

Elder Mistreatment

Training Manual and Protocol

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About this Manual

Health professionals and allied health workers need to know and recognize the clinical indicators of elder mistreatment (EM) and need to know what actions to take if they suspect EM. However, many healthcare professionals are not aware that EM even exists, and few are actually trained to screen and assess for EM. Understanding cultural competency is essential to any EM training. Different cultures perceive aging and caregiving differently and this has important implications for the way EM is viewed, assessed and treated.

Trainees We Want to Reach

- Nurses
- Health Services Administrators
- Clergy
- Physicians
- Psychologists
- Pharmacists
- Rehabilitation Therapists
- Social Workers
- Community Practitioners and Care Providers
- Dentists
- Geriatric Care Managers

Elder Mistreatment Overview

In 1992, U.S. Secretary of Health and Human Services Louis Sullivan created a major paradigm shift when he deemed EM a health issue as opposed to a law and order issue. Available data since then have shown EM is a serious and widespread problem affecting between 700,000 - 1.2 million Americans annually. {Pillemer & Finkelhor 1988 #4102} Concern over the capacity of clinical care providers to recognize and address EM will increase as the number of cases grows as baby boomers age. The diversity of the healthcare workforce and the role in modern health care systems demand a concerted effort to diagnose and manage elder mistreatment across the care continuum.

Objectives of the EM program at NYUCN

Establish a flexible program of educational & training opportunities for clinicians and health care personnel caring for older persons on the detection and management of elder mistreatment.

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Goals

- A culturally-competent curriculum disseminated widely for teaching New York State health, allied health professionals and others about EM.
- A new baseline for culturally-competent training in EM rigorously evaluated, available nationally.
- Internet Web site on EM with resources for learning and training on EM.
- Repository of educational resources and information on EM: Faculty and Current information about key topics related to EM readily available for training activities.
- Distance learning program for Self Instruction on Clinical Assessment of EM consisting of regularly updated instructional modules addressing specific aspects of EM.

Core Program



Content

- Concepts of elder mistreatment
- Clinical recognition of elder mistreatment
- Research on elder mistreatment
- Legal aspects of elder mistreatment
- The care continuum and elder mistreatment
- Contemporary elder mistreatment theories
- Clinical documentation of elder mistreatment
- The impact of elder neglect on clinical care

INTERDISCIPLINARY TEAM / CONTENT

- Geriatric interdisciplinary team training (GITT) - A train-the-trainers program for exercising effective leadership in complex social environments. {Fulmer, Flaherty, et al. 2003 #7612}
- Models for clinical team practice
- Dynamics of interdisciplinary clinical teams

- Case Studies in elder mistreatment

- Team Assessment of elder mistreatment
- The Elder Assessment Instrument (EAI) in Practice

Educational Resources on the Internet


http://www.hartfordign.org/continuing_ed/elder_mistreatment/

http://www.nap.edu/openbook.php?record_id=10406&page=339

http://www.nygec.org/index.cfm?section_id=23&course_id=1

<http://www.lifespan-roch.org/pdf/TargetElderAbuseReport.pdf>

Elder Mistreatment Pre-test

 1. The most common form of elder mistreatment is physical abuse.

True False

 2. Sexual abuse is only diagnosed when the patient describes rape.

True False

 3. Neglect is a lesser form of elder mistreatment.

True False

 4. Abandonment is a form of elder mistreatment.

True False

5. Elder mistreatment is a public health problem.

True False

6. New York State Law requires all health professionals to refer cases of elder abuse to Adult Protective Services for further investigation and assessment.

True False

7. The number of new cases of elder mistreatment reported in the United States each year is almost 500,000 and represent a major public health problem.

True False

8. All states have mandates related to elder mistreatment.

True False

9. Bruises over the chest and face are indicators of physical abuse.

True False

10. Elder mistreatment is primarily a legal problem that frequently involves health care professionals.

True False

11. Malnutrition is always an indicator of elder neglect.

True False

12. Hip fractures are not indicators of elder abuse in patients older than 75 years because these patients usually have osteoporosis and a history of frequent falls.

True False

13. A red-purple bruise is more severe and older than a yellow-green one.

True False

14. Skin lacerations are cuts with raised, inflamed edges.

True False

15. Decubiti are normal lesions of the skin in patients who cannot move without help.

True False

16. Patients who are unable to perform 4 activities of daily living (ADLs) are at less risk of mistreatment than patients who are isolated.

True False

17. Dehydration is a common presenting sign of elder neglect and can be complicated by confusion.

True False

18. Isolated elders are more vulnerable to elder mistreatment.

True False

19. Burns are common injuries in elders who live in nursing homes.

True False

20. Elders are never victims of sexual abuse.

True False

21. Only social workers are responsible for the assessment of elder mistreatment.


True False

22. Excessive or insufficient medication of an older patient is an indicator of EM.

True False

23. A demented patient's complaint of neglect or abuse should be confirmed by the care provider.

True False

 24. Alcoholism is a risk indicator of EM only if the care provider is a heavy drinker.

True False

Answer Key

1. F	5. T	9. T	13. F	17. T	21. F
2. F	6. F	10. F	14. T	18. T	22. T
3. F	7. T	11. F	15. F	19. F	23. F
4. T	8. F	12. F	16. F	20. F	24. F

Chapter 1

Overview

Elder mistreatment (EM) is not a new phenomenon. Social indicators support the idea that EM has existed for generations without being recognized. The increasing economic and societal complexities of modern times intensify certain risk factors of EM. In the past, family generations remained relatively intact, often living together in the same home where care was provided for both the younger and older members of the extended family unit. However, economic and social characteristics of modern societies in developed countries have changed the extended family model. Increased mobility of family members has resulted in fragmentation of families, thus, changing the way care is provided for elders.

These changes are occurring at a time when people are living longer and when elders are experiencing greater care and support needs that often result in increased demands on their family members. These influences greatly affect both the older adults who are in need of assistance, as well as family members who are responsible for providing such support. Often, the older adult becomes concerned with his/her increasing dependency and family members feel they are unable to adequately provide support. Stress surrounding these changes increases for

everyone involved. Everyday challenges include maintaining full-time employment, living in overcrowded housing conditions, and raising a family, while simultaneously striving for personal and emotional balance.

Elder mistreatment results from the actions of abuse, neglect, abandonment and exploitation of the elderly. It is a serious problem, and prevalent studies suggest that 700,000 to 1.2 million older adults experience some form of mistreatment each year. {Pillemer & Finkelhor 1988 #4102} Incidence studies report more than 400,000 new cases each year (National Research Council, 2003; The National Center on Elder Abuse at The American Public Human Services Association in Collaboration with Westat, Inc., 1998). In response to its magnitude, mandatory reporting laws, special services, and training protocols have been implemented by most states. The study of EM has progressed steadily over the past two decades, as evidenced by the existence of the *Journal of Elder Abuse and Neglect*, a peer-reviewed journal for new knowledge dissemination, as well as mandatory reporting laws regarding EM in 46 states (Capezuti, Brush, & Lawson, 1997).

Recognition and assessment of EM are very important aspects of clinical practice. The well-being and quality of life for older adults depend on it.

This training manual provides necessary and essential information to health professionals for the appropriate assessment of cases where elder mistreatment is suspected and provides clinical guidelines for practice.

State Reporting Laws

Forty-six states have instituted elder abuse reporting laws, but standardized guidelines for reporting and managing cases of EM have not emerged. In Florida, for example, state law requires all types of mistreatment to be reported to the state's adult protective services, while New York laws require reporting EM in nursing homes but not among community-dwelling older adults. All clinicians in professional practice need to develop judgment regarding what actions are desirable to ensure the best possible outcomes for older patients who are suspected EM victims. Assessing and reporting EM is consistent with best

practice professional ethics of both the American Medical Association and the American Nurse's Association that have produced guidelines for the diagnosis and treatment of EM (American Medical Association, 1994) to help introduce standards of ethical professional practice in regards to EM.

Terms and Definitions

Terms and definitions for EM vary from state to state. Legal definitions by state for EM can be found in the National Research Council's *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America* published by the National Academies Press in 2003. The following excerpt was taken from the Analysis of Elder Abuse and Neglect Definitions Under State Law chapter (pp 216-217).

New York State

Physical abuse means the non-accidental use of force that results in bodily injury, pain or impairment, including but not limited to, being slapped, burned, cut, bruised, or improperly physically restrained.

Sexual abuse means nonconsensual sexual contact of any kind, including but not limited to, forcing sexual contact or forcing sex with a third party.

Emotional abuse means willful infliction of mental or emotional anguish by threat, humiliation, intimidation, or other abusive conduct, including but not limited to, frightening or isolating an adult.

Endangering the welfare of a vulnerable elderly person occurs under NY CLS Penal § 260.32 when, being a caregiver for a vulnerable elderly person: 1. With intent to cause physical injury to such person, he or she causes such injury to such person; or 2. He or she recklessly causes physical injury to such person; or 3. With criminal negligence, he or she causes physical injury to such person by means of deadly weapon or dangerous instrument; or 4. He or she subjects such person to sexual contact without the latter's consent.

Endangering the welfare of a vulnerable elderly person under NY CLS Penal § 260.34 occurs when, being a caregiver for a vulnerable elderly person: 1. With intent to cause physical injury to such person, he or she causes serious physical injury to such person; or 2. He or she recklessly causes serious physical injury to such person.

Active neglect under NY CLS Soc. Serv. § 473 means willful failure by the caregiver to fulfill the care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment, willful deprivation of food, water, heat, clean clothing and bedding, eyeglasses or dentures, or health-related services.

Passive neglect under NY CLS Soc. Serv. § 473 means nonwillful failure of a caregiver to fulfill care-taking functions and responsibilities assumed by the caregiver, including but not limited to, abandonment or denial of food or health-related services because of inadequate caregiver knowledge, infirmity, or disputing the value of prescribed services. Self-neglect is defined separately.

Financial exploitation means improper use of an adult's funds, property or resources by another individual, including but not limited to, fraud, false pretenses, embezzlement,

conspiracy, forgery, falsifying records, coerced property transfers, or denial of access to assets.

Vulnerable elderly person under NY CLS Penal § 260.30 means a person 60 years of age or older who is suffering from a disease or infirmity associated with advanced age and manifested by demonstrable physical, mental or emotional dysfunction to the extent that the person is incapable of adequately providing for his or her own health or personal care.

Caregiver under NY CLS § 260.30 means a person who assumes the responsibility for the care of a vulnerable elderly person pursuant to a court order; or receives monetary or other valuable consideration for providing care for a vulnerable elderly person. (National Research Council, 2003)

Clinical Practice

The following terms and definitions are common when referring to elder abuse and mistreatment in clinical practice (Fulmer & O'Malley, 1987).

Abuse

Abuse refers to the willful infliction of physical pain, injury or mental anguish upon an older adult or to the willful deprivation of services considered to be necessary for physical and mental health by a caretaker. Evidence of abuse includes: unexplained bruises, a history of repeated falls, laboratory values or 8 clinical findings inconsistent with the patient's medical history or diagnosis such as repeated fractures or several neighboring bruises in various stages of healing. Any complaint or patient report of physical abuse calls for immediate attention and action.

Neglect

Neglect is understood as a state of deprivation of services that are considered necessary to maintain physical and mental health. Elder neglect can be the result of the inability of an elder to care for him or herself without some form of external assistance or support. Neglect also occurs when the person responsible to provide such support to the elder fails to fulfill his or her obligations. Neglect by a caregiver can be intentional or unintentional and can be evidenced by signs of listlessness, poor hygiene, malnourishment, inappropriate dress, decubiti, urine burns, or by a history of the patient being left alone in an unsafe situation or when unable to receive medications when needed or required.

Exploitation

Exploitation refers to the act or process of taking advantage of an older adult by another person or caretaker whether for monetary or any form of personal benefit that results in a gain or profit to the perpetrator. Examples of exploitation are the unexplained loss of social security or pension checks, any evidence that material goods are being taken in exchange for care, any evidence that personal belongings of the elder (house, jewelry, car) are being taken without consent or approval.

Abandonment

Abandonment refers to the desertion or willful forsaking of an elder by a caretaker, including foregoing duties, withdrawal, or neglect of obligations owed an older adult by a caretaker or other person responsible for care.

Theories/Frameworks of EM

The causes of EM are often multi-faceted. Several theories have been formulated in attempts to explain why elder mistreatment may occur (National Research Council, 2003; Fulmer, 2002)(Fulmer & O'Malley, 1987; Phillips, 1986).

Cycle of Family Violence

The “cycle of family violence” theory posits that a child who sees violence as a normative behavior may incorporate the behavior into their adult life. Another concept in this pattern is that there can be retaliatory behavior, a “getting-back at parents or older adults for their past cruelty.” Both warrant further empirical investigation.

Non-Normal Care Provider

This theory focuses on the care provider as the abuser and on how a person’s behavior can lead to mistreatment. Care providers who are substance abusers, mentally ill or developmentally-challenged, are more prone to mistreat older adults under their care than care providers without these conditions. When a clinician notes or suspects any of these problems in a caregiver, he or she must pay special attention to the older patients who should be carefully and discreetly questioned and examined for possible mistreatment. Interviews should be conducted separately from the caregiver so that the older adults can speak freely.

The Stressed Caregiver

The stressed caregiver may be a person who has too many demands on his/her time and acts out by mistreating older adults. This may be a “woman in the middle” of caring for her children and her parents at the same time. When stress increases, the ability to provide good care may decrease. Older adults who have stressed caregivers should be assessed for EM.

Isolated Older Adults

This theory focuses on the belief that isolated older adults are especially at risk for mistreatment because there are no “outside people” to have a watchdog-10 effect and advocate for them. Homebound elderly persons are especially at risk as they may not come to the attention of the health care system until it is too late. Severe dehydration, malnutrition, urine burns, bedsores and delirium may be present in such older adults.

Elder Dependency

Older adults who are dependent on others for their care are at risk for EM. Often, the more frail and dependent an adult is on a caregiver, the more likely there will be mistreated.

Summary

This chapter presented a brief overview of EM with a focus on definitions and signs and symptoms of selected categories of mistreatment (abuse, neglect, exploitation, and abandonment). Brief descriptions of EM theories concerning occurrences of mistreatment of elders also were discussed.

Chapter 2

Clinical Assessment and Evaluation

High risk situations for EM

- Drug or alcohol addiction in the family
- Isolation of the elder

- History of untreated psychiatric problems
- Evidence of unusual family stress
- Excessive dependence of elder on caretaker

Signs and symptoms of EM

Signs and symptoms of EM can be noted on the Elder Assessment Instrument (EAI) (Fulmer, Street, & Carr, 1984; Fulmer & O'Malley, 1987; Fulmer & Wetle, 1986; Fulmer, Paveza, Abraham, & Fairchild, 2000; Fulmer, 2003; Fulmer et al., 2004) included in the appendix of this clinical manual. The EAI is meant to be a screen, and is recommended as a first step in the identification of cases of EM. The items on the EAI instrument are highly sensitive to signs of mistreatment to avoid overlooking cases of neglect. When an item screens positive careful follow-up inquiry is required to ascertain the most appropriate action plan for promotion of the patient's well-being. Screening tools for EM should be incorporated into routine medical questioning to ensure that clinicians rule out suspected EM rather than overlook it. A history of substance abuse, mental illness or developmental disability are common characteristics among caregivers when EM is suspected. Older adults, who are dependent upon caregivers with such personal challenges, are at high risk for mistreatment. In addition, older adults may be isolated or unable to depend on anyone to assist and advocate for them.

A thorough assessment, evaluation, and inquiry is necessary to detect signs of EM. These signs can be difficult to recognize because health changes in older adults may present similarly to signs of mistreatment. In addition, many older adults experience side effects from polypharmacy and are cognitively impaired. Therefore, adept evaluations are necessary to reach an accurate diagnosis. Signs of mistreatment may be observed in the elder's physical appearance, by the nature and extent of injuries, the general state of health and by the overall family situation. Table 1 is a list of EM screening/assessment tools to be used in clinical practice. The EAI is included in chapter 4 of this manual.

Table 1. Description of Screening/Assessment Instruments*

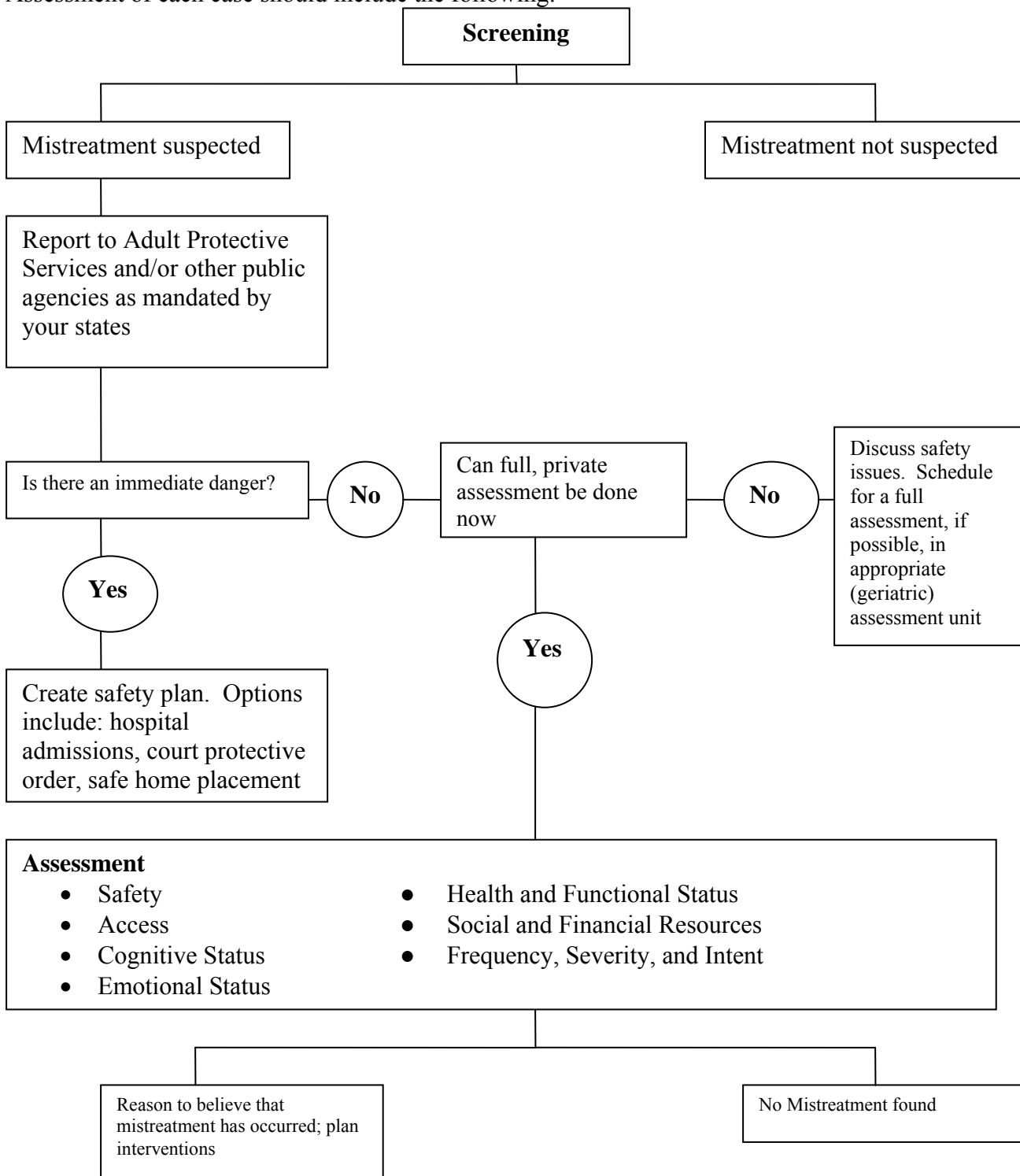
Authors (Year)	Name of Instrument	Method	Documented Psychometrics	Comments
Johnson, D (1981)	Screening Protocols for the Identification of Abuse and Neglect in the Elderly	Checklist requiring interview and period of observation 18 issues assessed	No	Used as a brief screen; setting not specified; Victim and caregiver
Ferguson, AD and Beck, C (1983)	H.A.L.F.	37-item checklist requiring interview and period of observation	No	Requires a somewhat lengthy social history; for all clinical settings; Victim and caregiver
Rathbone-McCuan, E and Voyles, B (1982)	Case Detection Guidelines	Reference list of risk factors and physical findings	No	Aimed at practitioners with little experience with EM cases; all clinical settings; Victim and caregiver
Tomita, SK (1982)	Elder Abuse and Neglect Protocol	Comprehensive outline describing an approach to abuse	No	In-depth assessment and intervention plan development; for social service agencies; Victim and caregiver
Fulmer, T; Street, S; Carr, K (1984) (Modified in 1992, 2000)	Elder Assessment Instrument – EAI	42-item checklist of selected common presentations of EM	Yes	Requires training, easily administered, suitable in home care, clinic hospital, emergency center; available in Spanish; Victim only

Hwalek, MA and Sengstock, MC (1986)	Hwalek-Sengstock Elder Abuse Screening Test – H-S/EAST	15-item questionnaire	Yes	Quick screen suitable in emergency or outpatient setting; Victim only
Straus, M (1978, 1979)	The Conflict Tactics Scale (CTS)	19 item self-report or interview	Yes	Inpatient or outpatient settings; sensitive questions; available in Spanish; Victim only
AMA (1992)	AMA Assessment Protocol	Checklist to utilize if abuse suspected	No	Depends on clinical acumen; all clinical settings; Victim only
Reis, M., Nahmiash, D., Shier, R., Senneville, C. (1995)	Brief Abuse Screen for the Elderly – BASE	5 standard questions	Yes	Quick screen suitable in emergency or outpatient setting; victim and caregiver
Reis and Nahmiash (1998)	Indicators of Abuse Screen – IOA	40-item checklist	Yes	Requires in-depth interview; setting not specified; victim and caregiver
Bass, DM; Anetzberger, GJ; Ejaz, FK; Nagpaul K (2000)	Screening Tools and Referral Protocol Stopping Abuse Against Older Ohioans: A Guide for Service Providers – STRP	A combination of several instruments; includes a referral protocol	Yes	A series of qualitative and quantitative measurements of practitioners change in understanding of abuse and or violence; all clinical settings; victim only

Fulmer, T., Guadagno, L., Bitondo Dyer, C., & Connolly, M. T. (2004). Progress in elder abuse screening and assessment instruments. *Journal of American Geriatric Society*, 52(2), 297-304.

INTERVENTION AND CASE MANAGEMENT: PART I

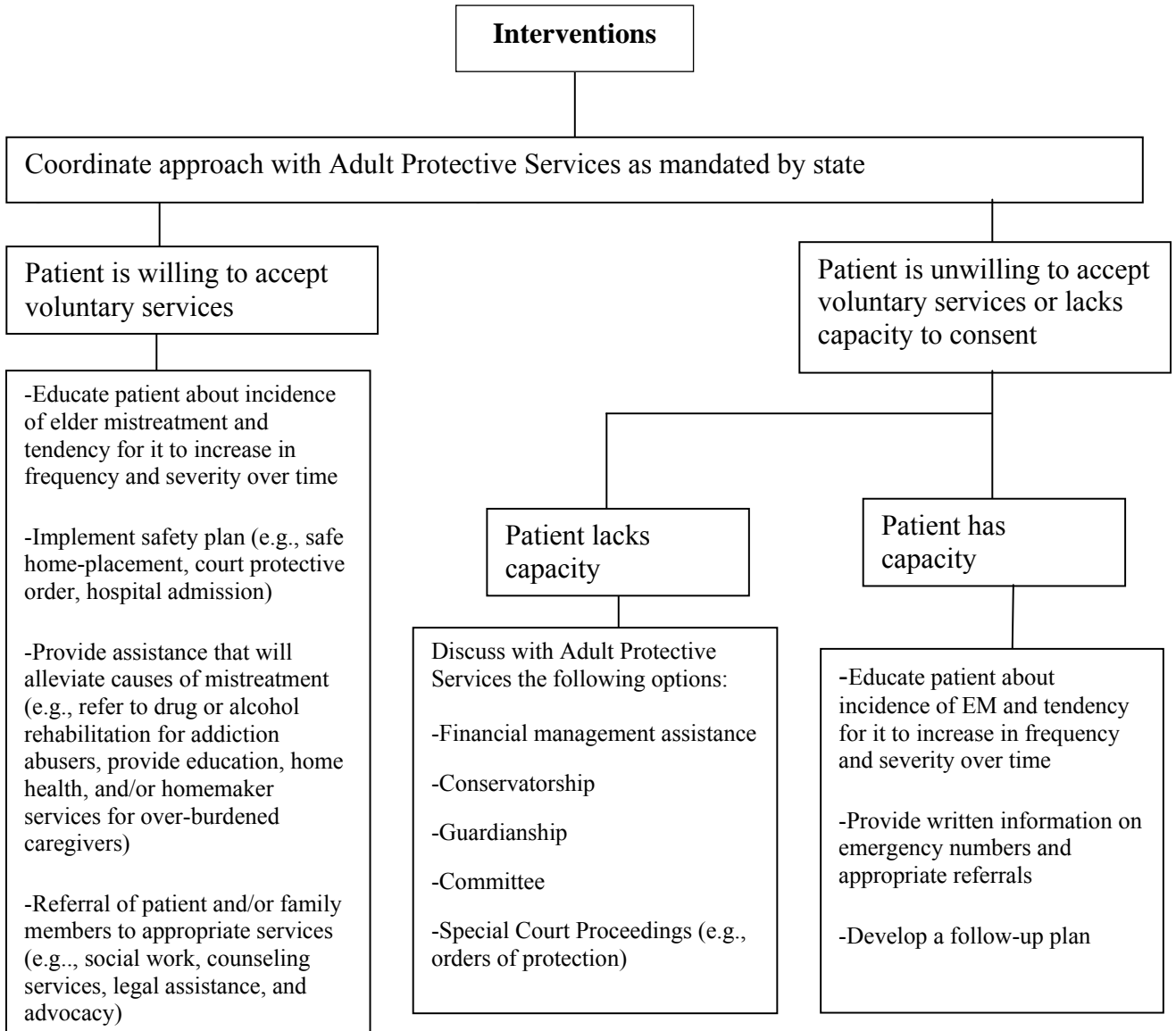
Screening and assessment for elder mistreatment should follow a routine pattern. Assessment of each case should include the following:



INTERVENTION AND CASE MANAGEMENT: PART II

Case management should be guided by choosing alternatives that least restrict the patient's independence and decision-making responsibilities, while simultaneously fulfilling state mandated reporting requirements. Interventions will depend on the patient's cognitive status and decision-making capability and whether the mistreatment is intentional or unintentional:

(Lachs & Fulmer, 1993).



Case Studies: (Hudson, 1989)

It is imperative for health professionals to become familiar with early warning signs of EM in order to protect victims and intervene. The following cases reflect situations in which further evaluation and follow-up are warranted.

Case 1: Abuse

An elderly woman, 93 years old, was brought to the emergency department (ED) by ambulance with a chief complaint of left hip pain. She was found lying on the floor at home in urine-soaked clothing by a home health aide. Her past medical history was significant for hypertension and hypothyroidism. She was under the care of a primary physician and was known to an area home-care agency.

On arrival to the ED, she was not oriented to person, time and place, responding “I don’t know” to multiple questions. A physical examination revealed ecchymoses over the right periorbital area and the right maxilla. She was tender to palpation over both sides of the anterior chest wall. Additional ecchymoses were visible on both delto-pectoral triangles, both shoulders, her left pelvic rim, right upper thigh and natal cleft. No fractures were evident.

Additional information obtained from a registered nurse (RN) at the home care agency who was familiar with her case provided valuable insight into the patient’s living situation. The patient resided with her daughter and son-in-law who were in their 70’s; the patient had been ambulatory and able to manage some activities of daily living (ADL’s) prior to her arrival to the ED; and the son-in-law had expressed great anger over having his mother-in-law live with him and his wife and wished to have her live elsewhere. The RN also reported observations of bruises on the patient’s back approximately four months earlier and expressed concern over the patient’s current extensive bruising.

The patient’s primary care physician also was contacted. Her last visit to him had been two months earlier, at which time he found her to be alert, clean, and able to report details concerning her own medical history. He confirmed that both the

patient's daughter and son-in-law had psychiatric problems and that there was tension in the family.

The patient's daughter was contacted by phone. She stated that her mother did not fall but had lowered herself to the floor to gain attention. The daughter was unable to explain the causes of her mother's bruises that were found upon examination at the ED.

Case 2: Abandonment

A 75-year-old woman was brought to the emergency department (ED) with hypothermia and confusion after she was found wandering outside by the police. The patient had a history of dementia and was being seen sporadically by a primary medical physician and at an area medical clinic.

In the ED, the patient was oriented to person, place, month and year, but was unable to clearly answer questions about recent events, family members, and activities of daily living (ADL). The patient's minister was contacted to obtain additional information. He described the patient as an outsider who lived in a disheveled apartment. She had a son in New York and a sister in New Haven but was estranged from both of them. After several efforts, telephone contact was established with the patient's son and her sister, but both refused to become involved with her situation.

The patient was medically evaluated, treated for hypothermia and upon improvement was cleared for discharge from the ED. A consultation request to the Department of Psychiatry for evaluation resulted in a diagnosis of dementia and some impairment of cognitive function without evidence of acute psychosis. She also was cleared for discharge by the psychiatry consultant.

Upon assessment, the patient was considered to be at risk for mistreatment because of her confusion, lack of support systems, and the events of the previous day.

Case 3: Self-Neglect

A 70-year-old female was brought to the emergency department (ED) by ambulance after the patient called 911 requesting transportation due to abdominal pain. Upon arrival to the emergency unit, the paramedics informed the social worker that the patient was living in deplorable conditions. They stated that there were animal feces on the floor. In addition, her single family home was extremely cluttered making movement from room to room very difficult. There was minimal food in the home and the patient denied having family or friends. The paramedics strongly recommended that the patient remain in the hospital and not be discharged back to her unsafe home.

Physical examination revealed an elderly unkempt woman in no apparent distress. She was oriented to time, person and place, was able to restate her medical complaints clearly and denied any previous medical history. The patient was diagnosed with gastroenteritis and was medically cleared for discharge.

The patient refused to consider an alternative living arrangement or home health care. It was ascertained from the Department on Aging that referral had been made to the Department on Aging one month prior, and the patient was found able to make her own decisions. Therefore, the case was closed. Department of Aging made a referral to the Health Department due to unsanitary home conditions.

The patient was discharged home from the ED with a scheduled appointment to visit the outpatient clinic for regular medical care.

Summary

The detection of signs and symptoms of EM may be challenging even for an expert practitioner. Increased awareness of assessment and evaluation tools as well as an understanding of the probable signs are instrumental in decreasing the number of undetected cases.

Chapter 3

Neglect

Elder neglect is one of the most complex concepts of EM and also is the most frequently reported category, accounting for over 70% of the APS cases annually (Blakely, 1991; The National Center on Elder Abuse at The American Public Human Services Association in Collaboration with Westat, Inc., 1998; Fulmer et al., submitted; Fulmer et al., 2004; Fulmer et al., 2003; Fulmer et al., 2002; Fulmer et al., 2000).

The previous definitions of EM frame the issue of neglect. However, detection and assessment are challenges clinically since there are many undefined constructs involved. Even the definition of neglect is problematic because it leaves many variables unclear. For example, how is poor hygiene defined? Who should be considered a responsible caretaker? And what if an elder chooses a life of self-neglect? These questions reflect the paucity of empirical data, and highlight the need for research to analyze this important area of clinical care.

Clinical evaluation

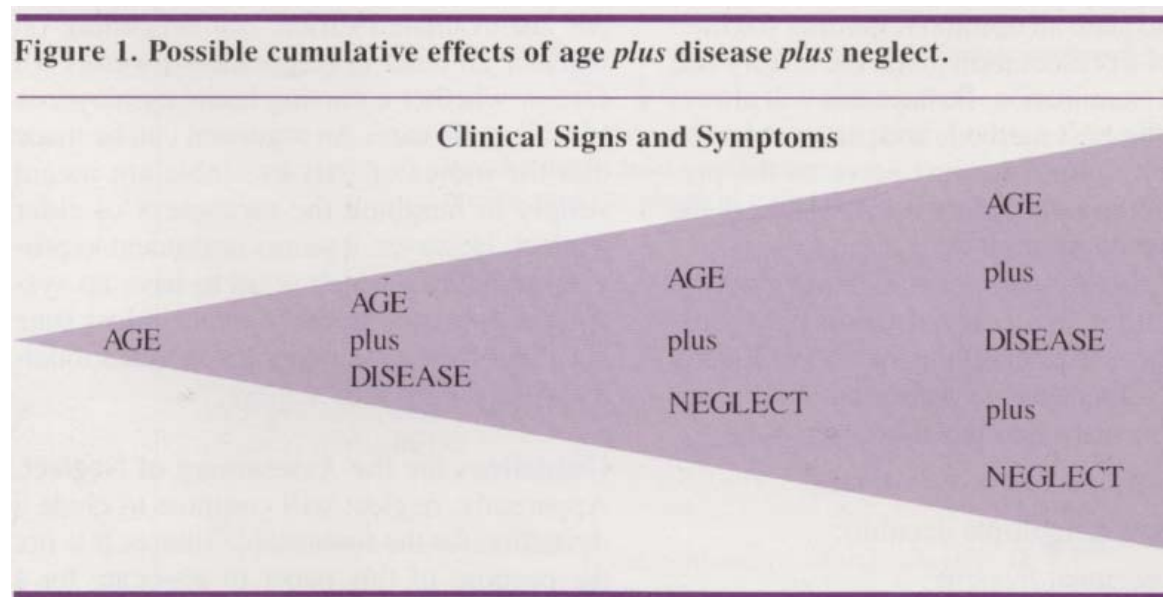
Health professionals rely on clinical evaluation to determine neglect cases where older adults seem to fall below an acceptable level of care. Generally, it is better to over-report cases of neglect as the consequences of under-reporting are more serious and can aggravate already poor health conditions. In addition, older adults have the right to self-determination; and in the absence of cognitive impairment, they can and should dictate their own preferences. The Adult Protective Services in each state will confirm a case as neglect or close the case when there is insufficient evidence to support the allegation.

Older adults can exhibit a range of age-related changes and signs and symptoms from diseases that often mimic signs of neglect. For example, poor hygiene is often considered a sign of neglect, but it also could be a result of poor vision or

decreased dexterity from arthritic hands. The decision tree in Figure 1 is a useful guide for processing signs and symptoms of neglect.

Summary

Neglect is a poorly-understood and complex phenomenon, which has serious ramifications for the elderly. Data supports that older adults who suffer from neglect may be seriously ill and have an increase in morbidity and mortality rates. It is incorrect and inappropriate to consider neglect a natural condition resulting from the aging process. Reporting possible neglect cases may potentially save the life of an older adult.



Fulmer T., & Ashley, J. (1986). Neglect: What Part of Abuse. *Pride Institute Journal of Long Term Home Health Care*, 5(4), 18-24.

Figure 2. Two examples of neglect indicators with possible causes of the indicator.

Indicator of neglect	Possible causes of indicator	Age	Age <i>plus</i> disease	Age <i>plus</i> neglect	Age <i>plus</i> disease <i>plus</i> neglect
Example 1 Fracture	Possible causes of indicator	Osteoporosis	Osteoporosis <i>plus</i> stress fracture	Osteoporosis <i>plus</i> inadequate assistance with ambulation	Osteoporosis <i>plus</i> stress fracture due to inadequate assistance with ambulation
Example 2 Poor Hygiene		Decreased visual acuity	Decreased visual acuity <i>plus</i> rheumatoid arthritis (pain)	Decreased visual acuity <i>plus</i> inadequate self-washing leading to poor hygiene	Decreased visual acuity <i>plus</i> rheumatoid arthritis (pain) leading to inadequate self-washing and resultant poor hygiene

(Fulmer & Ashley, 1986)

Chapter 4

The Elder Assessment Instrument

Assessment Instruments

Assessment instruments are practical tools for organizing information regarding EM. Numerous instruments and protocols are available and usually are tailored to the individual setting and within the context of existing state regulations. The Elder Assessment Instrument (EAI) is a useful tool for the evaluation of EM. The EAI is used as a framework for organizing information and data obtained during clinical interactions between clinicians and patients. This chapter describes the

general organization of the EAI and gives some information on the items of which it is composed.

Interviewing Process

For this and all interactions with patients and caregivers, the interviewer must be respectful of the privacy and comfort level the interviewee. The interviewer puts the patient at ease by maintaining a calm demeanor and a respectful approach. Interviewers should be well composed and behave in a confident, professional, and sensitive manner at all times. Interviewers must be cognizant that the interview is an intrusion into the patient's life, personal affairs, feelings and memories. Overall, interviewers must exhibit a profound respect for the patient's dignity and privacy at all times.

General Organization of the EAI

The EAI is a 51-item Likert scale assessment instrument that has been in literature since 1984, and has had several revisions. This instrument is comprised of seven sections that review signs, symptoms and subjective complaints of elder abuse, neglect, exploitation and abandonment. There is no "score". Application of the EAI usually requires 10 to 15 minutes. A patient should be referred to social services if any of the following exists:

- 1) If there is any evidence of mistreatment without sufficient clinical explanation
- 2) Whenever there is a subjective complaint by the elder of EM
- 3) Whenever the clinician believes there is high risk or probable abuse, neglect, exploitation or abandonment

Section 1: General Assessment

The first section is an initial assessment of the patient's general appearance. Upon engaging the patient in conversation, the interviewer begins by developing a general impression about the interviewee, casually observing his or her general appearance. This requires careful but discrete observation of the patient's affect, hygiene, nutrition, and skin integrity, clothing (clean, dirty or heavily soiled), strong unpleasant odors indicative of poor hygiene, oral hygiene, and difficulty controlling urination or defecation. Specifically, consider body weight, build, hair, nails, and evidence of injury such as sunburn, abrasions, lesions, ulcers, ecchymosis, or wounds. Note any general abnormalities or findings inconsistent with the history and diagnosis. Rate on a scale from 1 - 4 (1 = very good, 4 = very poor) the general appearance items on the EAI.

Section 2: Possible Abuse Indicators

5. **Bruising** – Ecchymosis is a dark-blue area of skin, larger than 3 mm in diameter that is caused by extravasations of blood into the skin commonly from blunt trauma. Presence of bruises do not always indicate abuse; however, bruises in the same location in different stages of healing may indicate mistreatment. Some lesions are clearly bruises and the score is 4, other older lesions are difficult to assess and the patient may deny a history that would suggest an event or incident that could have resulted in bruising. In that example, the clinician determines if the lesion is suggestive of probable evidence of bruising (score 3) or no probable evidence (score 2). If there are no lesions suggestive of a bruise then the score is 1.

6. **Lacerations** – External lacerations are wounds produced by tearing of superficial tissues and are distinguished from cuts or incisions. Lacerations may be small or large and may be caused in many ways, such as from a blow with a blunt instrument, falls, or an accident with machinery. Lacerations also can occur internally as when the capsule of the spleen tears following blunt trauma as in a car accident or after a fall.

7. **Fractures** – The clinician notes the presence or absence of fractures. Fractures that are inconsistent with the medical diagnosis may be indicators of abuse.

8. **Various stages of healing of any bruises or fractures** – Bruises or fractures in various stages of healing can suggest abuse.

9. **Bruises and/or trauma beyond what is compatible with alleged trauma** – Subjective bruises may appear incongruent with the subjective description of the event leading to the bruising or trauma. For example, a patient might state that they banged their arm on a door but an x-ray might show a compound fracture. In such a case a referral should be made to social services and further information should be sought.

10. **Evidence of sexual abuse** – Sexual abuse may be evidenced by the development of a sudden and uncomfortable gait, urinary tract infections, soiled clothing, itching, or burning in the genital area. Signs of abuse also include sudden changes in behavior, demeanor, or affect.

11. **Subjective complaint of abuse** – Often a verbal complaint is the only evidence of physical abuse.

Section 3: Possible Neglect Indicators

12. **Contractures** – Contractures form around the large joints of the arms and legs most notably around the elbows and knees. Contractures are not readily observable on inspection but become evident during clinical examination. Contractures are a shortening of the soft tissues around joints (like scars) that restrict the movements of the affected joint. Contractures are evident in a person who cannot extend an arm or a leg, as it happens to some patients after a stroke.

13. **Decubiti** - This is the plural for decubitus, which means bedsore. Bedsores or decubiti usually form on wet, moist skin of weight bearing areas of the body that are stationary for long periods. They are most common on the lower back of bed-ridden patients or patients who can not move about without help.

14. **Dehydration** – Several physical signs indicate dehydration and some are more obvious than others depending on its severity. When dehydration is severe, the mouth becomes dry and the lips chapped and cracked. With moderate dehydration grabbing a fold of loose skin of the arm, squeezing it gently and holding it for a few seconds and then releasing it reveals the sign of decreased turgor. When turgor is decreased the skin slowly returns to its normal position after a pinch and release.

15. **Diarrhea** – Diarrhea can be suspected from an odor or evidenced by soiling of the patient’s pants, skirt or bed sheets. Casually, ask the patient about any of these signs and about a history of bowel movements and diarrhea. Ask and act naturally while discussing this or any other issue that could make someone embarrassed or ashamed. Put yourself in the person’s position and consider how you would feel under such circumstances. Remember that loss of control of bodily functions can occur with many clinical conditions and under many circumstances.

16. **Depression** – Older adults who are isolated often become depressed. This can be evidenced by a change in eating habits or sleeping habits, isolation, becoming withdrawn, having a flat affect, loss of interest, guilt, anger, mood swings, or hopelessness.

17. **Impaction** – Impaction is the inability to move bowels or only doing so with extreme difficulty, stress, discomfort and pain. When severe, it may cause the patient to come to the ED for help. It also is noted on digital rectal examination of the patient by an examining clinician.

18. **Malnutrition** – Malnutrition often is noted in a person with a low BMI, sunken cheeks and temples and little muscle mass over the arms and legs. Such appearance can be the physical expression of many conditions including advanced cancer and may actually represent cachexia. The EAI attempts to disclose malnutrition as a reflection of neglect due to lack of a regular nourishing diet. Requirements for a well balanced diet vary slightly with age but in general should include consumption of adequate daily amounts of protein, fats, vitamins and minerals. Expressions of inadequate nutrition are varied and require a careful physical examination and appropriate laboratory tests. These important dimensions of nutritional inadequacies are beyond the scope of the EAI.

19. **Urine burns/Excoriations** – These are abrasions or scratches of the skin around the genito-urinary areas. Abrasions are superficial wounds resulting from rubbing or scratching against a rough surface. These lesions are observed during the physical examination of a clinician. A strong odor of urine or wetting of clothes from urination may alert the interviewer about the possibility of these lesions and trigger questions about the adequate support that the person receives for urinary function. The interviewer may be able to describe and inform about these lesions. The answer may

emerge during the clinical examination. The finding of urine burns or excoriation might reflect the inability of the person to have ready-access to a needed urinal or bed pan if he/she is unable to independently go to the bathroom.

20. **Poor hygiene** – Personal hygiene is defined as the individual practices related to health and cleanliness. In its broadest sense, it includes the general level of care in cleanliness and is reflected in the level of clothing, and oral and body condition. Is the person able to wash, dry and iron his/her clothes or does someone else do this? Is the person able to brush his/her teeth or take a shower or bath daily, regularly, when needed or requested? Are deodorant, cologne and other toiletries enjoyed by the person available and provided when needed or desired?

21. **Failure to respond to warning of obvious disease** – A dramatic example might be a patient with maggots or lice who is accompanied by a care taker or a patient with a stage IV pressure ulcer that has had no care or treatment.

22. **Inappropriate medications (under/over)** – Over- or under-medicating may be used by a caregiver to heavily sedate an older adult or cause mental anguish and pain by under-medicating a patient. Does the patient know the medications to take and when? Can the patient get the medications, dispense and take them without help? Does the patient independently take the correct dosage required for the entire period of prescribed treatment?

23. **Repetitive hospital admission due to probable failure of health care surveillance** – Patients may present at an emergency room so frequently that there should be concern regarding the surveillance of the primary care provider or care setting.

24. **Subjective complaint of neglect** - Does the person verbalize feelings of neglect?

Section 4: Usual Lifestyle

The fourth domain of the EAI examines the usual lifestyle of the interviewee as reflected in the seven general activities in field locators 14 – 20. The interviewer must rank the level of personal independence on a scale of 1- 4 based on the responses to general questions about these areas of daily life. A score of 1 means that the person can perform all activities related to the area of interest independently. A score of 4 means that the person is unable to perform any level of the activity without assistance. This assessment section seeks a clearer understanding of the amount of physical care required and the elder's dependency needs. Your questions should be posed clearly and in plain, understandable language but not in a condescending manner.

25. **Administration of medications** – Does the patient know the medications to take and when? Can the patient get the medications, dispense and take them without help? Does the patient independently take the correct dosage required for the entire period of prescribed treatment?

26. **Ambulation** – Can the person freely walk around without assistance of any kind? Uses a walker? Uses a wheelchair or crutches? How much help and support is required by the person to move? Does the person move regularly or primarily stay at home in a chair or bed?

27. **Continence** – Is the person able to control the urge to urinate or defecate? To what degree? Is help needed to go to the bathroom or to use a bedpan or urinal? Are these readily accessible and made available when needed? Is help available when needed, all the time, every time?

28. **Feedings** – Is food available and are meals prepared by the person or by someone else? Are three meals prepared and consumed daily? Is the person able to eat independently? Can the patient do so with all meals or only some (breakfast, lunch, dinner, snacks) or needs help with some kinds of food (i.e. soups or other liquids)? Does it take the patient a long time to eat a meal? Why?

29. **Maintenance of hygiene** – Personal hygiene is defined as the individual practices related to health and cleanliness. In its broadest sense, it includes the general level of care in cleanliness and is reflected in the level of clothing, oral and body condition. Is the person able to wash, dry and iron his/her clothes or does someone else do this? Is the person able to brush his/her teeth or take a shower or bath daily, regularly, when needed or requested? Are deodorant, cologne and other toiletries enjoyed by the person available and provided to him/her when needed or desired?

30. **Management of finances** – Questions about personal finances should be posed with sensitivity and discretion. Build from the general to the specific as you develop a sense of the person's level of independence in managing his/her personal finances. Is the person able to pay his/her bills when due or is assistance needed? How much help is needed? Are records kept to the person's satisfaction? Is the person confident that financial affairs are in order and bills are paid on time and appropriately? Is the person able to visit the bank alone or is help needed? Are banking transactions (deposits/withdrawals) performed independently, with assistance, or by someone else? Does the person have a will? How are health insurance and life insurance matters handled, and by whom? These questions, carefully worded according to the interviewee's sensibilities, should provide sufficient information for an adequate assessment of the person's ability to manage routine financial matters.

31. **Alcohol/Substance abuse** – A verbal complaint by the subject about past and present history is the only evidence of alcohol/substance abuse.

32. **Family support** – Does the person have any close relatives? Does the person receive any help or support from relatives? How close does the person feel to his/her relatives? Are relatives perceived as caring and loving? Do relatives visit

regularly? Are relatives interested in the person's affairs, situations, needs or problems? Is the person able to share with relatives feelings of joy or sorrow? Are special, memorable dates like a birthday, remembered by relatives?

Section 5: Social Assessment

This focuses on the broader social dimensions of a person's life and social interactions. The interviewer/evaluator assesses the quality of each of the nine aspects in the section on a scale from 1 to 4. A score of 1 means very good quality and a score of 4 means very poor quality. Any aspect that cannot be adequately assessed is scored as 9999. Section 5 is composed of field locators 33 – 41 on the EAI. The pattern of questioning is similar to Section 4 until the interviewer develops impressions about the quality of the person's living experiences of these social situations.

33. **Financial situation** – Is there enough money to meet expenses?
34. **Interaction with family** – How are relationships with other family members?
35. **Interaction with friends** – Many friends? How close? Help each other? Frequent contacts?
36. **Interaction with nursing home personnel** – Does the nursing attendant seem kind and attentive?
37. **Living arrangement** – Own/private apartment? Alone or shared with a relative or someone else?
38. **Observed relationship with care provider** – If both are present, how do they seem to relate to one another?
39. **Participation in daily social activities** – Participates in activities? Enjoys them? Why not?
40. **Support systems** – Does person feel able to call upon others to share worries, needs, etc.?
41. **Ability to express needs** – Is the person able to openly express feelings and emotions, particularly about needs or unhappiness within situations?

Section 6: Psychological Abuse

Assessment is based on the verbalized perceptions from the person who is receiving care. Emotional and psychological dimensions of the care include feelings of loneliness, being ignored, inability to receive information/updates on

topics of interest (also includes monotony and boredom from unchanged daily routines) and subjective complaint on neglect. Section 6 is composed of field locators 42 – 45, (on the Palm Pilot)

42. **Elder states being left alone for long periods of time** – Does the person feel this way sometimes?

43. **Elder states being ignored or given the “silent treatment”** – Does the person ever feel this way?

44. **Elder states failure to receive companionship, news, changes in routine, information**

45. **Subjective complaint of psychological abuse** – Does the person verbalize feelings of psychological abuse?

Section 7: Summary Assessments

This section is for the practitioner to comment on the evidence of EM noted through the use of the assessment instrument.

46. **Evidence of Abuse** – Refers to the willful infliction of physical pain, injury or mental anguish on an elder or to the willful deprivation of services considered necessary for physical and mental health by a caretaker. Unexplained bruises can be evidence of abuse as well as history of repeated falls, results of laboratory values that are inconsistent with the clinical history of the patient and by clinical evidence of fractures or bruises in various stages of healing. Any report by a patient of being physically abused calls for immediate action. Psychological abuse refers to the purposeful infliction of mental anguish, e.g. patient reports being called derogatory names, treated as a child, being frightened, humiliated, intimidated, threatened or isolated.

47. **Evidence of Neglect** – Disregard or failure to perform a task or function. Elder neglect refers to a state of deprivation of services that are considered necessary to maintain physical and mental health. Elder neglect can be the result of the inability of an older adult to care for him or herself without some form of external assistance or support. Neglect also occurs when the person responsible for providing such support fails to fulfill his/her obligations. Neglect can be evidenced by signs of listlessness, poor hygiene, malnourishment, inappropriate dress, decubiti, urine burns, or by a history of the patient being left alone in an unsafe situation or unable to obtain medications when needed.

48. **Evidence of psychological abuse** – Refers to the purposeful infliction of mental anguish, e.g. patient reports being called derogatory names, treated as a child, being frightened, humiliated, intimidated, threatened or isolated.

49. **Evidence of financial abuse** – Does the patient have sufficient financial resources for basic substantive needs? If the answer is yes but there is evidence

that these are not being met based on the information obtained during the interview, why is this so? Are the person's financial resources being mishandled by someone else who is responsible for them? Is the person struggling to handle financial affairs or refusing help from others because of lack of trust? Are financial resources being stolen or disappearing from the household or elsewhere? Has the person noticed that money runs out sooner than expected and that there seems to be less and less available to procure basic necessities that previously had been satisfactorily met?

Section 8: Disposition

50. The disposition section of the EAI document specifies whether referral to social services is made or recommended.

51. Referral to other: This is in the event the police or other specialty professionals are required.

Additional Comments:

The interviewer may determine that contextual information about the interview is needed for a clearer understanding of the data. Those comments should be noted in the record.

General Assessment	Very Good	Good	Poor	Very Poor	Unable to Assess
1. Clothing	1	2	3	4	9999
2. Hygiene	1	2	3	4	9999
3. Nutrition	1	2	3	4	9999
4. Skin integrity	1	2	3	4	9999

Possible Abuse Indicators	No Evidence	Probably No Evidence	Probably Evidence	Evidence	Unable to Assess
5. Bruising	1	2	3	4	9999
6. Lacerations	1	2	3	4	9999
7. Fractures	1	2	3	4	9999
8. Various stages of healing of any bruises or fractures	1	2	3	4	9999
9. Bruises and/or trauma beyond alleged trauma what is compatible with	1	2	3	4	9999
10. Evidence of sexual abuse	1	2	3	4	9999
11. Subjective complaint of abuse	1	2	3	4	9999

Possible Neglect Indicators	No Evidence	Probably No Evidence	Probably Evidence	Evidence	Unable to Assess
12. Contractures	1	2	3	4	9999
13. Decubiti	1	2	3	4	9999
14. Dehydration	1	2	3	4	9999
15. Diarrhea	1	2	3	4	9999
16. Depression	1	2	3	4	9999
17. Impaction	1	2	3	4	9999
18. Malnutrition	1	2	3	4	9999
19. Urine burns	1	2	3	4	9999
20. Poor hygiene	1	2	3	4	9999
21. Failure to respond to warning of obvious disease	1	2	3	4	9999

22. Inappropriate medications (under/over)	1	2	3	4	9999
23. Repetitive hospital admissions due to probable failure of health care surveillance	1	2	3	4	9999
24. Subjective complaint of neglect	1	2	3	4	9999

Usual Lifestyle	Totally Independent	Mostly Independent	Mostly Dependent	Totally Dependent	Unable to Assess
25. Administration of medication	1	2	3	4	9999
26. Ambulation	1	2	3	4	9999
27. Continence	1	2	3	4	9999
28. Feedings	1	2	3	4	9999
29. Maintenance of hygiene	1	2	3	4	9999
30. Management of finances	1	2	3	4	9999
31. Alcohol/substance abuse	1	2	3	4	9999
32. Family support	1	2	3	4	9999

Social Assessment	Very Good Quality	Good Quality	Poor Quality	Very Poor Quality	Unable to Assess
33. Financial situation	1	2	3	4	9999
34. Interaction with family	1	2	3	4	9999
35. Interaction with friends	1	2	3	4	9999
36. Interaction with nursing home personnel	1	2	3	4	9999
37. Living arrangement	1	2	3	4	9999
38. Observed relationship with care provider	1	2	3	4	9999
39. Participation in daily social activities	1	2	3	4	9999
40. Support systems	1	2	3	4	9999
41. Ability to express needs	1	2	3	4	9999

Psychological Abuse	No Evidence	Probably No Evidence	Probably Evidence	Evidence	Unable to Assess
42. Elder states being left alone for long periods of time	1	2	3	4	9999
43. Elder states being ignored or given the "silent treatment"	1	2	3	4	9999
44. Elder states failure to receive companionship, news, changes in routine, information	1	2	3	4	9999
45. Subjective complaint of psychological abuse	1	2	3	4	9999

Summary Assessments	No Evidence	Probably No Evidence	Probably Evidence	Evidence	Unable to Assess
46. Evidence of abuse	1	2	3	4	9999
47. Evidence of neglect	1	2	3	4	9999
48. Evidence of psychological abuse	1	2	3	4	9999
49. Evidence of financial abuse	1	2	3	4	9999

Disposition	YES	NO
50. Referral to social service	1	0
51. Referral to other	1	0
If yes, please specify	_____	

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- http://www.ci.nyc.ny.us/html/dfta/html/nyec_home.html - New York Elder Abuse Coalition
- <http://www.cyfernet.org/research/elderabuse.html> - Selected Resources On Elder Abuse: An Annotated Bibliography For Researchers And Educators
- <http://www.elderabusecenter.org/> - The National Center on Elder Abuse
- <http://www.ojp.usdoj.gov/ovc/infores/firstrep/> - U.S. Department of Justice, Office of Justice Programs, Office for Victims of Crime

