Vulnerable Populations Strategic Initiative: Program Analysis

Prepared for

Emergency Medical Services Division
Public Health – Seattle & King County

By

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Contents

Background

The Emergency Medical Services (EMS) Division, Public Health – Seattle & King County is partnering with the Seattle Fire Department (SFD), Aging and Disability Services (ADS), Adult Protective Services (APS), Seattle Police Department (SPD) and the University of Washington (UW) as part of EMS' Vulnerable Populations Strategic Initiative (VPSI). The overreaching goal of the VPSI is to conduct programmatic, scientific and population based evaluations to ensure that the interface between EMS and vulnerable populations leads to better outcomes for vulnerable adults by applying research evidence to practice. The initiative is focused on conducting needs assessments with EMS providers and local populations, identifying and implementing pilot interventions and evaluating the results.

In Seattle, the VPSI collaboration focuses on the interface between EMS and vulnerable adults at risk for neglect and abuse as part of the mandatory reporting requirement. The involved parties designed a six-month pilot study to better understand this population, including a dedicated full time ADS case manager to follow up on all SFD referred patients. The purpose of this evaluation was to make recommendations regarding the study design and implementation of the pilot.

Introduction

The Seattle Fire Department (SFD) trains emergency medical technicians (EMTs) to identify vulnerable patients at risk for neglect and abuse during their 9-1-1 visits. As EMTs provide pre-hospital basic life support services to many Seattle residents annually, these providers encounter situations that could indicate a case of abuse and/or neglect. Under Washington State Law Revised Code of Washington (RCW 74.34.020 and RCW 74.34.035) EMT's are "Mandated Reporters" and must report all suspected cases of adult abuse and/or neglect to the proper department and law enforcement agency. This report assessed the vulnerable adult abuse training for EMTs, identification and reporting of patients suspected of neglect or abuse and their coordination of care/referral of cases to Aging and Disability Services (ADS), Adult Protective Services (APS), and other key stakeholders, thus improving the health of at risk adults.

Definition of Key Terms

Critical to this evaluation is the identification of key terms associated with vulnerable adults at risk for abuse and neglect. States legislatures have been enacting laws related to abuse, neglect and financial exploitation of their elderly populations. This however has led to definitions that are inconsistent and vary state to state. Additionally national definitions of abuse and neglect of elderly populations are limited and inconsistent with state definitions of vulnerable adults and mandated reporters. This inconsistency has led to national data that is difficult to ascertain and analyze. The following are Washington State definitions of Mandated Reporters and Vulnerable Populations.

A Mandated Reporter under Washington State Law Revised Code of Washington (RCW 74.34.020) is defined as[i]:

1. An employee of a department of health.
2. Law enforcement officer.
3. Firefighters.
4. Paramedics.
5. EMT's.
6. Social workers: anyone engaged in a professional capacity during the regular course of employment in encouraging or promoting the health, welfare, support, or education of vulnerable adults, or providing social services to vulnerable adults, whether in an individual capacity or as an employee or agent of any public or private organization or institution.
7. Professional school personnel.
8. Health care providers (Physicians, nurses, et al.).
9. Employee and operator of a facility (Residence licensed facility, Assisted living facility, Nursing homes, Adult family homes, Residential habilitation centers).
10. Mental health personnel.
11. Adult day health personnel.
12. Adult day care personnel.
13. Home health personnel.
14. Home care personnel.

15. Hospice agency personnel.
16. County Coroner or medical examiner

In addition, clarification of who is a Vulnerable Adult is important because the term "Vulnerable Adult" does not have a uniform definition and varies state to state. The Washington State Legislature defines Vulnerable Adult as a person:

- Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or
- Is 18 years old and older who is found incapacitated or
- Who has a developmental disability or
- Admitted to any facility or
- Receiving services from home health, hospice, or home care agencies licensed or required to be licensed or
- Receiving healthcare services from an individual provider; or
- Who self-directs his or her own care and receives services from a personal aide.

Per RCW, vulnerable adult abuse is defined as "the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish". Abuse includes physical abuse, mental abuse, and sexual abuse of a vulnerable adult. Specific definitions are listed in Appendix I.

The following are guidelines for when to report suspected cases of abuse and/or neglect to law enforcement agencies according to the Revised Code of Washington (RCW 74.34.035)[ii]:

1. When there is reason to suspect that sexual assault has occurred.
2. When there is reason to suspect that physical assault has occurred or there is reasonable cause to believe that an act has caused fear of imminent harm.
3. When there is reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, mandated reporters shall immediately report to the department (APS).

4. A mandated reporter is not required to report to a law enforcement agency, unless requested by the injured vulnerable adult or his or her legal representative or family member, an incident of physical assault between vulnerable adults that causes minor bodily injury and does not require more than basic first aid, unless:

(a) The injury appears on the back, face, head, neck, chest, breasts, groin, inner thigh, buttock, genital, or anal area;

(b) There is a fracture;

(c) There is a pattern of physical assault between the same vulnerable adults or involving the same vulnerable adults; or

(d) There is an attempt to choke a vulnerable adult.

5. When there is reason to suspect that the death of a vulnerable adult was caused by abuse, neglect, or abandonment by another person, report the death to the medical examiner or coroner having jurisdiction, as well as the department and local law enforcement, in the most expeditious manner possible.

Each report, oral or written, must contain as much as possible of the following information:

a. The name and address of the person making the report.
b. The name and address of the vulnerable adult and the name of the facility or agency providing care for the vulnerable adult.
c. The name and address of the legal guardian or alternate decision maker.
d. The nature and extent of the abandonment, abuse, financial exploitation, neglect, or self-neglect.
e. Any history of previous abandonment, abuse, financial exploitation, neglect, or self-neglect.
f. The identity of the alleged perpetrator, if known.
g. Other information that may be helpful in establishing the extent of abandonment, abuse, financial exploitation, neglect, or the cause of death of the deceased vulnerable adult.

Literature Review

There is limited national statistics on the incidence and prevalence of elder abuse, neglect or exploitation. The lack of national statistics is attributed to the following:[iii]

- Uniform definitions of elder abuse are inconsistent and vary state to state.
- State statistics vary widely as there is no uniform reporting system.
- Comprehensive national data are not collected and analyzed.

In the absence of large-scale nationwide tracking system, independent studies of incidence and prevalence of elder abuse and neglect demonstrate the following statistics:

Elder abuse and neglect is estimated to affect 700,000 to 1.2 million American's annually (4% of all adults older than 65 years old).[iv] It is estimated that for every case of elder abuse, neglect, self-neglect or exploitation reported to authorities, five more go unreported.[v] Individuals from all races, ethnicities and socioeconomic groups have been victims of elder abuse and neglect and can occur anywhere from hospitals, private homes, and nursing homes. Cognitive impairment and poor health increases the risk of elder abuse/neglect by decreasing the elderly persons ability to report the abuse or defend himself/herself from it. Female elders are abused at a higher rate than males (65.7%), after accounting for their larger proportion in the aging population.[vi]43% of elder abuse occurs in those aged 80 years and older.[vii]

Self-neglect is the most commonly reported form of elder abuse and is increasing. Self-neglect occurs most often in persons who live alone or are socially isolated because they tend to have diminished support systems and the abuse is less likely to be noticed.[viii] A known person perpetrates approximately 90% of the elder abuse and neglect incidents, and two-thirds of the perpetrators are adult children or spouses.[ix] In 1999, a University of Iowa study found 242,430 elder abuse investigations from 47 states. The study showed significantly higher investigation rates were found for states that require mandatory reporting and tracking of reports (rate of 8.6 per 1,000 elders vs. 2.7 per 1,000 elders).[x]

Elder abuse has a substantial impact on morbidity and mortality. In a prospective, population-based cohort study conducted from 1993 to 2005, results showed that elders who experienced abuse had a significantly increased risk of overall mortality compared to those who had not been abused (HR, 1.39; 95% CI, 1.07–1.84). The study demonstrated increased

mortality risk for reported and confirmed elder abuse/neglect across all levels of cognitive and physical functioning.[xi]

Significant financial cost can be attributed to elder abuse and neglect. An estimated $5.3 billion of direct medical costs are associated with injuries occurred by elder abuse[xii] and the annual financial loss by victims of elder exploitation is estimated at $2.9 billion in 2009[xiii].

Education and training on determining a patient's risk factors and identifying signs of abuse by medical care providers and mandatory reporters have been shown to improve the recognition of elder abuse and neglect.[xiv] Early diagnosis of elder abuse and neglect allows authorities to take necessary steps in treatment and protection of vulnerable adults and to hasten morbidity and mortality associated with elder abuse and neglect.

Methods

The following methods were used in the evaluation of the current Seattle Fire Department Vulnerable Populations reporting process and data collection. These specific methods allowed an assessment of how well the current program has been implemented and maintained.

1. Researched existing data on elder neglect and abuse in the U.S, Washington State, King County, and Seattle.
    a. Reviewed SFD patient care records to identify vulnerable adult neglect and abuse. These records were identified using the SFD Vulnerable Adult Reporting Form.
    b. Interviewed EMS providers, ADS, SPD, and APS on the incidence and prevalence of vulnerable adult neglect and abuse, and current reporting practices.
    c. Identified patient characteristics and situational factors of at-risk patients.
    d. Evaluated the current mechanism for reporting by EMTs for at-risk patients and identified opportunities for improvement, including data needs.
    e. Analyzed APS WA State and King County vulnerable adult abuse/neglect data.
    f. Analyzed SFD Share Point Vulnerable Adult Case Information data.
2. Evaluated coordination of care and communication among the agencies involved in providing services to vulnerable adults (ADS, APS, EMS, SPD).

a. Evaluated the current communication methods and feedback loops between EMS/SFD, hospitals, APS, ADS and SPD regarding identification and reporting of at-risk vulnerable adults.

Reporting Process

The current process of reporting vulnerable adult's abuse and/or neglect by Seattle Fire Department (SFD) is as follows: (As reported by SFD)

1. During 9-1-1 dispatches, Seattle Fire Department EMS services evaluate and provide at scene care to the patient. If vulnerable adult abuse/neglect is suspected, the reporting SFD/EMS member completes a Vulnerable Adult Case Information form (Appendix II) once he/she returns to the fire/EMS station. This form is then emailed to the appropriate departments or agencies.
2. If the patient requires inpatient services they are transported to the designated hospital. The hospitals most commonly used are Harborview Medical Center, Swedish Medical Center, Virginia Mason Hospital, Highline Hospital, Northwest Hospital, and Veterans Hospital. Vulnerable adult abuse and neglect cases are also reported to case managers at the corresponding hospitals.
3. If vulnerable adult abuse/neglect is suspected and the patient resides in a private residence the incident is reported to Adult Protective Services (APS). APS investigates reports of alleged cases of abuse, neglect, exploitation and self-neglect of vulnerable adults 18 years of age or older. APS provides protective services to reduce or eliminate the risk of abuse, neglect, self-neglect, and exploitation.[xv]
4. If vulnerable adult abuse/neglect is suspected and the patient resides in a licensed care facility the incident is reported to Residential Care Services (RCS). RCS is responsible for the licensing and oversight of adult family homes, assisted living facilities, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities, and certified residential programs.[xvi]
5. If a crime is suspected at the scene of the incident, EMS notifies law enforcement (Seattle Police Department). Currently all cases of abuse/neglect are reported to SPD. The SPD investigates the incident and if there is substantial evidence of vulnerable

adult abuse and neglect then the King County Prosecutors Office charges and prosecutes the abusers.

6. Aging & Disability Services (ADS), a division of the Seattle Human Services Department, plans, coordinates, and advocates for a comprehensive service delivery system for older adults, family caregivers and people with disabilities in King County. ADS works to improve the health and quality of life for seniors and adults with disabilities; connect seniors and adults with disabilities with helpful resources; and provide help and support for caregivers.[xvii] Currently, all cases of vulnerable adult abuse/neglect are reported to Aging and Disability Services by SFD.

Figure 1: Seattle Fire Department (SFD) Vulnerable Adult Reporting Flowchart

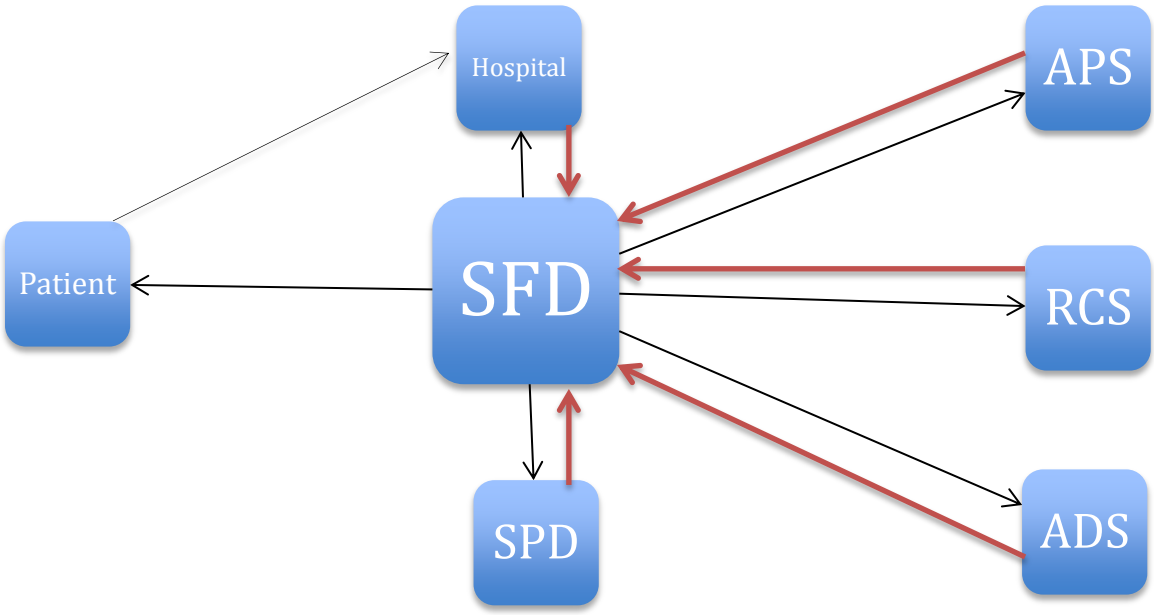


Figure 1: SFD-Seattle Fire Department, APS-Adult Protective Services, RCS- Residential Care Services, ADS- Aging and Disability Services, SPD-Seattle Police Department. Red arrows indicate lack of feedback.

As illustrated in Figure 1, once Seattle Fire Department reports cases of vulnerable adult abuse/neglect to the appropriate departments and agencies, SFD does not receive feedback on

the cases (indicated by red arrows). This lack of a feedback loop has led the SFD to create informal case follow-up between agencies.

Data Analysis and Results

The following table represents the number of Intakes assigned by APS for investigation, which span from 2000 to 2013. The table illustrates the number of Intake Reports by category.

Table 1: APS Statewide Intakes by Category.

Year	Intakes Assigned for Investigation	Physical Abuse	Sexual Abuse	Mental Abuse	Neglect	Self Neglect	Exploitation of Person	Financial Exploitation	Abandonment
2000	8,918	1,258	260	1,274	1,867	1,803	557	1,831	68
2005	15,293	2,168	383	2,214	2,975	3,107	885	3,512	49
2010	17,586	1,489	372	2,769	3,081	4,397	867	4,565	46
2013	26,845	2,076	501	4,312	4,428	6,328	1515	7,599	86

Table 2: APS Statewide % Change by Category.

Year Range	Intakes Assigned for Investigation	Physical Abuse	Sexual Abuse	Mental Abuse	Neglect	Self Neglect	Exploitation of Person	Financial Exploitation	Abandonment
2000-2005	+71.5%	+72.3%	+47%	+73.8%	+59.3%	+72.3%	+59%	+91.8%	-30%
2005-2010	+15%	-31.3%	-2.8%	+25%	+3.56%	+41.5	-2%	+30%	-6%
2010-2013	+52.6%	+39.4%	+34.7%	+55.7%	+43.7%	+44%	+74.7	+66.5%	+87
2000-2013	+201%	+65%	+92.7%	+238.5%	+137.2%	+251%	+171%	+315%	+26.5%

Tables 1 and 3 compares the Statewide and King County data regarding the number of intakes assigned for investigation in each category of mistreatment. The tables do not provide data if a vulnerable adult is the subject of multiple categories of mistreatment.

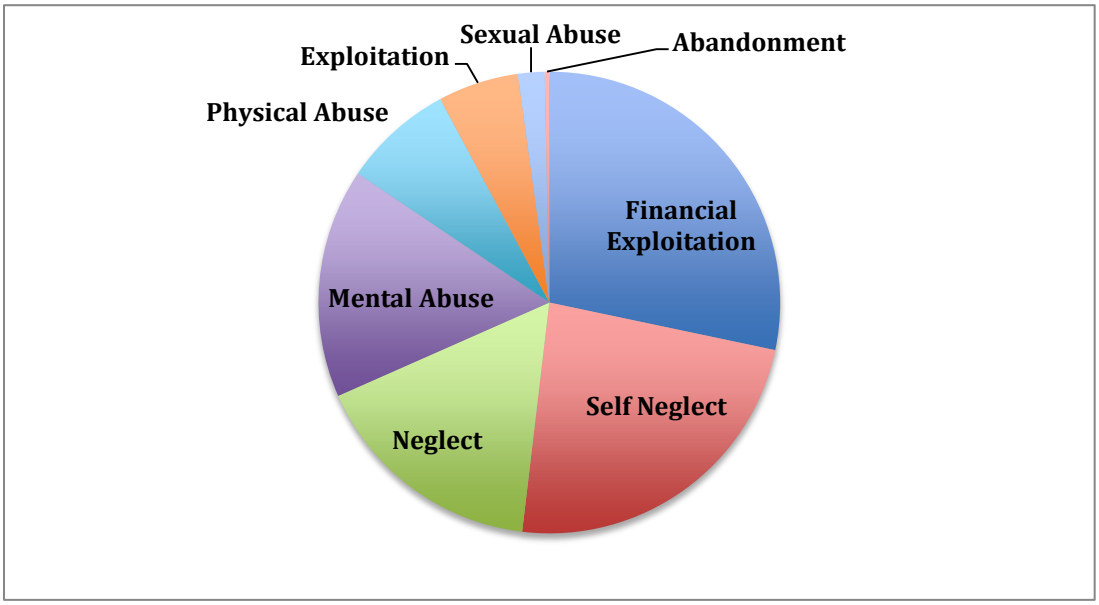
Table 3: APS King County, WA Intakes by Category.

Year	Intakes Assigned for Investigation	Physical Abuse	Sexual Abuse	Mental Abuse	Neglect	Self Neglect	Exploitation of Person	Financial Exploitation	Abandonment
2000	1,702	232	39	285	372	413	38	323	0
2005	3,644	580	74	473	804	807	216	673	17
2010	3,628	381	94	538	635	888	159	927	6
2013	5,423	465	103	703	851	1,455	459	1,358	29

Table 4: APS King County % Change by Category

Year Range	Intakes Assigned for Investigation	Physical Abuse	Sexual Abuse	Mental Abuse	Neglect	Self Neglect	Exploitation of Person	Financial Exploitation	Abandonment
2000-2005	+114%	+150%	+89%	+70%	+116%	+95.4%	+468.4%	+108%	
2005-2010	-0.4%	-34.3%	+27%	+13.7%	-21%	+10%	-26.4%	+37.7%	-64.7%
2010-2013	+49.5%	+22%	+9.6%	+30.7%	+34%	+64%	+188.7%	+46.5%	+383%
2000-2013	+218.6%	+100.4%	+164%	+146%	+128%	+252%	+1,107%	+320%	

Figure 2: Types of Vulnerable Adult Abuse and their Incidence. (APS WA State Data 2013)



The following data analysis and results was conducted on Seattle Fire Department SharePoint data. Seattle Fire Department began collecting data in 10/9/11 in the form of a Vulnerable Adult Case Information form (Appendix II) that is completed once vulnerable adult abuse/neglect is suspected during SFD/EMS 9-1-1 dispatches. For the purposes of this report only data from years 2012 and 2013 is being analyzed because years 2011 and 2014 do not contain full year data. In 2012 EMS responded to 54,192 9-1-1 calls of which 289 (0.53%) cases of vulnerable adult abuse/neglect were reported by SFD. In 2013 EMS responded to 53,221 9-1-1 calls of which 284 (0.53%) cases of elder abuse/neglect cases were reported by SFD. For Seattle and King County EMS vulnerable adult call volume map refer to Appendix III.

Table 5: Summary Table for Quantitative Variables of Seattle Fire Department SharePoint Data.

Variable	Mean	Range
Age in years (2012)	72.5	25-103
Age in years (2013)	76	29-97

Table 6: Summary Table for Qualitative Variables of Seattle Fire Department SharePoint Data.

Variable	Frequency	%
Sex of patient (2012)		
Male	90	31%
Female	199	69%
Sex of patient (2013)		
Male	96	34%
Female	188	66%
APS Notification (2012)		
Yes	256	89%
No	33	11%
APS Notification (2013)		
Yes	254	89%
No	30	11%
RCS Notification (2012)		
Yes	33	11%
No	256	89%
RCS Notification (2013)		
Yes	30	11%
No	254	89%

Discussion

Based on interviews with Seattle Fire Department, Emergency Medical Services and Aging and Disability Services, and data analysis of Seattle Fire Department Vulnerable Adult Share Point Data, the following areas have been identified for improvement and/or revision of current data collection and reporting practices of Vulnerable Adults by Seattle Fire Department:

Training: There is a need for training on identifying suspected Vulnerable Adult abuse and neglect by SFD/EMS personnel. A BLS training and education video was produced in conjunction with the King County Prosecutor's Office and Public Health - Seattle & King County, Emergency Medical Services Division but is not being used today. Also there is a lack of up-to-date and consistent training on reporting practices such as how to properly complete Vulnerable Adult Reporting Form (Appendix II) and Revised Code of Washington definitions of the categories of abuse/neglect (Appendix I).

Data Collection: There is a deficiency of data collection on suspected vulnerable adult abuse/neglect by SFD/EMS. The current Vulnerable Adult Reporting Form (Appendix II) consists of structural, contextual, and technical defects. The form does not collect demographic variables, categories of abuse/neglect, and other metrics that could be easily exported and analyzed.

Communication: There is an absence of a "feedback loop" between the stakeholders (SFD, EMS, hospitals, ADS, APS, RCS, and SPD). This has led to the creation of an informal follow up communication that is not sustainable or measureable. Feedback on the patient's progress provides vital information to SFD/EMS personnel and provides them with tools to better assist or treat the patient on future 9-1-1 dispatches. Also all reports are sent to stakeholders via email. The SFD email address is not generic but is an email address assigned to one person and only that person can view any feedback from stakeholders. Other agencies also employ this method. This use of non-generic email address to send/receive Vulnerable Adult Reporting Forms is not sustainable.

Personnel: Seattle Fire Department currently has only 1 person trained and tasked with communicating with the key stakeholders. Although all SFD/EMS personnel are "mandated reporters" and are required to complete and send the SFD Vulnerable Adult Reporting Form, they are not trained nor do they have direct access to feedback information that is provided.

Recommendations

Based on the finding from the data analysis, interviews of SFD, ADS, APS and literature review, the following are recommendations for program improvements:

1. Enhance the Seattle Fire Department web based Vulnerable Adult Reporting Form. (Appendix IV).
2. Train EMT's the updated reporting procedures and instructions on completing the enhanced Seattle Fire Department Vulnerable Adult Reporting Form. Training will consist of a Power Point presentation, which will be reviewed by all company officers with their crews.
3. Create a feedback loop to the Seattle Fire Department with a follow up form including actions taken by the case manager, Adult Protective Services, and Seattle Police Department.

The following are additional recommendations not addressed or to be determined upon completion of the pilot project:

1. Update the BLS training and education video that was produced in conjunction with the King County Prosecutor's Office and the EMS Division, Public Health - Seattle & King County. The revisions to this presentation should include updated reporting practices as well as examples of vulnerable adult abuse and neglect cases that have occurred in Seattle and King County. This presentation should be instituted as part of required Vulnerable Adult training by Seattle Fire Department.
2. Create a generic Seattle Fire Department email address for stakeholder feedback that can be viewed by all Seattle Fire Department personnel. For example, create an email address- vulnerableadult@seattle.gov instead of using john.doe@seattle.gov. This generic email address should be utilized by all stakeholder agencies.
3. Create a feedback loop via feedback forms with hospital case managers, Residential Care Services, and any other stakeholder reportable agencies.
4. Create lead personnel on every shift at Seattle Fire Department that would be responsible for reviewing vulnerable adult feedback information from stakeholders. Currently there is

1 individual that is responsible for reviewing feedback. This action would create sustainable communication between agencies.

Conclusion

Vulnerable adult abuse, neglect, exploitation, and abandonment continues to be unrecognized and underreported in Seattle, King County and nationwide. As the U.S population continues to age, the incidence and prevalence of abuse and neglect will continue to rise. The U.S Bureau of the Census is predicting that by 2030, 20% of the U.S population will be 65 or older, up from 12.3% in 1990. Continued training and education of medical personnel and mandatory reporters is necessary to recognize and report vulnerable adult abuse and neglect. Data collection and analysis by stakeholders is crucial to understand this societal problem. Nationwide standardization of reporting practices and definitions of abuse/neglect are necessary for data analysis and communication between agencies. These steps will ultimately lead to increased awareness and protection of vulnerable adults and decrease the incidence and prevalence of abuse and neglect.

Appendices

I. Definitions of Abuse

A. "Physical abuse" means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

B. "Mental abuse" means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

C. "Sexual abuse" means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program and a vulnerable adult living in that facility or receiving service from a program authorized whether or not it is consensual.

D. “Neglect” is defined as a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety.

E. "Self-neglect" means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an

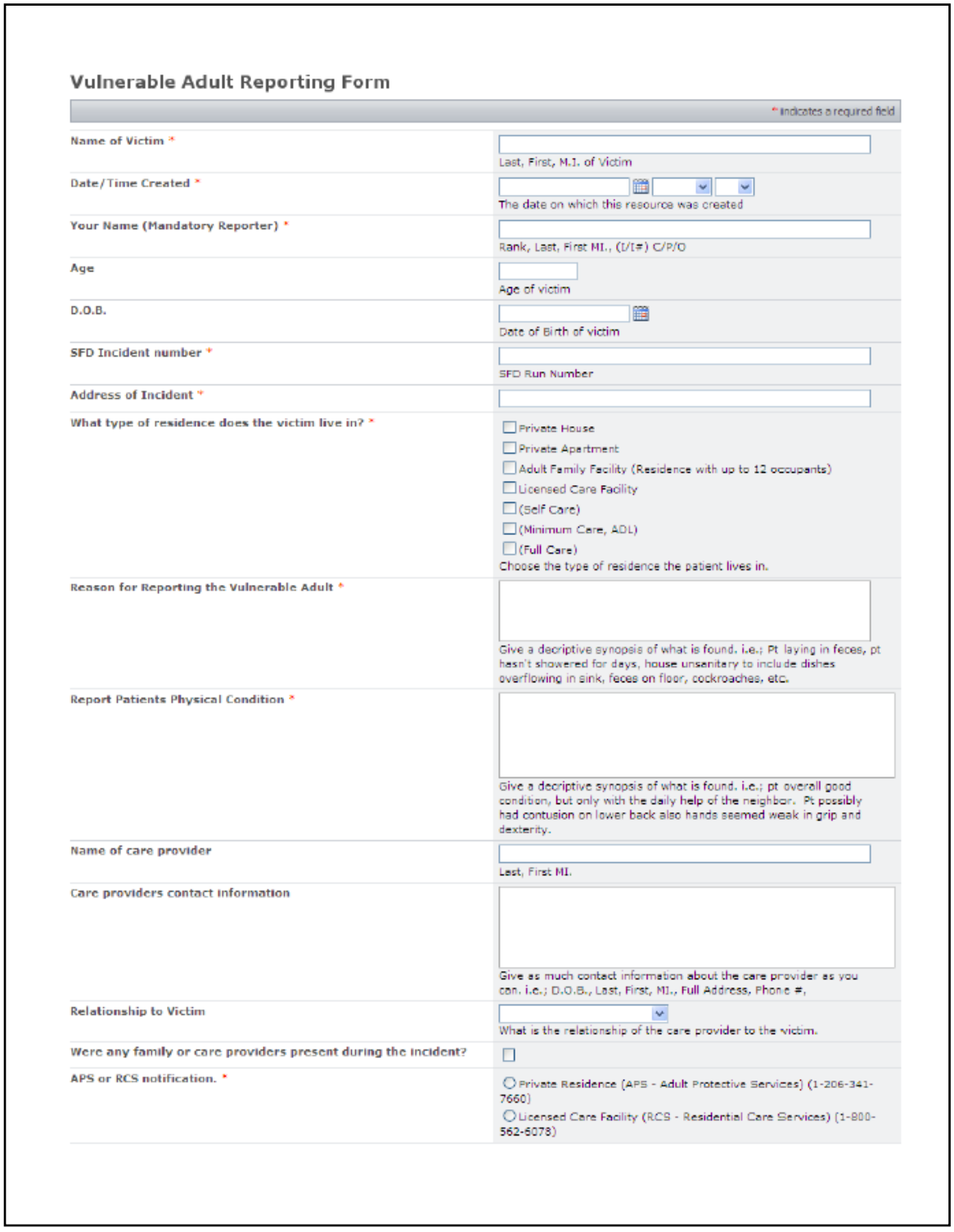
individual provider when the neglect is not a result of inaction by that agency or individual provider.

F. “Abandonment” is defined as action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

G. “Exploitation” is defined as an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

H. "Financial Exploitation" means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage.

II. Current SFD/EMS Vulnerable Adult Reporting Form.



Vulnerable Adult Reporting Form

* indicates a required field

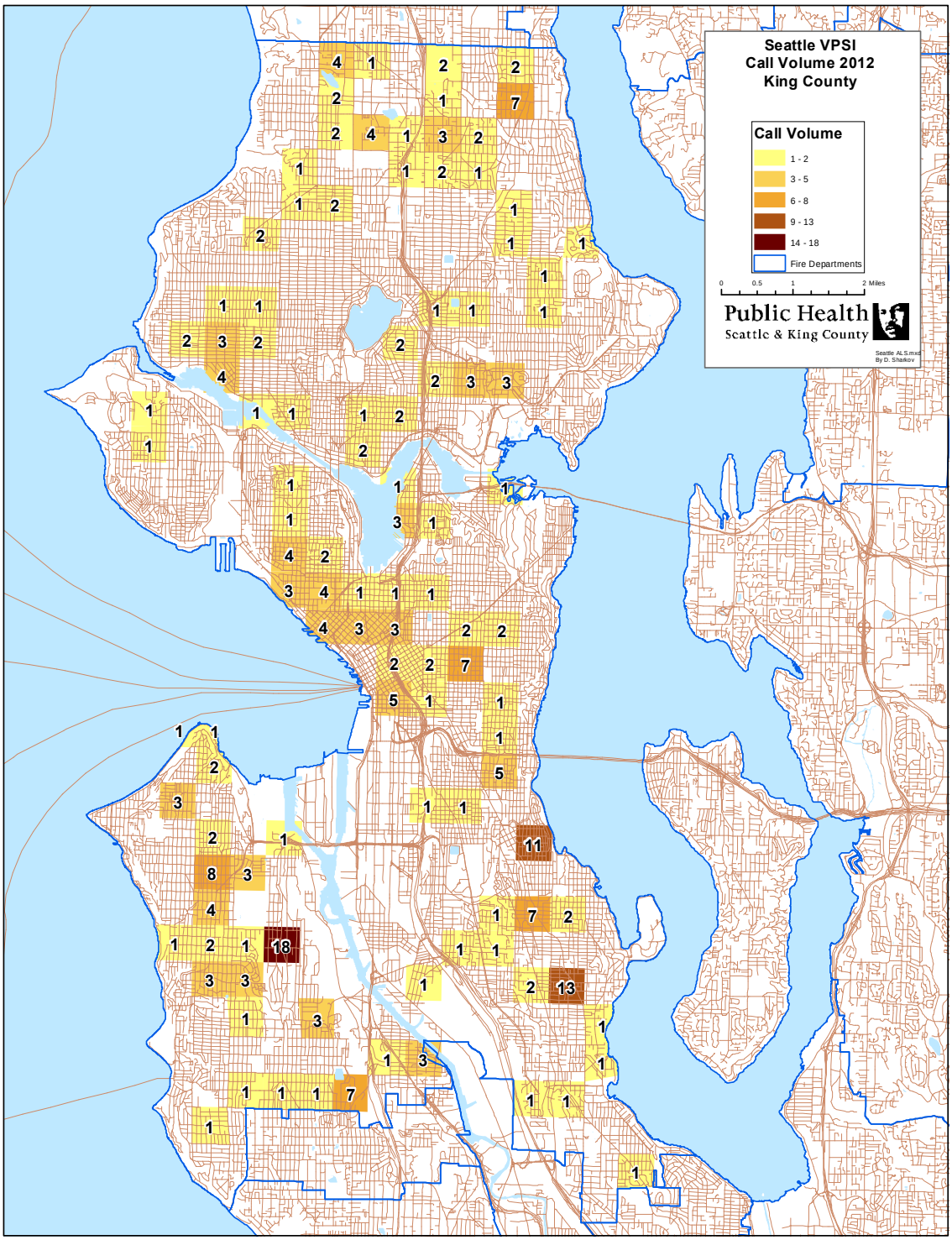
Name of Victim *	Last, First, M.I. of Victim
Date/Time Created *	The date on which this resource was created
Your Name (Mandatory Reporter) *	Rank, Last, First MI., (D/E#) C/P/O
Age	Age of victim
D.O.B.	Date of Birth of victim
SFD Incident number *	SFD Run Number
Address of Incident *	
What type of residence does the victim live in? *	☐ Private House ☐ Private Apartment ☐ Adult Family Facility (Residence with up to 12 occupants) ☐ Licensed Care Facility ☐ (Self Care) ☐ (Minimum Care, ADL) ☐ (Full Care) Choose the type of residence the patient lives in.
Reason for Reporting the Vulnerable Adult *	Give a decriptive synopsis of what is found. i.e.; Pt laying in feces, pt hasn't showered for days, house unsenitery to include dishes overflowing in sink, feces on floor, cockroaches, etc.
Report Patients Physical Condition *	Give a decriptive synopsis of what is found. i.e.; pt overall good condition, but only with the daily help of the neighbor. Pt possibly had contusion on lower back also hands seemed weak in grip and dexterity.
Name of care provider	Last, First MI.
Care providers contact information	Give as much contact information about the care provider as you can. i.e.; D.O.B., Last, First, MI., Full Address, Phone #,
Relationship to Victim	What is the relationship of the care provider to the victim.
Were any family or care providers present during the incident?	☐
APS or RCS notification. *	○ Private Residence (APS - Adult Protective Services) (1-206-341-7660) ○ Licensed Care Facility (RCS - Residential Care Services) (1-800-562-6078)

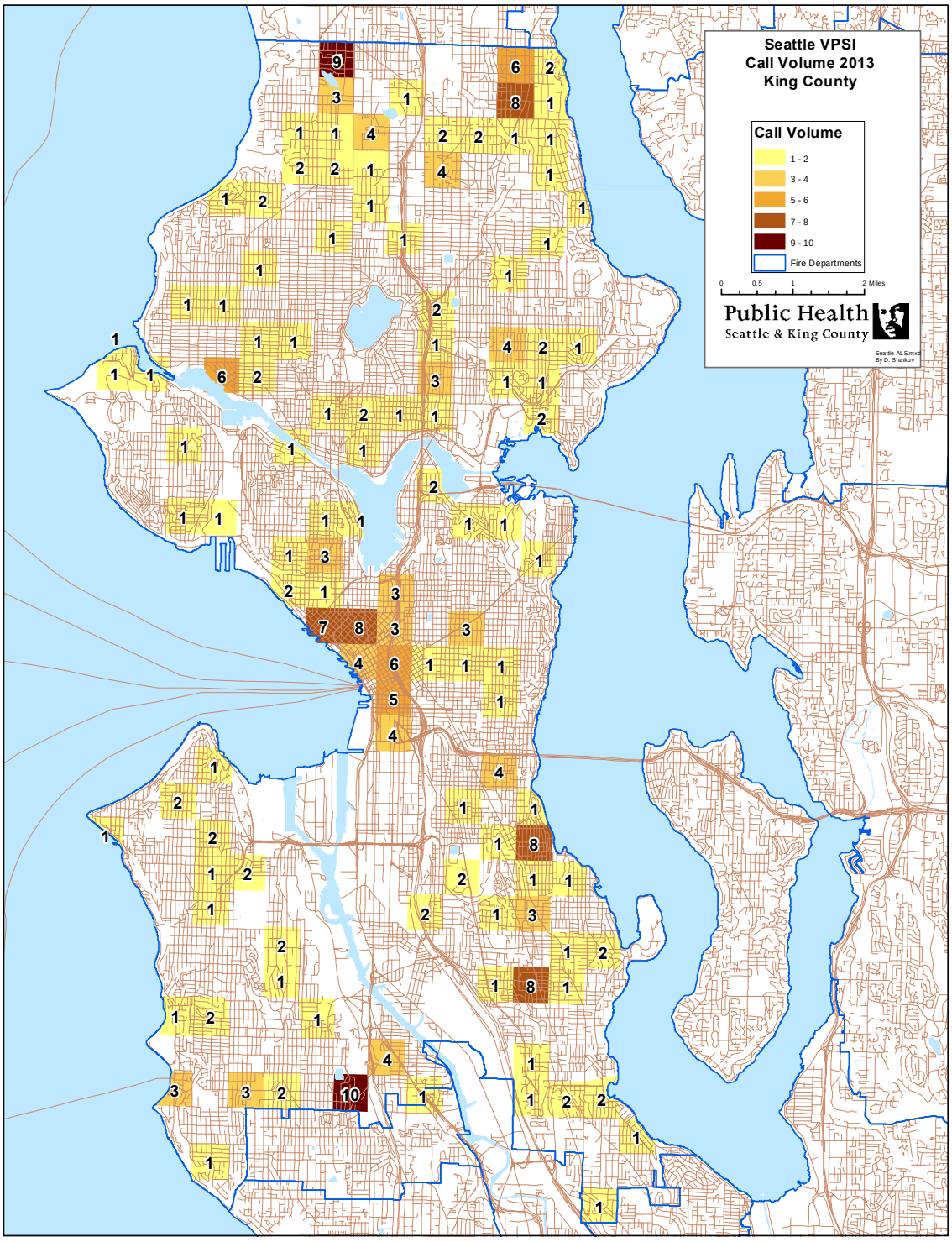
Vulnerable Adult Reporting Form

Page 2 * indicates a required field

APS or RCS notification. *	○ Private Residence (APS - Adult Protective Services) (1-206-341-7660) ○ Licensed Care Facility (RCS - Residential Care Services) (1-800-562-6078)
Contact information of APS or RCS *	Title, Last, First MI., of person you talked to at APS or RCS.
Date and time APS or RCS was notified *	12 AM 00 Date and Time you notified APS or RCS.
Did you leave a message on an answering machine at APS or RCS?	☐
Was SPD dispatched to the scene of the incident? *	○ Yes ○ No
Did you notify SPD after the incident? *	○ Yes ○ No
Is there a possibility of a crime at the scene? *	○ Yes ○ No
Describe Possible Crime Scene	Be very descriptive; paint a picture of the possible crime scene. Give facts, not what you think or suspect. Take and attach pictures to this section if you can, or call in the B.C. to take pictures.

III. Seattle/King County Vulnerable Populations Call Volume




Seattle VPSI
Call Volume 2013
King County
Call Volume
1 - 2
3 - 4
5 - 6
7 - 8
9 - 10
Fire Departments
0
0.5
1
2 Miles
Public Health
Seattle & King County
Seattle ALS.mxd
By D. Shakov

IV. Updated SFD/EMS Vulnerable Adult Reporting Form with ADS, APS, and SFD feedback sections.

EMS

SFD SharePoint Home > TRAINING DIVISION > EMS > Vulnerable Adult Case Information > New Item

Vulnerable Adult Case Information: New Item

Attach File * indicates a required field

SFD Incident Number *	SFD Run Number. Example: F140019137
Date Report Created *	10/8/2014 1 PM 00 The date on which this resource was created
Your Name (Mandatory Reporter) *	Rank, Last, First MI., (I/I#) C/P/O NOTE: You, the reporting SFD member, must be logged into SharePoint yourself to receive any sort of information about this Vulnerable Adult Case. If you are NOT currently logged in to SharePoint, Cancel the creation of this Vulnerable Adult Form, log out of this PC and then sign in with your own login and start over.
Incident Date and Time *	12 AM 00
Who called 9-1-1 and why (if known)?	
Address of Incident *	Please include City, State, and Zip Code
Name of Patient *	Last, First, M.I.
D.O.B. of Patient *	Date of birth of the patient
Age of Patient *	
Sex *	Male Female
Race	
Language Spoken	
Patient's Address *	Please include City, State, and Zip Code
Patient's phone number	Please use the following format: xxx-xxx-xxxx
Type of residence *	Private House Private Apartment Licensed Care Facility
Name of Licensed Care Facility	
Initial impression for reporting the patient	Physical Abuse Mental Abuse Sexual Abuse Neglect/Self Neglect Abandonment Exploitation/Financial Exploitation Other (Describe in comments below) Check all that apply
Comments (Initial impression)	
Description of your initial impression: Patient's Condition *	Bed Sores Bruising Edema Tenderness with palpation

- [ ] Malnourished
- [ ] Dehydrated
- [ ] Old wounds
- [ ] Wounds in various stages of healing
- [ ] Soiled clothing
- [ ] Poor hygiene/unbathed
- [ ] Frail/weak
- [ ] Evidence of coercion/verbal abuse
- [ ] Unable to stand without assistance
- [ ] Frequent falls
- [ ] Incontinent of urine/feces
- [ ] Medication non-compliant
- [ ] Non injury or illness
- [ ] Evidence of sexual abuse
- [ ] Other (Describe in comments below)

Check all that apply

Comments (Patient's Condition)

Description of your initial impression: Home & Environment *

- [ ] No food
- [ ] Unsanitary home (explain below)
- [ ] Unsanitary bathroom
- [ ] Unsanitary bed
- [ ] Hoarding conditions
- [ ] Rodent/insect infestation
- [ ] Human/animal feces around home
- [ ] Fall hazard around home
- [ ] Fire hazards in home (explain below)
- [ ] Neighbors assist with daily living
- [ ] No assistance in home
- [ ] Care provider unable to assist patient
- [ ] Visible weapons
- [ ] Dangerous animals
- [ ] Visible drug paraphernalia
- [ ] Restraints
- [ ] Lack of appropriate medical equipment or supplies
- [ ] Foul odor
- [ ] Other (Describe in comments below)

Check all that apply

Comments (Home & Environment)

Operations Company Actions *

- [ ] Patient Exam
- [ ] Trauma Exam
- [ ] Vitals
- [ ] Initial assessment
- [ ] Detailed history
- [ ] Backboard/C-collar
- [ ] Wound care
- [ ] Transported to hospital
- [ ] Lift assist to position of comfort
- [ ] Assisted with bathroom duties
- [ ] Cleaned patient of feces and urine
- [ ] Prepared meal for patient
- [ ] Reduced/minimized fire hazards
- [ ] Reduced/minimized fall hazards
- [ ] Communicated with family/friends/neighbor/care provider
- [ ] Other (Describe in comments below)

Check all that apply

Comments (Operations Company Actions)

If the patient was transported, which hospital?	○ Swedish Medical Center (dawn.st.aubyn@swedish.org) ○ Harborview Medical Center (hswsfd@uw.edu) ○ Veterans Hospital (joleen.shaughnessy@va.gov) ○ Virginia Mason Hospital (megan.bott@vmmc.org) ○ Northwest Hospital (ann.drummond@nwshea.org) ○ Highline Hospital (Alice Hayden (ahayden@highlinemedical.org) ○ Other (Describe in comments below)
If patient was not transferred to the hospital, why?	○ Patient refused against medical advice ○ No medical necessity ○ Alternate (primary care physician, clinic) ○ Other (Describe in comments below)
Comments (Hospital)	
Does the patient have a care provider? *	○ Yes ○ No ○ Unknown
Name of care provider (if known)	
Care provider's contact information	
Care provider's relationship to patient	What is the relationship of the care provider to the victim.
Other persons present during incident? *	○ Yes ○ No
If yes, please provide Name, Contact Information, and Relation	
Was Seattle Police Department requested? *	○ Yes ○ No
If yes, please provide SPD Case Number	
APS, RCS, Notification *	☐ Private Residence (APS – Adult Protective Services, 1-206-341-7660, JacksW@dshs.wa.gov) ☐ Licensed Care Facility (RCS – Residential Care Services, 1-800-562-6078, CRU@dshs.wa.gov) . . . When the "OK" button at the bottom of the form is clicked, an email will automatically be sent to either APS or RCS (or both) based on the choice made in this field. . . . .

	. Firefighters: you're done! Skip to the bottom and click on the OK button to save this report. . . .
ADS –Vulnerable Adult Intake Form *	ADS Vulnerable Adult Intake Form ▼
ADS –At the time of the incident, were services in place?*	○ Yes ○ No
ADS –If Yes, what are the initial services that are being provided?	☐ Case management ☐ State contracted in home care services ☐ Home health care ☐ Hospice ☐ Residential Care ☐ Volunteer chore services ☐ Private pay in home services ☐ Alcohol and substance use services ☐ Mental health services ☐ Primary care provider ☐ Guardian/POA ☐ Other (Describe in comments below) Check all that apply
ADS –Additional Comments (initial services)	
ADS –Is there a case manager assigned to the patient?*	○ Yes ○ No
ADS –If yes, please provide Name and contact information of the case manager	
ADS –Does the patient have a care provider?*	○ Yes ○ No . . . . –End of ADS Vulnerable Adult Intake Form–
ADS –Vulnerable Adult Assessment Form *	ADS Vulnerable Adult Assessment Form ▼
ADS –If yes, please provide the name, address, and contact information of the care provider	
ADS –Patient enrolled in services?*	○ Yes ○ No
ADS –If yes, what services?	☐ Case management ☐ State contracted in home care services ☐ Home health care ☐ Hospice ☐ Residential care ☐ Volunteer chore services ☐ Private pay in home services ☐ Alcohol and substance use services ☐ Mental health services ☐ Primary care provider ☐ Guardian/POA ☐ Other (Describe in comments below) Check all that apply
ADS –Additional Comments (enrolled in services)	

	–End of ADS Vulnerable Adult Assessment Form–
APS – Vulnerable Adult Feedback Form *	APS Vulnerable Adult Feedback Form
APS – Action taken by APS*	Assigned for investigation Screen out Already being investigated Protective services being provided Check all that apply
APS – Name and contact information of APS investigator if case assigned	–End of APS Vulnerable Adult Feedback Form–
SPD – Vulnerable Adult Feedback Form *	SPD Vulnerable Adult Feedback Form
SPD – Did SPD conduct site visit?*	
SPD – If yes, what were the findings?	Physical Abuse Mental Abuse Sexual Abuse Neglect Self Neglect Abandonment Exploitation Financial Exploitation Other (Describe in comments below) Check all that apply
SPD – Additional Comments (findings)	–End of SPD Vulnerable Adult Feedback Form–
ADS – Vulnerable Adult Outcome Form *	ADS Vulnerable Adult Outcome Form
ADS – Patient Outcome*	Refused services New services provided Continued to receive services

	○ Case closed ○ Unable to determine (too soon) ○ Other (Describe in comments below) ◉ Specify your own value:
Comments (Patient Outcome)	
ADS –If case closed, why?	○ No longer needed ○ Placement ○ Death ○ Other (Describe in comments below) ◉ Specify your own value:
Comments (Case closed)	

References:

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[xvi] http://www.altsa.dshs.wa.gov/professional/rcs.htm. Accessed July 15, 2014.

[xvii] http://www.agingkingcounty.org. Accessed August 3, 2014.