JAN
Leading Global Nursing Research   WILEY

Examining nurses' role in Adult Protective Services related to safeguarding older people

Pi-Ju Liu[1] ⓘ | Jessica Andrea Hernandez Chilatra[2] | Amanda Phelan[3]

[1]School of Nursing and Center on Aging and the Life Course, Purdue University, West Lafayette, IN, USA

[2]School of Nursing, National University of Colombia, Bogotá, Colombia

[3]School of Nursing & Midwifery, Trinity College Dublin, Dublin, Ireland

Correspondence
Pi-Ju Liu, School of Nursing, Purdue University, 502 North University Street, West Lafayette, IN 47907, USA.
Email: marianliu@purdue.edu

Funding information
This research did not receive any specific grant funding agencies in the public, commercial or not-for-profit sectors.

Abstract

Aim: To examine the role of Adult Protective Services' (APS's) nurses in helping abused, neglected and exploited older people, this study investigated how nurses' contribution differs from social workers. Though the majority of APS' workforce is staffed by social workers, some programmes also employ nurses.

Design: Secondary data analysis using convergent parallel mixed-method design was conducted.

Methods: Using survey data from the National Adult Protective Services Association, 99 nurses' responses between October 2014 and August 2015 were analysed to examine their agency characteristics, training and qualities, job responsibilities and interprofessional collaboration.

Results: The majority of nurses work with social workers or other professionals using a multidisciplinary team (MDT) approach. Among those carrying a caseload, 69% (49 out of 71) of nurses work in conjunction with social workers. Out of all nurses, 64% (63 out of 99) indicated participation in at least one MDT. While the responsibilities nurses provided were similar to social workers, nurses were also able to provide healthcare related services, in their professional competencies, without referral.

Conclusion: Nurses in APS are in a privileged position to investigate mistreatment and provide/coordinate direct care for victims.

Impact: Not much was known about nurses who directly investigate elder mistreatment and provide services to victims. This study was the first to highlight the nursing workforce in APS, and described the nurses' unique contribution to the field. Nurses functioned as both social workers and healthcare professionals in APS. Since victims of elder mistreatment often suffer from negative physical, psychological and social consequences, having nurses in APS benefits victims to receive and the programmes in providing better care and services.

KEYWORDS
Adult Protective Services, elder abuse, exploitation, mistreatment, multidisciplinary team, neglect, nurse, older people, training, vulnerable adults

1 | INTRODUCTION

The last century has demonstrated a remarkable shift in ageing demographics. Ageing is a feature of almost every country (United Nations, 2020b), with people over 65 years projected to represent 1:6 in the global population in 2050 as opposed to 1:11 in 2019 (United Nations, 2020a). In the United States (US), the Population Reference Bureau (2019) indicates a country population of approximately 52 million older people aged 65 years and older in 2018, representing 16% of the total population. This reflects the global ageing trend with a projected increase to 95 million or 23% of the population by 2060 (Population Reference Bureau, 2019).

Elder abuse is a societal challenge in many countries with the World Health Organization (2020) identifying 1:6 older people have experienced some type of abuse in the last year. As older populations rise globally, so does the potential of elder mistreatment. Consequently, safeguarding older people in the context of prevention and early intervention is a key responsibility of nurses (Phelan, 2018; Winterstein, 2012). In available data from Adult Protective Services (APS) agencies, there is a rising trend in the reporting of elder mistreatment cases, including abuse and self-neglect, with reports accepted for investigation increasing by 15.2 percent from 2016 to 2018 nationwide (Aurelien et al., 2019). Among all mistreatment cases investigated by APS, over 60% substantiated cases involved self-neglect (Aurelien et al., 2018). Studies also have found that about one in 10 Americans aged over 60 have experienced some type of abuse each year, including physical, psychological, sexual abuse, financial exploitation and neglect, with some older people simultaneously experiencing more than one type of abuse (Acierno et al., 2010; Lachs & Pillemer, 2015). However, prevalence figures reflect an underestimation (Phelan, 2020), as many cases are not identified, particularly in the context that such studies do not include older people living with dementia, who are particularly at risk of abuse (Cooper & Livingston, 2020).

The direct experience of elder mistreatment results in a variety of negative outcomes representing a global public health issue (Yunus et al., 2019). It is clear that victims need a multidisciplinary team (MDT) to address the complexity of case management, from elder mistreatment investigation to post-investigation services. This study examined nurses' role in APS related to older people, including how they contribute as autonomous professionals while working in the MDT.

1.1 | Background

1.1.1 | Consequences of elder mistreatment

As elder mistreatment becomes a pervasive social and public health concern, consequences of abuse, neglect, exploitation and self-neglect are devastating. An early study found the risk of death was significantly higher for abused, neglect or self-neglected older

Why is this research or review needed?

- Victims of elder mistreatment often suffer from negative physical and psychological consequences, and nurses' understanding of and response to holistic and person-centre care plays an important role in alleviating elder mistreatment.
- Nurses work with/in Adult Protective Services (APS) to investigate elder mistreatment and provide direct care, but not much is known about their work in safeguarding older people.

What are the key findings?

- The majority of APS nurses work with social workers or other professionals using a multidisciplinary team (MDT) approach.
- Nurses were seen to provide important inputs in negotiating complex cases and facilitated valuable perspectives, based on their unique understanding of older person care. This enhanced the functioning of APS teams, and ultimately, the care provided in such disciplinary collaborations.

How should the findings be used to influence policy/practice/research/education?

- Addressing elder mistreatment cases requires a MDT and nurses play an important role because of their healthcare knowledge and skills.
- APS nurses could benefit from having a supervisory nurse and a senior nurse on staff for consultation.
- Findings not only demonstrated APS nurses' abilities and how they were engaged in the workforce, they also revealed the need to build and expand adult safeguarding programmes beyond the social work model.

people, even after health, cognitive status and depressive symptoms were accounted for (Lachs et al., 1998). Among the various types of abuse investigated, older people experiencing caregiver neglect or financial abuse had the lowest survival rate (Burnett et al., 2016). Self-neglect was also associated a higher mortality rate, especially cancer-related or nutritional and endocrine-related mortality (Dong et al., 2009).

In addition to mortality, evidence also suggests that elder mistreatment is associated with hospitalization and nursing home placement, which can lead to premature death (Dong & Simon, 2013a, 2013b; Yunus et al., 2019). Some physical symptoms were found to be more prevalent among elder abuse victims, such as a higher falls rate, hypertension, pain, activities of daily living and functional impairment, nutritional concerns (such as weight loss, limited food access, lower levels of folate and vitamin D), urinary incontinence

and sensory impairment including hearing and vision (Ernst & Smith, 2011; Fang et al., 2018; Heath et al., 2005; Lachs et al., 1997; Reyes-Ortiz et al., 2018; Smith et al., 2006). Self-neglect was also found to be associated with lower level of physical function, increased rates of hospitalization, longer length of hospital stay, more frequent use of hospice but shorter time between admission and death (Dong, 2017). In addition to these symptoms, self-neglecting older people were also more likely to be reported as having bradycardia and electrolyte abnormalities (Burnett et al., 2006).

Apart from negative medical health outcomes, population-based studies found victims of elder mistreatment had lower levels of global cognitive function, episodic memory, calculation, perceptual speeds and executive functioning (Dong et al., 2011; Wood et al., 2014). Dementia can be prevalent among elder mistreatment victims, especially among those experiencing financial abuse or caregiver neglect (Cooper & Livingston, 2020; Heath et al., 2005). Though we cannot be certain if cognitive impairment is the cause or the consequence of elder mistreatment, one study found the onset of cognitive impairment was associated with new incidents of elder mistreatment among victims (Lachs et al., 1997), while dementia and other psychiatric conditions remain prominent risk factors in Medicare claims related to elder abuse (Mouton et al., 2019). Psychologically, older victims were also more likely to exhibit a higher level of depression and distress (Burnett et al., 2006; Lichtenberg et al., 2013; Luo & Waite, 2011), with financial abuse having a particular impact on mental health (Acierno et al., 2018). Learned helplessness, posttraumatic stress disorder, feelings of shame, anger and fear are also as potential psychological consequences (Park, 2019).

1.1.2 | Nurses' response to elder mistreatment

The physical and mental health vulnerabilities and consequences of elder mistreatment call for the inclusion of healthcare professionals in related assessment and intervention processes (Johnson, 2020). One model of potential application in addressing elder mistreatment is the Hardiker model (Hardiker et al., 1991). Originally developed in the United Kingdom in the context of child safeguarding, the model provides a template for levels of need ranging from universal to more focused services, depending individual child welfare and protection concerns. Level one represents mainstream services for all children; level two provides 'top up' services for children and families with additional needs; level three involves services for children and families with serious or chronic needs which involve state supervision, while level four provides for children with substantial needs who require state support (corporate) in the context of residential care (TÜSLA, 2013).

Applying the model to elder mistreatment, level one is general care services for older people. Level two denotes prevention and early intervention to address elder mistreatment risk factors, while level three represents the level of intervention needed from different service providers to support an older person due to chronic or serious problems. Level four represents the level of intervention needed to safeguard the older person through actions such as guardianship, or nursing home placement due to more permanent disability or mental health problems. Central to any actions is to work in partnership with the older person, supporting their rights, particularly in the context of the right to make a risky decision when decision-making capacity is present (Phelan & Rickard-Clarke, 2020). As the need for additional support increases with concurrent higher levels of intervention, it is likely the case management becomes more complex with a greater impetus on social and healthcare services to work together to address the older person's physical, social and mental health needs.

Since elder mistreatment leads to complex physical and mental health concerns (Yunus et al., 2019), nurses' understanding of and response to holistic and person-centre care plays an important role in alleviating elder mistreatment (Phelan, 2018). All nurses, regardless of setting, have an obligation to report suspected mistreatment of older people to APS. Primary care and acute care nurses are key professionals to detect suspected cases of abuse, since visiting healthcare providers could be the only interaction many isolated victims have with the outside world (Phelan, 2018). Nurses working in home healthcare are in an even more advantageous position to identify elder mistreatment, because direct observation during a home visit when an older person is in his/her home environment is more likely to result in the identification of mistreatment compared with an office visit where self-report measures were relied on (O'Brien et al., 2014). In many states, nurses are mandatory reporters of elder mistreatment, so the identification and referral of elder mistreatment is part of nurses' legal responsibility.

What is less known is that some nurses are also involved in the investigation of alleged elder mistreatment and post-investigation service provision. Of those cases reported to authorities, APS is often the front-line agency responsible for conducting investigation. Currently, APS is the only programme dedicated to addressing the mistreatment of vulnerable adults in the US (Liu & Anetzberger, 2019). Types of abuse investigated vary between jurisdictions, although the majority take on cases of elder abuse and self-neglect. Common types of elder abuse reported include physical, sexual, emotional, financial abuse and neglect. In addition to social workers, nurses work in APS to screen for elder mistreatment and detect vulnerabilities. Even if not working in APS, some nurses provide the coordinated care needed by victims through interprofessional collaboration with social workers (Baker & Heitkemper, 2005).

Nurses are most likely to detect signs of elder mistreatment and be able to provide interventions and preventative services, as Kleba and Falk (2014) argued that nurses are particularly suitable to represent healthcare in elder justice issues, because of their knowledge of the healthcare system and geriatric care. However, only two studies documented the outcomes of nurses working with/in APS. Baker and Heitkemper (2005) described nurses' role on interprofessional teams as consultants who participate in meetings to provide expert opinion, educate team members on pressure ulcers and cognitive disorders, and

provide rapid consultation and follow-up on cases requiring individual attention. In another study, when registered nurse (RN) practitioners worked with master degree-level social workers as a team to investigate and intervene on elder mistreatment, substantiation rates for neglect, financial and physical abuse were lower. Ernst and Smith (2012) explained that nurses focused more on medical and somatic symptoms due to their training in health, which would contribute to the decision-making for cases with healthcare issues, while social workers were trained to focus on social and external factors. Additionally, the nurse–social work teams achieved higher levels of risk reduction, likely because they took on more complex cases.

2 | THE STUDY

2.1 | Aim

Taken together, APS across the US hire nurses to work with/in a MDT to enhance investigations of elder mistreatment. However, after conducting a comprehensive literature search, we did not find enough literature to explain what role these APS nurses play in the agency. While we know community nurses play a key role in the identification, management and prevention of self-neglect and elder abuse (Band-Winterstein, 2018; Day & McCarthy, 2015; Day et al., 2015; Johnson, 2015; Mauk, 2011; Phelan, 2010), and nurses make unique contributions to interprofessional collaborative efforts to combat elder mistreatment (Capezuti, 2011; Erlingsson et al., 2011; Hirst et al., 2016; Kleba & Falk, 2014; Meeks-Sjostrom, 2013; Mont et al., 2016; Phelan, 2018; Pickering et al., 2016; Sullivan, 2015; Winterstein, 2012), there is scant focus on nurses working with/in APS to investigate and substantiate mistreatment beyond being mandatory reporters in healthcare. Therefore, this study aimed to analyse a national survey with APS nurses to examine aspects of their adult safeguarding role.

2.2 | Design

Secondary data analysis using convergent parallel mixed-method design (Creswell & Clark, 2018) was conducted using the National Adult Protective Services Association's (NAPSA) survey data. Quantitative and qualitative data were collected through the survey, analysed independently and the results interpreted together. In October 2019, the data were transferred to Purdue University.

2.3 | Sample/Participants

Once NAPSA launched the survey to learn more about nurses' role in APS in October 2014, state APS offices were contacted via email about the survey and asked to distribute the survey to nurses working in or with APS. This snowball sampling method was adopted, since it was unknown how many and where APS nurses worked. Respondents

TABLE 1 Number of respondent by state

	Frequency	Per cent
California	22	22.22
Delaware	1	1.01
Florida	14	14.14
Hawaii	7	7.07
Kentucky	3	3.03
Maryland	11	11.11
Massachusetts	2	2.02
Nevada	1	1.01
New Hampshire	1	1.01
New Jersey	4	4.04
New York	15	15.15
North Carolina	3	3.03
Ohio	1	1.01
Pennsylvania	1	1.01
Texas	1	1.01
Utah	2	2.02
Virginia	2	2.02
Wyoming	8	8.08
Total	99	100.00

who self-identified as nurses working in/with APS in the US were included. Though respondents working outside of the US should be excluded, no one stated that they worked outside of the US.

A convenience sample of 99 nurses responded to the survey. Responses came from 18 states (see Table 1) with California (22%) being the highest responder, followed by New York (15%), Florida (14%) and Maryland (11%). Nineteen nurses reported having a Bachelor of Science in Nursing degree, 45 had a RN degree, 27 had a master's degree, 7 had other degrees (e.g. MBA, Emergency Medical Technician, Licensed Clinical Social Worker) and 1 did not specify. Nineteen nurses identified themselves as working in rural areas, 11 in urban areas, 7 in suburban areas and 62 in a combination of areas.

2.4 | Data collection

The NAPSA nurse workgroup designed a 34-question survey to learn more about nurses' role in APS (see Appendix A), and the survey was programmed electronically in Qualtrics and opened from October 2014 to August 2015. Survey questions included agency characteristics, job responsibilities, training and interprofessional collaboration to gather quantitative data. Optional open-ended questions were proposed to gather in-depth qualitative data on (1) services provided that are outside of normal scope of nursing practice, (2) characteristics of a good APS nurse and (3) reasons for APS to have nurses on staff. Median response time for the survey was 12.43 min.

2.5 | Ethical considerations

The Institutional Review Board of Purdue University (protocol #IRB-2019-19) approved the study and provided annual oversight.

2.6 | Data analysis

For quantitative data analysis, descriptive statistics was used on most survey items to demonstrate frequency and percentage, with data coded and analysed using IBM SPSS version 24 software. For the three open-ended survey items, qualitative data were categorized, coded and analysed independently by two researchers using the Berelson content analysis method (Berelson, 1952) with the qualitative analysis tool Atlas.ti version 7.5.4 software. Figure 1 shows the coding tree on the three open-end questions. As mentioned in the design section, the quantitative and qualitative data analyses were

done separately, and brought together in the discussion section to understand APS nurses' role in safeguarding older people.

2.7 | Validity and reliability/Rigour

Since the survey was developed by the NAPSA nurse workgroup, who are nursing professionals working in APS, survey items should have face validity in capturing agency characteristics and job duties. In addition, results were interpreted in collaboration with NAPSA to ensure the understanding of results was aligned with the creation of survey items and APS nurses' experiences.

Additionally, trustworthiness of qualitative data analysis was enforced after codes were created through discussion between two researchers (first and second authors), the former has been working in elder mistreatment and APS research for over 10 years, and the other is a nursing professional. In addition, after two researchers
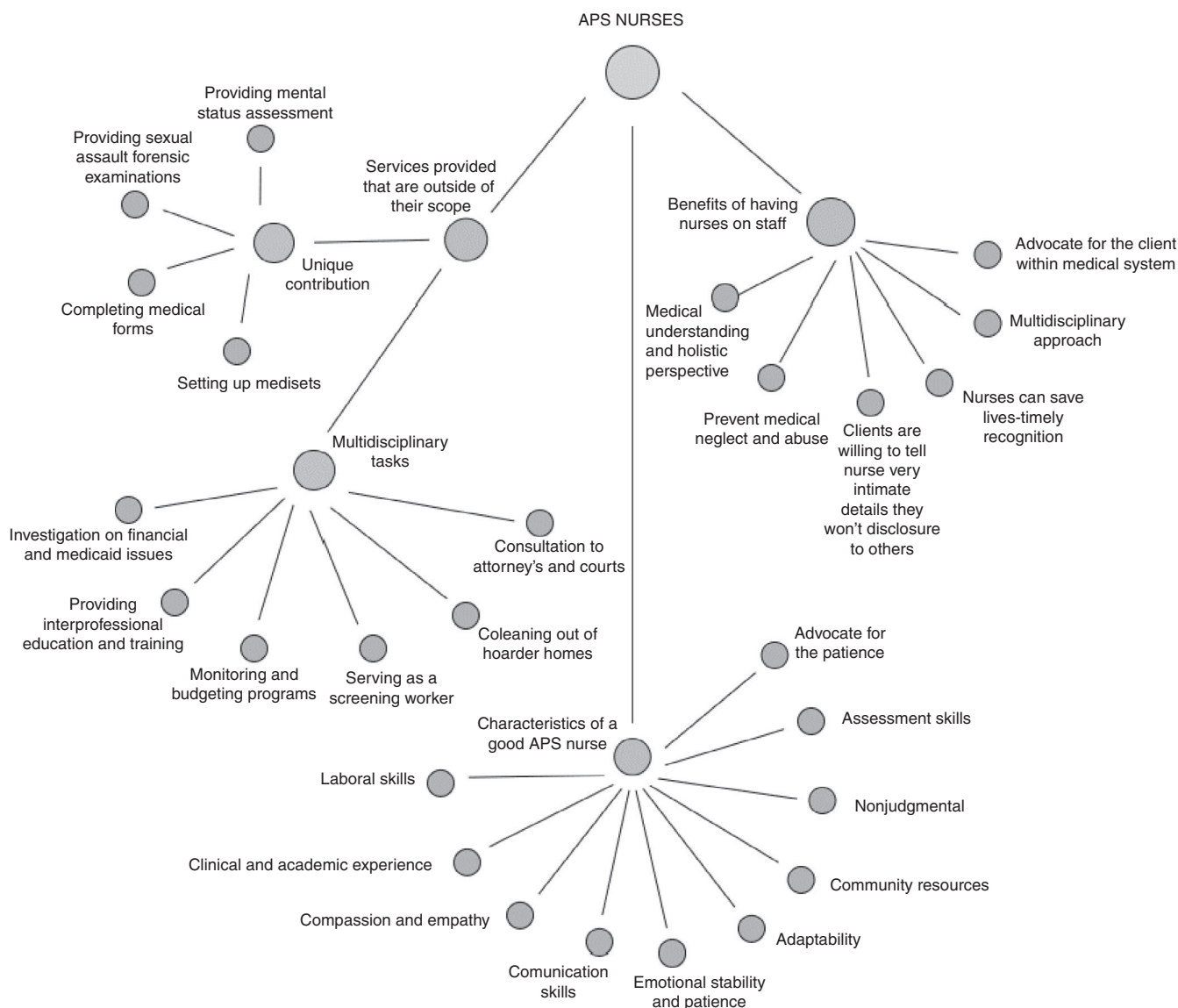

FIGURE 1 Coding tree

independently coding the qualitative data (second author and Andrew Butler), including the same nursing professional who created the codes, and a licensed clinical social worker familiar with APS, the two researchers who created the codes met to discuss different codes applied to ensure consistency and resolve discrepancies.

3 | RESULTS/FINDINGS

3.1 | Agency characteristics

Out of the 99 nurses, 65 were direct employees of APS or social services, 28 were contracted with another agency, two volunteered for their position, two said other and two did not respond to the question on employment agency. Those who worked in another agency identified home care service, public guardian/conservator, case management, child protective services and law enforcement as areas they worked in either part-time or full-time. The number of nurses employed in an agency ranged from one nurse to 15 or more nurses (see Table 2, top panel). Similarly, there was a range of nurse to social worker ratios, from the lower ratio of one nurse to 1–4 social workers, to a much higher ratio of one nurse to more than 75 social workers (see Table 2, bottom panel).

Sixty-one nurses did not report directly to a nurse supervisor (26 did, three did but also has someone else as a supervisor and nine did not respond). Forty-one nurses said their agency has a protocol in assigning a case or asking for consultation from a nurse (48 said

no and 10 did not respond). While 21 nurses received referrals from their APS supervisor, 27 from an APS worker, three from an intake/screening worker, 34 nurses received referrals from all three sources (6 from other and 8 did not respond). Twenty-six nurses said they received referrals through verbal requests, 16 through intake paperwork, 12 through a specific form asking for nursing investigation/consultation, 33 from all three sources (four from emails and eight did not respond). Fifty-two nurses did not have the option to use another nurse as a geriatric clinical resource (37 said they did and 10 did not respond). Seventy-two nurses did not have a doctor who signs off on the agency's policy and procedures for nurses (20 did and seven did not respond).

3.2 | Training and nurse qualities

Thirty-four nurses received orientation or training when they were hired to become APS nurses, 47 did not, nine said other and nine did not respond.

Respondents were asked an open-end question about the characteristics of a good APS nurse. As indicated in Table 3 by 54 APS nurses, the most common characteristic to facilitate nursing in the APS system involved highly developed laboural skills which included critical thinking, being detailed-oriented, working with various professions to put the client first and working under pressure. Another vital characteristic was clinical and academic experience covering mental health to injury identification to best serve clients.

TABLE 2 Agency characteristics

Number of APS nurses employed in agency	Frequency	Valid%
1	26	34.21
2	14	18.42
3	15	19.74
4–5	9	11.84
6–10	3	3.95
11–14	5	6.58
15 or more	4	5.26
Missing	23	
Total	76	100.00
Ratio of nurses to APS social workers in agency	**Frequency**	**Valid%**
1 nurse to 1–4 APS workers	31	42.47
1 nurse to 5–8 APS workers	10	13.7
1 nurse to 9–14 APS workers	10	13.7
1 nurse to 15–25 APS workers	10	13.7
1 nurse to 26–35 APS workers	6	8.22
1 nurse to 36–50 APS workers	1	1.37
1 nurse to 50–74 APS workers	2	2.74
1 nurse to more than 75 APS workers	3	4.11
Missing	26	
Total	73	100.00

TABLE 3 Characteristics a good APS nurse

Characteristic	Definition	Example quotes	Frequency	Per cent
Laboural skills	All the abilities that are essential in the work environment specially for an APS nurse, such as critical thinking, being detail oriented, able to work with a variety professions and personalities to put the client first, good interviewing skills, a knowledge of state/federal facility regulations, good writing skills, work under pressure, self-motivated, etc	"Part nurse, part detective for these types of cases because the investigative component is so important. Must have good organizational skills. [...] Must have good interviewing skills, a knowledge of state/federal facility regulations, good writing skills."—Nurse 2	30	55.56
Clinical and academic experience	APS nurse needs a solid nursing background, MED/SURG & Mental Health Nursing Practice experience, injury identification and recognition, knowledge about the older population, administration, functions policies and procedures. S/he also needs clinical experience before being in the APS nurse role	"Broad nursing experience is desired because the nurse can be asked to evaluate almost any kind of medical situation."—Nurse 2	21	38.89
Compassion and empathy	Being empathetic to the pain and suffering of the victim is vital for the patient/client. Compassion makes patients/clients more comfortable when they are suffering from mental, physical or emotional stress. It also refers to being respectful and sensitive of all cultures and beliefs	"APS nurse needs to be respectful and sensitive of all cultures and beliefs. They need to be able to incorporate the victim's cultures and beliefs into what they do for the victim."—Nurse 24	14	25.93
Communication skills	Having the ability to listen and speak to the victim at his or her level, in a verbal and nonverbal way, is essential. It also refers to the ability to communicate with other APS staff	"A good APS nurse needs to be able to explain things to victims at the level the victim is at, whether the victim has a doctorate degree or is mentally ill."—Nurse 24	12	22.22
Emotional stability and patience	This refers to having the ability to control the emotions, remain calm and think clearly under all circumstances, handle the additional stress associated with the situation; as well as the self-aware and good coping mechanisms to deal with trauma, abuse, and neglect of elders	"Emotional Stability: We involve ourselves in the 'worst of the worst' situations and must be able to handle the additional stress associated with the situation."—Nurse 44	12	22.22
Adaptability	Adaptability refers to being willing to tolerate and respect any / all types of environments, being flexible, able to work in unusual domestic circumstances such as hoarding, personal abandonment, often dirty and even unsafe homes	"The ability to handle difficult patients and their living environments (i.e., hoarding, self-neglect, etc.)."—Nurse 66	11	20.37
Knowledge of community resources	The APS nurse needs to be aware of the community resources available, not only what they are, but also how to use them, with whom and how to contact to use them in favour of the victim	"Extensive knowledge of what resources are available, who and how to contact and initiate these resources for the victim."—Nurse 24	8	14.81
Non-judgemental	The APS nurse should approach all people in need without preconceived judgement and open-minded. S/he should be able to not form an opinion until all the information is collected	"Able to approach all people in need without preconceived judgement based on the condition of their house or person"—Nurse 15	8	14.81
Assessment skills	The ability to recognize the verbal, as well as the non-verbal cues of various forms of abuse/neglect in vulnerable populations is basic to APS nurse. In addition, to quickly identify and address urgent medical needs should also be part of the skills a nurse should have	"The ability to recognize the verbal, as well as the non-verbal cues of various forms of abuse/neglect in vulnerable populations"—Nurse 76	7	12.96
Advocate for the older adult	An APS nurse who works on behalf of patients/clients should maintain quality of care and protect patients' rights. They intervene when there is a care concern, follow the proper channels, and work to resolve any patient/client care issues	"Willing to speak up when the environment is not safe for elders"—Nurse 50	4	7.41

Note: Sum of % is over 100%, because some nurses' response contains more than one codes.

Additionally, 14 respondents pointed to the need to be compassionate and empathic while 12 reported communication and interview skills as key to enable the APS nurse to effectively listen to and speak with client. The findings also pointed to the need for emotional stability and patience to help clients cope with trauma that resulted from mistreatment. Moreover, 11 respondents identified that the APS nurse should also be flexible and able to work in unusual domestic circumstances such as unhygienic or unsafe homes.

3.3 | Job responsibilities

Thirteen nurses carried a caseload, 15 acted as a consultant and 58 did both (12 had other responsibilities and 1 did not respond). Out of the 71 nurses who carried a caseload, 26 carried a caseload in conjunction with an APS worker, while 22 worked alone and 23 had both. Most of those who carried a caseload usually had one to nine cases (see Table 4).

The most common services, provided by over 50% of nurses, were home visits (N = 83), visual evaluation of the client (N = 81), client education (N = 71), evaluation of medications (N = 70), review of medical records (N = 66), referrals (N = 65), testifying (N = 61) and case reviews (N = 53; see Table 5 for all the services listed in the survey).

Respondents were asked if there were services they provide or have provided outside the normal scope of their nursing practice in an open-ended question. Out of 19 responses, results were

categorized into nurses' unique nursing contribution (e.g. provide mental status assessment) and their contribution as part of a MDT (e.g. provide interprofessional education and training, investigate financial and medical issues; see Table 6).

3.4 | Interprofessional collaboration

Nurses were asked to indicate elder and dependent adult abuse coordination teams they attended. Forty-one nurses attended a MDT that focuses on abuse and neglect issues, while eight attended a MDT that focused on general senior issues. Eight attended a death review team, three attended a financial abuse specialist team, two attended a vulnerable adult specialist team, two attended a forensic centre, one attended a team of elder abuse and identity theft and one attended domestic violence. Some nurses attended more than

TABLE 4 Nurse's caseload

Number of APS clients that a nurse normally has	Frequency	Per cent
Nurse who carries a caseload alone		
1–9	8	36.36
10–19	8	36.36
20–29	3	13.64
30 or more	3	13.64
Total	22	100.00
Nurse who carries a caseload in conjunction with an APS worker		
1–9	16	61.54
10–19	4	15.38
20–29	1	3.85
30 or more	5	19.23
Total	26	100,00
Nurse who has both kinds of caseload		
1–9	10	43.48
10–19	7	30.43
20–29	2	8.70
30 or more	4	17.39
Total	23	100.00
Total of nurses that carry caseload in general	71	

TABLE 5 Nurses' job responsibilities

Job responsibilities	Frequency	Per cent
Home visits	83	83.84
Visual evaluation of the client	81	81.82
Client education	71	71.72
Evaluation of medications	70	70.71
Review medical records	66	66.67
Referrals	65	65.66
Testifying (regardless of whether you have done so at this point)	61	61.62
Case reviews	53	53.54
Assist in obtaining capacity declarations	49	49.49
Non-invasive Measures (such as heart rate, blood pressure, pulse oximetry)	48	48.48
Hands-on evaluation of the client	46	46.46
Case management	46	46.46
Education for your agency and/ or hospital social workers	45	45.45
Placement coordination	44	44.44
Community education (outside of your agency)	42	42.42
Photographic documentation	31	31.31
Cross reporting	31	31.31
Transportation	18	18.18
Other	15	15.15
More "invasive" measures (such as blood sugar, urine testing)	12	12.12
Treatments	11	11.11

TABLE 6 Services provided by nurses that are outside of usual practice

Codes	Example quotes	Frequency	Per cent
Unique contribution			
Providing mental status assessment	"Brief Interview for Mental Status" – Nurse 20	2	10.53
Completing medical forms	"The Department of Public Social Services had asked that the public health nurses complete the SOC 873 form, the medical certification form requiring the public health nurses to deem the client disabled. The form was to be completed as an emergency bases until we are able to get the client a medical home." – Nurse 29	1	5.26
Providing sexual assault forensic examinations	"I perform sexual assault forensic examinations." – Nurse 80	1	5.26
Setting up MediSets	"I assist in setting up their mediset only if I have approved written med sheet from the MD." – Nurse 51	1	5.26
Multidisciplinary tasks			
Investigation on financial and Medicaid issues	"Client's financial issues, financial abuse Medi-Caid qualifications and issues dealing with benefits division." – Nurse 35	5	26.32
Providing interprofessional education and training	"Educate low enforcement when they do not comprehend your findings." – Nurse 18	5	26.32
Monitoring and budgeting programs	"Monitoring budget for various programs, Foster Home Licensing, covering 16 counties for 2 years, monitoring recidivism, and performing secretarial duties." -Nurse 45	2	10.53
Cleaning out of hoarder homes	"I have helped with the cleaning out of hoarder homes." – Nurse 26	1	5.26
Consultation to attorney's and courts	"I have provided consultation to attorney's and courts on cases involving vulnerable mentally ill clients who are facing incarceration for 'low level crimes' and are in need of linkage to medical, substance abuse and mental health services" – Nurse 44	1	5.26
Serving as a screening worker	"Once a month I serve as the On-Call Screening Worker in Adult Services for [County name] Department of Social Services. This is what the licensed & un-licensed social workers do" – Nurse 74	1	5.26

Note: Sum of % is over 100%, because some nurses' response contains more than one codes.

one team, and 36 did not indicate any MDT or coordination team participation.

The last open-end question asked respondents to make an argument for why APS needs to have nurses on staff. Out of 58 responses, 43 nurses said they provide a much-needed medical understanding and holistic perspective during investigations, many of the cases received are related to medical neglect or contain a medical component, which is sometimes difficult for other APS staff to understand or identify. Nurses not only have a solid understanding of the medical field, medical diagnosis, teaching and understanding of patient care and the healthcare system; they also understand the emotional and psychosocial needs of the client, which gives the investigation of the case a more integrated and complete view of the client's needs for their well-being. In addition, 12 respondents proffered that nurses' advocacy for the client in the medical system makes clients more aware and involved in their own care process. Nurses were identified as an essential component of the MDT by 10 respondents, because a nurse is able to collaborate with social workers in the assessment of the client and their circumstances, in addition to improving the quality of care received by clients (see Table 7).

4 | DISCUSSION

While most nurses identify and report elder mistreatment, nurses working with/in APS are in a unique position to not only investigate elder mistreatment allegations, but also provide or coordinate care that directly addresses individual elder mistreatment concerns. This places APS nurses in levels two to four of the Hardiker model, being involved as cases become more complex or deescalate in severity. As older victims are identified in levels two to four, assessments focus on the intensity of support from top-up support to supervisory services, to taking legal actions on behalf of the older person, or providing suitable accommodation where the older person is safeguarded. In all case management approaches, the need for a human rights approach, underpinned by self-determination, autonomy and following the victim's will, preference, values and beliefs is fundamental (Phelan & Rickard-Clarke, 2020).

This study captured APS nurses' agency characteristics, training and qualities, job responsibilities and interprofessional collaboration. The data provide an insight into the work and activities that APS nurses perform to respond to the existing needs of older people who experience situations of abuse, neglect and exploitation.

TABLE 7 Benefits of having nurses on staff

Benefit codes	Example quotes	Frequency	Per cent
Medical understanding and holistic perspective	"Nursing perspective and holistic view with understanding of medical and health care issues" – Nurse 47	43	74.14
Advocacy for the client within the medical system	"APS nurses are effective at linking clients to medical resources and advocating for quality healthcare such as referrals to specialists." – Nurse 63	12	20.69
Multidisciplinary approach	"The APS RN is a vital part of the team on cases that are medically complex and needing a nursing assessment, opinion or consult to recommend services or a course of action to protect these clients. Many times the nurse is needed at the site of occurrence for forensic purposes or to assist in the evaluation of mental capacity and competency. A plan of action with a nurse available can be expedited, and advantageous for the client. Having a social worker and nurse collaborating for the benefit of the client is a plus for the community at large." – Nurse 24	10	17.24
"Nurses can save lives"- timely recognition of problems	"Many times, our nurses and their evaluations have literally saved people's lives, e.g., client screaming when urinating, totally dismissed for several months by untrained ears, was sent to the ER immediately after RN, during investigation, heard him. He has a malignant tumor in his urethra." – Nurse 20	7	12.07
"Nurses are trusted" – willingness of clients to tell nurses very intimate details they don't disclosure to others	"Generally, most of society are willing to tell nurses the most intimate problems that they are having, as nurses are generally thought of as those health care workers that are healers of all problems. Nurses are generally looked at, as the group that will see one through most things with care, while not being judgmental." – Nurse 14	6	10.35
Prevent medical neglect and abuse	"APS PHN will coordinate and work in collaboration with medical providers to prevent medical neglect and abuse." – Nurse 36	1	1.72

Note: Sum of % is over 100%, because some nurses' response contains more than one codes.

Two-thirds of the nurses were direct employees of APS, and approximately one-third were the only nurse in their agency. Not having nurses routinely in direct APS is not unusual; for example, in other countries, safeguarding investigations are considered the dominant domain of social workers (O'Donnell et al., 2015). Unsurprisingly, as this is not a developed role in the APS, most of the respondents did not report to a nurse supervisor and did not have a doctor who signed off on the agency's policy and procedures for nurses. The combined information on agency characteristics raised questions on whether nurses feel isolated as the only/few healthcare professionals working in APS, and how supported they feel with a supervisor not in the healthcare profession. In addition, there may be issues related to formal professional regulation and scope of practice (Phelan, 2018). As suggested by the Administration for Community Living's (2020) guidelines for APS, nurses' performance should be evaluated by a supervisory nurse, preferably on staff. This is particularly important in the context of competencies in increasingly complex cases of elder mistreatment (Breckman et al., 2020; Kirk et al., 2019), which demand collaborative and proficient decision-making focused on restoring the older person to a lower care support level, if feasible. Additionally, since approximately half of the nurses indicated they received referrals specifically requesting a nursing investigation/consultation, this implies at least half of the nurses functioned as healthcare professionals in APS. Although it is unclear whether the other half of the nurse respondents were using for their healthcare expertise, it speaks to the need to have nurses in the APS workforce with specific professional guidance.

Less than half of the nurses received training to become an APS nurse. The need to increase health professionals' awareness and training on elder mistreatment has been a consistent theme in the literature (Ahmed et al., 2016; Baker & Heitkemper, 2005; Du Mont et al., 2015; Ernst & Smith, 2012; Ferreira et al., 2015; Lewis et al., 2019), so developing training materials and providing formal supervision is key in preparing healthcare professionals to address elder mistreatment. As some nurses reported some job responsibilities that were outside of usual nursing practice, preparing nurses to provide services that incorporates the nurses' professional skills (e.g. providing mental status assessment) and working with other professionals (e.g. investigating financial and Medicaid issues) could be considered as part of the training and supervision. The Administration for Community Living's (2020) guidelines also recommended ongoing education for nurses in medical, physical, emotional and social needs of APS clients. In this way, as older people experience abuse in all levels, a responsive, efficient and effective service can be offered by the APS nurse, both in his/her scope of practice and in the MDT.

Nurses working as a consultant work collaboratively with other professionals to help resolve elder abuse cases. However, in this study, the majority of nurses carried a caseload with over half carrying the caseload in conjunction with a social worker, which also demonstrated interprofessional collaboration. In addition to working with fellow APS colleagues, about two-thirds indicated participation in a MDT or other care-coordination team involving other professionals outside of APS. Nonetheless, nurses' awareness of the multidisciplinary approach benefits should be strengthened, since only 10 nurses identified it as a reason to have nurses on staff. The literature suggested that a MDT approach would produce better outcomes in APS investigations (DePrince et al., 2019; Ernst & Smith, 2012), and advocates for the inclusion of healthcare professionals, especially nurses, to be part of the diverse MDT to attend to the complex needs of victims (Du Mont et al., 2015).

In this study, the data demonstrated that APS nurses not only worked closely with their social work colleagues, but also took on additional job responsibilities related to healthcare. The most common services, provided by over 50% of nurses, involved tasks normally carried out by social workers, such as home visits and referrals. Even though social workers could also conduct visual evaluation of the client, case reviews, testifying in court proceedings and client education, social workers are more likely to find resources for victims instead of providing information. For example, nurses were more likely to identify medical concerns during visual evaluation of the client, case review and testifying for court. Nurses were also more likely to directly provide client education that address medical concerns such as wound care and diet suggestions. Services that social workers do not provide directly include evaluation of medications and review of medical records. Though fewer nurses reported the following as services they provide, social workers also do not conduct hands-on evaluation of the client (e.g. conducting a physical such as taking pulse, touching throat or stomach), non-invasive measures (e.g. heart rate, blood pressure, pulse oximetry), more-invasive measures (such as blood sugar or urine testing) and treatment (e.g. wound care). However, it is important that roles and responsibilities are clarified and team member knowledge shared (Johnson, 2020).

The qualitative data demonstrated ideal APS nurse qualifications and why APS should have nurses as part of their workforce. Excellent nursing knowledge, skills and experiences seemed to be the basic requirement for the position. In addition, APS nurses are expected to be empathetic, communicate well with clients and other social work colleagues, be emotionally stable and patient, as well as adapt to clients' various situations quickly. Most of these qualities are expected of all nurses, especially those working in geriatric care (Burhans & Alligood, 2010; Teófilo et al., 2019). Nurses also eloquently stated other benefits, with the majority saying nurses' medical understanding and holistic approaches help clients with medical issues, particularly related to helping navigate the healthcare system. Similarly, some nurses commented that advocacy for clients in the healthcare system, including client's functional and cognitive status, is more effectively done by

nurses. Most importantly, nurses are accustomed to working using a person-centre care approach, so that decision-making is self-directed and autonomous with nurses supporting and respecting individuals' health choices (Phelan & McCormack, 2016; Phelan & Rickard-Clarke, 2020; Russell et al., 2003). Since APS clients can turn down APS investigation and services as long as they have decision-making capacity, having the most trusting profession being part of the APS team can enable access to older people at risk of abuse.

4.1 | Limitations

There are a number of study limitations. The snowball sampling approach limited the generalizability of findings about APS nurses. In fact, we do not know how many more nurses in the country works with/in APS. In addition, as the data was collected in 2014–2015, advances or changes in the workforce may have occurred to include/ exclude nurses' work with/in APS. Future research should examine APS nurses' challenges, barriers and gaps that prevent them from better helping the abused, neglected and exploited as healthcare professionals at the front line, to establish best practices as APS nurses. Additionally, addressing APS outcomes to determine the unique contribution of nurses working with/in APS, including the impact they have on victims' lives, would also allow programmes with limited resources to advocate for hiring a nurse on staff using a solid evidence base.

5 | CONCLUSION

Victims of abuse, neglect and exploitation are often more vulnerable with poor physical and mental health (Phelan, 2020). Addressing elder mistreatment cases requires a MDT and nurses play an important role because of their healthcare knowledge and skills. This study is the first to recognize nurses' APS contribution in investigating mistreatment allegations and providing direct services to vulnerable and older people experiencing abuse, neglect and exploitation. Findings not only demonstrated APS nurses' abilities and how they were engaged in the workforce, they also revealed the need to build and expand adult safeguarding programmes beyond the social work model. Involving nurses who work in APS in the US, and in the traditionally social work environment globally, to understand the role they play and their importance as part of the MDTs is vital to detect, treat and eventually prevent elder mistreatment among the fast-growing and increasingly diverse ageing populations.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

Pi-Ju Liu conducted the study by requesting the data and drafted the manuscript. Jessica Andrea Hernandez Chilatra analysed the data and drafted the manuscript with Dr. Liu. Amanda Phelan provided a theoretical framework and edited the manuscript. All authors have agreed on the final version and meet at the following criteria: (1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; (2) drafting the article or revising it critically for important intellectual content.

PEER REVIEW

The peer review history for this article is available at https://publons.com/publon/10.1111/jan.14792.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the National Adult Protective Services Association. Restrictions apply to the availability of these data, which were used under license for this study. Data are available from the authors with the permission of the National Adult Protective Services Association.

ORCID

Pi-Ju Liu https://orcid.org/0000-0002-8762-5120

REFERENCES

Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *American Journal of Public Health*, *100*(2), 292–297. https://doi.org/10.2105/AJPH.2009.163089

Acierno, R., Watkins, J., Hernandez-Tejada, M. A., Muzzy, W., Frook, G., Steedley, M., & Anetzberger, G. (2018). Mental health correlates of financial mistreatment in the national elder mistreatment study wave II. *Journal of Aging and Health*, *31*(7), 1196–1211. https://doi.org/10.1177/0898264318767037

Administration for Community Living. (2020). *National voluntary consensus guidelines for state adult protective services systems updated*. Retrieved from https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf

Ahmed, A., Choo, W. Y., Othman, S., Hairi, N. N., Hairi, F. M., Mohd Mydin, F. H., & Illiani Jaafar, S. N. (2016). Understanding of elder abuse and neglect among health care professionals in Malaysia: An exploratory survey. *Journal of Elder Abuse and Neglect*, *28*(3), 163–177. https://doi.org/10.1080/08946566.2016.1185985

Aurelien, G., Beatrice, M., Cannizzo, J., Capehart, A., Gassoumis, Z., & Greene, M. (2018). *NAMRS FFY2017 report 2 – Key indicators*. Submitted to the Administration of Community Living, U.S. Department of Health and Human Services. Retrieved from https://acl.gov/sites/default/files/programs/2018-11/NAMRS FY17KeyIndicators.pdf

Aurelien, G., Beatrice, M., Cannizzo, J., Capehart, A., Gassoumis, Z., & Urban, K. (2019). *Maltreatment data report 2018*. Retrieved from https://acl.gov/sites/default/files/programs/2019-12/2018A dultMaltreatmentReport-Finalv1.pdf

Baker, M. W., & Heitkemper, M. M. (2005). The roles of nurses on interprofessional teams to combat elder mistreatment. *Nursing Outlook*, *53*, 253–259. https://doi.org/10.1016/j.outlook.2005.04.001

Band-Winterstein, T. (2018). Nurses' encounters with older adults engaged in self-neglectful behaviors in the community: A qualitative study. *Journal of Applied Gerontology*, *37*(8), 965–989. https://doi.org/10.1177/0733464816665206

Berelson, B. (1952). *Content analysis in communication research*. Free Press.

Breckman, R., Holt-Knight, D., Rachmuth, L., & Rivera, R. (2020). Advancing the elder abuse work of Adult Protective Services through participation on multi-disciplinary teams. *Generations*, *44*(1), 67–73.

Burhans, L. M., & Alligood, M. R. (2010). Quality nursing care in the words of nurses. *Journal of Advanced Nursing*, *66*(8), 1689–1697. https://doi.org/10.1111/j.1365-2648.2010.05344.x

Burnett, J., Coverdale, J. H., Pickens, S., & Dyer, C. B. (2006). What is the association between self-neglect, depressive symptoms and untreated medical conditions? *Journal of Elder Abuse & Neglect*, *18*(4), 25–34. https://doi.org/10.1300/J084v18n04

Burnett, J., Jackson, S. L., Sinha, A. K., Aschenbrenner, A. R., Murphy, K. P., Xia, R., & Diamond, P. M. (2016). Five-year all-cause mortality rates across five categories of substantiated elder abuse occurring in the community. *Journal of Elder Abuse and Neglect*, *28*(2), 59–75. https://doi.org/10.1080/08946566.2016.1142920

Capezuti, E. (2011). Recognizing and referring suspected elder mistreatment. *Geriatric Nursing*, *32*(3), 209–211. https://doi.org/10.1016/j.gerinurse.2011.04.005

Cooper, C., & Livingston, G. (2020). Elder abuse and dementia. In A. Phelan (Ed.), *Advances in elder abuse research: Practice, legislation and policy* (pp. 137–147). Springer.

Creswell, J. W., & Clark, V. L. P. (2018). *Designing and conducting mixed methods research* (3rd ed.). SAGE Publications Inc.

Day, M. R., & McCarthy, G. (2015). A national cross-sectional study of community nurses and social workers knowledge of self-neglect. *Age and Ageing*, *44*(4), 717–720. https://doi.org/10.1093/ageing/afv025

Day, M. R., Mulcahy, H., Leahy-Warren, P., & Downey, J. (2015). Self-neglect: A case study and implications for clinical practice. *British Journal of Community Nursing*, *20*(3), 110–115. https://doi.org/10.12968/bjcn.2015.20.3.110

DePrince, A. P., Hasche, L. K., Olomi, J. M., Wright, N. M., & Labus, J. (2019). A randomized-control trial testing the impact of a multidisciplinary team response to older adult maltreatment. *Journal of Elder Abuse & Neglect*, *31*(4–5), 307–324. https://doi.org/10.1080/08946566.2019.1682097

Dong, X. Q. (2017). Elder self-neglect: Research and practice. *Clinical Interventions in Aging*, *12*, 949–954. https://doi.org/10.2147/CIA.S103359

Dong, X., Mendes de Leon, C. F., & Evans, D. A. (2009). Is greater self-neglect severity associated with lower levels of physical function? *Journal of Aging and Health*, *21*(4), 596–610. https://doi.org/10.1177/0898264309333323

Dong, X., & Simon, M. A. (2013a). Association between reported elder abuse and rates of admission to skilled nursing facilities: Findings from a longitudinal population-based cohort study. *Gerontology*, *59*(5), 464–472. https://doi.org/10.1159/000351338

Dong, X., & Simon, M. A. (2013b). Elder abuse as a risk factor for hospitalization in older persons. *JAMA Internal Medicine*, *173*(10), 911–917. https://doi.org/10.1001/jamainternmed.2013.238

Dong, X. Q., Simon, M., Rajan, K., & Evans, D. A. (2011a). Association of cognitive function and risk for elder abuse in a community-dwelling population. *Dementia and Geriatric Cognitive Disorders*, *32*, 209–215. https://doi.org/10.1159/000334047

Du Mont, J., Kosa, D., Macdonald, S., Elliot, S., & Yaffe, M. (2015). Determining possible professionals and respective roles and responsibilities for a model comprehensive elder abuse intervention: A Delphi consensus survey. *PLoS One*, *10*(12), 1–24. https://doi.org/10.1371/journal.pone.0140760

Erlingsson, C., Ono, M., Sasaki, A., & Saveman, B. I. (2011). An international collaborative study comparing Swedish and Japanese nurses' reactions to elder abuse. *Journal of Advanced Nursing*, *68*(1), 56–68. https://doi.org/10.1111/j.1365-2648.2011.05712.x

Ernst, J. S., & Smith, C. A. (2011). Adult protective services clients confirmed for self-neglect: Characteristics and service use. *Journal of Elder Abuse and Neglect*, *23*(4), 289–303. https://doi.org/10.1080/08946566.2011.558800

Ernst, J., & Smith, C. A. (2012). Assessment in adult protective services: Do multidisciplinary teams make a difference? *Journal of Gerontological Social Work*, *55*(1), 21–38. https://doi.org/10.1080/01634372.2011.626842

Fang, B., Yan, E., Chan, K. L., & Ip, P. (2018). Elder abuse and its medical outcomes in older chinese people with cognitive and physical impairments. *International Journal of Geriatric Psychiatry*, *33*(8), 1038–1047. https://doi.org/10.1002/gps.4890

Ferreira, M., dos Santos, C. L., & Vieira, D. N. (2015). Detection and intervention strategies by primary health care professionals in suspected elder abuse. *Acta Médica Portuguesa*, *28*(6), 687. https://doi.org/10.20344/amp.6706

Hardiker, P., Exton, K., & Barker, M. (1991). The social policy contexts of prevention in child care. *British Journal for Social Work*, *21*(4), 341–359. https://doi.org/10.1093/oxfordjournals.bjsw.a055771

Heath, J., Brown, M., Kobylar, F. A., & Castano, S. (2005). The prevalence of undiagnosed geriatric health conditions among Adult Protective Service clients. *The Gerontologist*, *45*(6), 820–823. https://doi.org/10.1093/geront/45.6.820

Hirst, S. P., Penney, T., McNeill, S., Boscart, V. M., Podnieks, E., & Sinha, S. K. (2016). Best-practice guideline on the prevention of abuse and neglect of older adults. *Canadian Journal on Aging*, *35*(2), 242–260. https://doi.org/10.1017/S0714980816000209

Johnson, L. (2020). Multidisciplinary collaboration. In A. Carney (Ed.), *Elder abuse: Forensic, legal and medical aspects* (pp. 183–198). Elsevier.

Johnson, Y. O. (2015). Home care nurses' experiences with and perceptions of elder self-neglect. *Home Healthcare Now*, *33*(1), 31–37. https://doi.org/10.1097/NHH.0000000000000169

Kirk, C. A., Killick, C., McAllister, A., & Taylor, B. J. (2019). Social workers perceptions of restorative approaches with families in cases of elder abuse: A qualitative study. *The Journal of Adult Protection*, *21*(3), 190–200. https://doi.org/10.1108/JAP-12-2018-0029

Kleba, B. P. A., & Falk, N. L. (2014). The Elder Justice Act: What nurses need to know. *American Journal of Nursing*, *114*(9), 65–68. https://doi.org/10.1097/01.NAJ.0000453760.77129.8c

Lachs, M. S., & Pillemer, K. A. (2015). Elder abuse. *New England Journal of Medicine*, *373*(20), 1947–1956. https://doi.org/10.1056/NEJMra1404688

Lachs, M. S., Williams, C., O'Brien, S., Hurst, L., & Horwitz, R. (1997). Risk factors for reported elder abuse and neglect: A nine-year observational cohort study. *The Gerontologist*, *37*(4), 469–474. https://doi.org/10.1093/geront/37.4.469

Lachs, M. S., Williams, C. S., O'Brien, S., Pillemer, K. A., & Charlson, M. E. (1998). The mortality of elder mistreatment. *Journal of the American Medical Association*, *280*(5), 428–432. https://doi.org/10.1001/jama.280.5.428

Lewis, V. J., White, V., Hawthorne, F., Eastwood, J., & Robyn, M. (2019). Addressing elder abuse through integrating law into health: What do allied health professionals at a community health service in Melbourne, Australia, think? *Australasian Journal on Ageing*, *39*(2), 1–6. https://doi.org/10.1111/ajag.12720

Lichtenberg, P. A., Stickney, L., & Paulson, D. (2013). Is psychological vulnerability related to the experience of fraud in older adults? *Clinical Gerontologist*, *36*(2), 383–416. https://doi.org/10.1080/07317115.2012.749323

Liu, P.-J., & Anetzberger, G. J. (2019). Adult protective services. *Encyclopedia of Victimology and Crime Prevention*, 1–3. https://doi.org/10.4135/9781412979993.n4

Luo, Y., & Waite, L. J. (2011). Mistreatment and psychological well-being among older adults: Exploring the role of psychosocial resources and deficits. *Journal of Gerontology: Social Sciences*, *66*(2), 217–229. https://doi.org/10.1093/geronb/gbq096

Mauk, K. L. (2011). Ethical perspectives on self-neglect among older adults. *Rehabilitation Nursing Journal*, *36*(2), 60–65. https://doi.org/10.1002/j.2048-7940.2011.tb00067.x

Meeks-Sjostrom, D. J. (2013). Clinical decision making of nurses regarding elder abuse. *Journal of Elder Abuse and Neglect*, *25*(2), 149–161. https://doi.org/10.1080/08946566.2013.751818

Mont, J. D., Kosa, D., Macdonald, S., Elliot, S., & Yaffe, M. (2016). Development of skills-based competencies for forensic nurse examiners providing elder abuse care. *British Medical Journal Open*, *6*, 1–8. https://doi.org/10.1136/bmjopen-2015-009690

Mouton, C. P., Haas, A., Karmarkar, A., Kuo, Y.-F., & Ottenbacher, K. (2019). Elder abuse and mistreatment: Results from medicare claims data. *Journal of Elder Abuse & Neglect*, *31*(4–5), 263–280. https://doi.org/10.1080/08946566.2019.1678544

O'Brien, J. G., Riain, A. N., Collins, C., Long, V., & O'Neill, D. (2014). Elder abuse and neglect: A survey of Irish general practitioners. *Journal of Elder Abuse & Neglect*, *26*(3), 291–299. https://doi.org/10.1080/08946566.2013.827955

O'Donnell, D., Treacy, M. P., Fealy, G., Lyons, I., & Lafferty, A. (2015). The case management approach to protecting older people from abuse and mistreatment: Lessons from the Irish experience. *British Journal of Social Work*, *45*(5), 1451–1468. https://doi.org/10.1093/bjsw/bcu027

Park, E. O. (2019). Most prevalent type of elder abuse and its correlation with elder depression. *Acta Paulista De Enfermagem*, *32*(1), 95–100. https://doi.org/10.1590/1982-0194201900013

Phelan, A. (2010). Elder abuse and the community nurse: Supporting the patient. *British Journal of Community Nursing*, *15*(10), 472–478. https://doi.org/10.12968/bjcn.2010.15.10.78727

Phelan, A. (2018). The role of the nurse in detecting elder abuse and neglect: Current perspectives. *Nursing: Research and Reviews*, *8*, 15–22. https://doi.org/10.2147/nrr.s148936

Phelan, A. (2020). Introduction. In A. Phelan (Ed.), *Advances in elder abuse research: Practice, legislation and policy* (pp. 1–9). Springer.

Phelan, A., & McCormack, B. (2016). Exploring nursing expertise in residential care for older people: A mixed method study. *Journal of Advanced Nursing*, *72*(10), 2524–2535. https://doi.org/10.1111/jan.13001

Phelan, A., & Rickard-Clarke, P. (2020). Person centred approaches in capacity legislation. In A. Phelan (Ed.), *Advances in elder abuse research: Practice, legislation and policy* (pp. 23–37). Springer.

Pickering, C. E. Z., Ridenour, K., & Salaysay, Z. (2016). Best practices for the identification of elder abuse and neglect in home health. *Home Healthcare now*, *34*(4), 182–188. https://doi.org/10.1097/NHH.0000000000000373

Population Reference Bureau. (2019). Fact sheet: Aging in the United States. Retrieved from https://www.prb.org/wp-content/uploads/2016/01/aging-us-population-bulletin-1.pdf

Reyes-Ortiz, C. A., Ocampo-Chaparro, J. M., Campo-Arias, A., Holmes, H., & Halphen, J. (2018). Association between history of abuse and falling in older adults. *Journal of the American Geriatrics Society*, *66*(8), 1603–1607. https://doi.org/10.1111/jgs.15432

Russell, S., Daly, J., Hughes, E., & Russell, S. (2003). Nurses and 'difficult' patients: Negotiating non-compliance. *Journal of Advanced Nursing*, *43*(3), 281–287. https://doi.org/10.1046/j.1365-2648.2003.02711.x

Smith, S. M., Oliver, S. A. M., Zwart, S. R., Kala, G., Kelly, P. A., Goodwin, J. S., & Dyer, C. B. (2006). Nutritional status is altered in the

self-neglecting elderly. *The Journal of Nutrition*, *136*(10), 2534–2541. https://doi.org/10.1093/jn/136.10.2534

Sullivan, C. (2015). Elder justice: Preventing and intervening in elder mistreatment. *Nursing Outlook*, *63*, 610–613. https://doi.org/10.1016/j.outlook.2015.08.002

Teófilo, T. J. S., Veras, R. F. S., Silva, V. A., Cunha, N. M., dos Oliveira, J. S., & Vasconcelos, S. C. (2019). Empathy in the nurse–patient relationship in geriatric care: An integrative review. *Nursing Ethics*, *26*(6), 1585–1600. https://doi.org/10.1177/0969733018787228

TÜSLA. (2013). *Investing in families: Supporting parents to improve outcomes for children*. Retrieved from https://www.tusla.ie/uploads/content/Family_Support_CFA_Parenting_Support_Strategy.pdf

United Nations. (2020a). *2019 revision of world population prospects*. Retrieved from https://population.un.org/wpp/

United Nations. (2020b). *World population ageing 2019*. Retrieved from https://www.un.org/en/development/desa/population/publications/pdf/ageing/WorldPopulationAgeing2019-Report.pdf

Winterstein, T. B. (2012). Nurses' experiences of the encounter with elder neglect. *Journal of Nursing Scholarship*, *44*(1), 55–62. https://doi.org/10.1111/j.1547-5069.2011.01438.x

Wood, S., Rakela, B., Liu, P.-J., Navarro, A. E., Bernatz, S., Wilber, K. H., Allen, R., & Homier, D. (2014). Neuropsychological profiles of victims of financial elder exploitation at the Los Angeles County Elder Abuse Forensic Center. *Journal of Elder Abuse & Neglect*, *26*, 414–423. https://doi.org/10.1080/08946566.2014.88127

World Health Organization. (2020). *Elder abuse: Key facts*. Retrieved from https://www.who.int/news-room/fact-sheets/detail/elder-abuse

Yunus, R. M., Hairi, N. N., & Choo, W. Y. (2019). Consequences of elder abuse and neglect: A systematic review of observational studies. *Trauma, Violence & Abuse*, *20*(2), 179–213. https://doi.org/10.1177/1524838017692798

How to cite this article: Liu P, Hernandez Chilatra JA, Phelan A. Examining nurses' role in Adult Protective Services related to safeguarding older people. *J Adv Nurs*. 2021;77:2481–2497. https://doi.org/10.1111/jan.14792

APPENDIX A.

Survey questions designed by the National Adult Protective Services Association's Nurse Workgroup

1. Please provide your name (optional)
2. Please provide your email (optional)
3. What state do you work in?
   - Alabama
   - Arizona
   - Arkansas
   - California
   - Colorado
   - Connecticut
   - Delaware
   - District of Columbia
   - Florida
   - Georgia
   - Idaho
   - Illinois
   - Indiana
   - Iowa
   - Kansas
   - Kentucky
   - Louisiana
   - Maine
   - Maryland
   - Massachusetts
   - Michigan
   - Minnesota
   - Mississippi
   - Missouri
   - Montana
   - Nebraska
   - Nevada
   - New Hampshire
   - New Jersey
   - New Mexico
   - New York
   - North Carolina
   - North Dakota
   - Ohio
   - Oklahoma
   - Oregon
   - Pennsylvania
   - Rhode Island
   - South Carolina
   - South Dakota
   - Tennessee
   - Texas
   - Utah
   - Vermont
   - Virginia
   - Washington
   - West Virginia
   - Wisconsin
   - Wyoming
   - Puerto Rico
   - Alaska
   - Hawaii
   - I do not reside in the United States
4. If you work in a county based system, what county/parish to you work in?
5. Are you a/an…
   - BSN
   - PHN
   - LVN
   - RN

- MSN/MPH
- Other (please explain)

6. How long has your agency had APS nurses in any role? (If your agency has had nurses in the past, please answer this question regarding this time.)
   - One year
   - Two years
   - Three to five years
   - Six to ten years
   - More than ten years

7. If your agency has had nurses in the past, please tell us why they had been discontinued.

8. In your opinion, do you work in a mostly:
   - Rural area
   - Suburban area
   - Urban area
   - A combination of areas

9. Do you…
   - Carry a caseload?
   - Act as a consultant?
   - Both?
   - Other (Please explain)

10. Do you work…
    - As a direct employee of APS/social services?
    - Under contract from another agency?
    - Other (Please explain)

11. Which programs do you work for/ provide consultation to?
    - Adult Protective Services/ Full time
    - Adult Protective Services/ Part time
    - Medicaid funded home care services (e.g. IHSS in California)/ Full time
    - Medicaid funded home care services (e.g. IHSS in California)/ Part time
    - Case management funded by the Administration on Aging (e.g. MSSP in California) /Full time
    - Case management funded by the Administration on Aging (e.g. MSSP in California) /Part time
    - Public Guardian/Conservator/ Full time
    - Public Guardian/Conservator /Part time
    - Law Enforcement/Full time
    - Law Enforcement / Part time
    - Child Protective Services/Full time
    - Child Protective Services/Part time
    - Other (please explain)

12. What services do you provide? (check all that apply)
    - Home visits
    - Visual evaluation of the client
    - Hands-on evaluation of the client
    - Noninvasive Measures (such as heart rate, blood pressure, pulse oximetry)
    - More "invasive" measures (such as blood sugar, urine testing)
    - Evaluation of medications
    - Treatments

- Transportation
- Referrals
- Case reviews
- Case Management
- Client Education
- Community Education (outside of your agency)
- Education for your agency and/or hospital social workers
- Photographic documentation
- Cross reporting
- Testifying (regardless of whether you have done so at this point)
- Placement Coordination
- Assist in obtaining capacity declarations
- Review medical records
- Other (please explain)

13. Do you have a doctor who signs off on your agency's policy and procedures for nurses?
    - Yes
    - No

14. Is there a protocol in your agency stating when to assign a case to a nurse or to ask for a consultation?
    - Yes
    - No

15. Do your referrals come from…
    - The APS supervisor
    - The case carrying APS worker
    - The intake/screening worker (if the supervisor does not screen cases)
    - All of the above
    - Other (please explain)

16. How do you receive your referrals?
    - Verbal request
    - Receive the intake paperwork
    - Received a specific form requesting a nursing investigation/ consultation
    - All of the above
    - Other (please explain)

17. Is your direct supervisor a nurse?
    - Yes
    - Yes but I also report to another professional (e.g. an APS social work supervisor)
    - No

18. Do you have the option to use another nurse as a geriatric clinical resource?
    - Yes
    - No

19. Did you receive any orientation training for APS nurses when you were hired/contracted by APS?
    - Yes
    - No
    - Other (please explain)

20. Do you…
    - Carry a caseload alone (without an APS worker)

- Carry a caseload in conjunction with an APS worker
- Do both of the above
21. If you carry a caseload alone (without an APS worker), how many APS clients do you normally have?
    - 1–9
    - 10–14
    - 15–19
    - 20–24
    - 25–29
    - 30 or more
22. If you carry a caseload in conjunction with an APS worker, how many APS clients do you normally have?
    - 1–9
    - 10–14
    - 15–19
    - 20–24
    - 25–29
    - 30 or more
23. If both the above situations apply, how many APS clients do you normally have?
    - 1–9
    - 10–14
    - 15–19
    - 20–24
    - 25–29
    - 30 or more
24. How many APS nurses are employed by your APS agency?
    - 1
    - 2
    - 3
    - 4–5
    - 6–10
    - 11–14
    - 15 or more
25. What is the ratio of nurses to APS social workers in your agency?
    - 1 nurse to 1– 4 APS workers
    - 1 nurse to 5–8 APS workers
    - 1 nurse to 9–14 APS workers
    - 1 nurse to 15–25 APS workers
    - 1 nurse to 26–35 APS workers
    - 1 nurse to 36–50 APS workers
    - 1 nurse to 50– 74 APS workers
    - 1 nurse to more than 75 APS workers
26. Do you attend any of the following types of elder and dependent adult abuse coordination teams? (check all that apply)

- Mutli-disciplinary team (MDT) focused on abuse issues/cases
- Mutli-disciplinary team (MDT) focused on senior issues (e.g. Senior Round table, Adult Services Coordinating Counsel)
- Financial Abuse Specialist Team (FAST)
- Vulnerable Adult Specialist Team (VAST)
- Death Review Team
- Other (please explain)
27. Do you document in a database?
    - Yes
    - No
28. What database do you use?
29. What do you normally document (whether in a database or on a paper case)? (check all that apply)
    - Contacts/ case notes
    - Stand alone documentation
    - Medical/Nursing Assessment
    - Summary Narrative
    - Interventions
    - Meds list/vitals
    - Service Plan
    - Risk Assessment
    - Other (please explain)
30. When do you do cognitive assessments?
    - I don't do cognitive assessments
    - Only when there appears to be a problem
    - At the request of the APS social worker
    - On every single case
    - Other (please explain)
31. What screening tool are you using for cognitive assessment?
    - SLUMS
    - Mini mental
    - MoCA
    - CLOCKS
    - Short portable mental questionnaire
    - Mini-cog
    - Goldfarb
    - I don't use a specific tool
32. If there are services you provide (or have provided) that are outside the normal scope of your practice, please tell us about them:
33. What are the characteristics of a good APS nurse?
34. If you were asked to make an argument for why APS needs to have nurses on staff, what would you say? What are the benefits of having nurses on staff? (Please feel free to answer in bullet points)