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Identifying and Initiating Intervention for Elder Abuse and Neglect in the Emergency Department

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SYNOPSIS

Elder abuse and neglect are common and may have serious medical and social consequences but are infrequently identified. An ED visit represents a unique but usually missed opportunity to identify potential abuse and initiate intervention. ED assessment should include observation of patient-caregiver interaction, comprehensive medical history, and head-to-toe physical exam. Formal screening protocols may also be useful. ED providers concerned about elder abuse or neglect should document their findings in detail. ED interventions for suspected or confirmed elder

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abuse or neglect include: treatment of acute medical, traumatic, and psychological issues; ensuring patient safety; and reporting to the authorities

Keywords

elder abuse; elder neglect; elder mistreatment; financial exploitation; emergency department; geriatrics

The Emergency Department (ED) may play an important role in detection and intervention of elder abuse, a phenomenon with serious medical and social consequences that occurs commonly. Elder abuse encompasses behaviors or negligence against an older adult that results in harm or the risk of harm committed by someone in a relationship with an expectation of trust or when the victim is targeted because of age or disability. Abuse includes: physical abuse, sexual abuse, neglect, psychological abuse, and financial exploitation.^{1–5} Table 1 defines and gives examples of these types. Elder abuse victims frequently suffer from multiple types at the same time.^{1–5}

Elder abuse and neglect are complex phenomena with multiple underlying etiologies. Many theories have been proposed that offer insight into possible causes in some cases and may be useful to clinicians.³ Family violence may be a learned behavior, with abused children reaching adulthood and abusing not only their children but also perhaps their parents. In some cases, abuse or neglect may occur after an older adult develops functional and/or cognitive disability leading to activities of daily living impairment and overwhelming care needs, with a stressed caregiver becoming abusive or neglectful. In other cases, the abuser, often an adult child, may suffer from mental health issues, such as poorly or untreated mood disorder or schizophrenia, alcoholism or substance use, or a personality disorder. Multiple of these and other causes may simultaneously contribute in an individual case. Recent research has described several acute triggers that can lead to physical elder abuse, including a victim attempting to prevent the abuser from entering or demanding that he/she leave, victim threatening or attempting to leave/escape, threat or perception that the victim would involve the authorities, conflict about a romantic relationship, presence during/intervention in ongoing family violence, issues in multi-generational child rearing, conflict about the abuser's substance abuse, confrontation about financial exploitation, dispute over theft/destruction of property, and disputes over minor household issues.⁶

Elder abuse is unfortunately common, affecting 5–10% of community dwelling older adults each year.^{1–5,7} Nursing home residents are at even higher risk.^{8–12} Psychological abuse, financial exploitation, and neglect are more common, while physical abuse and sexual abuse occur less frequently.^{4,13,14} Elder abuse victims have a much higher mortality^{7,15,16} than other older adults, and victimization has been linked to poor medical outcomes including depression,¹⁷ dementia,¹⁷ and worsening of chronic conditions. Older adults suffering from elder abuse are more likely to present to the emergency department,^{18,19} be hospitalized,²⁰ and be placed in a nursing home.^{21,22} The direct medical costs of this phenomenon, though difficult to quantify, are estimated to be many billions of dollars each year.^{3,23} In the near future, with the growth of the older adult population, this is anticipated to increase dramatically.^{24–26}

Though common, serious, and costly, elder abuse is infrequently detected, with research suggesting that only 1 in 24 cases of abuse is identified and reported to the authorities.² Much of the morbidity and mortality is likely because of not detecting it and intervening. Given this, improving identification of and intervention for elder abuse have become important public health priorities.^{24–27}

Identifying Elder Abuse and Neglect in the ED: A Missed Opportunity

An ED presentation for injury or illness represents a unique opportunity to detect elder abuse and initiate intervention. EDs already play an important role in identifying and initiating intervention for child abuse^{28,29} and intimate partner violence among younger adults.^{30,31} A medical visit to the ED may be the only time a socially isolated older adult leaves their home.^{32–34} Existing research suggests that elder abuse and neglect victims are less likely to have outpatient care from a primary provider than other older adults but receive emergency care more frequently.^{18,19,35} A recent study found that 7% of cognitively intact older ED patients reported a history of physical or psychological mistreatment during the previous year.³⁶ Also, in an ED, an older adult is typically evaluated for several hours by providers from multiple disciplines, who are able to observe, interact with, and examine the patient, making it an environment with significant potential for detection.³²

Despite the unique potential of the ED visit, ED providers very infrequently detect and report elder abuse or neglect.^{37–39} A recent study found that elder abuse was diagnosed in only 0.013% of U.S. ED visits.³⁹ Further, only 1.4% of cases reported to Adult Protective Services (APS) come from physicians.³⁷ In a survey of APS workers, of 17 occupational groups, physicians were among the least helpful in reporting abuse.³⁸ Reasons for this are poorly understood but likely include inadequate training in elder abuse and neglect, lack of time and space to conduct a complete evaluation, and desire to avoid involvement in the legal system.^{39,40} Identifying elder abuse and neglect is made more challenging by difficulty in distinguishing between intentional and unintentional injuries. Many cases are subtle, as patients present with a variety of chief complaints and with non-specific findings. The abuser may present to the ED with the patient and actively try to avoid detection. The victim may be unable or unwilling to report the abuse or neglect. Despite these challenges, improving identification of and intervention for elder abuse and neglect are critical to improving the health and safety of these highly vulnerable patients.

ED Assessment

Identifying High Risk Patients

Research has examined potential risk factors for becoming a victim or perpetrator of elder abuse or neglect,^{4,13,14,41,42} and ED providers should incorporate this when evaluating older adults. Findings have been inconsistent regarding factors such as age, likely due to heterogeneity of causes and circumstances surrounding cases. Potential risk factors suggested by existing evidence are shown in Table 2. Notably, individuals who are cognitively-impaired are more likely to be victimized.^{43–45} Commentators have suggested that populations including military veterans⁴⁶ and lesbian/gay/bi-sexual/trans-gender older adults⁴⁷ may be at particularly high risk, but additional research is needed to explore this

further. Providers should consider these risk factors for elder abuse or neglect when evaluating elderly patients. Despite this, many cases happen in the absence of risk factors, so emergency providers need to have a high index of suspicion when assessing older adult patients.

Observation and Medical History

Obtaining a complete and accurate medical history is critical to evaluate for abuse or neglect. If a caregiver is present at the patient's bedside, the ED provider should initially carefully observe the patient/caregiver interaction, looking for any suggestions of a strained relationship. Observations that should increase concern for elder abuse or neglect are shown in Table 3.

An ED provider should take medical history from the patient alone without caregivers or family present and should ensure the patient of privacy and confidentiality. Many victims will be reluctant to report abuse or neglect because of guilt, shame, or fear of reprisal. If a language barrier exists, a professional translator or telephone service should be used. Caregivers or family members should not be used as interpreters, even if they are not suspected to be abusers. Indicators from the medical history that may suggest the possibility of elder abuse or neglect are described in Table 4. After exploring the patient's chief reason for presentation, the ED provider should explore the patient's functional status, cognition, care needs, and the safety of the home environment.⁴⁸ The clinician may also explore whether the patient feels isolated or depressed.⁴⁹ When concerns exist, an ED provider may follow up with questions about specific types of abuse or neglect. Potential questions are presented in Table 5. For patients presenting with injuries, questions should focus on how the injuries occurred, including inquiring directly about whether anyone has hit, punched, pushed, tripped, or kicked the patient. During the evaluation, ED providers should also observe behavioral signs that may offer clues that suggest elder abuse and neglect, including fear, poor eye contact, anxiety, low self-esteem, and helplessness.

It may be challenging to obtain a reliable history of elder abuse or neglect, particularly from those with advanced dementing illness. ED providers should still try to interview these patients as they would others, as research has suggested that older adults with dementing illness can often accurately relate how an injury occurred.^{50,51} If an older adult is unable to provide history, ED providers should seek collateral from other sources besides caregivers, such as other family members, the primary care physician, neighbors, or visiting nurses.

ED providers should also consider separately interviewing the caregiver or suspected abuser.⁴⁸ Doing so may reveal discrepancies from the patient's history. Further, a caregiver unfamiliar with an older adult's medical problems or regular medications may be neglecting them. Providers should explore whether changes or other stressors have occurred in the patient's household, whether the caregiver feels that the patient is a burden, whether any home help services or respite services have been made available, and what the caregiver's other dependents and responsibilities are. Clinicians should avoid being critical or accusatory but rather approach the interview as an opportunity to learn more about the patient. Acknowledging the challenges of caregiving and expressing sympathy may help build rapport.

Physical Exam

Even though it may be difficult in a busy ED, performing a comprehensive head-to-toe exam is essential to adequately evaluate for abuse and neglect. Providers should focus particularly on a full skin examination, including fingernails and toenails. Intra-oral examination is also helpful. Physical findings suspicious for physical abuse, sexual abuse, and neglect are shown in Table 6. The presence of multiple suggestive findings should raise a provider's index of suspicion.

Considering abuse is particularly important when assessing older adults presenting to the ED after injuries. Providers should always consider whether the physical findings are consistent with the reported injury mechanism. A patient sustaining five upper rib fractures after rolling off a bed two feet above the ground would be incongruent.

Researchers have begun to systematically explore differences between physical elder abuse-related injuries and accidental injuries, such as falls, to assist ED providers. This approach is analogous to the large body of research in children^{52–55} which has found that specific injury patterns, such as metaphyseal fractures and bruising not over bony prominences, occur very infrequently in accidents but commonly in child abuse. Recognizing these injury patterns is a cornerstone of child abuse detection, which ED providers do routinely. Differentiating intentional and unintentional injuries in older adults is more challenging than in children because of the normal physiologic changes that occur with aging^{56–60} including osteopenia, thinning of the skin, and easy bruising as well as the impact of medications commonly used including blood-thinners. Despite these challenges, researchers have reported clinically useful findings. A study comparing physical elder abuse victims to older adults with accidental injury found that abuse victims had bruises that were more often large (>5 cm) and found on the face, lateral right arm, or posterior torso.⁵⁰ Research has also shown that physical abuse and assault-related injuries most commonly occur on the head, neck, and upper extremities.^{59,61,62} Data from a study in progress suggest that injuries to the left cheek/zygoma, neck, and ulnar forearm may be much more common in abuse than accident.⁶³ In the future, clinical prediction rules may be developed using injury pattern-related findings to assist ED providers in identifying injuries potentially caused by abuse rather than an accident.

When sexual abuse is reported or suspected, particularly if evidence of trauma or vaginal bleeding exists on genitourinary examination,⁶⁴ an ED provider should conduct a complete sexual assault examination, as with younger victims. If the patient consents, this evaluation should include evidence collection by a trained sexual assault forensic examiner.

Imaging

Radiologists have played a critical role in the detection of child abuse in the ED for decades, identifying imaging correlates strongly suggestive of abuse.^{65–67} Unfortunately, only very limited radiology literature exists describing potential imaging correlates of elder abuse,^{59,68,69} and diagnostic radiologists typically do not receive any training in elder abuse detection.^{59,68} Despite this, potentially suggestive findings exist,^{59,68,69} including co-occurring old and new fractures, high-energy fractures despite low energy mechanism, distal

ulnar diaphyseal fractures, and small bowel hematomas.^{68,69} The ED provider should communicate any suspicion for elder abuse or neglect to the radiologist and ask him/her to focus on whether the imaging findings are consistent with the purported mechanism. Providers may also consider additional screening imaging tests, including maxillofacial CT scan and chest x-ray, to evaluate for acute and chronic fractures, analogous to the skeletal survey routinely performed in potential victims of child abuse.

Laboratory

While no laboratory blood or urine test is definitively diagnostic for neglect or abuse, certain findings may raise or increase suspicion. These include anemia, dehydration, malnutrition, hypothermia/hyperthermia, and rhabdomyolysis.⁷⁰ Multiple abnormal findings are likely more concerning than a single one. Though infrequently checked in ED practice, prescription medication and illicit drug levels may be useful when considering elder abuse or neglect.⁷⁰ Low or undetectable levels of medications prescribed to the patient may indicate intentional or unintentional withholding by a caregiver. Of particular concern is diversion of narcotic pain medications.⁷⁰ Alternatively, elevated levels of prescribed drugs may indicate overdose, while the presence of toxins of drugs that have not been prescribed may suggest poisoning.⁷⁰

The Value of a Team-Based Approach

Given the challenges in successfully identifying elder abuse and neglect in the ED, it is important to develop a team-based approach, leveraging the unique perspectives of the many professionals working in an ED and empowering everyone to contribute to detection.³² Most large EDs have social workers and case managers, and smaller ones typically have access to them in the hospital or on-call. These professionals provide counseling and assess patients' financial resources, support system, and social service needs. The importance of their role, particularly for older adults, has been increasingly recognized.^{71,72} Their social evaluation may reveal risks for or evidence of abuse or neglect not identified to medical providers. When possible, all dependent older adult ED patients being considered for discharge should be seen by a social worker or case manager. When limited resources don't allow this, ED providers should assist social workers and case managers in targeting the most vulnerable individuals who may benefit most from this assessment.

Nurses and patient care technologists (PCTs) provide bedside care and typically have much more face-to-face contact with patients, caregivers, and other family than do physicians. They may observe interactions between the patient and caregivers that raise red flags requiring further investigation.^{32,73} Also, nurses and PCTs often provide hygiene care for geriatric patients, including diaper changes.³² Careful examination during this care may identify otherwise missed suspicious physical findings.³² Other ED team members such as patient escort and radiology technicians spend time alone with a patient.³² Patients may feel more comfortable reporting abuse or asking them for help instead of physicians or nurses, particularly if the perpetrator is present in the ED, because the patient may perceive fewer consequences from such conversations.³² Radiologic technicians, who have the opportunity to privately assess and interview patients while conducting imaging examinations, may be particularly well-positioned to identify abuse.⁷⁴

Emergency Medical Services: A Potential Key Role

Older adults are four times more likely than younger patients to use Emergency Medical Services (EMS), representing 38% of total EMS responses transported to the ED.⁷⁵ EMS providers are the first clinicians to assess acutely injured and ill older adults after a 911 call, typically in the patient's home.^{32,76} These providers often may have critical information about the home environment and inter-personal dynamics between the patient, caregiver, and other family that may inform the ED assessment. EMS providers have an opportunity to observe hazards including extreme clutter/hoarding, inappropriately hot or cold temperature, vermin fenestration, or utilities such as water or electricity that aren't working. They can check whether the refrigerator is empty and what food is available. They can identify expired or unmarked medication bottles as well as multiple bottles or a single medication. As 911 calls are typically unplanned, an abusive or neglectful caregiver doesn't have time to clean up the home or patient before EMS arrives.³² Also, EMS providers may observe unusual or inappropriate interactions between caregivers and patients or evidence of drug or alcohol use. EMS may assess and provide care to older adults who refuse transport to the ED.⁷⁷ In a recent study, EMS providers reported that they were able to identify and frequently encountered elder abuse and neglect victims.⁷⁶ Previous research has shown that EMS can successfully screen older patients for mental health, environmental, and social problems including elder abuse and refer them to service agencies.⁷⁸

Despite this potential, EMS providers report difficulties effectively communicating their concerns to ED providers due to barriers including time constraints and ED staff who are unavailable or not receptive.⁷⁶ When possible, ED providers should proactively seek out pre-hospital personnel and inquire about their impression of the patient and the home environment, and EMS call report documentation should always be reviewed. Increasing use by EMS of electronic records accessible to ED providers may help to ensure that their observations are available to and utilized by ED providers.^{32,76}

Universal or Targeted Screening

Universal or targeted screening of older adults in the ED for abuse or neglect, either in triage or at another time during the visit, is a potential future step to improve identification. Currently, many EDs ask a single question about a patient's safety, but this is likely not adequate to assess for potential victimization, particularly as it is often asked in public with the potential abuser present. Though no elder abuse or neglect screening tools have been validated in an ED setting, several exist.^{32,79,80} Development and testing sponsored by the National Institute of Justice of an ED-specific screening tool is ongoing.³² The Elder Abuse Suspicion Index (EASI) is a short instrument that has been validated for cognitively-intact patients in ambulatory care settings and may be appropriate for the ED (see Table 7).⁸⁰

Documentation

Complete and accurate documentation is an essential part of ED care of potential victims of elder abuse and neglect. The ED provider should keep in mind that the medical chart may be used for investigation and prosecution, and quality of the documentation can significantly impact justice and protection for a victim.⁸¹ The patient's responses to questions should be

comprehensively documented, using the patient's own words whenever possible. Social information including functional status, caregiver's relationship to the patient, and living situation should also be documented. Providers should describe the physical exam in detail and include the general appearance of the patient when they first arrived in the ED. Potential signs of neglect, including dirty clothing, poor dental hygiene, and untrimmed nails should be described if present. For each injury, the ED provider should describe its size, location, stage of healing, and whether it is consistent with the reported mechanism. Using a body diagram/traumagram, which is available as part of many electronic medical records, may increase accuracy when describing findings. ED providers should photograph physical findings and add these photographs to the medical chart when possible and approved by hospital administration. These images may be helpful forensically in the future. To assist ED providers, a protocol for photographing injuries in the acute care setting was recently published.⁸²

Intervening after Elder Abuse Identification

When elder abuse or neglect is suspected or confirmed, an ED provider should: (1) treat acute medical, traumatic, and psychological issues, (2) ensure patient safety, and (3) report to the authorities. ED providers must first treat and stabilize any acute medical, traumatic, and psychological problems, including bleeding, fracture, dehydration, metabolic abnormalities, infections, and agitation. Exacerbations of chronic medical conditions may require management if the abuser has failed to give the patient their medications or to provide appropriate care. Hospitalization may be necessary if a patient needs extended treatment.^{20,83,84}

If an older adult patient is in immediate danger, the ED provider should ensure that he/she does not have contact with the suspected abuser. This may be challenging, particularly if the perpetrator is the healthcare proxy or power of attorney. Providers should consider involving the hospital administration and legal department to assist with issues including health care decision-making and guardianship. ED security may be necessary to watch and protect a patient or to remove a perpetrator from the ED. When this intervention is necessary, ED providers should consider involving social work, hospital administration and legal, and local law enforcement.

Interventional approaches may be more individualized if a patient is not at risk for imminent harm. The ED provider should attempt to contact and coordinate with the patient's primary care physician to ensure follow-up. Social workers should provide counseling, safety planning, and appropriate resources to the patient and caregiver, including: home health services, Meals-on-Wheels, medical transportation services, adult day care, senior centers, substance abuse treatment options, and respite care.

If a patient experiencing abuse or neglect declines intervention or services, an assessment of their capacity to refuse is needed. If available, an evaluation by a psychiatrist may be helpful in cases where the ED provider is unsure about a patient's decision-making capacity. When a victim has capacity to refuse care and/or request discharge, their choice to return to an unsafe environment must be respected. This is similar to ED management of intimate partner

violence among younger adults but different from child abuse. Even when a patient refuses intervention, the ED provider and social worker should attempt to offer psychoeducation about violence and abuse, discuss safety planning, suggest appropriate community services, and encourage the older adult to return to the ED whenever they desire. In cases where the victim does not have capacity, ED providers should proceed with treatments that are in their best interest, including hospitalization when appropriate.

ED providers should report cases of suspected or confirmed elder abuse or neglect to the appropriate authorities. Adult Protective Services (APS) is the agency that investigates these cases and where ED providers should report, but it is important to remain aware that APS operates much differently from Child Protective Services. APS will not begin investigating a case while a patient is in the ED or hospital, which is a “safe” environment. Their investigation will commence only after discharge. Therefore, ED providers should also consider contacting the local police department when concerned about a patient’s safety or believe a crime has been committed. In most but not all states, ED providers are mandatory reporters for elder abuse, and laws vary. Providers should become familiar with their state requirements. This information can be obtained from a state’s Department of Health website, and a summary is available at: <http://www.napsa-now.org/wp-content/uploads/2014/11/Mandatory-Reporting-Chart-Updated-FINAL.pdf>.

An ED-based multi-disciplinary consultation team intervention, modeled on child protection teams,^{28,29} may help ensure the safety and optimize the treatment of these vulnerable patients.^{32,85} This consultation team would be able to conduct a thorough medical, forensic, and social work assessment and assist with appropriate and safe disposition.^{32,85} This team would reduce the burden on ED providers who currently need to conduct all aspects of the assessment of treatment of complicated elder abuse and neglect victims while simultaneously managing other patients.⁸⁵ The presence of a team may, by offering resources to assist with care, increase ED providers’ willingness to pursue suspicions about elder abuse and neglect and therefore lead to higher rates of identification.⁸⁵ Elder protection consultation teams have been launched, and their impact is currently being evaluated.⁸⁵

Summary

Elder abuse and neglect are common and have serious medical and social consequences for victims but are seldom identified and reported. An ED visit offers a unique opportunity to identify victims and initiate intervention, which may dramatically improve their quality of life. Unfortunately, in current practice, ED providers seldom detect or report elder abuse or neglect. The field, however, is beginning to recognize the importance of this missed opportunity. The collaboratively authored geriatric ED guidelines advocate for additional education and quality improvement focused on elder abuse and neglect.⁸⁶ A review article on elder abuse⁷ was included in of the American Board of Emergency Medicine’s 2018 Lifelong Learning Self-Assessment Maintenance of Certification Curriculum.⁸⁷ Ongoing research is improving the ability of ED providers to assess and respond effectively. Maintaining a high index of suspicion for elder abuse and neglect and intervening when concern arises has potential to improve the health and safety of these vulnerable patients.

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KEY POINTS

- Elder abuse and neglect, which include physical abuse, sexual abuse, neglect, psychological abuse, and financial exploitation, are common and may have serious medical and social consequences but are infrequently identified
- An ED visit represents a unique but usually missed opportunity to identify potential elder abuse or neglect and initiate intervention
- ED assessment should include observation of patient-caregiver interaction, comprehensive medical history from the patient alone, and head-to-toe physical exam. Imaging and laboratory tests may be helpful. A team-based approach to detection including social workers and other ED professionals is valuable, and Emergency Medical Services providers may play a key role. Formal screening protocols may also be useful
- ED providers concerned about elder abuse or neglect should document their findings in detail, including complete descriptions of all physical findings including injuries and should consider using a body diagram/traumagram or photographing findings
- ED interventions for suspected or confirmed elder abuse or neglect include: treatment of acute medical, traumatic, and psychological issues; ensuring patient safety; and reporting to the authorities

Table 1

Types of Elder Abuse and Neglect

TYPE	DEFINITION	EXAMPLES
Physical abuse	Intentional use of physical force that may result in bodily injury, physical pain, or impairment	<ul style="list-style-type: none"> • Slapping, hitting, kicking, pushing, pulling hair • Use of physical restraints, force-feeding • Burning, use of household objects as weapons, use of firearms and knives
Sexual abuse	Any type of sexual contact with an elderly person that is non-consensual or sexual contact with any person incapable of giving consent	<ul style="list-style-type: none"> • Sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing • Unwanted touching, verbal sexual advances • Indecent exposure
Neglect	Refusal or failure to fulfill any part of a person's obligations or duties to an elder, which may result in harm – may be intentional or unintentional	<ul style="list-style-type: none"> • Withholding of food, water, clothing, shelter, medications • Failure to ensure elder's personal hygiene or to provide physical aids, including walker, cane, glasses, hearing aids, dentures • Failure to ensure elder's personal safety and/or appropriate medical follow-up
Emotional/psychological abuse	Intentional infliction of anguish, pain, or distress through verbal or nonverbal acts	<ul style="list-style-type: none"> • Verbal berating, harassment, or intimidation • Threats of punishment or deprivation • Treating the older person like an infant • Isolating the older person from others
Financial/material exploitation	Illegal or improper use of an older adult's money, property, or assets	<ul style="list-style-type: none"> • Stealing money or belongings • Cashing an older adult's checks without permission and/or forging his or her signature • Coercing an older adult into signing contracts, changing a will, or assigning durable power of attorney against his or her wishes or when the older adult does not possess the mental capacity to do so

Adapted from National Center on Elder Abuse. Types of abuse. Available at: <https://ncea.acl.gov/faq/abusetypes.html>. Accessed November 21, 2017.

Table 2**Potential Risk Factors for Elder Abuse**

FOR BECOMING A VICTIM

Functional dependence or disability
Poor physical health
Cognitive impairment/dementia
Poor mental health
Low income/socio-economic status
Social isolation/low social support
Previous history of family violence
Previous traumatic event exposure
Substance abuse

FOR BECOMING A PERPETRATOR

Mental illness
Substance abuse
Caregiver stress
Previous history of family violence
Financial dependence on older adult

Data from Refs 4,13,14,88

Table 3

Observations from Older Adult/Caregiver Interaction that Should Raise Concern for Elder Abuse or Neglect

Older adult and caregiver provide conflicting accounts of events
Caregiver interrupts/answers for the older adult
Older adult seems fearful of or hostile towards caregiver
Caregiver appears unengaged/inattentive in caring for the older adult
Caregiver appear frustrated, tired, angry, or burdened by the older adult
Caregiver appears overwhelmed by the older adult
Caregiver appears to lack knowledge of the patient's care needs
Evidence that the caregiver and/or older adult may be abusing alcohol or illicit drugs

Table 4**Indicators from the Medical History of Possible Elder Abuse or Neglect**

Unexplained injuries
Past history of frequent injuries
Elderly patient referred to as “accident prone”
Delay between onset of medical illness or injury and seeking of medical attention
Recurrent visits to the emergency department for similar injuries
Using multiple physicians and emergency departments for care rather than one primary care physician (“doctor hopping or shopping”)
Noncompliance with medications, appointments, or physician directions

Table 5

Questions for Use in Asking Patients about Elder Abuse

In the last 6 months:	
PHYSICAL ABUSE	<p>1) Has anyone tried to harm you? Have you been hit, slapped, pushed, grabbed, strangled, or kicked?</p> <p>2) Are there guns or other weapons in your home? Does anyone close to you have access to guns or other weapons?</p>
SEXUAL ABUSE	<p>3) Has anyone touched you in ways or places you did not want to be touched?</p>
NEGLECT/FUNCTIONAL STATUS	<p>4) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?</p> <p>a. If yes, have you had someone who helps you with this?</p> <p>b. If yes, how often do you receive help? Is this help enough?</p> <p>c. Have they done a good job? Are they reliable?</p> <p>d. What happens if no one is available to help?</p> <p>5) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, medical care, or anything else you need to stay healthy?</p>
PSYCHOLOGICAL ABUSE	<p>6) Has anyone close to you called you names, put you down, or yelled at you?</p> <p>7) Has anyone close to you ever threatened to punish you or put you in an institution?</p> <p>8) Have you felt sad or lonely at home?</p> <p>9) Have you felt afraid of anyone close to you?</p> <p>10) Do you distrust anyone close to you?</p> <p>11) Does anyone close to you drink or use drugs?</p>
FINANCIAL EXPLOITATION	<p>12) Has anyone tried to force you to sign papers against your will, or that you did not understand?</p> <p>a. Has anyone pressured you to give them money or property?</p> <p>13) Has anyone taken money or things that belong to you without asking?</p> <p>14) Does anyone close to you rely on you for housing and/or financial support?</p>

* Please explore any positive responses in more detail.

Table 6**Physical Signs Suspicious for Potential Elder Abuse or Neglect**

PHYSICAL ABUSE
Bruising in atypical locations (not over bony prominences/on lateral arms, back, face, ears, or neck)
Patterned injuries (bite marks or injury consistent with the shape of a belt buckle, fingertip, or other object)
Wrist or ankle lesions or scars (suggesting inappropriate restraint)
Burns (particularly stocking/glove pattern suggesting forced immersion or cigarette pattern)
Multiple fractures or bruises of different ages
Traumatic alopecia or scalp hematomas
Subconjunctival, vitreous or retinal ophthalmic haemorrhages
Intraoral soft tissue injuries
SEXUAL ABUSE
Genital, rectal, or oral trauma (including erythema, bruising, lacerations)
Evidence of sexually-transmitted disease
NEGLECT
Cachexia/malnutrition
Dehydration
Pressure sores/decubitus ulcers
Poor body hygiene, unchanged diaper
Dirty, severely worn clothing
Elongated toenails
Poor oral hygiene

Data from Refs 56,64,89–91

Table 7**Elder Abuse Suspicion Index (EASI)**

Questions 1 through 5 are answered by the patient. Question 6 is answered by the physician.

- 1** Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
- 2** Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care or from being with people you wanted to be with?
- 3** Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
- 4** Has anyone tried to force you to sign papers or to use your money against your will?
- 5** Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
- 6** Doctor: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

The patient can answer “yes,” “no,” or “unsure.” A response of “yes” on one or more of questions 2 through 6 should prompt concern for abuse or neglect.

From Yaffe MJ, Wolfson C, Lithwick M, et al. Development and validation of a tool to improve physician identification of elder abuse: the elder abuse suspicion index (EASI). J Elder Abuse Negl 2008;20:276–300; with permission.