

# Adult Protective Services Field Guide

Version 2, June 2022



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## Adult Protective Services Field Guide



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### **INTRODUCTION**

The Field Guide for Adult Protective Services is intended to provide the Adult Protective Services (APS) supervisor with an organized system to ensure that the new APS Professional gains the experiences and formal training needed to be an effective professional. This guide outlines twenty-three (23) Knowledge Areas identified as comprehensive for APS field work. These Knowledge Areas include basic field skills, as well as working with unique types of cases/situations. Although the Knowledge Areas are presented in order from basic to specialized areas, it is up to the supervisor to decide in what sequence these Knowledge Areas should be introduced. In other words, it is not necessary to introduce these in the specific order presented.

This guide may also be used to identify areas for needed development for the experienced APS Professional (whether experienced in APS or from a different agency), who may have mastered basic field skills (such as *Communication and Interviewing*-Knowledge Area 9), but require training in areas unique to APS (such as *Involuntary Case Planning*-Knowledge Area 20) or unique to the individual learner (such as remedial skills in *Documentation and Report Writing*-Knowledge Area 15).

### **HOW TO USE THE GUIDE**

Each of the 23 Knowledge Areas has a checklist of activities designed to support the skill/knowledge development for the worker. The supervisor, in collaboration with the learning worker, should use the Knowledge Areas to develop an individualized learning plan for the worker. The supervisor will need to coordinate their time to meet consistently with the worker to debrief the learning activities and provide one-on-one discussion with the worker to ensure the transfer of learning.

All necessary assignment and transfer of learning documents are included in the Appendices or linked to the corresponding website where they are located. Active links to the documents are in the respective Knowledge Areas.

When assigning a new APS professional to a particular type of case (such as *Self-Neglect Clients*-Knowledge Area 10), it is recommended that the APS professional perform the activities in that Knowledge Area as close to the field visit as possible (including the viewing of the associated eLearning, if indicated).

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While this guide provides tools, resources and learning activities, it is not intended to remove the supervisor from the learning process. The supervisor's role is **vital** to ensure the transfer of learning. As the supervisor, you remain the **best resource** for encouraging/guiding the APS professional through the learning process and ensuring that the skills acquired are applied.

## **PRELIMINARY ACTIVITIES FOR THE SUPERVISOR**

Prior to introducing the learning activities for the APS professional, the supervisor should perform the following tasks:

1.  Identify existing staff who demonstrate “best practices” regarding particular types of abuse cases and/or knowledge areas. Secure the consent of the experienced worker(s) to have the learning worker accompany on field visits, review documentation, and be available for peer support.
2.  Identify and have available case records which reflect best practices of documentation and organization.
3.  Ensure that the learning APS professional has access to a computer with Internet access and that pop-up blockers are off. To register for eLearning trainings, visit the [eLearning registration page](#) located on the Adult Protective Services Workforce Innovations (APSWI) website.
4.  Provide the worker with applicable laws, program policies and procedures, and written regulations used for APS work.
5.  Provide the worker the list of [Common APS Abbreviations](#) and tips on use of acronyms in documentation. Be sure to add any agency-specific acronyms commonly used in your agency. Supervisor to go through list with worker and confirm if any acronyms are not appropriate for use in documentation.
6.  Review the following three (3) online resources to supplement the APSWI eLearnings:
  - [Elder Abuse Guide for Law Enforcement \(EAGLE\)](#) offers short training videos and state-specific laws relevant to elder abuse from a law enforcement prospective.
  - [Lifting Up the Voices of Older Survivors](#) provided by the National Clearinghouse on Abuse in Later Life offers a video series that features older survivors who have experienced various forms of abuse, including intimate partner violence and sexual assault/abuse. Each video includes a discussion guide to reflect

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on the story and learn how to respond to survivors in similar situations.

- [Supporting Crime Victims with Disabilities Online Training](#) toolkit.

**Note:** Available eLearnings are highlighted in **teal**; registration instructions to view these trainings are given in the “Preliminary Tasks for Supervisors” on the previous page. All handouts/worker assignments are hyperlinked to the specific documents in the Appendices or linked to the corresponding website where they are located.

### **Knowledge Area 1: Overview of APS**

- Assignment 1.1:** Worker to view **APS Overview eLearning**
- Assignment 1.2:** Supervisor to review and walk-through activities located in [APS Overview Transfer of Learning Guide](#) with learning worker.
- Assignment 1.3:** Supervisor and worker to review [NAPSA’s APS Example Flowchart](#) (or one specific to your agency if it exists), for an overview of an APS case investigation and service provision.
- Assignment 1.4:** Worker to review types of abuse encountered in APS, using [Types of Abuse](#) handout and review case files which exemplify various types of abuse and understandable documentation. Supervisor to discuss any questions with worker.
- Assignment 1.5:** Supervisor and Worker discuss [Define Autonomy, Capacity and Incapacity](#) worksheet.
- Assignment 1.6:** Worker makes home visit(s) with experienced worker(s). If multiple home visits, arrange with different experienced worker each time. Supervisor to debrief with worker after each visit. ***This assignment should be repeated throughout the worker’s induction period.***

### **Knowledge Area 2: Values/Ethics**

- Assignment 2.1:** Worker to view **Ethics, Values and Cultural Responsiveness in APS eLearning**

- Assignment 2.2:** Worker to complete [Ethics, Values and Cultural Responsiveness in APS Transfer of Learning](#) Packet.

*Note: This TOL was designed to accompany either modality- eLearning or Instructor Led Training and provides opportunities to reflect on cultural responsiveness concepts such as implicit bias, privilege, and cultural humility as well as APS ethics and values.*

Ethics, Values and Cultural Responsiveness in APS is available as an instructor-led training.

### **Knowledge Area 3: Regulations**

*Note: this Knowledge Area can be skipped for APS professionals outside of California. Supervisor to explore regulations within their state/jurisdiction.*

- Assignment 3.1:** Worker to view **California Regulations for APS eLearning**
- Assignment 3.2:** Worker to review California APS Regulations on the [California Department of Social Services website](#).
- Assignment 3.3:** Worker to complete the [California Regulations for APS Transfer of Learning Guide](#) and review worksheets and answers with supervisor.

### **Knowledge Area 4: The Aging Process**

- Assignment 4.1:** Worker to view **The Aging Process eLearning**
- Assignment 4.2:** Worker to accompany another worker on a home visit (any type) and debrief with supervisor.
- Assignment 4.3:** Worker to complete [The Aging Process Transfer of Learning Guide](#) and debrief with supervisor.



### **Knowledge Area 5: Physical and Development Disabilities**

- Assignment 5.1:** Worker to view [Effectively Working with People Who Have Disabilities eLearning](#).
- Assignment 5.2:** Worker to review [Supporting Crime Victims with Disabilities Online Training Toolkit](#).
- Assignment 5.3:** Worker to view [THINK + change interview with Scott Modell](#) about forensic interviewing clients with intellectual and other developmental disabilities (IDDs).
- Assignment 5.4:** Worker to observe a home visit with client who has a sensory or developmental disability and debrief the experience with supervisor.
- Assignment 5.5:** If an opportunity becomes available, worker to observe a forensic interview.

### **Knowledge Area 6: Mental Health in APS**

- Assignment 6.1:** Worker to view [Mental Health in APS Practice eLearning](#)
- Assignment 6.2:** Worker to review and print out [List of Commonly Prescribed Psychotropic Medications](#) (written list may helpful on home visits and in documenting).
- Assignment 6.3:** Worker to define the terms “involuntary hold” and “gravely disabled” and identify which community agency or agencies have authority to assess for the holds.
- Assignment 6.4:** Worker to complete [Mental Health Issues in APS Transfer of Learning tool](#) and discuss questions with supervisor.

Mental Health in APS is available as an instructor-led training.

### **Knowledge Area 7: Substance Abuse in Mature Adults**

- Assignment 7.1:** Worker to view [Substance Abuse and Mature Populations eLearning](#)
- Assignment 7.2:** Worker to view interview on [Addiction and Recovery for Older Adults.](#)
- Assignment 7.3:** Worker to gather local substance abuse treatment programs geared toward older adults.
- Assignment 7.4:** Home Visit with a client who has a substance use disorder and debrief with Supervisor.

### **Knowledge Area 8: Dynamics of Abusive Relationships**

- Assignment 8.1:** Worker to view [Dynamics of Abusive Relationships eLearning](#)
- Assignment 8.2:** Worker to view "[Donna: Coercive Control and Abuse in an Intimate Partner Relationship from Lifting Up the Voices of Older Survivors](#)", and use discussion guide to debrief with supervisor.
- Assignment 8.3:** Worker to review and discuss with supervisor [Abuser Justifications and Defenses-APS Considerations](#) handout.
- Assignment 8.4:** Worker to make home visit on abuse by other case which focus on relationships. After visit, worker to debrief with supervisor re: how was abuse revealed; what questions were asked and what was the relationship between client and suspected perpetrator.
- Assignment 8.5:** Worker to read [Abuse in Later Life - NCALL - The National Clearinghouse on Abuse in Later Life.](#)
- Assignment 8.6:** Worker to complete the [Dynamics of Abusive Relationships Transfer of Learning Tool](#) and review worksheets and answers with supervisor.

**Optional Assignment:** Interview staff at a local domestic violence shelter about the services they provide. Identify domestic violence shelters that would accommodate those with physical impairments, and survivors of elder abuse.

Dynamics of Abusive Relationships is available as an instructor-led training.

### **Knowledge Area 9: Communication and Interviewing**

- Assignment 9.1:** Worker to view [Interviewing Skills for APS Workers eLearning](#)
- Assignment 9.2:** Supervisor to introduce and review necessary forms to be given to clients.
- Assignment 9.3:** Worker to complete [Transforming Leading into Non-leading Questions](#) worksheet.
- Assignment 9.4:** Worker to view the [APSWI Training Video: Successful Initial Home Visit, self-neglect](#) and [APSWI Training Video: Initial Home Visit, self-neglect, Gone Wrong](#) for comparison.
- Assignment 9.5:** Worker and supervisor to utilize the Professional Interview checklist and home visit activity review Communication Quiz available in [Professional Communication Transfer of Learning Guide](#).

Professional Communication is available as an instructor-led training.

Knowledge Area 10- 14: Go through each type of abuse, adjusting assigned home visits to match available cases

### **Knowledge Area 10: Self-Neglect Clients**

- Assignment 10.1:** Worker to view [Working with Self-Neglecting Clients eLearning](#)

- Assignment 10.2:** Supervisor and worker to complete Self-Neglecting Clients Transfer of Learning Guide for either the [eLearning](#) or [instructor-led training](#).
- Assignment 10.3:** Worker to review information about hoarding disorder International OCD Foundation website: [About Hoarding - Hoarding \(iocdf.org\)](#) and watch [Causes of Hoarding](#) video by Dr. Randy Frost.

Working with Clients Who Self-Neglect is available as an instructor-led training.

### **Knowledge Area 11: Caregiver Neglect**

- Assignment 11.1:** Worker to view **Caregiver or Perpetrator Neglect eLearning**
- Assignment 11.2** Supervisor and worker to review activities in the Caregiver or Perpetrator Neglect Transfer of Learning Guide for either the [eLearning](#) or [instructor-led training](#).
- Assignment: 11.3:** Worker to view [Elder Abuse: Neglect](#) from Eagle Roll Call Training Videos and discuss collaboration with law enforcement protocol with supervisor.

**Optional Assignment:** Worker to sit in on a caregiver support group.

Caregiver or Perpetrator Neglect is available as an instructor-led training.

### **Knowledge Area 12: Financial Exploitation**

- Assignment 12.1:** Worker to view **Financial Exploitation: An Introduction eLearning**
- Assignment 12.2:** Supervisor to discuss financial abuse as a part of the assessment; in other words, regardless of the type of abuse on the initial referral, ***always*** check for financial abuse.

- Assignment 12.3:** Worker to view [Financial abuse mini-modules](#) (5- including *Undue Influence*. Supervisor may need to debrief *Undue Influence*).
- Assignment 12.4:** Worker to watch "[Leonard and Meneleo: Financial Exploitation by Strangers](#)" and complete discussion guide.
- Assignment 12.5:** Worker to watch "[Mariana: Financial Exploitation by a Befriender](#)" and complete discussion guide.
- Assignment 12.6:** Supervisor and worker to review activities in [Financial Exploitation Transfer of Learning Guide](#).

Financial Exploitation is available as an instructor-led training.

### **Knowledge Area 13: Physical Caregiver Abuse**

- Assignment 13.1:** Worker to view [Responding to Physical Elder Abuse and Neglect eLearning](#)
- Assignment 13.2:** Supervisor and worker to review [Responding to Physical Elder Abuse and Neglect eLearning Transfer of Learning Guide](#).
- Assignment 13.3:** Worker to view [Elder Abuse: Physical Abuse](#) from Eagle Roll Call Training Video and discuss role of victim advocate. How does APS work with victim advocates; what are the similarities and differences?
- Assignment 13.4:** Worker to review [Identifying Medical Emergencies](#) handout.
- Assignment 13.5:** Worker to complete a Home Visit with another worker in which the allegation is physical abuse. The new worker may be the assigned worker or may be an observer depending on how many cases the new worker has already handled. (Supervisor must make the determination). Supervisor is to debrief the home visit with worker.

### **Knowledge Area 14: Elder Sexual Abuse**

- Assignment 14.1:** Worker to view [Elder Sexual Abuse eLearning](#)
- Assignment 14.2:** Worker to view "[Linda: Sexual Assault by a Neighbor](#)" video and complete discussion guide.
- Assignment 14.3:** Worker to view "[Tammy: Sexual and Physical Abuse in an Intimate Partner Relationship](#)" video and complete discussion guide.
- Assignment 14.4:** Worker to complete the entire Elder Sexual Abuse Transfer of Learning Guide for either the [eLearning](#) or [instructor-led training](#) but only do **ONE** vignette per exercise.

Elder Sexual Abuse is available as an instructor-led training.

### **Knowledge Area 15: Documentation and Report Writing**

- Assignment 15.1:** Worker to view [APS Case Documentation and Report Writing eLearning](#)
- Assignment 15.2:** Worker to complete the [Writing Exercise](#) handout.
- Assignment 15.3:** Worker and supervisor to complete activities located in [APS Case Documentation and Report Writing Transfer of Learning Tool](#).

*Note: This Transfer of Learning Tool is designed as a companion to NAPSA Core Competency Module #15: APS Case Documentation and Report Writing. It allows APS professionals to practice and polish their documentation skills using a collateral interview from a video clip.*

- Assignment 15.4:** Supervisor to do the [Experiential Activity](#) with the unit/entire staff to emphasize the importance of memory in documentation. Worker to review [General Guidelines to Improve Memory](#) (2<sup>nd</sup> page of Experiential Activity).
- Assignment 15.5:** Worker to review the [Case Consultation](#) handout with supervisor.

- Assignment 15.6:** Worker to review documents from previous 3 cases, using the APS Regulations check list (if in California) or the documentation checklist required by agency.
- Assignment 15.7:** Supervisor to introduce forms needed by agency.
- Assignment 15.8:** Worker to document observations of a home visit made with an experienced worker.
- Assignment 15.9:** Supervisor to review and discuss the worker's documentation focusing on quantity (the right amount of information) and quality (the right information stated appropriately).

APS Case Documentation and Report Writing is available as an instructor-led training.

### **Knowledge Area 16: Initial Investigations**

- Assignment 16.1:** Worker to view [Initial Investigation Part 1: APS Intake Interview eLearning](#)
- Assignment 16.2:** Worker to view [Initial Investigation Part 2: Worker Safety eLearning](#)
- Assignment 16.3:** Worker and supervisor to complete activities located in [Initial Investigations: Taking the First Steps Transfer of Learning Guide](#).

Initial Investigation: Taking the First Steps is available as an instructor-led training.

### **Knowledge Area 17: Assessing Client Capacity**

- Assignment 17.1:** Worker to view [Screening for Decision-Making Ability When Working with APS Clients eLearning](#)
- Assignment 17.2:** Worker to complete [Dementia-Specific Training for APS and Community Workers](#) eLearning offered by Alzheimer's Association.

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- Assignment 17.3:** Supervisor to introduce agency-specific capacity assessment tools/ behavioral indicators/questions.
- Assignment 17.4:** Worker to review [Factors Affecting Decisional Impairment in APS Clients](#) handout and discuss with supervisor.
- Assignment 17.5:** Worker to complete [Case Consultation Methods](#) worksheet and then discuss with supervisor.
- Assignment 17.6:** Using the agency's capacity assessment tool, worker complete an assessment of the client's cognition and then complete the [On the Job Training](#) handout.
- Assignment 17.7:** Worker to complete the [Screening for Decision-Making Ability When Working with APS Clients Transfer of Learning \(TOL\):Desk Guide](#) and review with supervisor.

Screening for Decision-Making Ability is available as an instructor-led training.

### **Knowledge Area 18: Risk Assessment**

- Assignment 18.1:** Worker to view [Risk Assessment in APS eLearning](#)
- Assignment 18.2:** Worker to listen to an intake call, using the agency's tool for determining risk. Worker to complete [Risk at Intake](#) handout. Supervisor to discuss handout and how risk assessment process begins at intake and ways the worker can gain additional information to intake information (exploration of previous records, contacting law enforcement, contacting collaterals).
- Assignment 18.3:** Worker to complete [Risk Assessment in APS Cases Transfer of Learning Guide](#) with supervisor support.

Note: This Transfer of Learning Guide is designed as a companion to NAPSA Core Competency Module 18: Risk Assessment. Designed as a user friendly chart, it provides APS professionals the opportunity to evaluate various risk factors and indicators, discuss the history and



context of each factor, identify mitigating factors and create service plans.

- Assignment 18.4:** Worker to complete the [Identify Risk Factors in the Various Domains](#) and discuss with supervisor.
- Assignment 18.5:** Worker to complete a home visit using the agency's risk assessment tool **or** use the framework of the **3 S's** (How **soon** might the abuse occur?, how **severe** would the abuse be? and how **sure** is the worker that the abuse will happen (likelihood). Worker to discuss with supervisor or with the lead worker.

Investigation: Risk Assessment is available as an instructor-led training.

### **Knowledge Area 19: Voluntary Case Planning**

- Assignment 19.1:** Worker to view [Voluntary Case Planning in APS eLearning](#)
- Assignment 19.2:** Supervisor to introduce any resources that are *always* given to clients (e.g. civil rights brochure, language form, Information on local Administration on Aging programs.)
- Assignment 19.3:** Supervisor and worker to complete Voluntary Case Planning in APS Transfer of Learning Guide for either [eLearning](#) or [instructor-led training](#).
- Assignment 19.4:** Worker to complete a home visit with another worker. After the home visit, determine the services needed with the worker and arrange visits with agencies that provide those services to get them put in place.

Voluntary Case Planning in APS is available as an instructor-led training and a blended training.

**Knowledge Area 20: Involuntary Case Planning**

- Assignment 20.1:** Worker to view [Involuntary Case Planning for APS Workers eLearning](#)
- Assignment 20.2:** Supervisor to familiarize the worker with the policy, procedure and forms necessary to refer a client for a guardianship/conservatorship.
- Assignment 20.3:** Supervisor to familiarize the worker with policy, procedures and agency expectations regarding Medical and Mental Health emergencies.
- Assignment 20.4:** Supervisor and worker to complete [Involuntary Case Planning and Intervention Process Transfer of Learning guide](#).

Involuntary Case Planning in APS is available as an instructor-led training and a blended training.

**Knowledge Area 21: Collaboration in APS Work**

- Assignment 21.1:** Worker to view [Collaboration in APS Work eLearning](#)
- Assignment 21.2:** Worker to attend a Multi-Disciplinary Team Meeting (or VAST, FAST, Death Review meeting).
- Assignment 21.3:** Complete the [Case Example](#) questions handout.

Collaboration in APS Work is available as an instructor-led training.

**Knowledge Area 22: Working with Criminal Justice**

- Assignment 22.1:** Worker to view [Working with the Criminal Justice System eLearning](#)

- Assignment 22.2:** Supervisor and worker to complete [Working with the Criminal Justice System Transfer of Learning Guide](#).

Working with the Criminal Justice System is available as an instructor-led training.

**Knowledge Area 23: Case closure**

- Assignment 23.1:** Worker to **Case Closure eLearning**
- Assignment 23.2:** Worker to review agency policies related to case closure.
- Assignment 23.3:** Worker to complete [Identify Factors and Conditions Which Indicate Appropriateness/ Inappropriateness of Closing an APS Case](#).
- Assignment 23.4:** Worker to complete [Case Consultation Methods: How the Helping Relationship Affects Case Closure](#).
- Assignment 23.5:** Worker to complete the case vignette exercise [Evaluate the Effectiveness of Service Delivery in 3 Key Areas \(Risk, Satisfaction and Adherence to Policy\)](#)
- Assignment 23.6:** Worker to review case closures with supervisor, using tools from preceding assignments.
- Assignment 23.7:** Worker to complete activity in [Case Closure Checklist Transfer of Learning](#).

Case Closure is available as a half-day instructor-led training.

**Appendices**

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## **Preliminary Task #5** (6 pages)

### **Common APS Abbreviations and Acronyms**

#### **Acceptable Usage in APS**

The ability to use acronyms and initializations in documentation can help increase efficiency in communication and daily work. The list below provides an overview of common acronyms and initializations often used in documentation or notes from APS professionals and their partners. While acronyms and abbreviations are non-inclusive, it is important to utilize acronyms and initializations appropriately as demonstrated in the example below.

#### **How to Use Acronyms and Initializations**

Acronyms: Initials linked that spell out and are pronounced as a word

Initializations: Initials used to abbreviate a term

On the first reference of an acronym or initialization, it is important to spell out the term followed by the letters in parenthesis.

Example:

*The Meals on Wheels (MOW) program provides daily meals to homebound older adults.*

#### **A)**

**AAA** – Area Agency on Aging

**ADA** – Americans with Disabilities Act

**ADD** – Attention Deficit Disorder

**ADHC** – Adult Day Health Care

**ADL** – Activities of Daily Living

**\*AIDS** – Acquired Immune Deficiency Syndrome

**ALANON** – Alcoholics Anonymous Support for Families/Friends

**ALF** - Assisted Living Facility

**ALS** – Amyotrophic Lateral Sclerosis

**AMA** – Against Medical Advice

**AP** – Alleged perpetrator

**Approx.** – Approximately

**APS** – Adult Protective Services

**ASHD** – Arteriosclerotic Heart Disease

\*When dealing with protected healthcare information and records, depending on agency policy, this information may be protected from case narrative document or it may be permitted as long as it abides by confidentiality guidelines.

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### **B)**

**B&C** – Board & Care

**BDI** – Beck Depression Instrument

**BRO** - Brother

**bid/b.i.d** – Twice Daily/Two Times a Day

**BP** – Blood Pressure

**bx** - Behavior

### **C)**

**CA** – Cancer

**CAD** – Coronary Artery Disease

**CCL** – Community Care Licensing

**CG** – Care Giver

**CHF** – Congestive Heart Failure

**CI** – Court Investigator

**CL** – Client

**CM** – Case Manager/Case Management

**CNA** – Certified Nursing Assistant

**COPD** – Chronic Obstructive Pulmonary Disease

**CP**- Care Provider

**CRMDT** - Cross Regional Multidisciplinary Team

**CVA** – Cerebrovascular Accident (stroke)

**CWS** - Child Welfare Service

### **D)**

**DA** – District Attorney

**d/c** – Discontinued

**D/C** - Discharge

**DD** – Developmental Disability

**DIL** – Daughter-in-law

**DJD** – Degenerative Joint Disease

**DM** – Diabetes Mellitus

**DNR** – Do Not Resuscitate

**DOB** – Date of Birth

**DPH** - Department of Public Health

**DPOA/HC** – Durable Power of Attorney/Health Care

**DSG** – Dressing

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**DTR** – Daughter

**DV** – Domestic Violence

**DX or dx** – Diagnosed/Diagnosis

### **E)**

**EDRT** – Elder Death Review Team

**EMT** – Emergency Medical Team

**ENI** - Evaluated Not Investigated

**ESRD/ERD** – End stage Renal disease

**ETOH** – Alcohol

### **F)**

**FA** - Father

**F.A.S.T.** – Financial Abuse Specialist Team

**FD** – Fire Department

**f/f or F2F** – Face to Face

**f/u** – Follow Up

### **G)**

**GDS** – Geriatric Depression Scale

**GI** – Gastrointestinal

**GP** – General Practitioner

**GRDDTR** – Granddaughter

**GRDS** – Grandson

**GSW** – Gun Shot Wound

**GYN** – Gynecology

### **H)**

**HA** – Housing Authority

**HBP** – High Blood Pressure

**HDM** - Home Delivered Meals

**HH** – Home Health

**HI** - Homicidal Ideation

**HIPAA** – Health Insurance Portability and Accountability Act

**HIV** – Human Immune Virus



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**HV** – Home Visit

**H&W** – Health & Welfare

**Hx** – History

### I)

**IADL** – Instrumental Activity of Daily Living

**ID** - Intellectual Disability

**IDDM** – Insulin Dependent Diabetes Mellitus

**IHSS** – In-Home Supportive Services

**ILS/ILP** – Independent Living Services/Program

**IM** – Intramuscular

**INCL** – Include/Including/Inclusive

**INEL** – Ineligible

**INFO** – Information

**IQ**- Intelligence Quotient

**IR** – Incident Report

**I&R** – Information and Referral

**IV** – Intravenous

### L)

**LE**- Law Enforcement

**LPS** – Lanterman, Petris, Short

**LTC** – Long-Term Care

### M)

**MCRT** - Mobile Crisis Response Team

**MCT** – Mobile Crisis Team

**MD** - Medical Doctor

**MDT** – Multi Disciplinary Team

**Meds** – Medications

**MH** – Mental Health

**MI** – Myocardial Infarction

**MMSE** – Mini Mental Status Exam

**MO** – Mother

**MOCA** – Montreal Cognitive Assessment

**MOW** – Meals-on-Wheels

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**MS** – Multiple Sclerosis

**MSSP** – Multi-purpose Senior Services Program

**MVA** – Motor Vehicle Accident

### **N)**

**n/a** – Not Applicable

**NIDDM** – Non-Insulin Dependent Diabetes Mellitus

**NIFFI** – No Initial Face-to-Face Investigation

**NOS** – Not Otherwise Specified

### **O)**

**O2** – Oxygen

**OT** – Occupational Therapy/Occupational Therapist

### **P)**

**PA** – Physician’s Assistant

**p/c** – phone call

**PCP** – Primary Care Provider

**PD** – Police Department

**PERT** – Psychiatric Emergency Response Team

**PG** – Public Guardian

**PH** – Public Health

**PHN** – Public Health Nurse

**POA** – Power of Attorney

**PT** – Physical Therapy/Physical Therapist

**PTSD** – Post Traumatic Stress Disorder

**PUD** – Peptic Ulcer Disease

**PVD** – Peripheral Vascular Disease

### **Q)**

**Q** – Every

**QD** – Everyday

**QH** – Every Hour

**QHS** – Every Night

**QID** – Four times a day

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**QOD** – Every other day

**Quad** – Quadriplegia

### R)

**RC** – Regional Center

**RCF** – Residential Care Facility

**RCH** – Residential Care Home

**RCU** – Restorative Care Unit

**RN** – Registered Nurse

**RO** – Restraining Order

**r/o** – Rule Out

**ROM** – Range of Motion

**RP** – Reporting Party

**Rx** – Prescription

### S)

**SC** – Subcutaneous

**SED** – Severely Emotionally Disturbed

**SI** – Suicidal Ideation

**SIS** - Sister

**SNF** – Skilled Nursing Facility

**SOB** – Shortness of Breath

**SOC** – Share of Cost

**SRO** – Single Room Occupancy (Hotel)

**SSA** – Social Security Administration

**SSI** – Social Security Supplement Income

**SSNR** – Social Security Number

**ST** – Speech Therapy/Speech Therapist

**SUD** - Substance Use Disorder

**SW** – Social Worker

### T)

**TIA** – Transient Ischemic Attack

**TRO** - Temporary Restraining Order

**Thx** – Therapy/Therapist

**Tx** – Treatment

## Adult Protective Services Field Guide

### **U)**

**UHV** - Unannounced Home Visit

**unk** - Unknown

**UTI** - Urinary Tract Infection

### **V)**

**VA** - Veterans Administration

**VNA** - Visiting Nurses Association

**VW** - Victim Witness Program

### **W)**

**W&I Code** - Welfare & Institutions Code

**w/** - With

**w/out** - Without

### **Y)**

**yo** - Year Old

**Assignment 1.4** (1 of 2 pages)

**Types of Abuse**

**Identify the abuse:**

In some cases, the abuse you are sent out to investigate may not be the abuse you find, or may not be the only abuse you find. Read the following short case scenarios. Then, using the definitions in the [National Voluntary Consensus Guidelines for State Adult Protective Services Systems](#), determine what type(s) of abuse you would be investigating.

1) Virginia Booth, age 62, has diabetes and lives with a personality disorder. She would walk very unsteadily in her mobile home park and yell at children, threatening them. She dumped trash on her neighbor's property. She had 10 cats and no litter boxes. The home smelled terrible and was in disrepair. Virginia was very resistant to the APS worker's intervention but the worker listened to her complaints and tried to address them. Virginia felt that the neighbors were plotting against her and the neighborhood kids were harassing and making fun of her. Virginia also said that park manager has raised her rent to try and get her to move. After further discussion, Virginia indicated that she recently began watching a television preacher and, based on her understanding of his message, she threw away all her medications.

2) APS received a report that Marcus Lorenz, age 82, had been hospitalized after being beaten by his son and caregiver, David Lorenz. When APS arrived at the hospital, Marcus' doctor stated that Marcus has a severe head trauma, bruises over his upper body from being kicked, as well as malnutrition. Marcus told APS that David beat him when he refused to give David permission to use his car. According to the police, David and the car are still missing.

3) Marcia Evan, age 72, was referred to APS because she is facing eviction from her apartment. During the initial interview, Marcia stated that she had been doing ok with money until her son moved in with her. Since she had been paying his living expenses as well as her own for the last five months, she is now behind on all her bills. Besides worrying about her bills and her eviction, Marcia is worried about her son. He has disappeared. She doesn't know why he left and whether he is ok. And, since he was doing the grocery shopping and taking her to the doctor, Marcia is concerned about how she will manage now.

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4) Shelly Albertson, age 76, is confined to her bed due to suffering from a stroke. She is nonverbal, and her domestic partner, Catherine, is her paid (by the state) caregiver. Her doctor reported to APS that he believes that she is not getting adequate care. During the first visit, APS found that Shelly had decubitus ulcers on her tailbone and bruises on her inner thighs. APS offered to arrange for additional care for Shelly, but Catherine refused stating that she need all the hours she is getting in order to pay the household bills.

Click [here](#) to return to Knowledge Area 1-Overview of APS

**Assignment 1.5** (1 of 2 pages)

**Define Autonomy, Capacity and Incapacity**

*ote: By discussing these issues up front, supervisors can get a sense of the new worker's attitude towards their role in APS. Many new workers are Nzealous in their desire/need to protect their clients, even if the client has capacity. Setting the tone for respecting the client's autonomy, even if the decisions are not comfortable for the worker, is an ongoing process.*

**Questions for Discussion**

- 1. What does autonomy mean to you? How would you define it?**
- 2. Have you ever made a bad decision? What happened as a result? Did anyone interfere with that decision? How did it make you feel?**
- 3. Under what circumstances should APS intervene when we see a bad decision being made?**
- 4. How do we know when our clients have the capacity to make their own decisions?**
- 5. There are times when the ability to make a decision may vary. Can you tell me what could influence that ability?**
- 6. How would you determine if your client has the capacity to make decisions?**

**Thoughts on Capacity:** *You may want to share these or share your own examples.*

- All clients have strengths and weaknesses. A professional determination is characterized by how well it addresses both the capacities and the incapacities of the client.
- Age, eccentricity, poverty, or medical diagnosis alone do not justify finding incapacity.
- APS workers have an ethical responsibility to protect the client's autonomy and self-determination by making certain that general incapacity is not assumed.
- Determining incapacity requires comprehensive and systematic assessment: the ability of the professional to view the client's whole life in context, to evaluate the skills needed to sustain that way of life, and to identify accurately authentic incapacities is the key to determinations that prove humane in the long-term.

Click [here](#) to return to Knowledge Area 1-Overview of APS



**Assignment 6.2 Commonly Prescribed Psychotropic Medications**

<b>Antipsychotics</b> <i>(used in the treatment of schizophrenia and mania)</i>	<b>Anti-depressants</b>	<b>Anti-obsessive Agents</b>
<b>Typical Antipsychotics</b>	<b>Tricyclics</b>	
Haldol (haloperidol)	*Anafranil (clomipramine)	Anafranil (clomipramine)
Loxitane (loxapine)	Asendin (amoxapine)	Luvox (fluvoxamine)
Mellaril (thioridazine)	Elavil (amitriptyline)	Paxil (paroxetine)
Moban (molindone)	Norpramin (desipramine)	Prozac (fluoxetine)
Navane (thiothixene)	Pamelor (nortriptyline)	Zoloft (sertraline)
Prolixin (fluphenazine)	Sinequan (doxepin)	
Serentil (mesoridazine)	Surmontil (trimipramine)	<b>Anti-anxiety Agents</b>
Stelazine (trifluoperazine)	Tofranil (imipramine)	Ativan (lorazepam)
Thorazine (chlorpromazine)	Vivactil (protriptyline)	BuSpar (buspirone)
Trilafon (perphenazine)		Centrax (prazepam)
	<b>SSRIs</b>	*Inderal (propranolol)
<b>Atypical Antipsychotics</b>	Celexa (citalopram)	*Klonopin (clonazepam)
Abilify (aripiprazole)	Lexapro (escitalopram)	Lexapro (escitalopram)
Clozaril (clozapine)	*Luvox (fluvoxamine)	Librium (chlordiazepoxide)
Geodon (ziprasidone)	Paxil (paroxetine)	Serax (oxazepam)
Risperdal (risperidone)	Prozac (fluoxetine)	*Tenormin (atenolol)
Seroquel (quetiapine)	Zoloft (sertraline)	Tranxene (clorazepate)
Zyprexa (olanzapine)		Valium (diazepam)
Paliperidone (Invega)	<b>MAOIs</b>	Xanax (alprazolam)
Lurasidone (Latuda)		Hydroxyzine (Vistaril)
<b>Mood Stabilizers</b> <i>(used in the treatment of bipolar disorder)</i>	Nardil (phenelzine) Parnate (tranylcypromine)	*Antidepressants, especially SSRIs, are also used in the treatment of anxiety.
Depakene (valproic acid)		
Depakote	<b>Others</b>	<b>Stimulants</b>
Eskalith	Desyrel (trazadone)	<b>(used in the</b>
Lithobid (lithium)	Effexor (venlafaxine)	<b>treatment of ADHD)</b>
Lithonate	Remeron (mirtazapine)	Adderall (amphetamine
Lithotabs	Serzone (nefazodone)	and dextroamphetamine)
*Lamictal (lamotrigine)	Wellbutrin (bupropion)	Dexedrine
*Neurontin (gabapentin)	Duloxetine (Cymbalta)	(dextroamphetamine)
*Tegretol (carbamazepine)	Desvenlafaxine (Pristiq)	Ritalin (methylphenidate)
*Topamax (topiramate)	<b>Anti-Panic Agents</b>	*Antidepressants with
	Klonopin (clonazepam)	stimulant properties,
	Paxil (paroxetine)	such as Norpramin and
	Xanax (alprazolam)	Wellbutrin, are also used
	Zoloft (sertraline)	in the treatment of ADH
	*Antidepressants are also used in treatment of panic disorder.	

**Assignment 8.3** (1 of 5 pages)

**ABUSER Justifications and Defenses<sup>1</sup>**

**APS CONSIDERATIONS**

<b>FORM OF ABUSE</b>	<b>Justification / Defense</b>	<b>Investigation Considerations</b>
<b>Physical</b>	"She fell."	<ul style="list-style-type: none"> <li>• Does the medical or physical evidence match suspect's/client's/witness' description of events?</li> </ul>
	"He's just clumsy."	<ul style="list-style-type: none"> <li>• Does the medical or physical evidence match suspect's/client's/witness' description of events?</li> </ul>
	"I was trying to help."	<ul style="list-style-type: none"> <li>• Does the medical or physical evidence match suspect's/client's/witness' description of events?</li> </ul>
	"She bruises easily."	<ul style="list-style-type: none"> <li>• Does the medical or physical evidence match suspect's/client's/witness' description of events?</li> <li>• Is the client taking medications that can cause a person to bruise easily?</li> </ul>
	"It was an accident."	<ul style="list-style-type: none"> <li>• Does the medical or physical evidence match suspect's/client's/witness' description of events?</li> </ul>

<sup>1</sup> Excerpts taken from Barron, T. (1998) *Financial Exploitation of Infirm Adults: A Prosecutor's Perspective*. Violence Against the Elderly and Disabled. 1(4), 53 – 64.

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	<p>"He has Alzheimer's disease. You can't believe what he says."</p>	<ul style="list-style-type: none"> <li>• Do the medical history and/or mental health experts support this assertion?</li> <li>• What are your observations of client/suspect/witness at different periods of time?</li> </ul>
	<p>"I was defending myself."</p>	<ul style="list-style-type: none"> <li>• Is there sign of a defensive injury?</li> <li>• Who is the predominant (or primary) physical aggressor?</li> </ul>
<p><b>Neglect</b></p>	<p>"She has always lived like this. She's not a good housekeeper."</p>	<ul style="list-style-type: none"> <li>• Are there sufficient resources to provide for the client's needs?</li> <li>• Has the client's capacity changed over time?</li> <li>• Is there a caregiver?</li> <li>• Do friends or family members support this statement?</li> </ul>

	<p>"I'm doing the best I can. Taking care of him is very difficult."</p>	<ul style="list-style-type: none"> <li>• Does the client have sufficient capacity to make informed decisions about care, including refusing to accept care or treatment?</li> <li>• Does the client have a history of refusing help?</li> <li>• Does the suspect have a duty to provide care?</li> <li>• Is the suspect receiving payment to provide care?</li> <li>• Has the caregiver been instructed on the client's condition, care needs and how to provide care?</li> <li>• Does caregiver have any special training in providing care?</li> <li>• Are the client's care needs obvious and would be apparent to the average person?</li> </ul>
	<p>"He doesn't want medication /medical treatment. I'm honoring his wishes."</p>	<ul style="list-style-type: none"> <li>• Is there documentation of person's wishes (for example, a do not resituate order [DNR])?</li> <li>• What is the client's capacity, as documented by a trained professional?</li> <li>• Are there historical statements of intent or the desires of the client?</li> </ul>
	<p>"She refused to eat."</p>	<ul style="list-style-type: none"> <li>• What is the health history of the person's condition?</li> </ul>

	<p>"I didn't know how sick she was or what she needed."</p>	<ul style="list-style-type: none"> <li>• Is there a medical history indicating how often client was taken to a doctor and what was told to the caregiver about the client's condition?</li> </ul>
	<p>"I'm just doing what they want."</p>	<ul style="list-style-type: none"> <li>• Do wills or advanced directives describing what the client wants exist?</li> </ul>
<p><b>Sexual</b></p>	<p>"She wants to have sex with me." or "She likes watching pornographic movies with me." (Suspect is trying to show consent)</p>	<ul style="list-style-type: none"> <li>• If the client has capacity, what is the client's account of what happened?</li> <li>• If the client does not have capacity, the client cannot consent.</li> </ul>
	<p>"She's my wife/girlfriend."</p>	<ul style="list-style-type: none"> <li>• If the client has capacity, what is the client's account of what happened?</li> <li>• If the client does not have capacity, the client cannot consent.</li> </ul>

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	"I was just cleaning or bathing him. This is not sexual abuse."	<ul style="list-style-type: none"> <li>• What does a health care provider say about whether appropriate caregiving techniques were being used?</li> </ul>
	"She came on to me."	<ul style="list-style-type: none"> <li>• If the client has capacity, what is the client's account of what happened?</li> <li>• If the client does not have capacity, the client cannot consent.</li> </ul>
	"We're consenting adults."	<ul style="list-style-type: none"> <li>• If the client has capacity, what is the client's account of what happened?</li> <li>• If the client does not have capacity, the client cannot consent.</li> </ul>
	"She acted like she liked it."	<ul style="list-style-type: none"> <li>• If the client has capacity, what is the client's account of what happened?</li> <li>• If the client does not have capacity, the client cannot consent.</li> </ul>
	"She's my wife. I have the right."	<ul style="list-style-type: none"> <li>• Check state marital rape laws. If the client has capacity, what is the client's account of what happened?</li> <li>• If the client does not have capacity, the client cannot consent.</li> </ul>
<b>Financial Exploitation</b>	Loan	<ul style="list-style-type: none"> <li>• What is the capacity of lender?</li> <li>• Is there written proof of the loan including the amount and period of loan and were other loans made?</li> <li>• What are the terms of repayment and were any repayments made?</li> </ul>

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	Gift for self or children	<ul style="list-style-type: none"> <li>• What is the capacity of the donor?</li> <li>• What is the value of the gift?</li> <li>• What is relationship between donor &amp; client?</li> <li>• Is there evidence of donor's intent to make a gift?</li> <li>• Why was a gift made? (Any promises or other inducements?)</li> </ul>
	Services Provided	<ul style="list-style-type: none"> <li>• What is the capacity of the person seeking the services?</li> <li>• What were the services; were they needed; how often were services provided; how well performed; were supplies provided?</li> <li>• What is the value of services vs. amount paid for them?</li> </ul>
	Permission	<ul style="list-style-type: none"> <li>• What is the capacity of the client?</li> <li>• Is there evidence of actual permission?</li> <li>• Were there promises or other inducements to get permission?</li> <li>• Who benefited?</li> <li>• How often was permission used?</li> <li>• What is the value of items obtained?</li> <li>• Did client understand what permission was used to do?</li> </ul>
	Quid Pro Quo ("She lets me live with her in exchange for helping with errands.")	<ul style="list-style-type: none"> <li>• What is the capacity of the client?</li> <li>• Was the marriage reasonable given the relationship between the parties?</li> <li>• Was the suspect legally able to marry?</li> <li>• Are there any suspect misrepresentations?</li> </ul>

## Adult Protective Services Field Guide

	Favor ("She freely gave me use of her car as a favor to me.")	<ul style="list-style-type: none"> <li>• What is the capacity of the client?</li> <li>• Who benefits from the favor; what did client receive in return; is the benefit reasonable?</li> <li>• How does it fit prior financial planning and actions of the client?</li> <li>• Did suspect receive payment to provide care?</li> <li>• What is client's relationship to business or person?</li> </ul>
	Lack of Knowledge ("But I do not know her PIN")	<ul style="list-style-type: none"> <li>• What is the contrary evidence?</li> <li>• Did the suspect have access to information?</li> <li>• Were there other acts for same goal? (e.g., forged her signature to get an ATM card in client's name)</li> </ul>
	Legal authority	<ul style="list-style-type: none"> <li>• What is the capacity of the client?</li> <li>• Is there legal authority in writing?</li> <li>• What does the legal authority cover and expressed or implied limitations?</li> </ul>
	Client has a mental illness	<ul style="list-style-type: none"> <li>• Is there a medical opinion of client's mental health?</li> <li>• Are there statements from friends and family about client's behavior prior to and after suspect came into life?</li> <li>• Does the client take any medications?</li> <li>• What was the client's behavior around time of questioned events? Is this conduct consistent with earlier times?</li> </ul>
	I'm the real victim	<ul style="list-style-type: none"> <li>• Who is benefiting financially?</li> </ul>



	<p>“We’re in love” married/in a relationship”:                  “We’re family”;                  “She’s like a mother to me; therefore, we share resources.”</p>	<ul style="list-style-type: none"> <li>• Who is benefiting financially?</li> <li>• What is true nature of relationship?</li> <li>• Are any cultural norms relevant for consideration?</li> <li>• Does suspect have other relationships or marriage licenses?</li> <li>• Does suspect have other income or debts?</li> <li>• Are client’s basic needs met?</li> </ul>
	<p>Purchase made as part of care</p>	<ul style="list-style-type: none"> <li>• Is there evidence of purchase being used to provide care?</li> <li>• Is the purchase necessary for care?</li> </ul>

Click [here](#) to return to Knowledge Area 8: Dynamics of Abuse Relationships

**Assignment 9.3** (1 of 3 pages)

**Transforming Leading into Non-Leading Questions**

**Instructions:** Please rewrite each question on the left so that it is no longer a leading question.

LEADING	NON-LEADING
1. Does your son cook your dinner?	
2. This picture must be of your care provider.	
3. I understand that you are having a problem with your son.	
4. Does your daughter use your credit cards?	
5. Did your grandson remember to give you your medications today?	

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6. Your caregiver didn't take you to the doctor, did she?	
7. Did your husband take away your car keys?	
8. Did he take you to his lawyer's office?	
9. Does she lock you in your bedroom every night?	
10. That must have made you very angry.	
11. Was watching pornography your son's idea?	
12. Isn't it true that you knew she couldn't repay you?	
13. How many times did he strike you?	

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14. Did she force you to write the checks?	
15. Did he tell you not to tell anyone?	

*Adapted with permission from Paul Needham*

Click [here](#) to return to Knowledge Area 9-Communication and Interviewing

**Assignment 13.4** (1 page)

**Identifying Medical Emergencies**

According to the American College of Emergency Physicians, the following are warning signs of a medical emergency:

- [Bleeding](#) that will not stop
- Breathing problems ([difficulty breathing](#), [shortness of breath](#))
- [Change in mental status](#) (such as unusual behavior, [confusion](#), difficulty arousing)
- [Chest pain](#)
- Choking
- Coughing up or [vomiting blood](#)
- [Fainting](#) or [loss of consciousness](#)
- Feeling of committing suicide or murder
- Head or spine injury
- Severe or persistent [vomiting](#)
- Sudden injury due to a motor vehicle accident, burns or smoke inhalation, near drowning, deep or large wound, etc.
- Sudden, severe pain anywhere in the body
- Sudden [dizziness](#), [weakness](#), or change in vision
- Swallowing a poisonous substance
- Upper [abdominal pain](#) or pressure

*Adapted from:*

<http://www.nlm.nih.gov/medlineplus/ency/article/001927.htm>

Click [here](#) to return to Knowledge Area 13: Physical Caregiver Abuse

**Assignment 15.2** (1 page)

**Writing Exercise:**

Demonstrate the use of clear, concise, and objective language.

Read the following statements and rewrite them so they are clear, factual, objective, and concise, adding information to support the observations.

1. Client was inappropriately dressed.
2. Daughter was very controlling and made the client afraid to speak.
3. Client was depressed and cried a lot.
4. This family is enmeshed and will not respond to therapy.
5. Son is mooching off his mother. He hasn't worked in years.
6. Caregiver has issues and treats the client very poorly.

Click [here](#) to return to Knowledge Area 15: APS Case Documentation and Report Writing

**Assignment 15.4** (1 of 3 pages)

**Experiential Activity:**

Discuss the importance of accurate recall and identify at least 3 memory improvement techniques. This activity is best done as part of a staff meeting to get feedback and sharing from a variety of individuals. If done with a large group, you may use the activity from the training module.

Instructions:

- Before the meeting select 15-20 small items that can be found in an APS household. These could include a prescription bottle (with name and dose written on it), an over the counter drug, a knife, a pet (stuffed, of course), an insect (plastic cockroach?), stuffed mouse, doilies, broken eyeglasses, a piece of rotten/fresh food, playing cards, hearing aide, knitting needles, matches, dirty clothing, a plant, social security check, cash, a beer can, etc.- just make sure there are a variety and some are significant and should be noticed. Make a list of all the items for your reference.
- Put all the items in a blanket or sheet, so they cannot be seen by the participants and put the closed blanket on a table in the front of the room. Ask participants to come around the table. Tell participants that when they go into a client's home, there will be a lot to notice other than the client. The cues in the environment may give them information which will help with their assessment. It is important for them to notice and remember what they observed.
- Tell them that in the blanket are \_\_\_\_ number of items that they might see in a client's home. Tell them you will open the blanket and give them one minute (no more) to observe the items in the blanket. After one minute, quickly close up the blanket and ask participants to take their seats. Then ask them to list everything they saw. Give them a few minutes.
- Ask if anyone got all \_\_\_\_ (number) correct? Then ask them what they found and write all items on flip chart. Check against your master list to see if anything was missing. Discuss reasons for missing things, ask them which items stood out for them, comment how different items may have different meaning to different people.

## **Assignment 15.4-con't**

### General Guidelines to Improve Memory

In addition to exercising your brain, there are some basic things you can do to improve your ability to retain and retrieve memories:

1. Pay attention. You can't remember something if you never learned it, and you can't learn something — that is, encode it into your brain — if you don't pay enough attention to it. It takes about eight seconds of intent focus to process a piece of information through your hippocampus and into the appropriate memory center. So, no multitasking when you need to concentrate! If you distract easily, try to receive information in a quiet place where you won't be interrupted.
2. Tailor information acquisition to your learning style. Most people are visual learners; they learn best by reading or otherwise seeing what it is they have to know. But some are auditory learners who learn better by listening. They might benefit by recording information they need and listening to it until they remember it.
3. Involve as many senses as possible. Even if you're a visual learner, read out loud what you want to remember. (If you can recite it rhythmically, even better.) Try to relate information to colors, textures, smells and tastes. The physical act of rewriting information can help imprint it onto your brain.
4. Relate information to what you already know. Connect new data to information you already remember, whether it's new material that builds on previous knowledge, or something as simple as an address of someone who lives on a street where you already know someone.
5. Organize information. Write things down in address books and datebooks and on calendars; take notes on more complex material and reorganize the



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notes into categories later. Use both words and pictures in learning information.

6. Understand and be able to interpret complex material. For more complex material, focus on understanding basic ideas rather than memorizing isolated details. Be able to explain it to someone else in your own words.

7. Rehearse information frequently and “over-learn”. Review what you’ve learned the same day you learn it, and at intervals thereafter. What researchers call “spaced rehearsal” is more effective than “cramming.” If you’re able to “over-learn” information so that recalling it becomes second nature, so much the better.

8. Be motivated and keep a positive attitude. Tell yourself that you want to learn what you need to remember, and that you can learn and remember it. Telling yourself you have a bad memory actually hampers the ability of your brain to remember, while positive mental feedback sets up an expectation of success.

**Assignment 15.5** (1 page)

**Case Consultation:**

Discuss confidentiality as it affects documentation relating to clients, law enforcement, and other professionals

Distribute and discuss your APS policy regarding confidentiality.

When discussing their documentation on cases in individual supervision, you may use the following guidelines to make sure that workers understand the confidentiality rules

- Check the wording of the documentation for statements that may have been exaggerated or minimized. Explore what worker wanted to achieve by distorting the documentation... was it to protect the client at any cost, was it to protect the worker's liability. Discuss the danger of biased documentation. Ask how that type of information may come back to haunt them.
- Ask if that documentation will be shared with anyone – who is allowed access to it and why.
- Ask who may need to scrutinize this documentation... and share any concerns about the way the material has been organized or documented, asking worker what could be improved.
- Explain that some of the complaints about APS include lack of sharing information on the outcome of an investigation. Ask how they would explain this to a referral source- a family member, neighbor, attorney, another agency.

Click [here](#) to return to Knowledge Area 15: APS Case Documentation and Report Writing

**Assignment 17.4** (1 of 3 pages)

**Factors Affecting Decisional Impairment in APS Clients**

<b>Chronic Pain</b>	May become the focus of attention and inhibit the ability to listen.
<b>Dehydration</b>	Can cause altered mental status, agitation or lethargy, lightheadedness and confusion. Speech difficulty, sunken eyes, weakness and lethargy are often attributed to other conditions. Chronic and acute-medical conditions, malnutrition and severe hot and humid weather can all cause dehydration.
<b>Delirium</b>	An acute, <u>reversible</u> disorder. It occurs suddenly, over a short period of time and fluctuates during the day. It may be caused by existing cognitive impairment, severe physical illness, stroke, Parkinson’s disease or dehydration, and can be aggravated by acute pain. Symptoms include changes in the way the client uses information and makes decisions, inability to focus, and uncharacteristic behavior. The client reports feeling “mixed up.”
<b>Dementia</b>	Involves a significant, persistent decline in functioning over a period of time. Depending on the type of dementia, the client may lose memory as well as some or all of cognitive functions such as language, motor activities, ability to recognize familiar stimuli, and/or executive functioning. Accurate diagnosis requires a detailed history as well as physical and neurological examinations. Some dementias are reversible.
<b>Depression</b>	The client reports feeling sadness, emptiness, detachment, loss of interest in usual activities, sleep disturbances, and/or weight loss. Speech is slowed, diminished or repetitive. Client may show anxiety or panic. Condition persists for more than two weeks and is not related to situational loss.

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<b>Disease</b>	Thyroid, diabetes, cancer, Parkinson's, heart disease, stroke and AIDS may cause diminished capacity as the diseases progress.
<b>Grief</b>	Intense grief reaction may result in temporary confusion, dependency, exhaustion and inability to make decisions.
<b>Hearing/Vision Loss</b>	Can mimic or exacerbate cognitive impairment. Communication difficulties due to sensory or physical impairments are often mistaken for confusion.
<b>Low Blood Pressure</b>	Can be due to medication error, causing dizziness, weakness and falling which could result in head injury.
<b>Low IQ</b>	May affect client's understanding of choices, risks and benefits.
<b>Malnutrition</b>	Protein energy malnutrition and low levels of vitamin D lead to weakness, diminished ability to provide self-care and ultimately to decreased cognition.
<b>Medication Mismanagement</b>	Drug interactions and adverse reactions are common and can be serious. May be due to client's visual or cognitive impairment, inability to afford prescriptions, or functional illiteracy. Medication misuse frequently causes mental impairment. Antibiotics and cardiovascular drugs are the most frequent causes of adverse effects.
<b>Physically Ill</b>	May result in electrolyte imbalances that cause confusion and prevent rational decision making.
<b>Psychosis</b>	Difficult to detect. Symptoms include delusions, hallucination, agitation.
<b>Substance Abuse</b>	Older adults become inebriated with lower levels of alcohol consumption—leads to malnutrition and alcohol dementia. Also,

## Adult Protective Services Field Guide

	alcohol intake in conjunction with certain medications can have a greater impact on older individuals than younger individuals.
<b>Stress/Anxiety</b>	Anxiety disorder is more prevalent than depression among older adults. Older women are more at risk than men. May be the result of family violence or Post Traumatic Stress Disorder.
<b>Traumatic Brain Injury</b>	May be the result of physical abuse or a fall. Falls are the most common injury in older adults due to weakness, environmental hazards, dizziness, alcohol, medications or stroke. A client with sudden changes in mental status after a fall may have subdural hematoma.
<b>Urinary Tract Infection</b>	Most common infection in older adults. Can present as acute change in cognitive status. May result in delirium.

Source: Otto.2007

Click [here](#) to return to  
**Knowledge Area 17: Assessing  
Client Capacity**

**Assignment 17.5** (1 page)

**Case Consultation Methods**

When the new worker has questions about the capacity of an APS client, you may use these questions as a guideline:

**1. Can the client understand relevant information?**

- *Please give me an example of "relevant information".*

**2. What is the quality of the client's thinking process?**

- *What is an example of how you would assess the "quality of client's thinking process"?*

**3. Is the client able to demonstrate and communicate a choice?**

- *Give an example of a client who demonstrates and communicates a choice.*

**4. Does the client appreciate the nature of his/her own situation?**

- *What questions could you ask to determine if the client appreciates the nature of his/her own situation?*

Click [here](#) to return to **Knowledge Area 17: Assessing Client Capacity**

**Assignment 17. 6** (1 page)

**On the Job Training:**

Explain to the worker that they do not perform a total capacity assessment, but they get enough information between the interview questions and from the agency tool to know when it is appropriate to take the next step.

For this OJT, the worker will go out on a real case where there is an issue of capacity, and interview the client, using the tool the agency requires. After the visit, spend some time processing it with the worker and then ask for feedback on:

- What was your experience like using this tool?
- What information did it give you?
- What information do you still need?
- How will you get that information?
- What is your next step?

Click [here](#) to return to Knowledge Area 17: Assessing Client Capacity

**Assignment 18.2** (1 of 2 pages)

**Risk at Intake**

Have new workers receive an intake call. Ask them to identify possible risk factors from the information provided to them by the referring party. Ask them the following questions and have them explain/ justify their answers.

- **Does the situation meet the criteria of a client being at risk?** *(This requires their knowledge of the legal guidelines of your APS statute/program).*
  
- **Do you need to go out immediately or can you wait until after you have handled more urgent cases?** *(This requires their knowledge of APS policy as well as awareness of what constitutes immediate risk)*
  
- **Are elders/dependent adults in immediate danger?** *(This requires them to ask specific questions about what the referring party observed as well as asking about support systems, medical issues, psychiatric history, condition of the home, etc.)*
  
- **Why are they calling now? Did something just happen?** *(This may require them getting some history of previous calls, cases, relationship issues)*



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- **Does the client understand what's going on?** *(This requires them to ascertain details of what was observed, the credibility/professional judgment of the referring party)*
- **Is the client capable of making decisions?** *(Who says so and how do they know? What has been tried in the past?)*
- **What's at risk** (life, health, property)? *(This will help them decide what kind of intervention may be needed and what other disciplines or collaterals need to be contacted)*
- **What are the consequences of delay?** *(Is there someone available to supervise? If a perpetrator is arrested, can the client manage alone?)*
- **Are emergency or protective measures and services are needed?** *(This requires them know when it is appropriate to call law enforcement or mental health screeners)*

Click [here](#) to return to Knowledge Area 18: Risk Assessment



**Assignment 21.3** (1 of 2 pages)

**CASE EXAMPLE**

Lani is an 83-year-old widow with physical impairments whose only living relatives are an adult grandson, granddaughter and ex-daughter-in-law. The grandson moved in with Lani after Lani husband's death. Lani later asked the grandson to leave because he contributed nothing to the household, was allegedly abusing drugs, and wrecked a car she bought for him. He had also become verbally and physically abusive. The grandson refused to move out.

The first report of the grandson's abusive behavior came to APS from the ex-daughter-in-law (i.e. his mother). The second report came from the domestic violence specialist referred by APS after the first report. Per the domestic violence specialist, Lani disclosed her desire for grandson to move out, but declined to participate in mental health services. APS confirmed physical and psychological abuse by the grandson. During the course of the investigation, the APS worker also discovered concerns about financial abuse by the grandson, granddaughter and ex-daughter-in-law, and advised Lani to take out restraining orders on all three of her relatives. Lani refused to request a restraining order against her relatives, as she believed it was a family matter. Lani sought support through her church. Her minister did a home visit. Since Lani had last attended church (6 months ago), the minister noted that she had lost weight, wasn't eating, seemed confused, and was recovering from pneumonia. He also noted that her arthritis was making it more difficult to ambulate and to complete routine household chores such as shopping, cleaning and cooking. He spoke to the grandson. The visit from her minister triggered another argument with her grandson. After the minister left, the grandson slapped Lani so forcefully that she fell to the ground. The grandson also broke Lani's cell phone, and Lani did not have a landline. Lani was taken to the hospital and treated for her injuries. The grandson claimed that Lani was demented and had attacked him.

Discussion questions:

1. What are Lani's strengths?
2. What are your hypotheses about what might be happening with Lani/what she might need?

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3. Name some of the stakeholders/Multidisciplinary team (MDT) partners who might become involved in this case, and benefits of involving those agencies/partners.
4. What might be sources of conflict in the ways that various MDT members might view this case?
5. What might be some areas of assessment/need that MDT members might agree on?

Click [here](#) to return to Knowledge Area 21 – Collaboration in APS Work

**Assignment 23.3** (1 of 2 pages)

**Identify Factors and Conditions Which Indicate Appropriateness/  
Inappropriateness of Closing an APS case**

Provide your agency's APS case termination policy to new worker for review before you meet with her/him. Then, ask:

- According to the policy, what is the goal of APS intervention?

- According to policy, what are the circumstances under which a case can be closed?

- According to the policy, what is required of worker in order to close a case?  
(*specific documentation, reports, etc.*)

### Assignment 23.3-cont

#### **Discussion Questions: Identify factors and conditions which indicate appropriateness/inappropriateness of closing an APS case**

New workers to APS may have varied backgrounds. Some may have been in the social work field for many years, others may be fresh out of school, others may have come from a completely different field. Although case termination is discussed in most social work schools, APS termination is more complex and involves more than just the emotional piece that is normally addressed. These questions will start new workers thinking about the issues around terminating APS clients and well as some of the ethical principles.

- What are the most common reasons for terminating a case in APS? (*Risk ameliorated or reduced, unable to locate, client refused services, client referred to another agency, client placed, client deceased*)

- What do you see as some of the challenges facing workers when deciding whether to terminate a case? (*doing too much, not doing enough, dealing with the community or family response, something bad happening to the client right after the case is closed, newspaper articles about what APS did or didn't do..*)
- What are some of the ethical issues involved with closing an APS case? (*share NASW ethics handout and use for discussion if desired*)
- How do you know if you have done enough, covered all your bases? (*made a thorough risk assessment, made sure the client understood all her options, contacted all appropriate collaterals, made sure that worker actions were not a result of personal issues..*)

**Assignment 23.4** (1 of 3 pages)

**Case Consultation Methods:**

**Explain how aspects of the helping relationship affect the outcome of the case at termination**

Using a new case, help worker connect how the establishment of a helping relationship can help them in the successful termination of the case.

- Discuss the following stages of the helping relationship as it pertains to their particular case situation. Have there been challenges? What has the worker done to address the challenges? Alternately you can go through these stages at a unit meeting and let coworkers listen to challenges and make suggestions.
  - **Help clients to clarify the key issues calling for change.** *Challenges may include: client mental status, client not seeing a problem or a need for change, client resistance to agency intervention, client fear or shame regarding actions of a caregiver/alleged perpetrator.*
  - **Help clients determine outcomes.** *Challenges may include: how do I get an unwilling client (due to mental health, cognitive impairment or other reason) take part in the process? My goals and the client's goals are not the same.*
  - **Help clients develop strategies for accomplishing goals.** *(Challenges may include: client doesn't see a way out due to depression or hopelessness or loyalty to alleged perpetrator, strategies are sabotaged, resources are limited or non-existent, there is not enough time to build a relationship because caseloads are so high and demanding, worker's goal may be different from the client's goal)*
- An important element in case termination is determining whose needs were met. Was the intervention provided primarily to help the worker sleep at night, or to appease the community, or because it was the least restrictive alternative which respected the client's wishes as much as possible? Ask how personal issues may get in the way when deciding when it is appropriate to terminate a case.
- Individually or in a unit meeting, read the worker statements and ask what might be going on with the worker:

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- "That client was so abusive to me. She was never satisfied with what I was offering her. She reminded me of my mother- always critical. I got so tired of going there and accomplishing nothing. This client probably has a personality disorder and there is no treatment for that. The last straw was putting in a home health aide- the client called and yelled at me, saying she didn't want "those people" in her home. She is a racist and nobody will be able to help her."
- "That place was so scary. I thought I would fall through the porch and break my ankle. I have never seen such a disgusting home. And there were at least 10 cats. The smell was awful. I had to take my clothes off as soon as I got home from the visit... there must have been fleas and I got bitten. The client chooses to live this way. This is her lifestyle and I need to respect that. The neighbors may not like it, but I am closing the case."
- "He is such a sweet old man. I seem to be the only one who understands him. I got him meals on wheels, and a home health aide, and a friendly visitor. I used emergency funds to clean up his home. I found furniture for him. I enjoy listening to his stories about the war and about his life. I can't close the case yet. He really needs me and I know that no other worker will take the time to understand him the way I do."
- "This case has been referred 3 times before. The abusive son moves in.. case opened. He is arrested for some infraction, case closed. I tried to get her to file a restraining order. She promises she won't take him back, but she always does. They have such a codependent relationship. Can't she see that he is no good?"

I've had the case opened for a long time, I admit, but it is not worth closing it. The son will be out of jail in 3 months and the client is worried about him. I can't imagine going through all the paperwork again, so I might as well just sit on it and wait."



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Individually or at a unit meeting ask worker how these feelings may surface for clients and workers... ask for examples.

<b>Feeling</b>	<b>Client</b>	<b>Worker</b>
Dependence		
Fear		
Guilt		
Anxiety		
Relief		
Cultural values		
Resistance		

Click [here](#) to return to Knowledge Area 23 - Case Closure

**Assignment 23.5** (1 of 2 pages)

**Case Vignette: Evaluate the Effectiveness of Service Delivery in 3 Key Areas (Risk, Satisfaction and Adherence to Policy)**

In order to ensure that APS intervention is working, we need to find a way to figure out if our work has been successful. It is helpful to look at these 3 factors when we are determining if the desired outcome has been reached. We look at risk/safety issues (is client safer/healthier and how do we know that), quality of life issues (what might be the client's perspective on the outcome) and the legal-ethical- procedural issues (has intervention met those criteria). Share this vignette and ask them to answer the questions.

Henrietta Pulowski, age 62, was referred to APS due to self-neglect. She has multiple sclerosis and a personality disorder. She would walk very unsteadily in her neighborhood and yell at children, threatening them. She dumped trash on her neighbor's property. She had 10 cats and no litter boxes. The house smelled terrible and was in disrepair. It took 3 visits to be able to assess the situation as client refused worker's entry in the beginning. She was very resistant to worker's intervention but worker listened to her complaints and tried to address them. Ms. Pulowski felt that the neighbors were plotting against her and the neighborhood kids were harassing and making fun of her. Ms. Pulowski asked that worker not contact her daughter. Worker felt the need to contact the daughter for more collateral information, since client would not share any information. Daughter was very angry and said she was tired of these complaints. She then called her mother and told her to behave. At worker's next visit, she was denied entry. Ms. Pulowski said worker had betrayed her. She used very abusive language to the worker and told worker that she needed no help and she was fine. Worker contacted the local mental health department and asked them to evaluate Ms. Pulowski's for an involuntary psychiatric hold. The mental health clinician did not find that client met the criteria for a hold. Case was terminated due to refusal of services.

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1. What is the evidence that the client is safer and no longer at risk (or at reduced risk)? *There is no clear evidence. Worker used the mental health evaluation as proof that client was not at risk. There was no evidence that the client had cognitive impairment or critical mental health concerns.*
  
2. What is the evidence that client's self-determination was respected and the least restrictive interventions were taken? *Client's wishes were not respected – the calling of her daughter – perhaps the reasons she didn't want worker to call daughter could have been explored with her. It is unclear if calling the mental health department was a result of concern for client's safety or to cover the worker's decision to terminate.*
  
3. What is the evidence that the case was handled ethically and legally, and agency procedures were followed? *It seems that worker's patience was tested by this type of client and interventions were taken in spite of the client instead of necessarily for her benefit. There are some ethical questions regarding the worker's behavior.*

Click [here](#) to return to Knowledge Area 23: Case Closure

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