| 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) <b>Doctor:</b> Elder abuse <u>may</u> 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 Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada) February 21, 2006. (Registration # 1036459)

[Mark J. Yaffe](#), MD

McGill University, Montreal, Canada

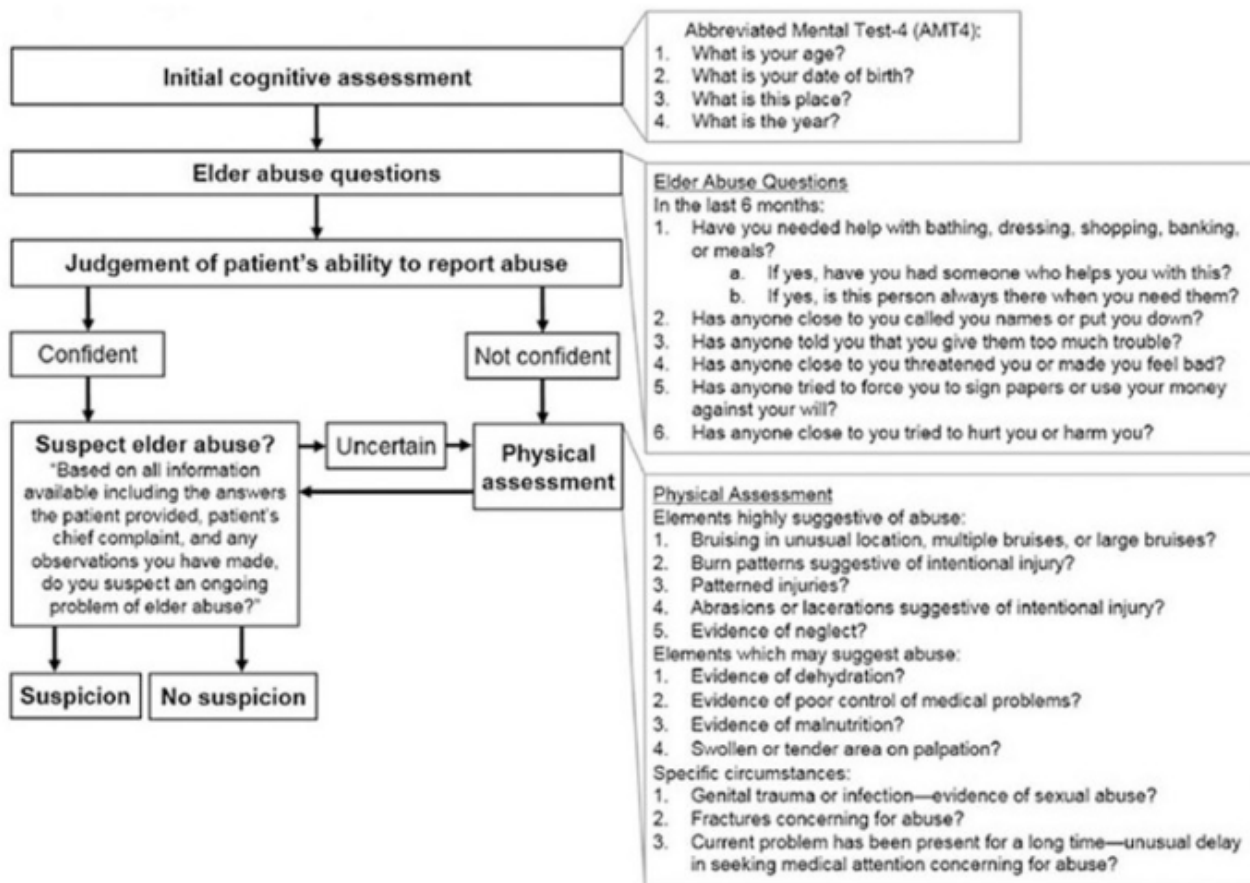
[Maxine Lithwick](#), MSW

CSSS Cavendish, Montreal, Canada

[Christina Wolfson](#), PhD

McGill University, Montreal, Canada

# ED SENIOR AID TOOL



# RISK FACTORS RELATED TO ELDER MISTREATMENT

| For becoming a victim                                                                                                                                                                                                                                                                                                                                                                                                                                                              | For becoming a perpetrator <sup>+</sup>                                                                                                                                                                                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Functional dependence or disability*</li> <li>• Poor physical health</li> <li>• Cognitive impairment/dementia* (especially if challenging behaviors)</li> <li>• <i>Mental health</i></li> <li>• Low income/socioeconomic status</li> <li>• Social isolation or poor social support</li> <li>• <i>Previous history of family violence</i></li> <li>• Previous traumatic event exposure</li> <li>• <i>Substance use disorder</i></li> </ul> | <ul style="list-style-type: none"> <li>• <i>Mental illness</i></li> <li>• <i>Substance use disorder</i></li> <li>• Care partner stress</li> <li>• <i>Previous history of family violence</i></li> <li>• Financial dependence on older adult</li> </ul> |
| <p><b>Many cases of elder mistreatment occur in the absence of any risk factors</b></p>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                        |

\*Strongest risk factors

<sup>+</sup>Assessment of care partner stress may identify opportunities for mistreatment prevention

# MEDICAL AND SOCIAL HISTORY (1 of 2)



Whenever possible, **older adults should be interviewed alone**

Many patients are reluctant to report mistreatment because of guilt, shame, fear

If responses suggest mistreatment may be occurring, progressively focused follow-up questions are indicated:

- **First ask:** “Is there any difficult behavior in your family you would like to tell me about?”
- If the answer is positive, possible questions to follow include:
  - “Has anyone tried to hurt or hit you?”
  - “Has anyone made you do things you did not want to do?”
  - “Has anyone taken your things?”

Mistreatment may be defined differently within different cultures of racial and ethnic groups

# MEDICAL AND SOCIAL HISTORY (2 of 2)



## Interview patients with cognitive impairment as they would others

- Consider seeking collateral information from other family members, neighbors, visiting nurses, when it will impact clinical decision-making or immediate safety

## Stress, isolation, depression of the care partner is relevant to the health of the older adult

- Consider privately interviewing the care partner
- Consider the care partner's skill level, situational understanding, and available resources for caregiving
- Counsel and offer resources to overwhelmed or stressed care partners

Effective assessment detects mistreatment without placing undue suspicion on well-meaning care partners or undermining a family's ability to care

- **Some care partners can be well-meaning and still neglectful**

# OLDER ADULT/CARE PARTNER INTERACTIONS THAT SUGGEST POTENTIAL MISTREATMENT



Older adult and care partner give conflicting accounts of events

Care partner interrupts/answers for the older adult

Older adult seems fearful of or hostile toward care partner

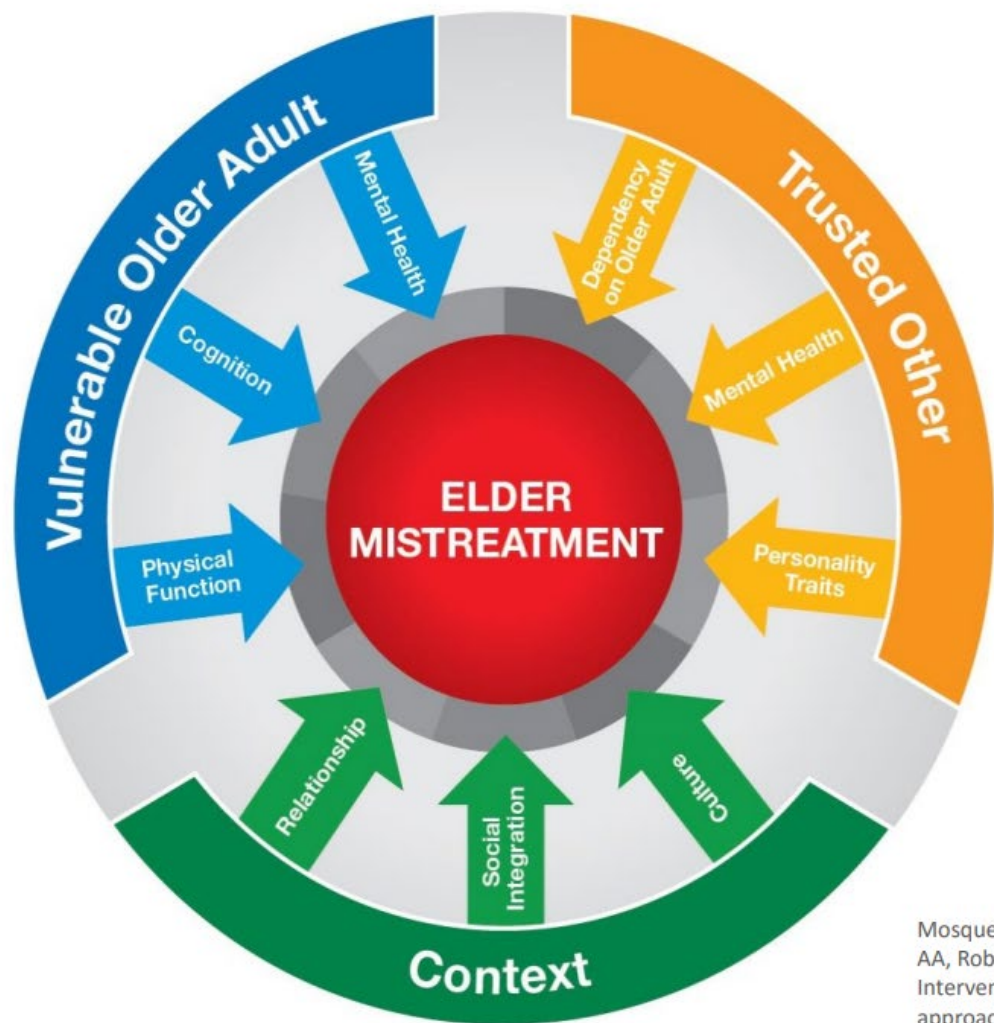
Care partner appears unengaged, inattentive in older adult's care

Care partner appears frustrated, tired, angry, burdened by older adult

Care partner appears overwhelmed by older adult

Care partner seems to lack knowledge of older adult's care needs

Evidence that care partner and/or older adult may have an alcohol or substance use disorder



Mosqueda L, Burnight K, Gironda MW, Moore AA, Robinson J, Olsen B. The Abuse Intervention Model (AIM): A pragmatic approach to intervention for elder mistreatment. *J Am Geriatr Soc.* 2016.

## Case #2

84-year-old female with history of high cholesterol, atrial fibrillation and thalamic stroke in 2020. Since then, no longer able to drive. Still lives at home but lacks insights into her deficits, missed paying bills, misses even doses of medications, forgets to hydrate and has had multiple medical visits for syncope and falls over the last 6 years.

Younger sister and brother-in-law live nearby and were helping a lot right after the stroke. During office visits, the sisters would argue over whether the patient missed medications or not and caregiver lacked sympathy and understanding of the limitations her sister has since the stroke. Soon, the sister stopped attending appointments. The patient updated her medical POA to other siblings who live out of state.

# THE CARE PARTNER–OLDER ADULT DYAD

- **Do not assume the older adult is inevitably the victim** in dysfunctional older adult and care partner relationship
- Consultation with social workers, psychologists, or psychiatrists can be useful to determine the facts in the situation and the perspectives of each involved party
- Detailed investigation is the role of Adult Protective Services
- Legal reporting requirements are not limited in any way by considerations of relationship difficulties or contextual subtleties

# CARE PARTNER LIMITATIONS

- **Care partners may have limitations that undermine their ability to provide adequate care**
- Care partner lack of insight about their own cognitive impairment may lead to resistance to recommendations
- Frank discussions about realistic future and optimal next steps for adequate care are critical
  - Maintain a collaborative approach and therapeutic alliance to identify changes the care partner will accept
- If the older adult is in danger, transfer to the hospital and report to Adult Protective Services

# Abuse Intervention Model



Mosqueda L, Burnight K, Gironde MW, Moore AA, Robinson J, Olsen B. The Abuse Intervention Model (AIM): A pragmatic approach to intervention for elder mistreatment. *J Am Geriatr Soc.* 2016.

## Case #3

- Mrs. A is an 80 year old female who presents to the Emergency Department with her son.
- Mrs. A has mild cognitive impairment
- Her clothes appear dirty, hair tangled, bruises on her upper arms – dismissed
- She had poor eye contact
- Son seemed uninterested
- She was admitted to the hospital for pneumonia and acute kidney injury (an abnormal lab value)
- Case started with APS from the ED

# EXAM FINDINGS SUSPICIOUS FOR VARIOUS TYPES ABUSE (1 of 2)

| Type           | Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physical Abuse | <ul style="list-style-type: none"><li>• Bruising in atypical locations (not over bony prominences / on lateral arms, back, face, ears, neck)</li><li>• Patterned injuries (bite marks, injury consistent with the shape of a belt buckle, fingertip, other object)</li><li>• Wrist or ankle lesions or scars (suggesting inappropriate restraint)</li><li>• Burns (cigarette pattern, stocking/glove pattern suggesting forced immersion)</li><li>• Multiple fractures or bruises of different ages</li><li>• Traumatic alopecia or scalp hematomas</li><li>• Subconjunctival, vitreous, retinal ophthalmic hemorrhages</li><li>• Intraoral soft-tissue injuries</li></ul> |

# EXAM FINDINGS SUSPICIOUS FOR VARIOUS TYPES ABUSE (2 of 2)

| Type         | Findings                                                                                                                                                                                                                                                                              |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Sexual Abuse | <ul style="list-style-type: none"><li>• Genital, rectal, oral trauma (including erythema, bruising, lacerations)</li><li>• Evidence of sexually transmitted infection</li></ul>                                                                                                       |
| Neglect      | <ul style="list-style-type: none"><li>• Cachexia/malnutrition</li><li>• Dehydration</li><li>• Pressure injuries</li><li>• Poor body hygiene, unchanged incontinence briefs</li><li>• Dirty, severely worn clothing</li><li>• Elongated toenails</li><li>• Poor oral hygiene</li></ul> |

# MEDICAL PROVIDER ROLE

## INDICATORS OF POSSIBLE MISTREATMENT FROM THE MEDICAL HISTORY

- Unexplained injuries
- Past history of frequent injuries
- Older adult referred to as “accident prone”
- Delay between onset of medical illness or injury and seeking medical attention
- Recurrent visits to the emergency department for similar injuries
- Nonadherence to medications, appointments, clinician recommendations

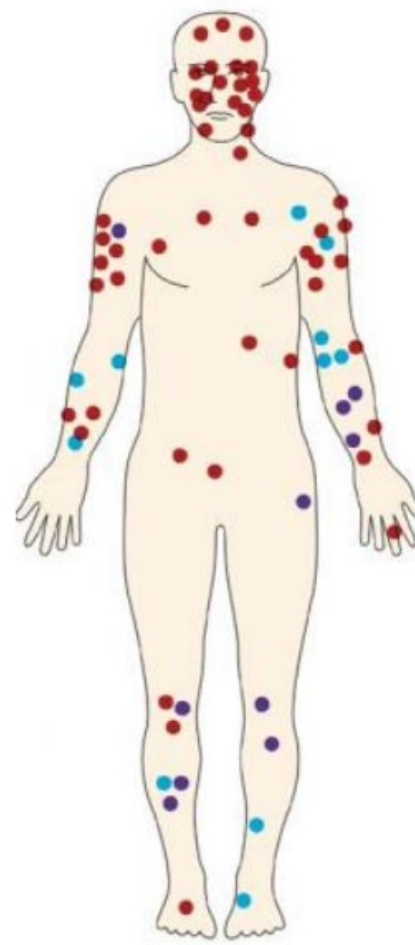
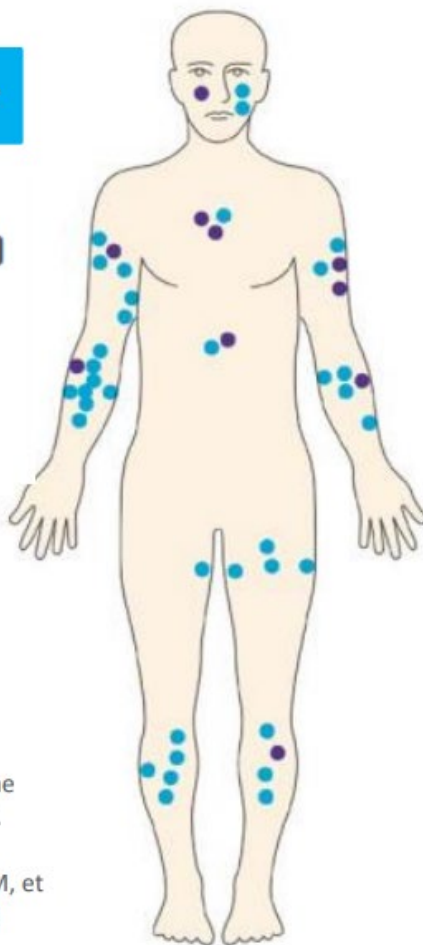
## Accidental

## Inflicted

Anterior

ORIGIN OF BRUISE  
(as reported by elder)

- Unknown
- Accidental
- Inflicted



Mosqueda L, Burnight K, Liao S. The life cycle of bruises in older adults. JAGS. 2005.

Wiglesworth A, Austin R, Corona M, et al. Bruising as a marker of physical elder abuse. JAGS. 2009.

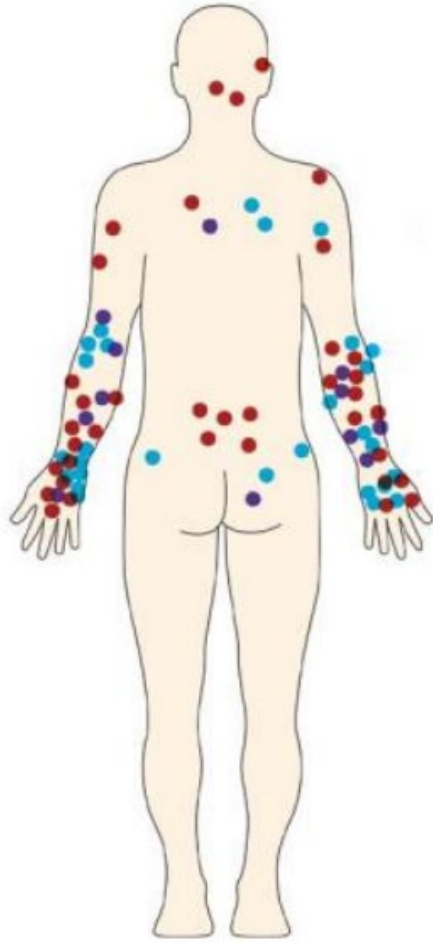
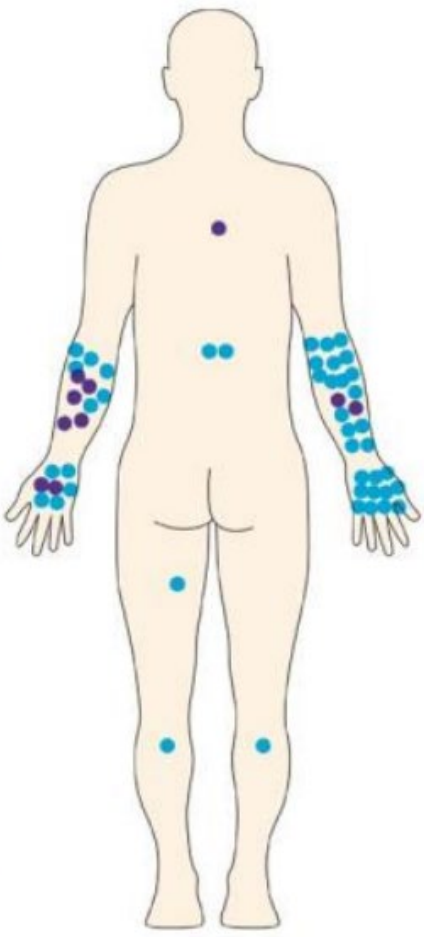
# Accidental

# Inflicted

Posterior

ORIGIN OF BRUISE  
(as reported by elder)

- Unknown
- Accidental
- Inflicted



Mosqueda L, Burnight K, Liao S. The life cycle of bruises in older adults. JAGS. 2005.  
Wiglesworth A, Austin R, Corona M, et al. Bruising as a marker of physical elder abuse. JAGS. 2009.

Mosqueda 2019. AGS: Disrupting the Silent Winter: Geriatrics' Role in Stopping Elder Mistreatment

# MORE ABOUT ASSESSMENT

**Distinguish abuse from accidents** by considering if physical findings are consistent with reported mechanism of injury

- In one study, bruises from physical abuse were often large (>5 cm) and on the face, lateral right arm, posterior torso
- In other studies, physical abuse and assault-related injuries were commonly on the head, neck, upper extremities
- Injuries to the left cheek/zygoma, neck, ulnar forearm may be much more common in abuse than accidents

For reported/suspected sexual abuse, consider sending the patient to the emergency department for comprehensive sexual assault evaluation by a forensic examiner

In emergency departments, do not simply treat and release patients whose home situation merits further assessment

# IMAGING STUDIES

- Diagnostic radiologists typically not trained to evaluate for elder mistreatment
  - **Findings suspicious for abuse:**
    - Concurrent old and new fractures
    - Fracture appearance inconsistent with injury explanation offered
    - Distal ulnar diaphyseal fractures
    - Small-bowel hematomas
  - Consider additional screening, including maxillofacial CT scan and chest radiograph, to evaluate for acute and chronic fractures
-

# TRAUMA-INFORMED CARE

Ongoing abuse or neglect, as well as previous traumatic experiences, may cause depression, anxiety, PTSD

Trauma-informed care involves patients' need for respect, acceptance, and safety by maximizing their choice and control, while minimizing additional trauma

# TRAUMA INFORMED CARE

Clinicians should attempt to provide trauma-informed care to people who have experienced elder mistreatment by:

- Avoiding words such as violence, abuse, neglect, mistreatment, criminal behavior if the patient does not initially conceive of what has occurred in this way
- Asking permission before touching a potential survivor of abuse
- Emphasizing the intention to maintain privacy and confidentiality

# SIGNS THAT WARRANT FOLLOW-UP FOR POTENTIAL PSYCHOLOGICAL ABUSE

- Care partner impatience, irritability, demeaning statements towards older adult
- Ambivalence or high levels of anxiety, fearfulness, anger toward the care partner
- Uncharacteristic withdrawal
- Lack of adherence to treatment recommendations
- Frequent requests for sedating medication
- Frequently cancelled appointments
- Changes in cognitive function or mood

## Case #4 Nursing home

- 76 y.o. male with past medical history of advanced dementia with frequent falls, difficulty accepting care and occasional aggressive behavior towards staff was sent to the ED for evaluation of chest pain
- In the ED, the patient was resisting taking off his t-shirt for the EKG, when staff cut it off. The t-shirt was “filthy”
- When the t-shirt was removed the staff found a large bruise on his torso. When the ED staff called to ask facility staff about it, they were unaware of the injury
- The patient was also found to be in soiled depends. His fingernails were very long with possible excrement under them. His hair does not appear to have been washed for a long time. He is unshaven.
- The ED staff call APS to report

# INSTITUTIONAL MISTREATMENT

- Nursing home residents are at a higher risk of mistreatment than community-dwelling older adults
- Factors that increase likelihood of mistreatment:
  - Poor working conditions
  - Low salaries
  - Inadequate staff training and supervision
  - Disruptive or insulting behavior by the older adult

# INSTITUTIONAL MISTREATMENT

- **CMS issued rules to protect the rights of facility residents,** including prohibiting facilities from forcing residents into arbitration, allowing residents/families to sue
- Each state has long-term care ombuds who identify, investigate, and resolve complaints made by or on behalf of residents, and advocate for residents of nursing homes

# CASE 1 (1 of 3)

An 85-year-old man is brought to the emergency department because his visiting nurse noted a blood glucose meter reading of 40 mg/dL.

- The patient's medical history includes type 2 diabetes mellitus.
- He has not visited his primary care clinician since his wife's death 6 months ago.
- He now lives alone and has no relatives living nearby. His clothing is soiled and smells of urine.
- His response to questions about his diabetes regimen is, "I don't know, I want to go home now!"

## Physical examination:

- Appears thin with temporal wasting.

# SELF-NEGLECT

- When an older adult's health or safety is threatened because they do not perform or refuse assistance with essential self-care
- Associated with an increased rate of 30-day hospital readmissions and increased mortality
- **Self-neglecting older adults may not appreciate that their health and safety are at risk** because of cognitive impairment, depression, psychosis, substance use disorders, other mental disorders
- **It is important to separate self neglect from poverty conditions which an older adult cannot control**

# SIGNS OF NEGLECT

| Behavioral                                  | Environmental                      | Physical                                     |
|---------------------------------------------|------------------------------------|----------------------------------------------|
| Not eating                                  | Not maintaining a safe environment | Cachexia                                     |
| Not taking medications                      | Hoarding                           | Dehydration                                  |
| Sparse social network – isolated, estranged | Pets                               | Pressure ulcers                              |
|                                             |                                    | Poor hygiene, unchanged disposable underwear |
|                                             |                                    | Elongated toenails                           |

# LAB FINDINGS SUSPICIOUS FOR ABUSE OR NEGLECT

- Multiple abnormal findings should increase concern, but **laboratory tests cannot definitively diagnose or exclude mistreatment**
- **Dehydration, malnutrition, and rhabdomyolysis** may indicate neglect
- Low levels of prescribed medications may indicate withholding (intentional or unintentional) by a care partner
- Increased levels of prescribed medications may indicate overdose (intentional or unintentional) or lack of appropriate supervision
- Presence of toxins or not prescribed medications raises the question of poisoning; consider consulting local poison center for guidance

# CASE 1 (1 of 3)

An 85-year-old man is brought to the emergency department because his visiting nurse noted a blood glucose meter reading of 40 mg/dL.

- The patient's medical history includes type 2 diabetes mellitus.
- He has not visited his primary care clinician since his wife's death 6 months ago.
- He now lives alone and has no relatives living nearby. His clothing is soiled and smells of urine.
- His response to questions about his diabetes regimen is, "I don't know, I want to go home now!"

## Physical examination:

- Appears thin with temporal wasting.

# CASE 1 (2 of 3)

Which one of the following is the most appropriate next step in the evaluation of this patient?

- A. Perform Mini–Mental State Examination.
- B. Perform a urinalysis.
- C. Consult the psychiatry team.
- D. Call adult protective services.

# CASE 1 (3 of 3)

Which one of the following is the most appropriate next step in the evaluation of this patient?

- A. *Perform Mini–Mental State Examination.***
- B. Perform a urinalysis.
- C. Consult the psychiatry team.
- D. Call adult protective services.

# ASSESSING COGNITIVE IMPAIRMENT/DEMENTIA

- What is the context when a decline in cognition comes into question
    - - ER, hospital, doctor's office, patient's home
  - Delirium vs Dementia
  - Changes in cognition and/or function reported by patient or trusted care partners/friends/family
  - Cognitive Testing Tools (MMSE, MOCA, SLUMS)
  - Things to Consider;
    - Substance use, Medications, acute illness, changes in mood/anxiety
-

# DOCUMENTATION

Medical records may be used for investigation and prosecution:

- Comprehensively document the patient's responses to questions, in their own words whenever possible
- Comprehensively report the physical examination, including the patient's general appearance and potential signs of neglect
- Describe all injuries in detail (size, location, stage of healing, whether consistent with reported mechanism)
  - Using a body diagram may increase accuracy
- Consider photographing physical findings and adding the photographs to the medical record

# MANAGEMENT OF SELF-NEGLECT

Assess the older adult's capacity to understand:

- Risks and benefits of the situation
- Consequences of allowing the circumstances to continue

Keep in mind that capacity is decision-specific:

- Capacity to make decisions about health care
- Capacity to make financial decisions
- Capacity to determine with whom one associates

**When appropriate, the older adult's right to autonomy and self-determination must be honored**

# INTERVENTION (1 of 3)

- How safe and should a safer environment be considered for the older adult?
- Does the older adult have a social network that can be called on to help and/or to monitor for abuse?
- What services and resources are available locally to support the care of the older adult and care partners?
- Are there any care partners who have health conditions of their own that need attention?
- Does this situation need the expertise of others (eg, case management, nursing, social work), and if so, who would best serve the older adult's needs?
- Should the situation be reported?

# INTERVENTION (2 of 3)

- Factors governing the clinician's course of action:
  - Exact nature and degree of the mistreatment
  - Whether the patient and/or care partner(s) can or will cooperate with evaluation and intervention
  - Availability of social workers and case managers
  - Local resources in support of interventions for mistreatment
- Health department consultation can be a useful early step
- APS can provide information and direct assistance
  - **But, older adults cannot be compelled to engage with APS**

# INTERVENTION (3 of 3)

## Helpful websites:

State departments of public health are usually responsible for investigating cases of abuse and neglect in nursing homes

National Adult Protective Services Association

National Center on Elder Abuse

Elder Justice Roadmap

# THE MEDICAL-LEGAL INTERFACE

Know your state's laws  
about reporting elder  
mistreatment

Reports are confidential

Important to report  
concern for mistreatment,  
**even if based on suspicion  
alone**

Penalties can be assessed  
against a non-reporter in  
some regions

A clinical reporter is  
protected from litigation  
unless it can be proved that  
the report was made  
maliciously

If mistreatment in nursing  
homes is identified or  
suspected, report it to the  
state department of public  
health, APS, or the state's  
long-term care ombuds

# SUMMARY (1 of 2)

- Mistreatment of older adults is a common phenomenon that has serious medical and social consequences, but it is dramatically underrecognized by clinicians and often not reported to authorities.
- Mistreatment affects as many as 10% of community-dwelling older adults and includes physical abuse, sexual abuse, neglect, psychological/emotional abuse, and financial exploitation.
- Although some presentations of mistreatment are dramatic on cursory evaluation, many are subtle and require a high index of suspicion and careful assessment.

## SUMMARY (2 of 2)

- Implementing formal screening protocols may be valuable.
  - Clinical assessment should include observing patient-care partner interactions, obtaining history from the patient alone, and performing a head-to-toe physical examination.
    - Laboratory and imaging tests may be helpful.
  - When concerned about mistreatment of an older adult, clinicians should ensure the patient's immediate safety, document findings in detail, and report to the appropriate authorities.
  - Clinicians should know how to access and be familiar with the role and duties of Adult Protective Services and the long-term care ombuds in their local area.
-

# Questions? Reflections?

