Elder abuse and neglect (EA/N) affects over 1 million older adults each year, and disproportionately affects persons with dementia and older women. Home healthcare professionals are in an advantageous position to assess for, identify, and report EA/N. Lack of knowledge on EA/N risk factors, assessment tools, and mandatory reporting guidelines often prevent professionals from identifying and reporting EA/N. This article provides practical guidance on EA/N risk factors, assessment tools, and reporting responsibilities that can easily be implemented in practice.

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Elder abuse can include physical, emotional, sexual, and financial abusive acts.
Elder Abuse & Neglect Risk Factors

There is generally a lack of research on factors related to the older adult and risk for EA/N on which to guide practice, though some have suggested that a shared living arrangement (Amstadter et al., 2011), alcohol abuse by the older adult (Shugerman et al., 2003; Vandeweerd et al., 2013), and aggressive behaviors displayed by a person with dementia (Vandeweerd et al.) are related to EA/N. Additionally, the National Center on Elder Abuse (1998) found that compared to men, women experience higher rates of EA/N including physical abuse (71.4%), emotional abuse (76.3%), financial abuse (63%), and neglect (60%). More recent research also suggests women are more likely to be victims of elder abuse (Laumann et al., 2008). It is unclear whether women are more likely to experience EA/N because of gender-based dynamics often underlying violence, because of population demographics in which older women outlive older men, or a combination of both.

Family members are more likely to commit EA/N as compared to other social groups (i.e., neighbors, friends) (Amstadter et al., 2010; National Center on Elder Abuse, 1998). Among family members, adult children (specifically daughters) are thought to be the most common perpetrators (Acierno et al., 2010; Pickering, Pieters, et al., 2015). Suggested risk factors for EA/N related to the perpetrator include mental illness (Acierno et al.), depression (Coyne et al., 1993; Paveza et al., 1992), poor premorbid relationship history (Phillips, 2008; Pickering, Pieters, et al., 2015), and substance abuse (Acierno et al.; Amstadter et al., 2011; Anetzberger et al., 1994; Lachs & Pillemer, 2004).

Although there are established risk factors for EA/N, assessment should not be guided by risk factors alone. Violence does not discriminate and affects persons from all circumstances, and as such, routine assessment for EA/N is recommended for all patients. Identifying at risk families through a thorough and systematic EA/N assessment can facilitate practitioner’s decisions throughout the reporting process and connect families to supportive resources.

QualCare Scale

As each home healthcare assessment can vary by profession, agency requirements, and individual patient circumstances, it is essential to have a systematic way of assessing for and identifying EA/N to support decision making regarding reporting. In addition, such an assessment must be able to be implemented into a home healthcare worker’s routine assessment without adding significant time to the home visit, to reduce burden on the patient and their family. The QualCare scale offers this ability to assess for EA/N amid a routine home assessment.

Prior empirical work with nurses and social workers in home healthcare found that these practitioners considered the quality of the caregiving situation, not the quality of the older adult—caregiver relationship, when making judgments about EA/N (Phillips & Rempusheski, 1985). Based on this work, the QualCare scale was designed as a direct observational rating scale intended to quantify the quality of caregiving to support identification of EA/N (Phillips et al., 1990a). The QualCare scale is a 52-item scale designed specifically for use by nurses practicing in home healthcare and is organized by six subscales: environmental, physical care, medical care maintenance, psycho-social care, human rights, and financial (Phillips et al., 1990a, 1990b).

Scale Administration

The QualCare scale focuses on identifying the met and unmet needs of the older adult regardless of the mechanisms causing them, by assessing the older adult as a care recipient, the family member/friend as a caregiver, and the two as a caregiving dyad. The scale is completed after an unstructured minimum 1- to 2-hour geriatric home healthcare assessment that covers a broad variety of areas (Phillips et al., 1990a), such as an intake type assessment done for service planning and creation of person-centered care plans. The unstructured geriatric home healthcare assessment should explore a variety of areas related to caregiving including self-care and caregiving responsibilities, emotional support, home environment, communication, and dynamics between the older adult and caregiver. The assessment should explore the older adults’ values and goals, opportunities they are given to contribute to the family, and whether their choices and decisions are respected and followed. It should also explore the caregivers’ values and goals in relation to caregiving, and the relationship dynamics of the dyad with a focus on how they impact caregiving activities.

Following this assessment, the rater completes the QualCare scale as a way of reframing the
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Outline data to make conclusions about the quality of caregiving. The rater is asked to rate each item of the QualCare scale on a 5-point Likert scale ranging from worst possible care to best possible care. Scores for each subscale are averaged to provide an overview of the caregiving situation and likelihood of EA/N (Phillips et al., 1990a, 1990b).

**Validity & Reliability**

There is an evidence base to support the use of this scale in practice. In development of the scale, much attention was given to ensuring the content validity of the instrument, or the match between items and scales to the theoretical constructs being measured (Phillips et al., 1990a). Additionally, initial pilot testing found acceptable levels of interrater reliability (measured through percent agreement, ≥0.70 criterion across all checks), internal consistency (Cronbach’s alpha = 0.81–0.95 across subscales), and criterion validity (bivariate correlations between 8 criterion variables and the QualCare scale/subscales) (Phillips et al., 1990b).

**Strengths**

The developers of the QualCare scale argue that thinking of EA/N in terms of met and unmet needs and as a product of caregiving helps to reduce the difficulty practitioners often experience with the assignment of value judgments often associated with the legal-based definitions of EA/N (Phillips et al., 1990a). Determining EA/N based on quality of caregiving, rather than legal standards, may be more comfortable for healthcare professionals and empower them to report. Moreover, because the scale provides a quantified measurement of quality of caregiving (i.e., averaged scores across subscales), it is possible to continually evaluate the effect of implemented interventions on the reduction of EA/N through repeat assessments to monitor changes in scores.

An additional strength of this instrument is the replication of the original results by external investigators. Researchers in Canada translated the QualCare into French in order to further examine the criterion validity of the QualCare (Bravo et al., 1995). Their results support original findings that

**Limitations**

A drawback to the QualCare scale is that it does require a dedicated training program to ensure interrater reliability between practitioners. In the Canadian evaluation of the QualCare scale they found low rates of interrater reliability which the researchers attributed to the need for further training on the process of scoring the scale (Bravo et al., 1995). A QualCare scale training program for nurses and social workers has been tested in Michigan with good results, which can be replicated by others (Pickering, Ridenour, et al., 2015).

As completing the QualCare scale depends on a thorough geriatric home healthcare assessment to determine the older adult’s caregiving needs and the extent to which they are being met, it is not appropriate for use by home healthcare aides or unlicensed home healthcare professionals. However, practitioners can discuss findings with home healthcare aides and advise on assessment criteria that need to be monitored. Additionally, evaluation of the criterion validity of the QualCare scale suggests that scores indicating poorer quality caregiving are correlated with EA/N (Phillips et al., 1990b); however, it is unclear at what cut point the scores definitively represent EA/N. Because EA/N needs to be reported regardless of perceived severity or type of abuse, it is recommended providers look at the mean score for each individual subscale of the QualCare and if the score is higher than 3.5 to consider reporting.

**Recommendations for Practitioners**

As this scale was developed and evaluated with home healthcare nurses, it is highly suitable for use by home healthcare practitioners. Most standard home healthcare intake assessments, such as the Outcome and Assessment Information Set (OASIS-C1) or State-funded Medicaid Waiver programs, serve as an excellent basis for the minimum 1- to 2-hour geriatric home healthcare exam needed to complete the QualCare scale. Conceptually, there is much overlap in the assessment areas.
if the victim has a vulnerability (regardless of their age) with state definitions on what makes someone “vulnerable” also varying. Anyone who qualifies for state-supported programs (such as Medicaid Waiver, meals on wheels, etc.) or to receive skilled care in their home can be assumed, for the time in which they are in the program, to be vulnerable because having a caregiving need is an eligibility requirement for these services.

Currently most U.S. states and territories, with the exception of New York, the District of Columbia, and Puerto Rico, designate healthcare professionals as mandatory reporters and designate penalties for failing to report. The majority of states are clear that mandated reporters are required to report if they have reasonable cause to believe EA/N is occurring. This means that if you have reasonable suspicions that EA/N is occurring, based on your thorough assessment, training, and expertise as a clinician, then you should report regardless of perceived severity of the EA/N. Importantly, you do not have to confirm EA/N is definitely occurring prior to reporting. You also are required to report regardless of the perceived motivations, intentions, or causes of the abuse. In all states, adult protective services is the official agency charged with investigation of abuse and neglect. So for example, although you may perceive the cause of the EA/N is caregiver lack of knowledge (rather than criminal activity or malicious intent), you are still required to report as it is up to adult protective services to investigate and decide this.

How to Report
As a mandatory reporter, it is your obligation to know what is expected of you by your state including what state definitions are and how reports should be filed. Most states have hotlines that mandatory reporters use to file their reports, and some use online reporting. The National Center on Elder Abuse has compiled references on mandatory reporting legislation, resources, and phone numbers for all states (National Center on Elder Abuse, 2015). This resource also provides information on policies for whether the EA/N occurred in the private home, nursing home, other care/adult residential facility, or mental health facility. Reporting requirements, including where the report gets filed, do vary by the location the EA/N occurred in.

Concerns Regarding Reporting
Practitioners often have concerns regarding how reporting will impact their patient (Rodríguez et al.,
2006). It is important to remember that though there is a legal imperative requiring the report to be made, the events that occur after reporting remain subject to the patient’s consent. When a report is filed, the patient is visited by adult protective services. The older adult can refuse the visit as well as any services offered by adult protective services. Filing a report does not mean anyone will go to jail or that the older adult will be removed from the home. Though they are possibilities, legal intervention is infrequent (Navarro et al., 2013). The purpose of reporting is to trigger a response to get the older adult and their family connected with resources to help prevent potential or reduce ongoing EA/N and promote health and wellness.

Home healthcare practitioners are fortunate in that they are able to build ongoing relationships with patients and families. Adult protective services protect the anonymity of the reporter when they investigate. If there remains concerns about the impact of reporting EA/N on the ongoing relationship with the patient, one may want to consider explaining the necessity of reporting to the patient, reasoning for doing so, and what will happen after the report is filed. Clear communication may foster patient understanding regarding the reporting process and the events that may follow. It is important to note there has been no research on safety risks for victims of EA/N and therefore it is currently inadvisable to inform the family and/or suspected perpetrator that a report will be filed.

Summary
Healthcare providers are designated as mandated reporters for EA/N because they are viewed as a safety net for victims. With the expansion of community-based and in-home services, there are increasing numbers of older adults receiving services by home healthcare practitioners. Thus, these providers are in a key role regarding the identification of victims. Routine assessment for EA/N using an evidence-based, valid, and reliable tool such as the QualCare scale can increase identification and mandatory reporting compliance.

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