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# Use of a Safety Risk Profile in the Management of Elder Self-Neglect: A Clinical Demonstration Project

In 2001, the Geriatric Research, Education and Clinical Centers (GRECCs) in Sepulveda and West Los Angeles, CA merged to form the VA Greater Los Angeles Healthcare System (VAGLAHS) GRECC—making it one of the largest centers of geriatric care serving veterans in the nation. Affiliated with the David M. Geffen School of Medicine at the University of California, Los Angeles and a part of the Multicampus Program in Geriatrics Medicine and Gerontology, the VAGLAHS GRECC has multiple clinical and research foci. These include endocrinology of aging, Alzheimer disease, immunosenescence, polypharmacy, falls prevention and management, osteoporosis and osteoarthritis management, sleep disorders, geriatric rehabilitation, quality of care, and health care utilization in elderly patients.

At the time of this project, **Dr. Wang** was an advanced fellow in geriatrics medicine at the VA Greater Los Angeles Healthcare System (VAGLAHS) Geriatric Research, Education and Clinical Center (GRECC), West Los Angeles, CA. She is now the director of hospice and palliative care at Kaiser Permanente, Los Angeles, CA. **Dr. Wilkins** is a clinical neuropsychologist, **Ms. Spaziano** is a clinical social worker, and, at the time this project was conducted, **Ms. Burruel** was a social work student, all at the VAGLAHS GRECC. Ms. Burruel is now a social worker for the VAGLAHS Adult Day Health Care program. **Dr. Rofail** is a clinical pharmacist, **Ms. Guzman-Clark** is a gerontological nurse practitioner, **Dr. Harada** is the education specialist in the office of the associate chief of staff for education, **Dr. Dhanani** is the director of the geriatric evaluation and management unit, and **Dr. Castle** is the clinical director, all at the VAGLAHS GRECC. In addition, Dr. Wilkins is an associate clinical professor of medicine, Ms. Guzman-Clark is an assistant clinical professor of nursing and a doctoral candidate, Dr. Harada is an adjunct professor of medicine, and Drs. Dhanani and Castle are clinical professors of medicine, all at the University of California, Los Angeles.

The VAGLAHS GRECC is one of the first GRECCs to demonstrate and publish the beneficial effects of the Geriatric Evaluation and Management program, a clinical model that applies geriatric assessment by an interdisciplinary team to improve quality of life and clinical outcomes for older adults. This interdisciplinary staff is well aquainted with complex patient cases, which make up the majority of referrals to the VAGLAHS GRECC program.

Over the years, we realized that some of the most difficult cases to manage have been related to suspected patient self-neglect. Part of the reason these cases prove so complicated is that evidence-based resources for dealing with patients who self-neglect have not been developed. To address this need, the VAGLAHS GRECC staff decided in 2006 to undertake a clinical demonstration project involving the development of a standardized protocol for assessing and managing elderly patients identified as being at risk for self-neglect.

## A NATIONAL AND LOCAL PROBLEM

Elder self-neglect, defined as the behaviors of an older adult that threaten his or her own health or safety, often involves an elderly person refusing or failing to provide himself or herself with adequate food, water, clothing, shelter, safety, hygiene, or medication.[1] As a result, it can have such consequences as malnutrition, dehydration, physical trauma, worsening of underlying medical conditions, or financial loss.[2] The problem also has been associated with high mortality[3–4] and nursing home placements.[5]

The National Center on Elder Abuse considers elder self-neglect to be a form of abuse,[6] and when viewed this way, the problem may represent the most common form of elder abuse. A 2000 survey found that it was the primary category of elder mistreatment to be investigated, as well as the primary category of elder mistreatment to be substantiated, by adult protective services (APS) in the United States. Data from

The VHA's Geriatric Research, Education and Clinical Centers (GRECCs) are designed for the advancement and integration of research, education, and clinical achievements in geriatrics and gerontology throughout the VA health care system. Each GRECC focuses on particular aspects of the care of aging veterans and is at the forefront of geriatric research and clinical care. For more information on the GRECC program, visit the web site (http://www1.va.gov/grecc/). This column, which is contributed monthly by GRECC staff members, is coordinated and edited by Kenneth Shay, DDS, MS, director of geriatric programs for the VA Office of Geriatrics and Extended Care, VA Central Office, Washington, DC.

APS in 44 states indicated that 39% of investigations involved self-neglect, and data from APS in 40 states indicated that 42% of substantiated allegations involved self-neglect.[6] A 2006 study of elder abuse reports filed on behalf of patients from the VAGLAHS GRECC during a three-year period had results that were similar to those of the national survey described above—self-neglect was found to be a factor in 12 (39%) of the 39 reports.[7]

## ASSESSMENT AND MANAGEMENT ISSUES

Despite laws that require health care providers to report suspected elder abuse in 33 states, physicians have low rates of reporting such cases.[8] Elder self-neglect, which currently lacks an operational definition, is particularly difficult for providers to assess and would benefit from studies using standardized instruments and case definitions to evaluate its relationship with functional decline and other health outcomes.[9] It has been postulated that providers fail to report self-neglect because they do not recognize its signs or they fear that reporting it would harm or offend patients or increase physician liability by identifying an unsafe condition with no alternatives.[9,10] Providers also may be dissuaded from filing reports by concerns that they have inadequate evaluation skills and could wrongly deprive patients of their autonomy.[11] Finally, physician surveys suggest a lack of awareness of mandated reporting of elder abuse due to self-neglect, lack of protocols to manage neglect, and a belief that their states have insufficient supportive resources.[12–15]

Difficulties with assessing and managing elder self-neglect may be related to our limited knowledge about the problem. Although both the risk factors for and the consequences of self-neglect include social isolation, cognitive impairment, depression, and frailty, the etiology of self-neglect is unclear.[16–18] From a psychological perspective, self-neglect may occur as a result of interpersonal problems that threaten the identity and sense of control that a person has over himself or herself. With increasingly complex care management, self-neglecters struggle to maintain overall control of themselves and may disregard self-care as they strive to avoid any disruption to the usual continuity of their lives.[18,19]

But the greatest challenge with regard to assessing and managing elder self-neglect may stem from the fact that medical professionals are obligated to protect elderly patients from harm and health risks while, at the same time, respecting these patients' autonomy.[17,20] This challenge is emphasized by the National Center on Elder Abuse's definition of self-neglect, which excludes situations "in which a mentally competent older person (who understands the consequences of her/his decisions) makes a conscious and voluntary decision to engage in acts that threaten her/his health or safety."[21] The implication is that patients may knowingly place themselves at risk for harm if doing so is an exercise in lawful, autonomous decision making that does not pose a serious and immediate health risk. Therefore, determination of decision making capacity should be an essential step in assessing elder self-neglect.

## OUR INTERDISCIPLINARY ASSESSMENT PROTOCOL

We developed a protocol to standardize the assessment and overall management of older adults believed to be at risk for self-neglect (Figure). The protocol is aimed specifically at managing the care of older veterans who have been admitted to the hospital for reasons that are believed to involve self-neglect but who want to return home. It could be adapted, however, to an outpatient case management approach—especially since most cases of self-neglect are chronic.

The protocol begins with the suspicion that a hospitalized patient is self-neglecting. Its first step is for each member of an interdisciplinary GRECC team—including a physician, a nurse, a social worker, a pharmacist, a neuropsychologist, a nutritionist, a physical therapist, and an occupational therapist—to assess the patient's key safety risk factors according to their individual disciplines. These risk factors may include problems with appropriate care or support at home, the presence of neuropsychological diagnoses, dietary issues, or physical limitations. The team members use both self-reports and standardized tools commonly used in clinical practice for their evaluations.[22–29] The evaluations include recommendations to address specific safety concerns and estimates of the patient's potential to overcome his or her limitations. If possible, the staff involve caregivers early in the hospital course so that caregivers can view the patient's specific identified impairment in self-care, monitor the patient's progress, and be trained to assist the patient.

Staff members then meet to present their individual evaluations. During this meeting, they use a VAGLAHS GRECC–developed worksheet, entitled Safety Risk Profile/Decisional Capacity in Older Adults, to record the collective evaluations for social, medical, neuropsychological, nutritional, and functional limitations. (For a copy of the worksheet, e-mail Dr. Castle at steven.castle@va.gov.) With the worksheet as a guide, the staff members discuss specific areas of concern and options for addressing those areas. The worksheet also lists several interventions—such as calling APS, placing the patient in an assisted living facility, or enrolling him or her in the Meals on

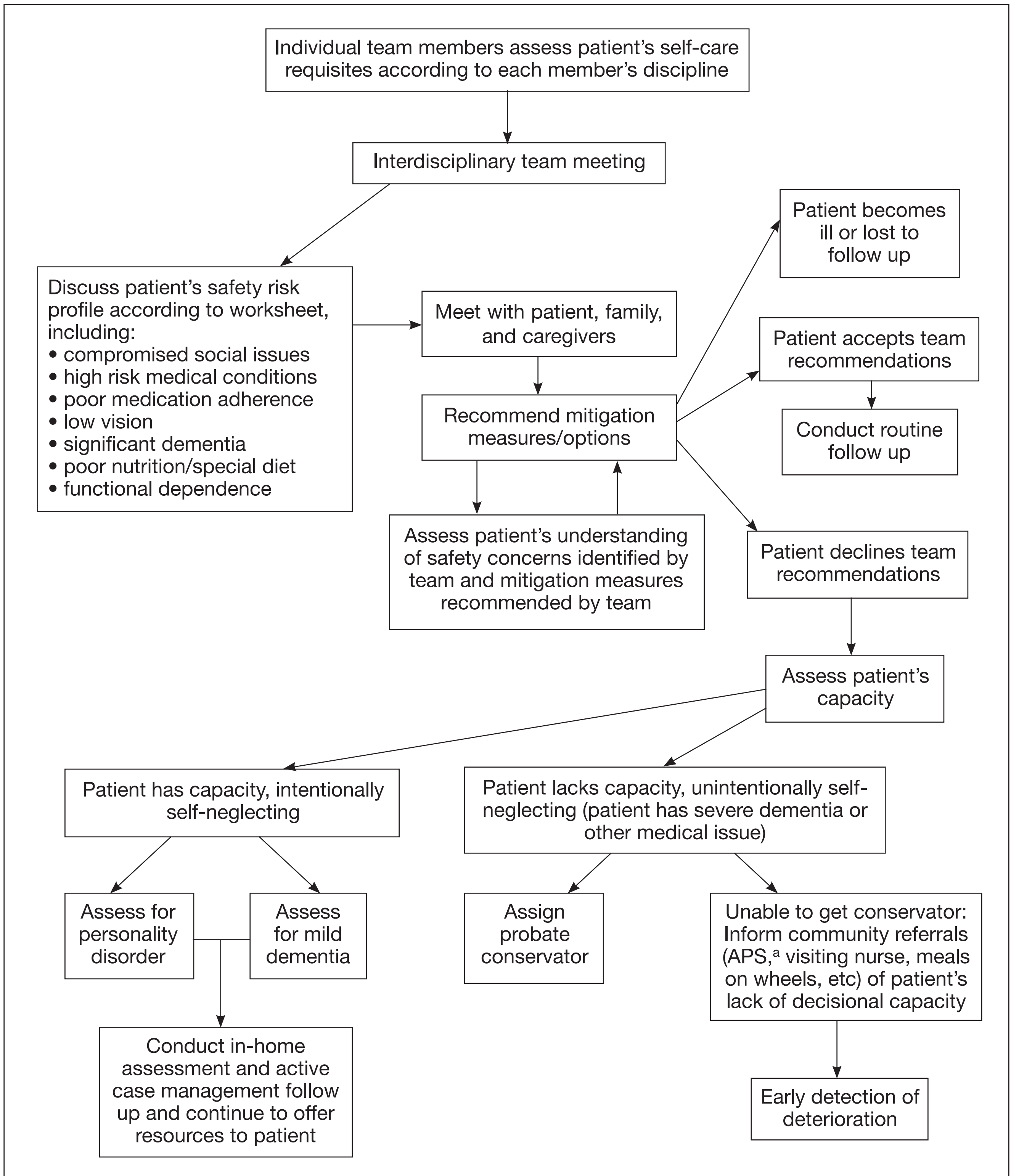


Figure. Flow chart illustrating the VA Greater Los Angeles Healthcare System Geriatric Research, Education and Clinical Center's interdisciplinary team protocol for assessing a patient's self-care requisites. [a]APS = adult protective services.

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Wheels program—that correspond to each limitation to self-care. The team ultimately may choose to recommend one or more of these interventions to the patient in order to mitigate his or her identified limitations.

Finally, the interdisciplinary team meets with the patient, the patient's family members, and caregivers to discuss the assessment findings, any self-care training that has been provided to the patient, and the team's recommendations for mitigating areas of concern. The team addresses any concerns raised by the patient or the patient's family members or caregivers, presents information by writing main recommendations on a large paper tablet, and gives the tablet to the patient and his or her family members or caregivers.

In some cases, the team must take the additional step of assessing the patient's decision making capacity. This step may be necessary when a patient declines all team recommendations and plans on returning to an unsafe environment. It also may be necessary if a patient is readmitted, with impaired self-care abilities again identified, and it is determined that the patient failed to implement the team's prior recommendations. The Safety Risk Profile/Decisional Capacity worksheet is an important resource in such cases, as it serves as documentation of the efforts that have been made by the patient's medical providers, family, and caregivers to address the self-neglecting behaviors. The worksheet also can provide objective evidence that a patient lacks the capacity to understand the risks and consequences of his or her decisions, which can support the pursuit of a surrogate decision maker or the seeking of a probate conservatorship to protect the patient from harm.

In assessing a patient's decision making capacity, the team determines the patient's understanding of safety concerns related to his or her inability to provide self-care and return home, any mitigating options, and reasons why the patient has chosen a particular approach to self-care. The standardized tool used for the decision making assessment is the MacArthur Competence Assessment Tool–Treatment (MacCAT-T).[30–32] This structured interview examines the elements of legal competence to consent to treatment; in this case, it is directed toward the understanding and choices related to impaired self-care requisites. MacCAT-T can be used by psychologists or primary care providers, including nurse practitioners. The patient should be able to state the benefits, risks, and consequences of choices in relation to his or her ability to provide self-care. Evidence of impaired capacity to make reasonable self-care decisions includes inability to engage in rational discussion, demonstration of inadequate health practice, or a lack of follow-through on disease or health management.

Given the high prevalence of cognitive impairment with age, it is probable that adults with intact decision making capacity on initial evaluation may not manifest the same capacity over time.[33] Our protocol systematically documents the team's specific concerns of the patient's risk for self-neglect on discharge. This allows for cohesive management of any changes in capacity postdischarge since documentation of findings and recommendations are located in the patient's electronic medical record.

## IN CONCLUSION

Self-neglect is a complex problem that is often overlooked and poorly managed. Although it often presents as a "crisis," it rarely occurs suddenly. Often, the situation is not improved by prolonged hospitalization, which may contribute to deconditioning.[34] Determination of decision making capacity in elder self-neglect is an essential step in assessment. The standard interdisciplinary protocol and Safety Risk Profile/Decisional Capacity in Older Adults worksheet described in this column can help guide clinicians in the management of older adults who self-neglect. ●

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