TARANAKI DISTRICT HEALTH BOARD

Violence Intervention Programme

Taranaki DHB
Elder Abuse
Management Policy

VIP
violence intervention programme

Funded by Ministry of Health & TDHB

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ELDER ABUSE AND NEGLECT MANAGEMENT POLICY

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Introduction

1. The Taranaki District Health Board (DHB) is committed to the strategic actions and behaviours of We Work Together By:
    - Treating people with trust respect and compassion
    - Communicating openly, honestly and acting with integrity
    - Enabling professional and organisation standards to be met
    - Supporting achievement and acknowledging successes
    - Creating healthy and safe environments
    - Welcoming new ideas

2. This Elder Abuse and Neglect Policy has been developed in accordance with the principles of action including the Treaty of Waitangi principles, recognising Te Whare Tapa Wha and kaupapa principles. This is consistent with cultural training offered and mandated within the Taranaki DHB.

Purpose

3. The purpose of this policy is to provide Taranaki DHB community and hospital-based staff with a framework to identify, assess and family violence; elder abuse and neglect.
4. It recognises the important role and responsibility staff have in the accurate detection of elder abuse and neglect.

Scope

5. This policy applies to all Taranaki DHB staff, including volunteers, students, contractors and visiting clinical staff to the Taranaki DHB. In particular, it has significance for those working in clinical settings.

Terms and Definitions

6. **Family Violence:** Violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, intimate partner violence and elder abuse.
7. **Physical Abuse:** Includes all acts of violence that may result in pain, injury, impairment or diseases, may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations etc) though the difference between accidental injury and abuse can be slight and require expert investigation.
8. **Psychological/Emotional Abuse:** Includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, removal of decision-making posers (in relation to adults) and (in relation to child)

exposing the child to physical, psychological or sexual abuse of another person. Concerted attacks on an individual's self-esteem and social competence results in increased social isolation.

9. **Sexual Abuse:** Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.
10. **Intimate Partner Violence – also called Partner Violence:** Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same sex), former marital partners and former non-marital partners.
11. **Routine Enquiry:** Routine enquiry, either written or verbal, by the health care providers to individuals about personal history of partner abuse. Unlike indicator based questioning, routine enquiry means routinely questioning all women aged 16 years and over about abuse. The enquiry is usually made within the social history.
12. **Elder Abuse:** Elder Abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm and distress to an older person

Principles

13. The Ministry of Health's Family Violence Assessment and Intervention Guideline guides this policy.
14. Health services should identify, assess, offer referral and advocate for victims of family violence.
15. Health services that care and protect victims of family violence are build on a bicultural partnership in accordance with the Treaty of Waitangi.
16. All people using the services of the Taranaki DHB are assessed and managed in a culturally safe environment. The Maori Health team is available for cultural support. All staff are able to recognise and be sensitive to other cultures.
17. Staff are competent in the identification and management of actual or suspected family violence through the organisation's violence intervention programme infrastructure including policy and procedures, standardised documentation, education programme and access to consultation.
18. Requirement to integrate care through a coordinated approach with community providers.

Roles and Responsibilities

19. The **Taranaki DHB** is responsible for ensuring:
    - An organisation-wide framework for the management of elder abuse and neglect and associated policies and procedures.
    - Regular training for staff on the policy and related procedures.
    - Regular monitoring of the policy to assess compliance.
    - Adequate support (e.g. access to consultation) and supervision for staff.
    - Activities are properly resourced and evaluated.

20. **Managers** of departments/services will support the implementation of this policy within their department/service as coordinated by the Violence Intervention Programme Coordinator.

21. All **Taranaki DHB staff** have a responsibility to be aware of this policy, follow appropriate procedures and attend appropriate training.

22. All **clinical staff** have a responsibility for the assessment and intervention of family violence. Responsibilities include:

- Being conversant with the DHB's family violence intervention policy and procedures.
- Understanding the referral and management of suspected or disclosed elder abuse and neglect.
- Attending initial training and regular updates appropriate to their area of work.
- Providing or accessing Taranaki DHB specialist health services that may include:
    - Cultural assessments
    - Mental Health assessments
    - Diagnostic medical assessments
    - Social work services, counselling and therapy resources.
- Ensuring clinically and culturally safe practice, for example consulting a senior colleague during the intervention and seeking peer-support/supervision when elder abuse and neglect is suspected or disclosed.

23. **Violence Intervention Programme Coordinator** responsibilities include:
- Coordinating the Violence Intervention Programme implementation within services, working with service leaders to ensure system support is readily available.
- Ensuring this policy remains current and aligned with national standards.
- Providing cyclical workforce training in accordance with the Taranaki DHB Violence Intervention training plan.
- Ensuring quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.

Supporting Information

24. Legislation:
- Code of Health and Disability Services Consumers' Rights
- Crimes Act
- Domestic Violence Act
- Health Act
- New Zealand Bill of Rights
- Privacy Act
- Summary of Offences Act

25. Taranaki DHB Policies and Procedures:
- Child Protection Policy
- Intimate Partner Violence Management Policy

26. Associated Documents
- Family Violence Assessment and Intervention Guideline, Ministry of Health, 2016

Maori and the Family Violence Intervention Programme

Information from Maori service providers indicates that financial abuse and emotional abuse are more common forms of elder abuse than physical or sexual abuse. Often there will be long-standing family issues that may need to be addressed, and a history of family violence may be present. The older person may be experiencing grief at a loss of trust, aroha and support from whanau. In addition, in a high proportion of cases seen by Maori elder abuse service providers, the client has some form of dementia.

Asking for help is likely to be difficult for many Maori, as a sense of shame and stigma can be associated with elder abuse. Older Maori have traditionally been treated with respect as leaders of iwi, hapu and whanau. This Taranaki DHB Elder Abuse and Neglect Management Policy has been developed in accordance with the Treaty of Waitangi

principles, and recognising Te Whare Tapa Wha. This is consistent with cultural training offered and mandated within the Taranaki DHB.

Maintaining the safety of koroua and kuia must be paramount. Any practices or interventions that health care providers engage in should not further endanger or disadvantage the older person. Ensure practice is safe clinically and culturally.

See Appendix 1: Maori and Elder Abuse.

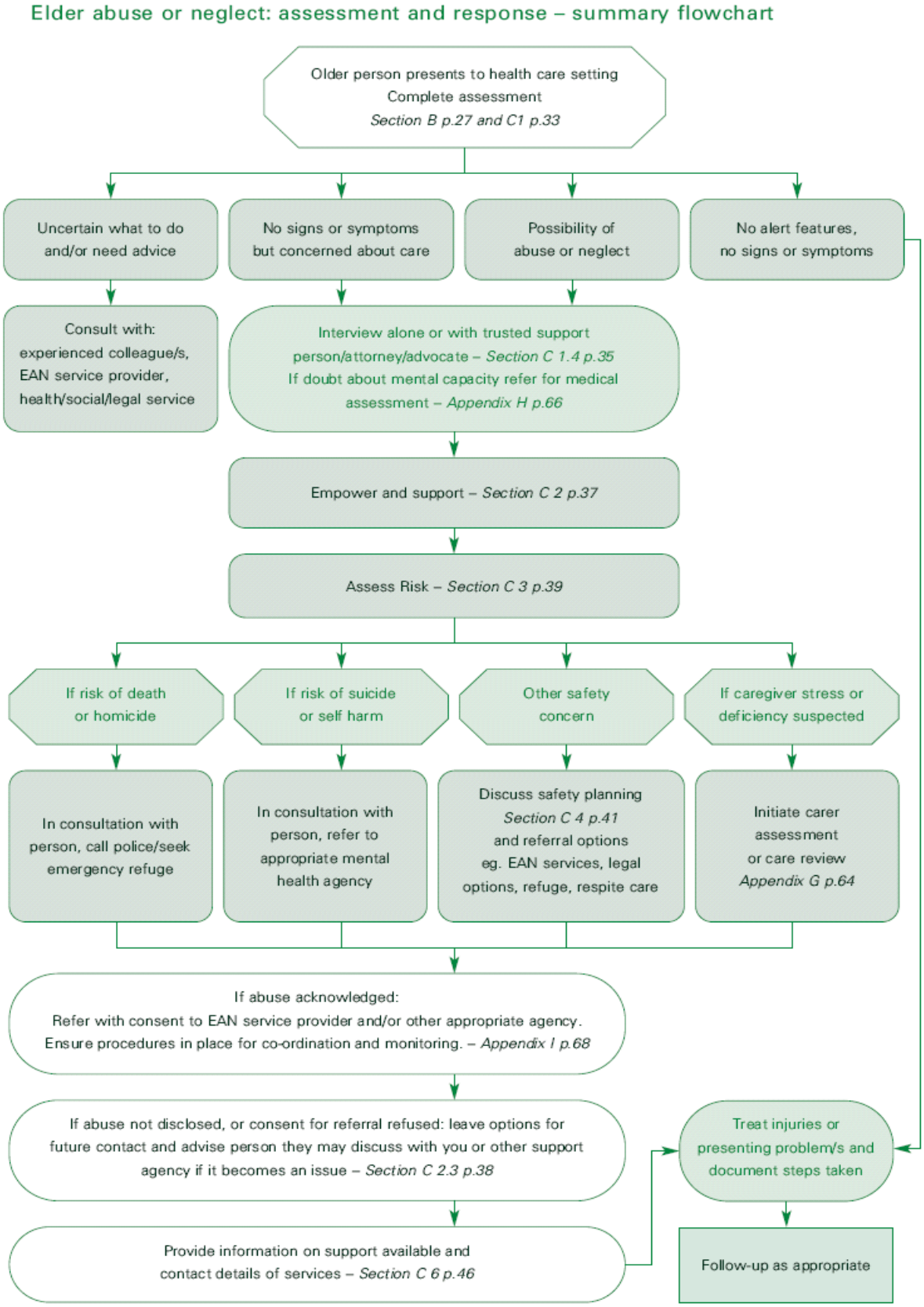
Pacific Peoples and the Family Violence Intervention Programme

Financial abuse or neglect and emotional abuse are more frequently observed categories than physical abuse or sexual abuse, which is rarely identified. Pacific older people living in extended family households, and in particular women and those with chronic illness, may be at greater risk of being abused.

Traditionally, older family members have been cared for by their family and within the extended family structure. Caring is seen as a responsibility and a duty and can result in a reluctance to ask for help, which in some Pacific cultures can be viewed as something that is to be offered rather than requested. Anecdotal information suggests that pacific people can be especially reluctant to report abuse or injury. Occurrences of abuse are unlikely to be spoken of or referred to in literal or direct terms. An older person may instead say, for example, that he or she is unhappy. Embarrassment and shame, fear of community scrutiny or extended family distress are common reasons why abuse of older people is kept private and therefore unreported.

See Appendix 2: Pacific Peoples and Elder Abuse.

Elder Abuse Intervention Flowchart



Brief Intervention Model: A Six-Step Process

1. Identify

Health care providers working with older people should always be alert for features that may indicate the possibility of abuse, because most abuse goes undetected. Questioning for elder abuse is recommended when alert features or signs and symptoms of abuse or neglect are present.
Include general questions during an assessment to help identify alert features.

Direct elder abuse questions will be used for all older adults who present with alert features or signs and symptoms of elder abuse, and may be used where risk indicators suggest there is the potential for elder abuse.

See Appendix 3: Elder Abuse Screening Recommendations (for different settings).
See Appendix 4: Signs and Symptoms associated with Elder Abuse and Neglect.
See Appendix 5: Identifying Elder Abuse and Neglect.

2. Support and Empower Persons Experiencing Abuse

Disclosure of elder abuse is a difficult step, and many victims feel shame and guilt, and have been told by the abuser that they are responsible for the abuse they experience. Clear messages are needed that support and reassure those experiencing abuse that they are not at fault, and that help is available. Hearing these messages from health care providers is one of the most powerful interventions that health care professionals provide.

Involve Maori staff for support as appropriate, for example the Maori Health Team (Kai Awhina).

Involve Pacific staff for support as appropriate, for example the Taranaki Pasifika Services Trust.

See Appendix 6: Guidelines for Supporting and Empowering Persons Experiencing Abuse.

3. Assess Risk

The purpose of the risk assessment is to identify where immediate help is needed, make appropriate and timely referral, and lay the foundations for working with the older person so that solutions can be found that will help reduce the risk of elder abuse. The safety, wellbeing and rights of the older person must always be the main focus.

See Appendix 7: Guidelines for Risk Assessment.

Health care professionals are responsible for conducting a preliminary risk assessment with persons experiencing abuse in order to assess the level of immediate risk for the older person leaving the health care setting, and to determine appropriate referral options. Where ongoing safety concerns are identified, early referral to support agencies is the preferred intervention both for follow-up assessment of the circumstances of suspected or actual elder abuse and neglect, and for case planning and co-ordinated intervention.
The presence or absence of injuries or other evidence of abuse are not prerequisites for making a referral. **DO NOT discuss concerns or actions with a caregiver.**

4. Plan Safety

If elder abuse and /or neglect is identified or suspected a plan for safety needs to be made following the risk assessment. A multidisciplinary team approach is the preferred option. Consult with an experienced colleague or person(s) with training in elder abuse response and intervention. Information from the risk assessment process described in the previous section will help to ensure that acute needs are identified and included in the safety plan.

See the Family Violence Community Directory in your department for contact details including phone numbers.

See Appendix 8: Guidelines For Health And Risk Assessment (Step 3).

On rare occasions staff may identify issues of patient or staff safety secondary to a disclosure of family violence.

See Appendix 11: Guidelines on Notifying the Police (Re: Family Violence).

5. Referral Agencies

Referral agencies are a vital service for the support of victims of abuse. Taranaki DHB has established interagency processes with a range of organisations and agencies (refer to the Family Violence Community Directory in your Department). Note: It is not necessary for an incident of abuse to be proven before making a referral. The actual point at which to make a referral will be a matter of professional judgement, and will be influenced by:

- Completing the VIP Family Violence Community Services Referral Form.
- the level and urgency of safety concerns
- the readiness of the older person to disclose information on abuse and their willingness to accept referral
- the complexity of the older person's physical, social and mental health needs.

6. Document

In situations of identified or suspected physical or sexual elder abuse, accurate documentation is an important part of keeping victims safe because the clinical record may help in future legal action, for example securing a Domestic Protection Order or prosecuting assault. An objective, systematic history and risk assessment is therefore essential. Standard professional requirements also apply (e.g. a legible signature and designation).

See Appendix 13: Guidelines for Documentation of Family Violence.

Confidentiality is paramount. An **Accessory File** for Family Violence disclosures should be created and held in medical records (identifiable on the medical records screen). The VIP Elder Abuse and Neglect Risk Assessment and Documentation Form should be completed, placed in a sealed envelope, marked "Confidential" and forwarded to the Medical Records Manager. This information will be loaded onto to the IBA system and is available to designated Taranaki DHB computer users.

Safety and Security

At times it may be necessary to suppress patient details and provide secure processes for discharge of persons who are being abused. The guidelines for use when staff assess the safety of a victim of abuse to be high risk are outlined in the VIP Intimate Partner Violence Policy.

In these circumstances, staff may choose, in consultation with the victim, to:

- ensure persons making public enquiries about the victim are given no details by suppressing all details on the hospital computer
- use a safe process to discharge the family to an advocacy agency, e.g. women's refuge. This may include informing an inquirer that the patient has left the hospital before this is so and/or denying knowledge of where the patient has gone.

Staff Resources

Training

Family Violence training is mandatory for all staff working with children and women.

The training includes:

- Pre-training information (pre-reading document/online training package)
- A full day (8 hour) training session.

Access to the Violence Intervention Programme training can be obtained through:

- Stargarden on the Intranet
- Taranaki DHB Learning and Development Administrator Extn 7649
- Taranaki DHB Co-ordinator of Violence Intervention Programme Extn 8973
- Taranaki DHB Child Protection Co-ordinator Extn 8437

Staff are also required to undertake in-service training as indicated and refresher training biannually. Advanced training will be offered to designated staff.

Supervision and or peer support

Clinical supervision and or peer support for staff is recognised as an important requirement to ensure the practice of routinely questioning women for intimate partner violence remains safe for the individual and staff.

Clinical supervision and or peer support is mandatory for staff to whom a disclosure has been made and is available within the service/department.

The Employee Assistance Programme is also available should further counselling be required. Contracted professional staff provide this confidential offsite support and employees are encouraged to self-refer to this programme. To access the service please call EAP Services Ltd on 0800 7872867 (STRATOS)

Taranaki DHB Employees and Family Violence

The Taranaki DHB Employee Assistance Programme (EAP) is available to support employees experiencing or perpetrating family violence. Contracted professional staff provide confidential offsite services and employees are encouraged to self-refer to this programme. To access the service please call EAP Services Ltd on 0800 7872867.

MoH Family Violence Assessment and Intervention Guidelines (2016)

This resource is available here and on the Ministry of Health website.

Other resources

A number of other resources have been written to support safe practice in family violence. These include a directory of community family violence services, cue cards with sample framing and risk assessment questions, specific intimate partner violence documentation form and a support card for victims.

Reference Documents

Type	Document Title(s)
Organisational Policies	• Taranaki DHB Intimate Partner Violence Management Policy and Guidelines • Taranaki DHB Child Protection Management Policy and Guidelines • Taranaki DHB Reportable Events Policy Taranaki DHB Interpreter Service Policy • Taranaki DHB Digital Photography Procedure (Patient Clinical Images) • Taranaki DHB Appropriate Access to Health Information Policy.
Legislation	• Privacy Act (1993) • Crimes Act (1961) • Crimes Amendment Act (No. 3) 2011 • Domestic Violence Act 1995 • Vulnerable Children's Act 2014
Associated Documents	• Ministry of Health. Family Violence Assessment and Intervention Guidelines; Child Abuse and Intimate Partner Violence. Wellington: Ministry of Health, 2016. • Ministry of Health He Korowai Oranga, the – Māori Health Strategy

For further information contact the Taranaki DHB Violence Intervention Programme Co-ordinator

APPENDIX 1 Terms and Definitions[1]

The following terms and definitions will be used through-out this document:

Family Violence	Violence or abuse of any type, perpetrated by one family member against another family member. It includes child abuse, intimate partner violence and elder abuse
Elder Abuse	Elder abuse is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm and distress to an older person
Physical Abuse	Includes acts of violence that may result in pain, injury, impairment or diseases, may include hitting, choking or in any way assaulting another person, and also under/over medication. There is usually visible evidence of physical abuse (bruising, fractures, burns, lacerations etc) though the difference between accidental injury and abuse can be slight and require expert investigation.
Psychological/Emotional Abuse	Includes any behaviour that causes anguish or fear. Intimidation, harassment, damage to property, threats of physical or sexual abuse, removal of decision-making powers (in relation to adults) and (in relation to a child) exposing the child to physical, psychological or sexual abuse of another person. Concerted attacks on an individual's self-esteem and social competence results in increased social isolation.
Sexual Abuse	Includes any forced, coerced or exploitive sexual behaviour or threats imposed on an individual, including sexual acts imposed on a person unable to give consent, or sexual activity when an adult with mental incapacity is unable to understand.
Intimate Partner Violence *(also* called partner abuse*)*	Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.
Routine Enquiry	Routine enquiry, either written or verbal, by health care providers to individuals about personal history of partner abuse. Unlike indicator-based questioning, routine enquiry means routinely questioning all women aged 16 years and over about abuse. The enquiry is usually made within the social history.

1 Ministry of Health. Family Violence Assessment and Intervention Guidelines; child abuse and intimate partner violence. Wellington: Ministry of Health, 2016.

APPENDIX 2 Maori and Elder Abuse

This section from the Family Violence Intervention Guidelines1 was developed with consultation from the Ministry of Health Family Violence Guideline Advisory Committee, Te Oranga Kaumatua Kuia Disability Support Service and Te Puni Kokiri. This appendix aims to enable health care providers to have some understanding of the issues that underpin abuse and neglect for Maori, and strategies to improve responsiveness to Maori.

The proportion of older Maori is currently small but is rapidly growing. Numbers of older Maori are projected to increase by eight times within the next 50 years. The prevalence of elder abuse among Maori has not been established.

The occurrence of abuse in Maori whanau has both historical and contemporary causes and can be attributed to the complex interaction of many sociological, economic and cultural factors. The historical context and process of colonisation have distanced Maori from their traditional roles and social supports. With the breakdown of traditional whanau structure, loss of beliefs and values, including Te reo Maori, patterns of behaviour have emerged. For some Maori a change in the way violence is viewed, from being a public iwi and hapu concern to a private whanau issue. Older Maori have traditionally been treated with respect as leaders of iwi, hapu and whanau.

The Family Violence Intervention Programme (FVIP) has developed this programme within the founding principles of the Treaty of Waitangi. Consultation with Te Whare Punanga Korero (Maori Health Governance Group) has been a valued component of the programme from planning, through the implementation and evaluation phases.

Principles of Action

E tau hikoi I runga I oku whariki
E tau noho I toku matapihi
E hau kina ai toku tatau toku matapihi.
Your steps on my whariki (mat), your respect for my home,
Opens my doors and windows.

Health care providers should ensure the service they provide is safe and respectful of Maori older person's beliefs and practices. The delivery of culturally safe and competent intervention that responds to Maori victims is supported by the following principles:

- accessibility of their service to victims of family violence
- recognition of the diversity of Maori in their culture and their experience of violence
- knowledge and understanding of Maori holistic frameworks of health
- knowledge and development of responsive services for Maori
- accountability
- partnerships with iwi, hapu and Maori that are sustained
- that the context of the whanau and the community are incorporated within the delivery of services.

Safety and Protection

- Maintaining safety of koroua and kuia must be paramount. This includes only questioning the older person about abuse when they are alone
- Do not assume that the whanau should be involved – offer plans of action the older person can take (these may or may not include whanau)
- Affirm the elder's right to a safe, non-violent environment
- Offer referral to Maori or mainstream elder abuse and neglect services

- Ask Maori older person if they would like support from the Maori Health Team (Kai Awhina), this may also include Kaumatua or Kuia
- Manage risk factors.

The provision of a Maori-friendly environment

- Provide a welcoming, relaxing environment, incorporating Maori images and te reo Maori in design, signage and greeting
- Have Maori staff available
- Convey a genuine attitude that is gentle, welcoming, caring, non-judgemental and respectful
- Do not rush. Leave time to think about and respond to questions
- Ask open-ended questions
- Offer resources and support.

The provision of culturally safe and competent interactions

- Engage the Taranaki DHB Maori Health Team (Kai Awhina) to provide cultural guidance during the planning, implementation and evaluation of the Family Violence Intervention Programme
- All Taranaki DHB staff are required to attend cultural training.

A collaborative community approach to elder abuse should be taken

- Staff should be aware of the referral agencies appropriate for koroua and kuia who experience abuse or neglect
- Staff should recognise that for solutions to be meaningful to older Maori, other sectors may need to be involved.

APPENDIX 3 Pacific Peoples and Elder Abuse

There are seven main Pacific communities represented in New Zealand, Samoa, Tuvalu, Tokelau, Fiji, Tonga, Niue, and the Cook Islands. Family violence among Pacific communities in New Zealand occurs in the context of social change brought about by the migration from the Pacific, alienation from traditional concepts of the village, family support, extended family relationships and in combination with the socio-economic stressors, for example scarce resources may be stretched between the demands of everyday living as well as customary obligations, such as those to the church and remittance to family members who have remained in the Pacific.

Victim Safety

- Maintaining safety of the older person must be paramount. This includes only questioning the older person about abuse when they are alone
- Do not assume that the fanau should be involved – ask the older person what plan of action they want (it may or may not include the fanau)
- Have staff or qualified interpreters who speak Pacific languages available
- Affirm the older person's right to a safe, non-violent home
- Offer options for plans of action for the older person
- Offer referral to Pacific or mainstream elder abuse and neglect services
- Manage risk factors.

The Provision Of A Pacific-Friendly Environment

- Convey a genuine attitude that is gentle, welcoming, caring, non-judgemental and respectful
- Do not rush, leave time to think about and respond to questions
- Ask open-ended questions and provide explanations of what is happening
- Ensure that the confidentiality of your discussions is understood
- Offer resources and support that meets the ethnic specific needs of the older person

The Provision Of Culturally Safe And Competent Interactions

- Develop knowledge and understanding of the effects of migration on Pacific peoples.
- Identify and remove barriers for older Pacific people accessing health care services
- Pacific protocols are observed where possible
- Qualified interpreters are to be used where appropriate Refer Interpreter Service Policy.

A Collaborative Community Approach To Elder Abuse Should Be Taken

- Staff should be aware of the referral agencies appropriate for older Pacific people who are experiencing abuse and neglect
- Recognise that for solutions to be meaningful to older Pacific people, other sectors may need to be involved
- **Do not assume that the fanau or church should be involved in supporting the older person - ask what plan of action the older person wants (it may or may not include the family or the church).**

APPENDIX 4 Recommended Elder Abuse Routine Enquiry for Different Clinical Settings

The Family Violence Assessment and Intervention Guidelines offer a range of recommended routine enquiry guidelines for various services, which are repeated here. Each service and unit in Health*care* Services will develop a unit-level policy, specifying where, when, how often and by whom family violence questioning will be undertaken. The following are *guidelines only*.

Health Care Setting

Direct questioning for elder abuse is recommended when signs and symptoms or alert features are present. Routine enquiry of all older people whether signs and symptoms are present or not is not recommended for elder abuse. However, health care providers should always remain vigilant and be aware of risk factors and alert features. Proactive questioning about abuse may be indicated in the absence of signs and symptoms when multiple risk factors are present.

Health care providers need to be aware that older women may also be at risk of intimate partner violence and should maintain a high index of suspicion.

When Should Routine Enquiry for Elder Abuse Occur?

Primary Care Settings:

- When the older person presents with signs and symptoms indicative of abuse.
- Whenever alert features or signs and symptoms are identified.
- Where proactive or comprehensive health assessment reveals alert features or signs and symptoms.

Emergency Department/Urgent Care Settings:

- At any emergency department visit when the older person presents with signs and symptoms indicative of abuse.
- Prior to discharge from an emergency department when proactive assessment identifies alert features or signs or symptoms.

Mental Health Settings:

- When the older person presents with signs and symptoms of abuse.
- When comprehensive assessment identifies alert features or signs and symptoms.

Inpatient Settings:

- When the older person presents with signs and symptoms of abuse.
- Prior to discharge when proactive assessment identifies alert features or signs or symptoms.

Residential Care Settings:

- When the older person presents with signs and symptoms of abuse
- When comprehensive assessment identifies alert features or signs and symptoms

Routine Enquiry for abuse may be indicated in the absence of signs and symptoms when there are multiple risk factors present, or may be initiated by a request from the older person or their carer/family/whanau support.

APPENDIX 5 Signs and Symptoms Associated with Elder Abuse and Neglect

Caution: These factors may raise suspicion of abuse but are not diagnostic. Avoid jumping to conclusions. The whole situation needs to be taken into account.

Behavioural signs

Behaviours that the older person may exhibit:

- shows signs of being afraid of a particular person/people
- appears worried and/or anxious for no obvious reason
- becomes irritable or easily upset
- appears depressed, withdrawn
- loses interest
- has sleep disturbances
- has suicidal wishes
- has frequent shaking, trembling and/or crying attacks
- has rigid posture
- presents as helpless, hopeless, sad
- uses contradictory statements not resulting from mental confusion
- is reluctant or hesitant to talk openly; waiting for the caregiver to answer
- avoids physical, eye or verbal contact with caregiver or service provider.

Behaviours that the person inflicting abuse may exhibit:

- blaming the older person for his/her behaviour (eg, wandering, incontinence)
- not wanting the older person interviewed alone
- refusing treatment for the older person
- seeking medical attention from a variety of doctors/medical centres
- responding defensively, making excuses, being hostile or evasive
- excessively concerned or unconcerned
- minimal eye, physical or verbal contact (culturally relevant)
- treating the older person like a child
- using threats, insults, harassment
- taking control of the older person's money or other resources
- difficulty managing their own life.

Physical Abuse

• abrasions	• bed sores
• bleeding	• bruises
• burns	• cuts/lacerations
• dehydration	• direct beatings
• dislocations	• fractures
• grip marks	• hypothermia
• internal injuries	• malnutrition
• over-sedation	• poisoning
• punctures	• scalding
• sprains	• swelling
• welts	• wounds

Sexual Abuse

- bruising or bleeding, pain itching in the genital area
- sexually transmitted disease
- difficulty in walking or sitting
- recoiling from being touched
- fear of bathing or toileting.

Psychological Abuse

- resignation
- fear
- shame
- depression
- mental confusion
- marked passivity
- anger
- insomnia.

Financial Material Abuse

- failure to pay rent or other bills on behalf of the older person
- sale of property by an older person who seems confused about the reasons for the sale
- lack of money for necessities
- lack of money for social activities
- depletion of savings
- disappearance of possessions
- management of a seemingly competent older person's finances by another person
- signs of misuse of an enduring power of attorney, with control over an older person's property/financial affairs for personal gain and to the detriment of the older person's welfare
- signatures on documents/cheques not resembling the older person's signature
- reluctance to make a will or have budget advice.

Active/Passive Neglect

- Malnourishment or dehydration
- Hypothermia
- Weight loss with no apparent medical cause
- Pallor**,** sunken eyes, cheeks
- Injuries that have not been properly cared for
- Poor personal hygiene
- Clothing in poor repair; inappropriate for season
- lack of safety precautions, supervision
- absence of appropriate dentures, glasses or hearing aids when these are needed
- abandoned or left unattended for long periods
- medicines not purchased or administered
- no social, cultural, intellectual or physical stimulation.

Self-Neglect

- reclusive
- frugal
- shrewdness, fear, distrust
- inappropriate eating habits
- malnourished**,** dehydrated
- filthy and unhealthy living environments

- collecting and/or hoarding rubbish
- absence of basic hygiene and personal care
- inappropriate or unusual clothing
- menagerie of pets
- inability or refusal to pay bills
- fiercely guards independence and privacy.

Adapted from Age Concern New Zealand,1992.

APPENDIX 6 Guidelines for Identifying Elder Abuse and Neglect (Step 1)

Routine enquiry of all older people in the absence of signs and symptoms is currently not recommended, due to a lack of validated abuse enquiry methods where the safety and benefits have been evaluated. Health care providers should remain vigilant and may choose to question older adults about abuse in the absence of alert features or signs and symptoms, when concern is raised by the presence of a number of high risk factors.

1.1 Alert features

The following features should be alerts to the possibility of abuse, and the need to expand history taking and assessment procedures.

- There is incongruity between observations and information from the older person, or a discrepancy in perceptions of the older person and the suspected abuser.
- There is any discrepancy between an injury and the history, unexplained injuries, conflicting stories, vague or bizarre explanations, or denial.
- There are frequent requests for care or treatment for comparatively minor conditions.
- There is a delay in seeking care or reporting an injury.
- The older person is described as 'accident prone' or has a history of injury, untreated injuries and multiple injuries, especially at various stages of healing.
- There are repeated accident or emergency attendances of the older people from the same care setting.
- There are manifestations of inadequate care, including poor hygiene or nutritional status, poorly controlled medical conditions, frequent falls and confusion.
- A relative or carer appears overly protective or controlling, or the older person displays unexplained anger or fear towards the carer or relative.
- There is an apparent inability to afford food, clothing, housing or social activities, or questionable use of the older person's possessions/property/funds.

1.2 Questions for older people who may be at risk of abuse

Asking the older person to describe their situation in a general way may be an effective way to open discussion. More direct verbal questions are appropriate if indicated by earlier responses and as the interview progresses, when trust and rapport have been established and when there is a high degree of suspicion that elder abuse exists. Gentle probing and supportive statements made by the health care practitioner can reduce defensiveness.

Open-ended, non-judgmental questions that commence with an enquiry about a typical day are recommended. Questioning should naturally progress to an assessment of activities and enquiries about levels of dependency, care giving and family relationships.

1.3 General questions to assist identification of alert features.

Older adults may be asked:

- How are things going at home/in residential care?
- How are you spending your days?
- How are you feeling about the amount of help you are getting at home/in -care?
- How do you feel your (husband/daughter/other caregiver) is managing?
- Do you have everything you need to take care of yourself?

Where a combination of alert features are apparent or where signs and symptoms of abuse are identified direct questioning for elder abuse should follow.

1.4 Direct questions for use when the presence of alert features or signs and Symptoms indicate possible elder abuse:

- Has anyone at home ever hurt you?
- Has anyone ever taken anything that was yours without your consent?
- Has anyone ever made you do things you didn't want to?
- Has anyone ever touched you without consent?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you to take care of yourself when you needed help?

1.5 Questions for the Caregiver.

***DO NOT** discuss concerns or actions with a caregiver:*

- if it will place either the older person being abused, or you the health care provider, in danger
- if the family/whanau may close ranks and reduce the possibility of being able to help an older person
- if an investigation by police is under way.

If you have any doubts or are uncomfortable about discussing concerns about possible abuse with the older person's caregivers, you should first consult with senior staff and/or with elder abuse services where available. Measures to ensure your own safety include having a second staff member present during the interview.

Where interview of the caregiver is appropriate and safe

Use open-ended, non-judgmental questions about care giving, level of dependency, family and home environment, concerns, stress indicators and support networks.
For example:

- How is (the older person receiving care) getting on?
- How has life changed for you since becoming a caregiver?
- Have you been able to talk with someone about these changes?
- How has having (the older adult) dependent on you affected your relationship?
- Do you know what practical help is available to assist you?

If you suspect the caregiver may be the abuser

The caregiver may be under stress and frightened about what will happen. Putting them at ease while trying to find the facts is not easy but will be the most productive way of checking the seriousness of the situation and assessing what needs to be done. In most cases asking the caregiver to describe what is involved in the day-to-day care of the older person will open up the discussion and enable the health care provider to check for stress, financial difficulties, health and other problems, as well as the caregiver's ability to manage the care.

For example:

- What kinds of things do you have to do now as part of caring for (the older person)?
- Are you able to get a break or have enough time for yourself?
- Do you ever worry that (the person being cared for) is not safe?
- Are you ever worried that you might hurt your (relative/person being cared for)?

APPENDIX 7 Guidelines for Validating and Supporting Victims of Abuse (Step 2)

2.1 Supporting the older person being abused

2.1.1 Listen to the person's story

- Acknowledge what they have told you, be empathetic, non-judgemental and non-blaming. Example "That must have been terrifying. You are a strong person to have survived that."
- Encourage them to go on. Example, "Tell me about that".

2.1.2 Validate

- "You are not alone, others experience abuse in their home/rest home/hospital".
- "You are not to blame for abuse.
- "You did not deserve or provoke the abuse, abuse is never ok".
- "Your reactions are a normal response to trauma".

2.1.3 Inform

- "I can seek help for you and your family/caregiver".
- "You have the right to live free of fear and abuse".
- "What they are doing is also a crime, it is not just a family or private matter".

2.2 Support for the older person's caregiver(s)

2.2.1 If circumstances permit you to discuss concerns or actions to be taken with a person's caregiver, follow these principles.

- Broach the topic sensitively.
- Help the caregiver feel supported and able to share any concerns they have with you.
- Help them understand that you want to help keep the older person safe, and support them in their care of the person.
- Where options exist, support the caregivers to make their own decisions.
- Involve extended family/whanau and other people who are important to them.
- Be sensitive to, and discuss, the older person's or caregiver's fears about approaching other agencies such as elder abuse and neglect services, police, social services, hospital staff, and other agencies.
- Be clear that your role is to keep the older person safe.

2.3 Older Persons who deny abuse or refuse support

2.3.1 If elder abuse is suspected, but the individual does not acknowledge that it is a problem:

- Leave the door open for further contact and state that if abuse does become a concern, you are available to discuss it with them if they would like to.
- Provide them with the means of contacting appropriate support agencies.
- Look for further indicators at the next consultation.
- Undertake danger assessment.

If the older person acknowledges abuse but refuses support

The older person's willingness to accept help, make choices and handle change will effect assessment and intervention options. Older persons (and/or their abuser) may need a particular service but choose not to accept it, and reasons for this may need to be explored. Barriers to accepting intervention can include fear, lack of initiative or motivation, or practical

issues such as lack of transport or mobility issues. The person may fear having to leave their home or may misunderstand the impact of service provision. Assistance to overcome barriers or the support of an advocate can be offered as appropriate.

If the older person is competent and informed of the options and facts but still refuses to accept services, this must be respected. Leaving the door open for future contact and providing information on available support and contact numbers is important.

Practitioners working with persons experiencing abuse can face ethical and clinical dilemmas, including situations where there are no good solutions for the older person and/or their family/whanau or carer. It is important that the practitioner has support available and that supervisory and interdisciplinary assistance is provided to support decision-making when ethical and clinical dilemmas are involved.

APPENDIX 8 Guidelines for Health and Risk Assessment (STEP 3)

3.1 Danger Assessment

The level of immediate risk and need for an urgent referral will depend on the type and severity of abuse and the immediate situation of the person experiencing abuse. Assessment of the following factors can assist in danger assessment. However, there are no absolute indicators that can predict risk. The greater the number of indicators, the greater the risk.

Immediate Safety Risk

- Is there evidence of life-threatening injuries or danger of significant harm, death or homicide?
- Is there a risk of suicide or significant self-harm?

High Danger Risk

- Is the abuser present?
- Is the person afraid to go home or to be left alone?
- Is the person unable to defend or care for themselves if left alone?
- Has a threat to kill or threat with a weapon been made?
- Has there been physical abuse increasing in severity?
- Has the abuser access to weapons, particularly firearms?

Other factors to consider

- Have threats of suicide or homicide been made?
- Is alcohol or substance abuse involved?

3.2 Risk Of Suicide Or Self-Harm

A history of abuse is recognised as one factor contributing to suicide risk. Practitioners need also to be aware that older men are a group at greater risk of suicide. Any older person expressing suicidal ideas should be treated very seriously. A suitably trained mental health clinician should be contacted to assist anyone who has expressed suicidal thoughts, or following any act of attempted suicide or deliberate self-harm. Health care providers need to consider assessing possible suicide of identified victims.

Signs associated with high risk of suicide include:

- Previous suicide attempts
- Stated desire/attempt to kill oneself
- A well-developed concrete suicide plan, or access to a method to implement their plan
- Planning for suicide (for example, putting affairs in order)

Other factors that are frequently associated with the risk of suicide or self-harm may also be symptoms of abuse. Factors include depression, extreme anxiety, agitation or enraged behaviour, excessive drug and/or alcohol use or. Make direct enquiries to assess if the abused person is thinking about committing suicide, or has attempted suicide in the past.

Any person expressing suicidal ideation should be assessed by a mental health clinician before they are discharged home.
Because of the abuse issues, joint referral to elder abuse services may also be warranted. The most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuser.

APPENDIX 9 Guidelines for Safety Planning (STEP 4)

4.1 Deciding What Action To take

When deciding on the action to take, consider that following questions:

- What is the least disruptive option for the older person?
- Is immediate referral for treatment or specialist assessment required?
- Will the action being considered cause further harm?
- Have the rights of the older person, and their carer, been considered?
- What services are available?
- Who needs to be notified?
- What support is available to assist with action taking?

Confidentiality and keeping the older person informed of your actions are essential. The older person has the absolute right to make an informed decision about what action is taken and when. The older person may refuse assistance. This can be extremely difficult for service providers. If there is a reasoned choice, the decision must be respected.

It is important to note that most cases of elder abuse and neglect are not crisis situations. Often the problems are long standing and complex and will take time to work through. There are often no immediate solutions.

4.2 For The Small Proportion Of Persons With Acute Safety Concerns

- Is the abuser here now?
- Does the abused person have a safe place to go when leaving the consultation?
- Is emergency assistance required (eg, police, acute hospital admission or safe bed facility)?
- Is urgent referral to mental health services required?

Always remember the person's rights. Quick solutions may have adverse effects in the long term. For example, removing an older person from their home may cause them enormous stress and may have other repercussions. This is usually a last resort intervention. Relocation is sometimes necessary, but not always for the person being abused: sometimes it is the abuser who needs care or accommodation.

Decisions about reporting a suspected incident of abuse to the police should, except on rare occasions, be made in consultation with the abused person. Reporting an incident to the police with the person's consent can endanger their safety, as filing charges may enrage the abuser.

On the rare occasion that the healthcare provider believes a person's life is in immediate danger, police may be notified without the person's permission. The Privacy Act 1993 is not breached if the health care provider has acted in good faith to protect the patient from serious harm.
See Appendix 10: Guideline for Notification of Police re Family Violence.

The Health Information Privacy Code 1994 is not breached when the disclosure of information is necessary to prevent or lessen a serious and imminent threat to:

(i) Public health or public safety; or
(ii) The life or health of the individual concerned or another individual

For any serious events involving staff or patients/clients, including any events where the police are required to be notified (refer to the Adverse Event Reporting Policy – Taranaki

DHB, and Disclosure of Health Information Policy – Taranaki DHB, Guidelines for the Disclosure of Health Information to the Police – Taranaki DHB and Patient Property Policy – Taranaki DHB), the Unit Manager or Duty Manager (if after hours) and the Quality & Risk Manager should be **notified immediately.**

4.3 For Older Persons With Ongoing Safety Concerns

- Make contact during the consultation with EAN services.
- Where appropriate, suggest the person consider obtaining a protection order through the Family Court. Social workers, Women's Refuge and other family violence prevention advocates can provide assistance with obtaining such orders.
- Identify an ongoing support system (eg, family, friends who may help).
- Ensure that the person has a list of contact numbers for specialist elder abuse services.
- Provide the person with information that will help them plan for safe exit from an abusive situation.
- Ensure they are aware of the legal support available to them and how to access it.
- In the case of neglect by self or others, as appropriate contact general practitioner, health, social or legal services.

Provide a copy of the community agency support card, with phone numbers and a brief safety plan.

4.4 For All Abused Patients

- Advise the older person about the possibility of an increase in the frequency and severity of abuse without outside help.
- Support the person, irrespective of their choices. Understand that it is important for each person to make their own choices. Frequently the person may choose not to take any action at this time, but be aware that your support can make it easier for the person to seek further assistance when they are ready.
- Decide if you are going to make a referral now or defer making a referral.
- As appropriate to your role, identify a date for review or refer for follow-up. Periodic reassessment for all cases of suspected abuse is needed, regardless of whether evidence of abuse is conclusive.
- Leave the door open so they have a future point of contact.
- Getting "safer" is a process, not a single act. The role of the health professional is to assist the older person to make themselves safer, not to 'rescue' them.

4.5 Legal Options

There are legal powers available for the Court to intervene and to provide protection where appropriate. The Domestic Violence Act 1995 provides protection for victims of abuse through court protection orders. Psychological abuse is also treated as violence. Note that the abuser does not have to be a spouse or family member for the Domestic Violence Act to apply.

Abusers can be charged under section 151 of the Crimes Act 1992 for failing to provide 'necessities of life' for people who are unable to provide care for themselves.

The Protection of Personal and Property Rights Act 1988 allows for the appointment of an attorney (ordinary power of attorney or enduring power of attorney) or welfare guardian to act on behalf of another person. The Act also provides for overturning (revoking) an existing enduring power of attorney where the attorney is believed to be acting contrary to the best interests of the older person.

4.6 In A Residential/Institutional Setting

Additional enquiries to consider include:

- Is the older person and their family aware of the concern and /or incident?
- Is the nurse manager or other people in the home/hospital aware of the incident(s)?

If so, what action has been taken?

- Is there anyone else who is aware of the situation and has contact with the older person (e.g., doctor, social worker, rest home/hospital visitor)?
- Who needs to be notified of concerns and/or incidents?
- What immediate and longer-term steps need to be taken to ensure the older person's safety?

In the case of a certified rest home or hospital, abuse can be reported to HealthCERT in the Ministry of Health, the local District Health Board, or to the Health and Disability Commissioner. Local elder abuse and neglect services can explore cases of suspected abuse and report cases to HealthCERT for further investigation. Additional points of contact are the New Zealand Private Hospitals Association, Residential Care New Zealand and Age Concern New Zealand.

4.7 Worker Safety

Monitoring and protecting your own safety is important at all stages, and should include the following:

- Be aware of warning signs of aggression, including threatening comments to you or others, attempts to block your exit and increasing agitation or irritation.
- Do not discuss concerns or actions with a carer or family/whanau member if you are uncomfortable or concerned that doing so will place you or others in danger.
- Remove yourself promptly if you feel at risk.
- In a community setting, do not visit alone a home where you believe there may be violence occurring or the violent person may be present.
- Tell others of your visiting plan, park your car on the road where you will be able to drive away, lock your car and keep the keys under your control.
- Document concerns and notify incidents.

APPENDIX 10 Guideline for Notification of Police for Family Violence

This guideline sets out the procedure for staff when issues of patient or staff safety are identified secondary to a disclosure of family violence (FV). There are two circumstances in which this guide will apply:

1. There are clear and present safety issues identified for victims of family violence (based on risk assessment)
2. Staff perceive that their own safety may be at risk.

The procedures outlined below will ideally be discussed with and agreed to, by the person who is the victim of abuse. However, in cases of clear and present danger staff do not require the patient/client's consent to refer to the Police. The safety of the person is the paramount consideration. If an individual who is a victim of violence expresses fear of the perpetrator or others, s/he is likely to be correct. It is appropriate in this case for DHB staff to contact the police without consent under Rule 11 of the Privacy Code 1994.

Rule 11 permits disclosure without the person's consent where it is not desirable or practicable to obtain consent and: disclosure is necessary for the maintenance of the law including the prevention and investigation of offences (Rule 11(2)(i); or disclosure is necessary to prevent or lessen a *serious* and *imminent* threat to the life or health of the patient/another individual, or to public safety (Rule 11(2)(d).

Disclosure must only be to the extent necessary for the particular purpose. The purpose of disclosure should be made clear so the person receiving the information (e.g. police) knows the limited purpose to which it can be put.

Principles to consider when taking the step of notifying the police against the person's wishes.

Staff often face real dilemmas when deciding whether to notify police about family violence. There are no firm rules regarding informing police about family violence, however the final decision should consider the following:

1. Safety for the person, public and staff should be the paramount consideration. This also includes risk to children living in the home, recognising the significant co-occurrence of intimate partner violence (IPV) and child physical abuse. The greater the severity and frequency of IPV, the more likely the children are to be victims of physical abuse.
2. If police become involved this may result in further violent acts towards the victim (note victim's fear of retaliation)
3. The individual's relationship with the clinician may be affected if the rights of their rights are felt to be compromised (disclosing the information without consent)
4. Intimate partner violence intervention recognises the following:
    a. The victim is an expert in their own environment and surroundings, s/he may know the reaction a referral to the police would create
    b. The victim is encouraged to take control of the decisions around keeping safe, unless there are immediate issues of safety for either the victim or their children
5. There are no legal requirements to report crimes (e.g. assaults) to the police. However ethically DHB staff have a responsibility to notify police if we suspect any of the following;
    a. Ongoing safety issues, such as further violence to this victim or others if perpetrator remains at large
    b. Injuries that may be life-threatening

6. If there is uncertainty amongst the team about the actions required, team discussion should follow with a consensus being reached on the outcome. Please consult the Clinical Charge Nurse.

ACTIONS

1. Notification to Police due to an individual's safety

In the event staff decide to call the police for reasons of safety for the individual, take the following steps;

1. Advise the person of the need to notify the police and that an ongoing safety plan will be discussed
2. Inform security and Duty Manager (if after-hours) of the concerns regarding safety
3. Ring the Police (111) and advise them of the current situation with information disclosed
4. Refer to the Appropriate Access to Health Information Policy" which is available on intranet under Forms and Templates or attached to this policy
5. On the arrival of the Police to the department, the Police should complete the Consent for the Collection and Release of Information form.
6. Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and should include:
    a. The disclosure of abuse, including all relevant history and verbatim statements
    b. The injuries sustained pertinent to their inquires
7. Staff should facilitate the introduction of the Police to the individual and ensure privacy for their ongoing discussions.

2. Notification to Police for staff safety reasons:

1. Advise the individual (abused person) of the need to notify the police and that an ongoing safety plan will be discussed
2. Inform security and Duty Manager (if after-hours) of the concerns regarding safety within department
3. Ring the Police and advise them of the current situation within the department and concerns regarding safety based on assessment and information disclosed as appropriate
4. On the arrival of the Police to the department, provide them with a summary of the issues of safety, as they are known. There is no breach of privacy in the provision of information to the Police if wider safety concerns are identified based on general observations.
5. If the report/information provided to the Police includes information disclosed by a person then complete a Consent for the Collection and Release of Information form.
6. Once this form is completed, staff can provide the appropriate and relevant information without concerns regarding breach of privacy. Information shared should be related to the referral to the Police and can include:
    a. The disclosure of abuse
    b. The injuries sustained as pertinent to their inquiries

7. Facilitate the introduction of the Police to the abused person and ensure privacy for their ongoing discussions.

APPENDIX 11 Guideline for Referral and Follow-Up (Step 5)

All identified Elder Abuse victims need to have appropriate referrals made and follow-up planned.

If the older person is in imminent danger, or at high risk, the health care provider needs to make sure the appropriate referral and support agencies are contacted during the consultation.

If the older person is at moderate risk, or might benefit from early intervention, the health care provider needs to make sure that the person has the information necessary to contact appropriate health, social support or community services.

All Elder Abuse victims need to know that they are not responsible for and do not deserve the violence they have experienced, and need assistance to contact support services and access legal options for protection.

Appropriate follow-up also needs to be undertaken. Elder Abuse is a health issue that merits appropriate follow-up in its own right. Additionally, the presence/history of elder abuse may affect the way in which follow-up is delivered when responding to other health issues. If elder abuse is currently an issue, safety procedures for re-contacting the person, as well as implications for the person's ability to adhere to treatment regimens for physical and mental health conditions need to be considered.

While follow-up will vary depending on the needs of the older person, the resources and training of the health care provider, and the point at which the person has entered the health system (e.g., primary or secondary care services), at least one follow-up appointment (or referral) with a health care provider, social worker, or elder abuse advocate should be offered after identification.

Imminent danger/high risk

a) Referral

- Discuss your concerns with the older person, and if at all possible, at the time of consultation, make contact with elder protection- or other support services, and consider contacting the Police.
- Consider in-patient admission (if a patient). If the older person is admitted to hospital, make plans for ensuring safety while on the ward.
- Make sure the older person has contact details, and a means of contacting emergency services if required.

b) Follow-up

Plan to follow-up with the older person at a later date, and/or pass on relevant information for other health care providers to follow-up about their safety later (e.g., if discharged from hospital, ensure their primary care provider knows about and can follow-up on safety issues).

Moderate risk, or older persons with ongoing safety concerns

a) Referral

- If possible in your area, make contact *during* the consultation with an elder protection service.
- Suggest the person consider obtaining a EPOA(Property & Welfare) through the Family Court. Elder Protection Services can provide assistance with obtaining such orders.
- Identify an ongoing support system (for example, family, friends who may help).
- Ensure that the older person has the elder protection services contact numbers and a means of contacting them.

- Ensure the older person is aware of the legal support available to them, and how to access it.

b) Follow-up

With any issue that affects health; appropriate follow-up is an important component of overall care. Elder Abuse is a health issue that merits appropriate follow-up in its own right. Additionally, the presence / history of IPV may affect the way in which follow-up is delivered when responding to other health issues. If IPV is currently an issue, safety procedures for re-contacting the person, as well as implications for the person's ability to adhere to treatment regimens for physical and mental health conditions need to be considered.

At least one follow-up appointment (or referral) with a health care provider, social worker, or elder protection advocate should be offered after identification or disclosure.

Sharing of information between clinicians

Developing and implementing safe and appropriate systems for sharing information about Elder Abuse between clinicians (e.g., between hospital-based and primary care and community providers) is important because:

- the information usually has a big impact on health, and healthcare information needs to be shared appropriately
- often the clinician to whom the person has disclosed the sensitive information is not the long-term health care provider, and thus cannot provide ongoing care or support
- failure to share information appropriately has been linked with adverse outcomes (including death).
- individuals need to have a role in determining who information should be shared with. They can best be supported to make these decisions if the health care provider explains to them why the information should be shared and how this might take place.

Examples:

> 'Is it OK if we let your GP, Dr X, know that you have been to see us and what we talked about in relation to your partner's behaviour? That way, your GP will be informed about what is going on for you, and can help you with your health needs better (help you plan for your safety).'
>
> 'It would be helpful for your doctor to know what you have been going through so she can help support you. I can write her a separate note with the referral.'

After identification or disclosure of current or past elder abuse

At least one follow-up appointment (or referral) with a health care provider, social worker or elder protection advocate should be offered after disclosure.

> 'If you like, we can set up a follow-up appointment (or referral) to discuss this further.'
>
> 'Is there a number or address where it is safe to contact you?'
>
> 'Are there days/hours when we can reach you alone?'
>
> 'Is it safe for us to make an appointment reminder call?'

Responding to elder abuse persons at follow-up

At every follow-up visit with people who have previously identified or disclosed being in an abusive relationship:

- Review the medical record and ask about current and past episodes of elder abuse (if alone).
- Communicate concern and assess both safety and coping or survival strategies

‘I see from reviewing your notes that previously you talked to us about what was happening in your relationship at home. How have things been for you since you were here last?’

‘I am concerned about you, and your health and safety.’

- Repeat the routine enquiry questions.
- Repeat the health and risk assessment questions.
- Provide intervention again, based on findings of current health and risk assessment.
- Review the older person’s options for increasing safety (individual safety planning, talking with friends or family, seeking support from advocacy services and support groups, legal options, transitional/temporary housing, seeking support from Work and Income, etc.).

For current and previous victims of elder abuse:

- Ensure the person has a connection to a primary care provider.
- Coordinate and monitor an integrated care plan with community-based experts as needed, or other health care specialists, trained social workers or trained mental health care providers.

APPENDIX 12 Guidelines For Documentation Of Elder Abuse (Step 6)

6.1 Documentation Steps

Record the disclosure on the VIP Elder Abuse and Neglect Risk Assessment and Documentation Form.

6.1.1 Note the stated or suspected cause of the injuries and when they allegedly occurred. "Assaulted by partner" is not sufficient. A vague history is readily challenged in court and therefore would not help keep a victim safe. Be specific, e.g. "Miss X alleges she was hit with a closed fist/kicked by John Smith".

6.1.2 Record history obtained. Specify aspects you saw and heard, and which were reported or suspected. Use the individual's words as much as possible. Use quotation marks for specific disclosures where appropriate, e.g. "John punched me".

6.1.3 State the identified perpetrator's name and relationship to the person

6.1.4 Mark site(s) of old and new injuries on the body injury map

6.1.5 Describe estimated age of injuries, coloration and measure size

6.1.6 For suspected cases of abuse, record your opinion as to whether the injury is consistent or inconsistent with the person's explanation

6.1.7 Note the action taken by the clinician, referral information offered and follow-up arranged

6.1.8 Include the date, time, a legible signature and designation

6.1.9 Indicate in notes discreetly that Elder Abuse has been disclosed. For example, ticking the coded box in the notes

6.1.10 Forward the Elder Abuse Identification/Documentation Form to medical records as outlined in Point 6 (Page 7).

6.2 Collection of Physical Evidence

In certain circumstances collection of evidence may be required for legal proceedings
Steps to take in the collection of evidence include:

- Place torn or blood-stained clothing and/or weapons in a sealed envelope or bag (these can be provided by the Police).
- Mark the envelope with the date and time, the person's name, and the name of the person who collected the items. Sign across the seal.
- Keep the envelope in a secure place (e.g., a locked drawer or cupboard) until turned over to the Police. Document in your clinical record the time and date that you handed it over, and to whom the envelope was given.

6.3 Photographs

The use of photographs to document injuries may be appropriate in some circumstances. If photographs with the potential to be used as evidence in legal proceedings are taken then the Digital Photography Procedure (Patient Clinical Images) must be adhered to.