

Module # 18: Elder Abuse and Neglect

Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum

Module # 18: Elder Abuse and Neglect

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I. Overview

- A. Elder Mistreatment is a health care problem which continually rises as the elder adult population grows.
- A. Between one and two million Americans age 65+ have experienced mistreatment at the hands of those whom they depend on. (National Research Council Panel to Review Risk and Prevalence of Elder Abuse and Neglect, 2003)
 - B. Elder mistreatment can result in long term health consequences including death. The condition encompasses physical, psychological, financial, sexual abuse, caregiver and self neglect, exploitation and abandonment. (Fulmer, T. & Greenberg, S. 2008)
- B. The detection of elder mistreatment is difficult, so is monitoring for trends and prevalence
- A. Social stigma, fear of retribution and shame keep people from reporting incidents.
 - B. For every one case of elder mistreatment reported to authorities five more go unreported. (National Center on Elder Abuse at American Public Human Services Association, 1998)
 - C. Statutory and Regulatory definitions and reporting methods are different in every state. (The National Committee for the Prevention of Elder Abuse & The National Adult Protective Services Association, 2006, p. 9)
 - D. Mechanisms such as advanced interdisciplinary training and uniform state wide reporting to monitor trends would enhance Elder Abuse detection.

II. Learning Objectives

1. Define “elder mistreatment” and “elder neglect”.
2. Describe the prevalence of elder abuse in the United States.
3. Describe the multiple forms of elder mistreatment.

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4. Provide an overview of the risk factors for elder mistreatment.
5. Outline the steps of an elder mistreatment assessment.
6. Identify approaches to including elder abuse assessment in the traditional interdisciplinary team model of geriatric assessment.

III. Definitions

A. Elder Mistreatment

A. The American Medical Association's Diagnostic and Treatment Guidelines on Elder Abuse and Neglect defines elder mistreatment as "The act of omission or commission that results in harm or threatened harm to the health or welfare of an older adult." The act can be either intentional or unintentional. The term encompasses elder abuse and neglect. (Cobbs, E.L., Duthie, E. H., & Murphy J.B., (Eds.) 1999)

B. The majority of substantiated reports of elder mistreatment occurred in domestic settings, followed by long term care settings, hotels, motels, workplace and assisted living facilities. (The National Committee for the Prevention of Elder Abuse & The National Adult Protective Services Association, 2006, p.19)

IV. Demographics

A. 50 states and the District of Columbia have Adult Protective Services (APS) statutes establishing APS programs for identification and investigation of elder abuse and neglect. (Capezuti, Brush & Lawson, 1997, 23(7), 24-32)

A. Adult Protective Services substantiated 88,455 reports of elder mistreatment on persons aged 60+ in 24 states. (The National Committee for the Prevention of Elder Abuse and The National Adult Protective Services Association, 2006, p.16)

B. Adult Protective Services substantiated 46,794 reports of self neglect on persons aged 60+ in 20 states. (The National Committee for the Prevention of Elder Abuse and The National Adult Protective Services Association, 2006, p.16)

C. "Total reports of elder and vulnerable adult abuse for people of all ages represent a 19.7% increase from the 2000 survey. Of the 565,747 reports, 253,426 reports were for those 60 years of age and older. Women made up 65.7% of elder abuse victims and 52.7% of alleged perpetrators." (Teaster, P.B., & Dugar, T.A., 2005)

D. 20.8 % of victims were between the ages of 60 and 69, 36.5% were between 70-79 and 42.8 % 80 years of age and older in 20 states where 75.1%

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of perpetrators were under the age of 60 in 7 states. (The National Committee for the Prevention of Elder Abuse and The National Adult Protective Services Association, 2006, p.19)

E. The relationship between the alleged perpetrator and the victim were mostly adult child 32.6% then other family members 21.5 %, unknown relationship 16.3% and spouse or intimate partner 11.3% in 11 states. (The National Committee for the Prevention of Elder Abuse and The National Adult Protective Services Association, 2006, p. 20)

V. Forms of Elder Mistreatment

A. Abuse – Also known as “mistreatment” or “maltreatment and is harmful behavior directed toward an older person by a family member or professional caregiver whom the older person trusts or depends on for assistance. (Fulmer, T. & Greenberg, S. 2008)

B. Neglect-Intentional or unintentional harmful behavior on the part of an informal or formal caregiver in whom the older person has placed his or her trust. Examples include the refusal or failure to carry out a caretaking responsibility such as withholding food, medicine, or aids (glasses, dentures), and actual abandonment of the older adult.

C. Active Neglect-The caregiver refuses or fails to fulfill a caretaking obligation, including a conscious and intentional attempt to inflict physical or emotional distress on the elder; deliberate abandonment, or deliberate denial of food or health-related services.

D. Passive Neglect-In this type of mistreatment, the caregiver unconsciously or unintentionally refuses or fails to care for the older person. Examples include abandonment, non-provision of food or health-related services because of inadequate knowledge, laziness, infirmity or disputing the value of the prescribed service, includes failing to meet the older adults social and emotional needs. Usually occurs when the care giver is overburdened.

E. Physical Abuse-Physical mistreatment entails the infliction of physical pain or injury, physical coercion, or confinement against one’s will. Examples include pushing, shoving, shaking, slapping, kicking, punching, hitting, bruising, burning, sexual coercion or molestation, force-feeding and improper use of physical restraints or medications.

F. Physical Neglect-The caregiver neglects to provide the goods or services that are necessary for optimal functioning. Examples include not giving or delaying needed health care, such as meals and water, failure or delay in medical treatment, physical therapy, and washing, and failure to provide such assistive devices as glasses, hearing aids, or canes, inadequate housing, failure in preventing or treating bed sores.

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G. Psychological/Emotional Abuse-This type of mistreatment entails psychological and mental anguish and despair. Examples include insulting, ignoring, yelling, threatening remarks, mean jokes, humiliation, treating the older adult as an infant, harassment, forced isolation and controlling behavior.

H. Psychological Neglect-The caregiver fails to provide social or emotional stimulation and opportunities for social interaction, such as leaving the older adult alone for long periods of time. Denying contact with other family members. Other examples include ignoring requests of the older person and failing to give him new or information.

I. Financial Exploitation-This is illegal or unethical exploitation and/or use of cash, credit cards, funds or other financial resources of the older person. Examples include coercing the individual to sign contracts or sign over assets or making changes in a will, forging signatures, cashing checks without consent, stealing money and or possessions.

J. Financial/Material Neglect-In this type, the caregiver fails to use the available funds or resources which are needed to provide an optimal quality of life for the older person such as not providing necessities for daily living such as food, shelter, medicine, hygiene or failing to pay bills.

K. Violation of Person Rights-The older person's rights and capability to make decisions for him-self are ignored. Examples include denying privacy, autonomy in decision making with respect to health care and other personal issues (e.g., marriage) and forcible placement in an institution.

L. Self-Abuse or Self-Neglect-This occurs when the older person commits any of the above activities on himself or herself for example not providing oneself with food, shelter, neglecting personal hygiene and not seeking adequate medical care.

VI. Risk Factors For Elder Mistreatment And Abuse

A. Care Giver Stress

The older person is overly dependent for physical, emotional and financial support which may become burdensome to the care giver.

B. Who is susceptible

The frail and more physically vulnerable who require physical care from family caregivers.

C. Mental illness in older person, family members and caretakers

Older person or Caregiver experiencing depression/delirium/progressing dementia/anxiety/agitation/passive behavior/evasiveness/fear or confusion. (Greenberg, D., 2009)

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D. Other contributing factors-caregiver and or older person partaking in (Wagner, L., Greenberg, S. & Capezuti, E., 2002)

- A. Alcoholism
- B. Drug abuse
- C. Childhood trauma
- D. Family violence
- E. Financial strain/poverty
- F. Increased age
- G. Isolation of caregiver or older adult

VII. Elder Mistreatment Assessment

A. Interdisciplinary assessment and intervention planning is most important in keeping the elder adult safe and in good health. Physicians, nurse practitioners, nurses, social workers along with other professions are the make-up of interdisciplinary teams.

- A. Find a confidential intimate environment.
- B. Interview and evaluate the elder adult and the caregiver separately then together. Assess for cognitive functioning and decision making capacity to evaluate risk benefit and potential consequences of the presenting situation and of interventions.
- C. Gather history by beginning with general, open-ended questions and move toward more specific questions, avoid leading the individual. For example, “General: ask about living situation, relationships, functional status/assistance? Specific: Do you feel safe at home? Are you afraid of anyone? Has anyone threatened you (verbally or physically)? Has anyone touched you without permission? Has anyone asked you to sign documents you don’t understand? Has anyone taken your things without permission? Has anyone refused to help you when you needed it? Are you alone a lot of the time? Are you prone to encountering accidents? Questions for caregivers: How long have they cared for the patient; Do they understand and are they able to verbalize the elder persons medical condition; have the caregiver describe their responsibilities in caring for the elder adult; get an understanding of how the caregiver copes with their responsibilities.” Note inconsistency in stories and their reactions to questions be mindful of body language (yours and theirs). Try not to judge or become confrontational. Allow for empathy in relation to care giving burden. Remember your work is with the entire family and many times there are no villains’ only victims in elder mistreatment. (Greenberg, D., 2009)

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- B. Physical Indicators of Mistreatment
 - A. Be aware of inadequately explained injuries for instance bruises usually bilaterally due to grabbing, black eyes, welts, lacerations, rope marks, fractures, untreated injuries, bleeding broken eyeglasses, use of physical restraints, sudden change in behavior and pressure ulcers. (Fulmer, T. & Greenberg, S., 2008)
 - B. Unexplainable dehydration or malnourishment, excessive weight loss and lose rings. (Greenberg, D., 2009)
 - C. Be aware of lack of cleanliness, grooming, personal hygiene, inappropriate clothing in relation the weather, no assistive devices and mismanaged medications. (Greenberg, D., 2009)
 - D. “Presence of head injury, hair loss, or hemorrhaging beneath the scalp. Signs of possible sexual abuse: discharges, bruising, bleeding or trauma around genitalia or rectum, unexplained venereal disease or genital infections.”
- C. Behavior of the Patient Indicating Mistreatment (Greenberg, D., 2009)
 - A. Be aware of crying and silences.
 - B. The patient acting overly medicated or overly sedated.
 - C. Fearful of speaking in caregivers presence and appears anxious and eager please.
 - D. Be aware of expressions of anxiety, confusion, withdrawal, shame, fear, embarrassment, depression, hostility, secrecy and vague complaints.
 - E. The older adult makes little to no eye contact or communication.
 - F. Explanation is not consistent with the medical findings.
- D. Assessing the Caregiver-usually primary caregiver (Greenberg, D., 2009)
 - A. Makes threatening remarks and or behavior.
 - B. Is defensive and shifts blame.
 - C. The presenting stories conflicting.
 - D. Caregiver insults and is aggressive towards the elderly person.
 - E. Withholds attention, security and affection.
 - F. Gives excuses for failing to provide care.

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- G. With holds food or medication.
- H. Caregiver experiencing unusual fatigue and or depression.
- I. There is prevalence of substance abuse.
- J. There is a history of abusive behavior.
- K. Explanations given by the elder adult and the caregiver conflict.

VIII. Elder Mistreatment Interventions

- A. Goals (Greenberg, D., 2009)
 - A. To protect the elder adult and ensure safety.
 - B. “Develop and implement safety plan, such as safe home placement/discharge, hospital admission and/or protective court order”
 - C. Possible removal from harmful or potentially harmful situation, with the approval of the elder adult or without when decision ally incapacitated to choose. (Fulmer, T. & Greenberg, S., 2008)
 - D. Work towards having more oversight for the elder adult and increasing caregivers.
 - E. Assist with guardianship if indicated
 - F. In reducing the risk of future mistreatment work towards improving functional capacity, ease dependency and stress of the caregiver.
 - G. Discuss entitlement and resources.
- B. Begin with Creating a Joint Plan
 - A. Assess whether there is a willingness to accept the intervention. If there is resistance to help assess whether the elder adult is capable of making decisions and understanding there consequences. “Competent older adults have the right to remain in dangerous situations (if no duress or undue influence.” (Greenberg, D., 2009)
- C. Key Questions to Guide Interventions
 - A. “How safe is the patient if I send him or her back to the current setting?
 - B. What services or resources are available to help a stressed family?
 - C. Does the elderly person need to be removed to a safe environment?

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D. Does this situation need an unbiased advocate to monitor the care and finances for this patient?"

D. Reporting Mistreatment:

A. Close to all states have a requirement designating health care professionals to report suspected elder mistreatment to a state authority.

E. Community Resources Available to Victims: (Greenberg, D. 2009)

A. Case management services

B. Protective services

C. Support counseling services

D. Victims' services network, police services

E. District Attorney's office-Bronx District Attorney's Office Elder Abuse Coordinator for Criminal Offenses

F. Legal services specializing in the elderly

G. Social Service Support-JASA Home evaluation DIFTA/NORCC case management, CHHA

H. Respite services-Hebrew Home for the Aged Harry & Jeanette Weinberg Center for Elder Abuse Prevention

I. Reporting Laws- Social Service Law 473-B reporting of endangered adults, confidentiality insured

J. Adult Protective Services Voluntary/ Involuntary-Financial Management/Article81/Heavy Duty Cleaning

K. Emergencies 911

IX. A Unique Intervention Model (Dyer, C.B. & Goins, A.M., 2000)

A. "Geriatric interdisciplinary teams focus on the overall condition of the patient and may be limited in ability to intervene in cases of abuse or neglect.

B. Adult Protective Services specialize in assessment and intervention in cases of possible neglect or abuse- focus here precludes comprehensive medical assessment

C. In light of above factors, Baylor College of Medicine Geriatric Program has collaborated with Adult Protective Services (APS) Division, making an APS representative a member of the Geriatric Interdisciplinary Team.

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- D. Interdisciplinary care plan now includes findings from APS assessment.
- E. Assessments are carried out both in outpatient geriatric clinic and in the older clients' homes.
- F. This model fully addresses 3 vital domains of older adult's life: a) medical problems b) social milieu, and c) functional status. Medical and APS assessments complement each other to address each domain."

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Learning Resource A

Elder Abuse/Neglect Screening Assessment Tool

Patient's Name: _____ Date: _____

Introductory comment: No matter how well people get along there are times when they disagree on major decisions, get annoyed about something the other person does, or just have arguments because they are in a bad mood or for some other reason. People also use many different ways of trying to settle their differences. I am going to read you some things that people do when they have arguments or problems, and ask you whether this has ever happened to you.

<u>Ask patient directly:</u>	Yes	No	Comments
1. Has anyone ever hurt you?	_____	_____	_____
2. Has anyone ever touched you when you didn't want to be touched?	_____	_____	_____
3. Has anyone forced you to do something against your will?	_____	_____	_____
4. Has anyone ever taken anything that was yours without permission?	_____	_____	_____
5. Have you ever given anything away even though you really didn't want to?	_____	_____	_____
6. Does anyone ever talk or yell at you in a way that makes you feel lousy or bad about yourself?	_____	_____	_____
7. Are you afraid of anyone?	_____	_____	_____
8. Has anyone ever threatened you?	_____	_____	_____
9. Has anyone ever refused to help you take care of yourself when you needed help?	_____	_____	_____
10. Has anyone used your money in a way you did not like?	_____	_____	_____
	Y	N	Comments

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11. Do you have ready access to a telephone? _____
12. Do you live with anyone, or have any close family members who abuse drugs or alcohol, or have a psychiatric or emotional illness? _____
13. Do you feel that your basic needs for food, clothing, shelter and medications are adequately available to you all the time? _____
14. Are you able to go out of your house when you want? _____
15. Are you happy with how often you see your relatives and friends? _____

If any answers to questions 1-11 are “yes” or 12-15 are “no”, please elaborate and consider consulting the Elder Abuse Team.

Physical Assessment

Describe patient’s general appearance (e.g., inadequate or inappropriate clothing, dirty or odorous): _____

Check if any of the following are present:

<input type="checkbox"/> Bruises	<input type="checkbox"/> Rashes
<input type="checkbox"/> Fractures	<input type="checkbox"/> Scars
<input type="checkbox"/> Burns	<input type="checkbox"/> Welts
<input type="checkbox"/> Lacerations	<input type="checkbox"/> Punctures
<input type="checkbox"/> Abrasions	<input type="checkbox"/> Decubiti
<input type="checkbox"/> Other	

Stages of decubitus/pressure ulcers:

I. Redness not resolving after 20 minutes following relief of pressure, epidermis intact.
II. Break in skin involving the epidermis. May appear as a blister with erythema

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and/or induration.
III. Skin break exposing subcutaneous tissue.
IV. Skin break exposing muscle and bone.

Dating of Bruises:

Date	Appearance
0-2 days:	Swollen, tender
0-5 days:	Red-blue
5-7 days:	Green
7-10 days:	Yellow
10-14 days:	Brown
2-4 weeks:	Clear

Status of Assistive Devices:

If patient needs and does not have devices, or patient has but does not use devices, this may be evidence of neglect.				
Device	Needs	Has	Uses	Explanation
Dentures				
Cane				
Walker				
Hearing Aid				
Other				

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Ask Patient Directly:

Has anyone ever prevented you from obtaining or using aides?

* Yes _____ No _____

* If yes, please explore further and consider consulting the Elder Abuse Team.

Reference:

Written by: Pamela Ansell, MSW, Mount Sinai/Victim Agency Abuse Team Project, New York City.; Judy S. Bloom, MPA, Montefiore Medical Center Elder Abuse Project;
Karl Pillemer, PhD, University of New Hampshire's Family Research Laboratory;
Contributors: Barbara Paris, MD and Meryl Weiss, RN, Mount Sinai/Victim Services Agency Elder Abuse Project.

This tool is adapted from a research survey titled "Family Relationship of the Elderly," developed by the Center for Survey Research, University of Massachusetts-Boston and the center for Family Studies University of New Hampshire (Fall, 1985).

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Winter, 1988

Learning Resource B

Case Studies

Case Study # 1: Ms. R.

Ms. R is an 85-year old woman who lives in a New York City apartment with her 60-year-old daughter, Ms. S. Ms. R was born in Puerto Rico and moved to the mainland shortly after she was married. All four of her children were born in New York. Three of Ms. R's children are married, and two of them along with their spouses, retired and moved to the Miami area a few years ago. One daughter lives in central New Jersey. Ms. R has 11 grandchildren, and five of them live within an hour's trip of New York City. Ms. S has never married, and after her mother was widowed, Ms. S gave up her own apartment and moved in with her mother.

Recently, Ms. R developed a high fever and was diagnosed with pneumonia. Her physician admitted her to the hospital, where her daughter sits at her bedside for most of the day. When you speak to Ms. S, she tells you that Ms. R frequently seems to "lose track of time." In fact, before admission to the hospital, Ms. R was awake much of the night at home and slept during the day. As a result, Ms. S says she herself is very tired most of the time and is experiencing difficulty at work.

After a few days of intravenous therapy and antibiotics, Ms. R recovers from pneumonia, and plans are made for her to be discharged home. Ms. S expresses concern to you that her caregiving responsibilities are becoming somewhat overwhelming, and she is feeling very stressed.

*Source: Mariano C, Gould E, Mezey M, Gulmer T, eds. Best Nursing Practices in Care for Older Adults: Incorporating Essential Gerontologic Content into Baccalaureate Nursing Education. 2nd ed. New York: The John A. Hartford Foundation Institute for Geriatric Nursing, Division of Nursing, School of Education, New York University; 1999.

Case Study # 2: Dr. S.

Dr. S. is a 74-year-old divorced woman, mother of one son, retired neurologist, who was referred to the Geriatrics Practice by her orthopedic surgeon for general evaluation and medical care. Dr. S.'s medical diagnoses included hypothyroid disease, severe arthritis of the hip, and memory loss. Her son accompanied Dr. S. to her medical visit. She was agitated, tearful, uncooperative with a physical examination, and unable to provide a history. Her son was cooperative but appeared unrealistic about his mother's capabilities.

Dr. S. was subsequently seen in the Gero-Psychiatry Clinic and hospitalization was recommended. During this admission, past medical history came to light indicating physical and emotional abuse by her son. Protective Services for Adults previously knew the case and Guardianship procedures were already underway.

The patient's son was upset by her hospitalization and repeatedly requested that his mother be discharged. He denied abusing his mother and felt that other people were just trying to take her money. Dr. S. was discharged of the care of a home attendant and a guardian was instituted. The son was given limited supervised visitation privileges.

Dr. S. was started on physical therapy in her home. Physical therapists were unable to work with the patient due to her dementia and agitation. A private therapist, experienced in working with dementia patients was recommended but the guardian would not pay for the services. The guardian subsequently requested that the patient's psychotropic medications be increased to help calm her down, as she could no longer afford to pay the two 12-hour home attendants.

Questions:

1. Should we have been able to detect a history of abuse on the day of the initial visit?
2. Do we feel that the guardian was acting in the best interest of the patient?
3. What role does the medical team have in contacting the courts or Protective Services for Adults to advise about concerns about guardians and financial difficulties?

Source: Paris, B and Kahan, F. Geriatric Medicine Update and Board Review. *Clinical Workshop: Elder Mistreatment*. 2000

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