Clinician's Role in the Documentation of Elder Mistreatment

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As the population ages, elder mistreatment is a growing concern in North America, and it includes physical and financial abuse and neglect. Careful documentation of the history, physical examination, and diagnostic data help achieve a clinical assessment that may be crucial to the outcome of a legal case and the protection of a patient. Good medical documentation ultimately saves clinicians time and demonstrates competency. This article discusses the items clinicians need to document in suspected cases of elder mistreatment. The emphasis is on issues that are above or beyond those performed in a routine clinical encounter.

Key words: *elder mistreatment, elder neglect, elder abuse, financial exploitation, forensic documentation*

Introduction

With the aging of the North American population, elder mistreatment (a term preferred to *elder abuse* since it encompasses mistreatment beyond physical and sexual abuse) is expected to be a growing problem. Estimates suggest that close to a quarter of a million community-dwelling Canadians have experienced some form of mistreatment since reaching the age of 65, at a prevalence rate between 4 and 6%.[1] Elder mistreatment has been shown to be an independent risk factor for mortality in older adults.[2]

Clinicians, therefore, need to be proficient in documenting cases of suspected elder mistreatment. Medical documentation has legal and forensic implications on top of the clinical applications. Proper documentation can lead to the protection of older patients' autonomy, finances, and even their life and health.

This article discusses the items clinicians need to document in suspected cases of elder mistreatment. The discussion covers the issues specific to the three most common forms of elder mistreatment: neglect, physical abuse, and financial exploitation. Table 1 provides general principles of documentation applicable to most forms of elder mistreatment. The emphasis in this article is on issues that are above or beyond those performed in a routine clinical encounter. The discussion follows the clinical format of the interview and history-taking, the physical examination, and assessment.

Interview and History-Taking

Neglect

Other than the actual presence of neglect, the most important distinction to document in cases of suspected neglect is whether the neglect is self-inflicted or inflicted by others. This distinction has important legal implications because self-neglect is not considered a crime.[3] To establish this distinction, several factors must be documented. The dependence of a patient upon others should be recorded using standard instruments such as Katz *et al.'s* activities of daily living[4] or Lawton *et al.'s* instrumental activities of daily living.[5] The responsibilities of the caregivers as they understand them and as the patient understands them should also be documented. These responsibilities should be juxtaposed in the medical records next to the amount of care that the caregivers and patient state is actually provided. Clinicians should include whether a verbal or written contract exists for caregiving duties and what type of payment, if any, is provided for the caregiving.

The history should also include the impact or consequences of the failure to provide care. The adherence to medications should be documented, including who is responsible for giving medications and how medication administration is being monitored. Any delays in seeking care should be recorded in the medical chart. The caregivers' understanding of the harm or potential harm to the patient from their actions or inaction needs to be stated in the records, preferably in their own words.

Physical Abuse

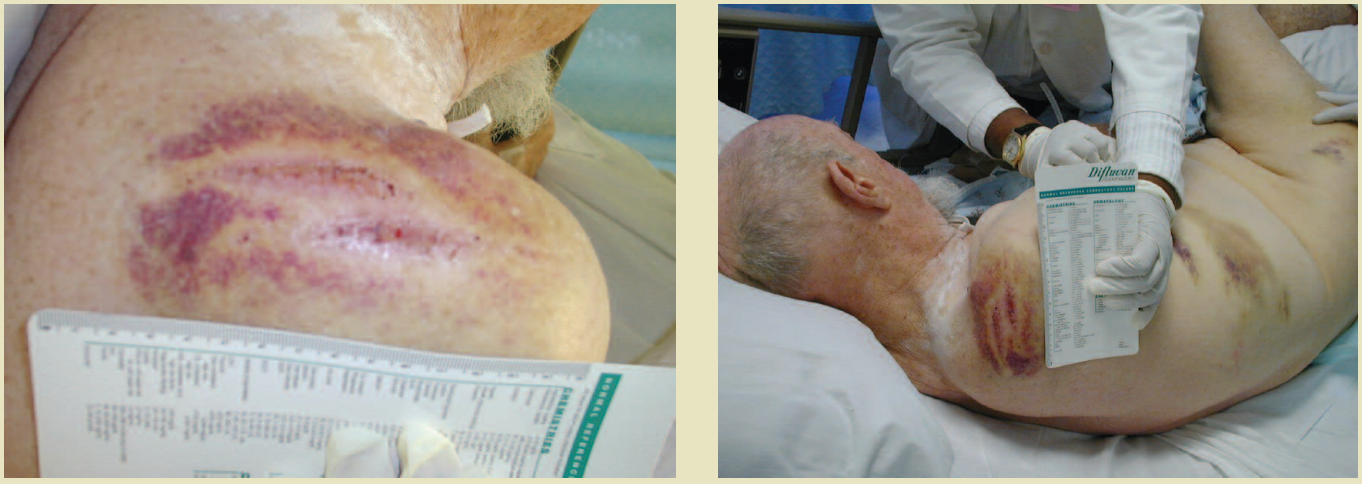
Documenting the cause or mechanism of an injury as stated by the patient is important. This documentation may seem intuitive and obvious, but biases toward the memory and reliability of older patients (ageism) may prevent such statements from being recorded or taken seriously. A recently completed study on inflicted bruises showed that there was a correlation between a patient's ability to recollect the cause of a bruise and the abuse of the patient.[6] This study compared confirmed abuse cases to cases of spontaneous or accidental bruises in normal older adults, most of whom could not recall how their bruises occurred. The history section should comment on the reliability of the sources of information and highlight any discrepancies in the information between sources.

The critical determination in history-taking is the distinction between an acci-

Table 1: General Approach to Documentation of Elder Mistreatment

Interview and History-Taking	Physical Examination	Assessment
Document response to open-ended questions	Document the patient's physical and cognitive abilities	Provide the reasons that lead to your conclusion, i.e., "connect the dots"
Use direct quotations	Highlight findings that deviate from or contradict claims made in the history	Specify the degree of the mistreatment
Interview patient separate from caregiver or suspected perpetrator	Record the interaction of the patient with caregiver	Specify the severity of harm or potential harm to the patient
Document discrepancies between different sources	Document observed inappropriate concern by caregiver: • overconcern, e.g., a perpetrator refuses to leave the examination room when asked • underconcern	Document your level of confidence that mistreatment occurred, e.g. "definite" "probable" "possible" "unlikely"
Ensure documentation by multiple professionals from different disciplines	Record any change in patient behaviour when caregiver leaves: • e.g., shrinking down with head bowed and eyes to the floor • increased anxiety or agitation	Document the patient's capacity to make decisions
Document reliability of the source	Record skin lesions on a body diagram	Record report to the appropriate authorities
Record the patient's cognitive and functional statuses	Take pictures of any lesions (see Table 3)	

Figure 1A and B: Bruise with Central Clearing and Linear Demarcations



These photos illustrate several points. The clear regions and the linear nature of the bruise suggest this bruise was not accidental. The two vantage points allow the viewer to see both the larger context (B) and the details (A). The inclusion of the ruler within the images allows for documentation of the lesion's size.

Source: courtesy Dr. Solomon Liao

dental cause of an injury versus an inflicted cause. Documentation should include past injury patterns and the risk of accidental injury, for example, falls. A thorough documentation of medications taken (including over-the-counter and herbal medications) is needed to ensure that contributing factors, such as medications that contribute to falls or bruising, are considered.

Financial Exploitation

Documentation should focus on the eight elements that are necessary to constitute financial abuse[7] (Table 2). These eight elements are based upon the only evaluation framework for financial abuse that is based upon empirical evidence.[8] The remainder of the documentation should address the patient's capacity to make financial decisions, focusing on the patient's present and past cognitive abilities (including any diagnosis of dementia or cognitive impairment) and whether the decisions made are consistent with the patient's past pattern of decisions. Particular attention should be given to medications that can impact a patient's mental status.

Table 2: Eight Elements of Financial Exploitation

Elements	Examples
1. Vulnerable elder	Cognitive impairment Emotional dependence Depression Bereavement
2. Trusting relationship with perpetrator	Romantic interaction Family member Caregiver Professional relationship, e.g., accountant, lawyer
3. Isolation and control of the older person or transaction	Limit contacts to family members Controls communication with others Accompanies patient to banks Controls credit cards, automated teller machine (ATM) cards, or cheques
4. Exertion of undue influence	Deceit Coercion Intimidation Persuasion
5. Lack of concern for the welfare of the older person	Benefit to older person not proportional to cost Use of assets for other's benefit
6. Lack of ethics in the transactions	Violation of standards or professional code Violation of role boundary
7. Secretiveness	Lack of disclosure Lack of verification
8. Change of assets during the vulnerable period	Change of title of property Movement of money from one account to another Change of trust or will

Physical Examination

Neglect

Documentation of the physical examination should begin with the general state of the patient. Findings that indicate the hydration and nutritional statuses of the patient should be recorded. The record should also pay attention to the hygiene of the patient, including the smell of urine, urine stains on the clothes, and fecal stains on underwear.

Certain areas of the body are most commonly neglected, and specific attention should be paid to those: the feet, the groin and genital areas, and the breast folds. The presence and severity of any infections, such as fungal, should be documented. Other areas of focus include areas of pressure such as bony prominences. In addition to the routine clinical documentation of ulcer characteristics (e.g., location, size, and stage), the medical record should pay particular attention to possible indictors of neglect such as the amount of necrotic material or eschar, the amount of drainage, and signs of infection.

Physical Abuse

As in real estate, documentation of physical abuse cases is largely about "location, location, location." Lesions, such as bruises, burns or ulcers, in skin folds warrant particular attention in abuse documentation because natural causes for lesions in these areas are rare (see Table 3 for examples.) Bruising in the head and neck areas should be closely documented since it has been associated with abuse cases.[6] The pattern of the lesions is of next importance in documentation. Again, since nature rarely causes lesions that are circumferential, linear, or have central clearing, such lesions require careful documentation (Figure 1A and B).[9] Recurrent lesions or lesions of different ages may suggest multiple episodes of abuse. However, studies show that the colour of a bruise cannot be used to estimate its age.[10] Discrepancies between the physical examination and the account of the injury should be highlighted in the

Table 3: Characteristics of Nonaccidental Physical Lesions

Suspicious Factors	Examples
Location:	
• Skin folds	Axilla, under breasts, in groin, popliteal fossa
• Head and neck region	
Pattern:	
• Circumferential	Burn around the entire foot—dipped into hot water, not due to spilt coffee
• Linearity or sharply demarcated margins	Ligature or restraint burns around wrist
• Central clearing	Bruise around the entire bicep area bilaterally—from grabbing the arms
	"Tram track" bruises from a coat hanger
	Bruise with rectangular normal skin in the middle—strike from a spatula

records. Clinicians should take pictures of any lesions (Table 4). Finally, the size of lesions is important to record. For example, bruises >5 cm have been associated with abuse cases, whereas bruises <1 cm have been associated with spontaneous or accidental causes.[6]

Financial Exploitation

Much of the physical examination necessarily focuses on the patient's mental status. Documentation should focus on the patient's memory, ability to attend to or focus on a task, and ability to perform simple mathematics. The patient's judgment and insight should be assessed and recorded, as well as his or her ability to abstract complex concepts. The patient's mood and affect should be documented. Any sensory impairment should be recorded, along with the patient's ability to sign a document.

Laboratory Studies

Neglect

Laboratory values that suggest malnutrition or dehydration are particularly important to document. Medication levels can serve as evidence that drugs are being improperly administered or not given at all. Nonadherence to prescribed regimens can be recorded in terms of electrolyte levels (e.g., potassium and magnesium for diuretics), glycosylated hemoglobin, and thyroid function tests.

Physical Abuse

In physical abuse cases, laboratory studies are of less importance than imaging studies. Perhaps the only relevant laboratory values to record are those related to coagulation and platelet count. If head trauma has occurred, the results of a computed tomography of the head should be documented for the presence of fractures, hematomas, and other hemorrhages. Bone radiographs should document not only acute fractures and dislocations but also older factures that suggest a recurrent pattern of trauma.

Table 4: Tips on Photographic Documentation

Use a digital camera. Avoid using instant cameras whose pictures fade and are of poor quality.
If a crime is suspected, photographs should be taken by police crime scene investigators.
If professional medical photographers are available, use them.
Take both close-up and distant pictures to provide perspective and the location of the lesion.
Take pictures from at least two different angles. This is particularly important for three-dimensional lesions with swelling or depth such as hematomas and ulcers.
Include a ruler in the picture.
Include the patient's name and date or label the picture with name and date.

Assessment

Neglect

The assessment section should document a conclusion statement about whether, from a medical perspective, neglect occurred. It should include documentation on the severity of that neglect and where the case lands in the spectrum of self-neglect verse neglect by others.

Physical Abuse

Clinicians should document their conclusion about whether the injuries seen are consistent with an accidental mechanism or an inflicted one. Physicians need to record not only the actual harm done but also the potential harm or risk for harm to the older adult. This assessment should record the frailty of the patient and the likely consequences of the injury on functional impairment or survival.

Clinical Pearl

Documentation of a patient's mental status and capacity to make decisions facilitates most cases of elder mistreatment.

Key Points

- Elder mistreatment includes physical abuse, financial abuse, and neglect (by self or by others.)
- An accurate documentation of key elements of the history, physical findings, and diagnostic data help achieve clinical and forensic conclusions.
- Assessment and documentation of a patient's health, cognitive and functional statuses, and social and financial resources are critical to the management of elder mistreatment.
- Photographs are valuable evidence.
- Suspected mistreatment should be reported to the appropriate authorities.

Financial Exploitation

Clinicians' conclusions should comment on a patient's degree of vulnerability and decision-making capacity. Physicians may also want to document their degree of confidence that financial exploitation has occurred.

Conclusion

Medical documentation in cases of elder mistreatment serves more than just clinical purposes. It also has legal and forensic implications. Clear and precise medical documentation may make or break a case. Good documentation ultimately saves clinicians time by reducing questions and phone calls from investigating agencies and potentially avoiding the need to testify in person. Good documentation also demonstrates the clinicians' competency, especially on a witness stand.

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