OSCE Station

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Reviewed By: Dr. Davidson
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Topic: Elder abuse

CanMEDS Roles	Medical Expert	Communi-cator	Collaborator	Manager	Scholar	Advocate	Professional
	X	X				X	X
Specific CanMEDS Competencies:							
Medical Expert	• Identify elder abuse and/or neglect in a comprehensive and timely manner. • Determine capacity and assessing risk in cases of elder abuse and/or neglect. • Knowledge of substantive and procedural ethics principles that can that help guide decision making in cases of elder abuse and/or neglect.						
Communicator Health advocate Professional	• Address the resident's questions in a way that is appropriate to their expected level of training and knowledge. • Respond to an individual patient's health needs by advocating with the patient within and beyond the clinical environment • Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards						

Format	Video & Questions	Full Role-Play	Scripted Dialogue	Paper Case & Questions	Lab Results
		X			

Age/Gender	Adult	Child	Geriatrics	Female	Male
			X	X	

Instructions for the Candidate:

In this station you are a consultant psychiatrist working on-call. Dr. Zoidberg, a first-year psychiatry resident is working with you. He just started his residency, and this is his first call shift as a resident. You receive a call from nursing staff on the psychiatry inpatient unit informing you about a patient wanting to leave the hospital. You are currently busy on another consultation and send Dr. Zoidberg to attend to the matter. He contacts you via telephone to discuss the matter.

You will have 20 mins for this station.

Please let the examiner know when you are ready.

I would like to review the patient you asked me to see if you have a moment. I assessed Tragedeigh, a 78-year-old female, widow, who currently lives with her son, Bob Sleigh. She's a retired teacher.

She was voluntarily admitted to Psychiatry following an outpatient assessment this past Friday. Given that it's a long weekend, she has not been assigned to a Psychiatrist. Her nurse is quite concerned about her wanting to leave the hospital. They placed her on a nursing hold until we can assess her.

Her admission assessment indicates that the ER Psychiatrist noted the patient was referred by her GP who had concerns regarding possible depression but had difficulty getting a history. She was brought to her family physician's on Friday by her close friend and neighbour Pegasus who usually accompanies Tragedeigh to all her doctor's appointments. Pegasus found it a bit unusual when Tragedeigh didn't call her to confirm her ride to her monthly hair appointmentas she's always done in the past. She decided to check on her. According to Pegasus, upon entering Tragedeigh's apartment she found her staring blankly at the wall. Tragedeigh did not engage in conversation other than answering yes or no to questions. Her apartment appeared unkempt, and her personal hygiene was very poor. She had little to no food in her apartment.

Pegasus encouraged her to go to the doctor. She was initially reluctant to go to the appointment. Several days ago, Pegasus found her searching the garbage room for food. When Pegasus approached, she quickly turned around and walked away without saying a word. Pegasus found this very odd as Tragedeigh is usually very talkative and pleasant. Pegasus then attempted to call her son Bob, however, she was unable to reach him. Pegasus rarely sees Bob at the apartment complex but any time she has, he appears intoxicated. A few weeks ago, she heard shouting coming from Tragedeigh's apartment. She suspects it was Bob but wasn't sure whom it was directed toward.

The diagnostic impression is ?MDD. Management plan is:
1. Admit to psychiatry "voluntary".
2. CBC, renal & liver panel, electrolytes, lipids, TSH, vitamin B12, folate. ECG. Routine vitals.
3. Start: Mirtazapine 15mg PO HS.
4. Consult internal medicine.

Upon arrival to hospital, Tragedeigh appeared malnourished, was hypotension & tachycardic with a low grade fever. Her arms and trunk were covered in excoriations, a few that looked infected. Antibiotics and IV hydration were started by internal med. Following 24 hours of treatment, she appeared more alert, and was oriented. Repeat lab tests are within normal limits, however, due to ongoing hypotension & tachycardia she requires additional IV hydration along with antibiotic treatment

I assessed her today but despite informing her of the reasons why she should remain in hospital, she's adamant about leaving. She notes doing well both physically and mentally. She denies any signs consistent with depression, anxiety, psychosis, or any other psychiatric illness. Denied homicidal or suicidal ideation. She does not believe medications will help and refuses to take Mirtazapine and the antibiotics. She would like her IV removed. Just as I was finishing up, her son Bob arrived and insisted she must go home. I attempted to explain that it would be against her medical best interest, however, Bob is adamant about taking her home. He notes that he acts as her "power of attorney" for financial and personal care and ultimately its his decision whether she stays or leaves. I have asked them to wait until I was able to speak with my staff.

1. Should I let her go home with her son? They insist they want to go home.

No. I am concerned that there may be elder abuse occurring. Don't discharge without a thorough assessment. I am going to come to the unit to assess her with you.

2. Oh, why do you suspect elder abuse?

Upon presentation to the ER she had poor hygiene with infected excoriations. Despite living with her son, Bob, the apartment is unkempt and she is malnourished. She was seen digging through the garbage. Her friend heard her son yelling and shouting. Her son has also been observed to be intoxicated.

3. Are there different type of 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 or distress to an older person. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, and emotional abuse; financial and material abuse; abandonment; neglect; and serious loss of dignity and respect.

Source: http://www.who.int/ageing/projects/elder_abuse/alc_toronto_declaration_en.pdf

4. Is elder abuse a crime?

While the *Criminal Code* does not contain the specific offence of "eleder abuse", certain types of elder abuse can be a crime and as such, are punishable under the *Code*. Physical abuse such as assault, theft, sexual abuse, neglect or failure to provide the necessities of life, financial abuse, uttering threats

5. Do we need to call the police?

In Canada, there are no federal laws making elder abuse reporting mandatory. Most provinces state "may" report but no formal obligation or duty to report.HOWEVER, there are some provinces and territories that do (Nova Scotia, Newfoundland and Labrador, and the Northewest Territories. (For individual provinces: see elder-law.ca)

It is important to determine first if she has capacity to make decisions. Elder abuse raises the ethical dilemma of autonomy/choice making. If she has capacity and does not want to report and as a physician, you report this may mean a breach of confidentiality. From the CMPA statement on elder abuse, "physicians similarly do not have a duty to report a criminal offence related to elder abuse to the police. This would generally be considered a breach of confidentiality unless there was consent from the patient or substitute decision-maker".

Source: https://www.bcli.org/project/practical-guide-elder-abuse-and-neglect-law-canada and https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2016/elder-abuse-and-neglect-balancing-intervention-and-patients-right-to-confidentiality

6.Are their certain risks or red flags that I should pay attention to that might make an elderly more likely to be abused?

■ isolation,
■ lack of support,
■ cognitive impairments (i.e., dementia),
■ responsive behaviours (e.g., verbal or physical aggression),
■ living with a person who has a mental illness,
■ living with people engaging in excessive consumption of alcohol or illegal drugs,
■ dependency on others to complete activities of daily living (including banking),
■ recent worsening of health, and
■ arguing frequently with relatives.

Source: Cohen, Halevy-Levin, Gagin, Prilutzky, & Friedman, 2010; Davies et al., 2011; Lindbloom, Brandt, Hough, & Meadows, 2007; Perez-Carceles et al., 2009; Spencer, 2010; Wiglesworth et al., 2009)

7. How do I know if Mrs. Sleigh is being abused? What are some signs I should look for?

Table 3: Possible Signs of Abuse and Neglect

POSSIBLE SIGNS OF ABUSE	POSSIBLE SIGNS OF NEGLECT
Physical/Psychological/Sexual ■ injuries to the upper extremity, trunk, head, neck and/or anogenital regions ■ depression, anxiety ■ change of behavior/mood in presence of the person abusing or neglecting ■ unexplained burns and bruises (may be in different stages of healing) ■ fractures (may be in different stages of healing) ■ evidence of sexual abuse (e.g., genital infections, trauma, bruising on inner thigh) ■ signs of hair being pulled ■ inadequate explanation or documentation of any injury (from employees) ■ evasive or defensive responses (from employees) **Financial** ■ irregularities in bank accounts and bills ■ living conditions that do not match income ■ missing money and personal belongings ■ payments to strangers or new "best friends" ■ inappropriate use of power of attorney authority ■ deception or coercion with regard to payments, gifts or change in wills	■ dehydration ■ malnutrition ■ low blood albumin level ■ pressure ulcers/sores ■ poor body and oral hygiene/grooming ■ depression ■ despair ■ unclean living conditions

(Erlingsson, Carlson, & Saveman, 2003; Lindbloom et al., 2007; Winterstein, 2012; Murphy, Waa, Jaffer, Sauter, & Chan, 2013; Perez-Carceles et al., 2009; Davies et al., 2011; Wiglesworth et al., 2009)

8. So what can we do? It sounds to me like she doesn't quite understand the gravity of the situation and what would happen if this goes on for longer. Does this mean she doesn't have capacity?

Capacity assessments are particularly important in cases of elder abuse/neglect, because capable adults are entitled to make decisions that incapable patients are not. Capable patients can choose to live in risky situations, including with people who may be abusive. When patients are deemed incapable, there can be greater justification to limit their autonomy in favour of protecting the older adult from harm. This stems from the physician's duty to protect a vulnerable patient who may lack the self-reliance and the ability to independently access support and assistance when needed.

The healthcare professional who is proposing a treatment or care plan is responsible for assessing whether patient is capable of making a treatment-related decision. The physician who is proposing admission and/or caring for patient has responsibility to assess whether patient has the ability to understand and appreciate the consequences of refusing treatment and leaving against medical advice.

The rule of thumb is that a person is considered capable unless a healthcare professional has "reasonable grounds" to suspect otherwise. Mrs. Sleigh's confusion and disorientation may suggest incapacity but alone is insufficient evidence. The test for capacity varies depending on province/territory; however, three clusters of patient abilities are generally required for competence: 1) ability to formulate/communicate a preference, 2) ability to understand and appreciate the information provided, and 3) ability to reason through the consequences of accepting or declining a recommended treatment or treatment plan.

The patient retains all decision-making authority until she lacks the abilities in at least one of these domains; as the power of attorney for personal care, her son can only make decisions on her behalf once incapacity has been established.

Capacity can fluctuate, and should be reassessed whenever (1) a patient's condition materially changes, for instance, Mrs. Sleigh's capacity to make decisions may improve as her dehydration and infection resolves, and (2) whenever a new treatment or service is proposed - that is, capacity assessments are specific; Mrs. Sleigh may be able to consent to one intervention and not another. In the event of uncertainty regarding determination of capacity, a second opinion should be sought

Source: https://www.royalcollege.ca/rcsite/bioethics/cases/section-1/elder-abuse-neglect-e

9. If she has capacity, can we certify her?

Mrs Sleigh requires acute care and the physician and treating team should negotiate with her in an attempt to keep her in hospital until her condition has stabilized and a "safe" discharge can be ensured. Her son has indicated he wants to take her home but the patient needs to be engaged in this decision (preferably in private, at least for the initial conversation). It is important to try to determine what is underlying her to want to go home. If her son is abusing her, she may be reluctant to disclose this to us. She is dependent on him.

Capable patients are legally entitled to leave AMA; however, any refusal of treatment or care should be carefully documented.

If the patient can fully appreciate and understand the actual or potential risks and consequences associated with returning home (malnutrition, falls, isolation, increased risk of morbidity/mortality etc), then she has the right to choose to do so.

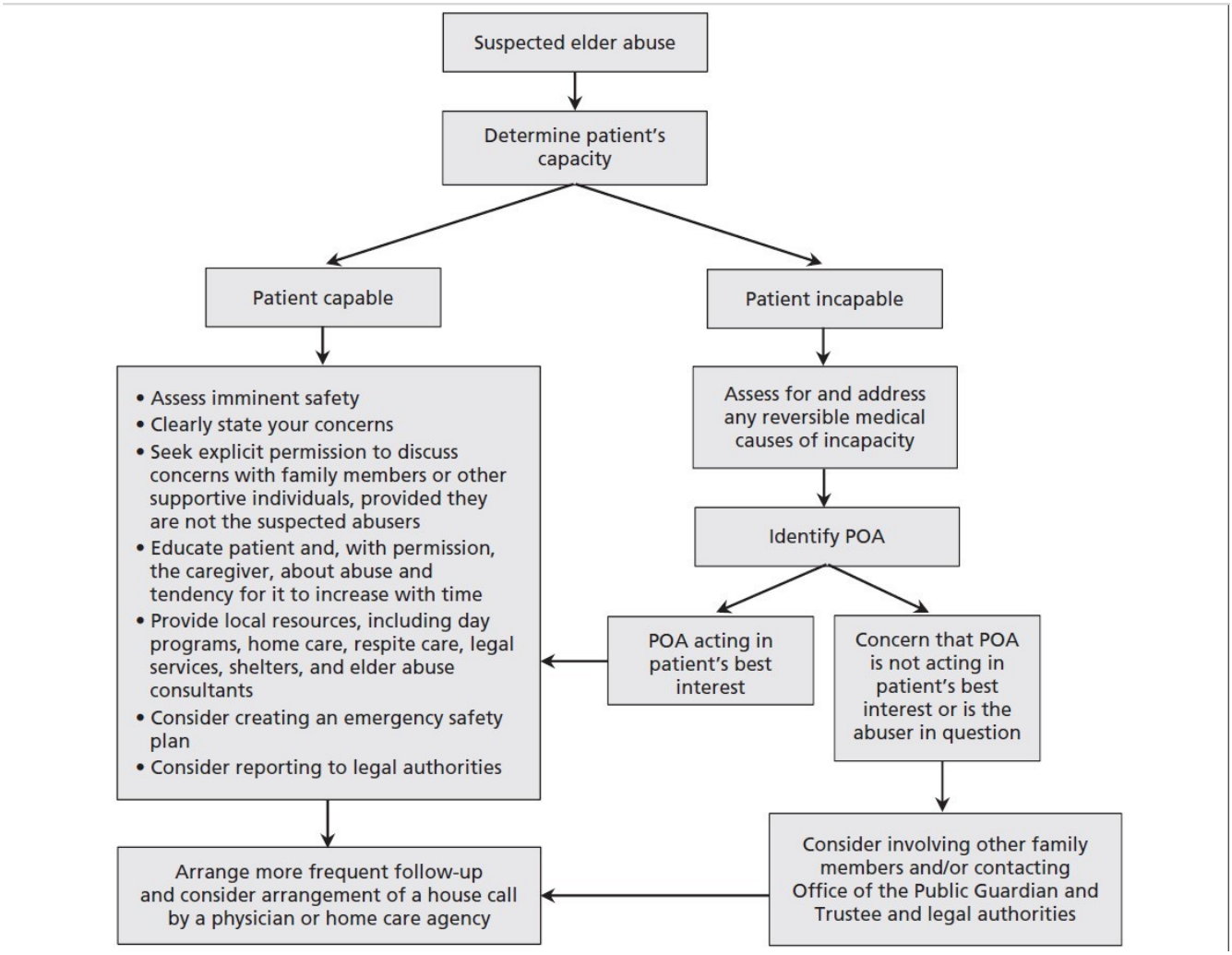
If she is capable to make decisions regarding her health, then we are not able to certify.

Health professionals are often uncomfortable when patients make decisions to live at risk, voicing concerns about patient safety and wellbeing, professional responsibility, and organizational liability. However, these concerns do not override the right of capable older adults to make decisions about how they choose to live their own lives. If patient is capable and insists on returning home, then a risk mitigation and harm reduction approach may be helpful. The team should consider: what can be done to minimize the risks she is facing?

It is important that we educate her regarding elder abuse. We can discus with her local resources such as home care, respite, legal resources (Public Guardian /Trustee), police, and shelters.

A harm reduction approach to care would explore the interventions she believes are most useful, as well as develop an understanding of risks in the context of her values, wishes and life experience. A comprehensive discharge plan might be put into place to support her desire to return home and mitigate potential risk. This plan could include: referral and follow up with home based community care organizations; Meals on Wheels programs; developing a Safety Plan; expanding the circle of care to include willing friends or neighbours; ongoing education, support and respite for her son; and ensuring follow up with relevant care providers. The expectations and responsibilities for care held by both the patient and the treating team should be clearly defined and documented.

Striking a mutually acceptable balance between patient autonomy and patient well-being may prove challenging. Negotiating these cases takes time and inter-professional collaboration. The care team should hold a meeting to discuss the key issues at stake, consider different possible courses of action, and weigh the potential benefits and burdens associated with each course of action.



Wang, X et al. Elder abuse: an approach to identification, assessment and intervention *CMAJ* 2015.187(8)
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