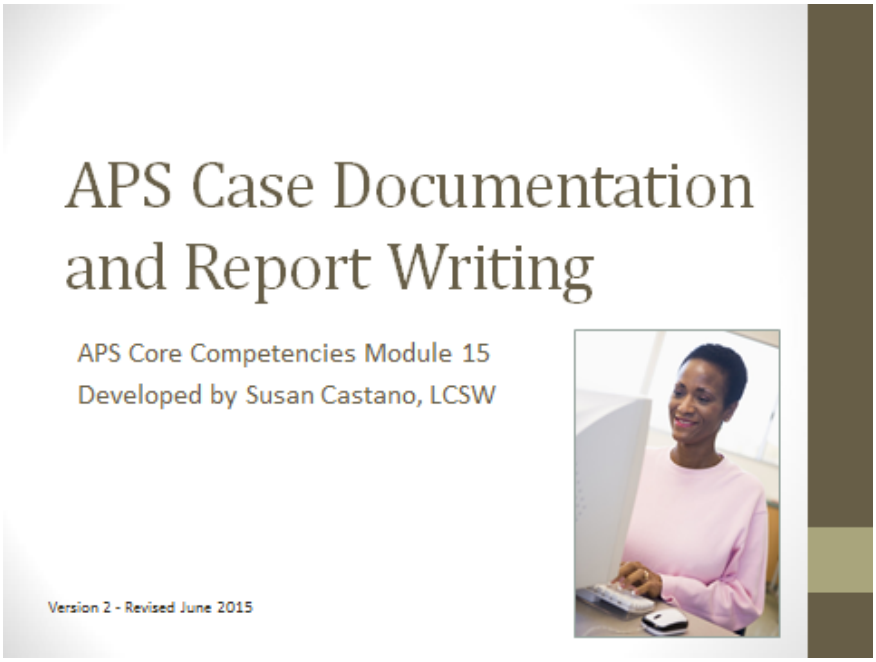
APS CASE DOCUMENTATION and REPORT WRITING

Participant Manual



Module 15

Participant Manual - APS Case Documentation & Report Writing

School of Social Work

This training was developed by the Adult Protective Services (APS) Training Project a program of the Bay Area Academy, San Francisco State University School of Social Work. The APS Training Project is funded by the California Department of Social Services, Adult Services Branch with additional funding for this training provided by California State University Sacramento IHSS Training Project.

Curriculum Developer
Susan Castano, LCSW

Curriculum Revisions 2015
Krista Brown

Revised 2015. Central California Adult Services Training Academy, California State University Fresno, Social Welfare Evaluation, Research, and Training Center with funds from the APS Training Contract, California Department of Social Services (CDSS).

INTRODUCTION

APS TRAINING PROJECT – BAY AREA ACADEMY

We are pleased to welcome you to the APS Documentation Skills and Report Writing training for new APS workers.

The Adult Protective Services (APS) Training Project, a program of the Bay Area Academy/San Francisco State University, works to identify training needs, priorities and emerging issues among county Aging & Adult Services staff - with an emphasis on APS and In-Home Support Services (IHSS) training priorities. The project works in numerous partnerships to develop APS training curriculum and deliver core and specialized training to enhance the skills and knowledge of county social workers who serve vulnerable seniors and adults with disabilities within the State of California.

APS Training Project's overarching goal is to develop and deliver statewide, standardized core curricula for new APS/IHSS social workers and to share these trainings on a national scale through our partnership with the National Adult Protective Services Association (NAPSA). Professional training opportunities are a critical step toward ensuring APS social workers have the appropriate tools to serve their clients.

The Project is a founding member of the APS Regional Training Academy Consortium (RTAC) and the National APS Training Partnership. Our partners include:

- Academy for Professional Excellence/Project MASTER, Central California Child Welfare Training Academy and the Northern California Training Academy
- California Department of Social Services, Adult Services Branch
- California State University Sacramento IHSS Training Project
- Protective Services Operations Committee of the California Welfare Director's Association (PSOC)
- California Social Work Education Center Aging Initiative (CalSWEC)
- National Adult Protective Services Association Education Committee (NAPSA)

PARTNER ORGANIZATIONS

Lori Delagrammatikas, Program Coordinator for MASTER
The Academy for Professional Excellence
6505 Alvarado Road, Suite 107
San Diego, California 92120
(909) 213-6059
ldelagra@projects.sdsu.edu
http://theacademy.sdsu.edu/programs/

Krista Brown, Project Coordinator for APS Training Project
The Academy for Professional Excellence
(510) 459-0731
krbrown@projects.sdsu.edu
http://theacademy.sdsu.edu

Kathleen Quinn, Executive Director
National Adult Protective Services Association
920 South Spring Street, Suite 1200
Springfield, IL 62704
(217) 523-4431 / (271) 522-6650
Kathleen.quinn@apsnetwork.org

Susan Castano, Chair
NAPSA Education Committee
2066 East Wellington Rd
Newtown, Pa 18940
(215) 860-6967
scastano@comcast.net

Kathy Young, Chair
Protective Services Operations Committee of the County Welfare Director's Association
505 Poli Street
Ventura, CA 93001
kathy.young@ventura.org

Kathy Sniffen, Coordinator
CalSWEC Aging Initiative
University of California, Berkeley
School of Social Welfare
Marchant Building, Suite 420
6701 San Pablo
Berkeley, CA 94720-7420
(209) 605-3875
kasniffen@sbcglobal.net

Bay Area Academy – 2201 Broadway, Ste 100, Oakland, CA 94612 – Tel: 510-419-3600 / Fax: 510-663-5532 / Website: www.bayareaacademy.org

ACKNOWLEDGMENTS

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and Bay Area Academy staff members. The APS Training Project would like to thank the following individuals and agencies:

Agencies

Academy for Professional Excellence/Project MASTER
Alameda County Social Service Agency
California Department of Social Services, Adult Services Branch
California State University Sacramento IHSS Training Project
California Social Work Education Center Aging Initiative
Contra Costa County Adult and Aging Services
Napa County Health and Human Services
San Francisco County Department of Adult and Aging Services
San Mateo County Adult and Aging Services
Solano County Elderly and Disabled Adult Services

Regional Curriculum Advisory Committee

Lisa Lahowe, APS/Chief Assistant Public Guardian, Alameda County
Eloise Sotelo, APS Supervisor/Trainer, Contra Costa County
Candy Akman, APS Supervisor, Napa County
Sara Stratton, APS Supervisor/Trainer, San Francisco County
Kelly Semprich, APS Supervisor, San Mateo County
Lynda Fuller, APS/IHSS Supervisor, Staff Development, Solano County

Committees

APS Core Curriculum Committee
National Adult Protective Services Association Education Committee
Protective Services Operations Committee of the California Welfare Directors Association

Curriculum Developer

Susan Castano, LCSW

Special Consultants

Candace Heisler, JD, Legal Consultant
Tristan D. Svare, Deputy District Attorney, San Bernardino County

Curriculum Revisions 2015

Krista Brown

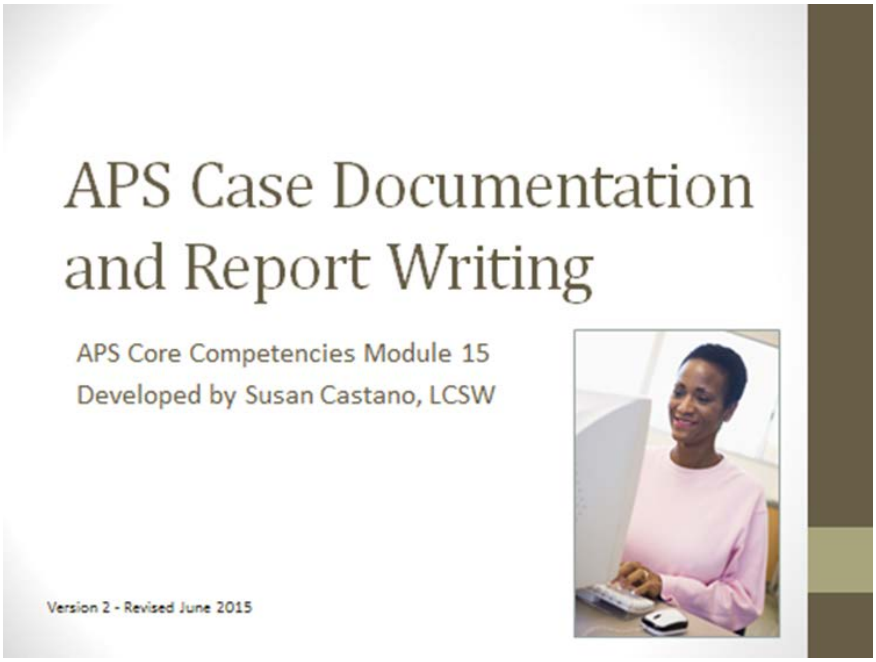
TABLE OF CONTENTS

Appendix

COURSE OUTLINE

Content	Total Time	Activities	Slides/Handouts
Introductions, Overview & Icebreaker	30 min	Introductions, Evaluation, Warm-up Activity	Slides 1-8 Letter to Participants ID Code Assignment
Documentation Overview	45 min	Lecture/Discussion Individual Activity Large Group Process	Slides 9-19 Handout 1-3
BREAK	15 min.		
Clear, Factual, Objective & Concise Documentation	90 min.	Lecture/Discussion Small/Large Group Activities	Slides 20-30 Handout 4-8
LUNCH	60 min.		
Memory Tips and Documentation Equipment	30 min	Lecture/Discussion Group Activity	Slide 31-33 Handout 9-12
Ethical Considerations and Confidentiality Related to Documentation	30 min	Lecture/Discussion	Slide 34-36 Handouts 13-14
Report Writing for Court	30 min	Lecture/Discussion Large Group Activity	Slides 37-40
BREAK	15 min		
Conservatorship Documentation and Report Writing Activity	60min	Lecture & hand outs	Slides 41-43 Handouts 15-16
Closing & Evaluations	15 min	Q & A & evaluations.	Slide 44 Evaluations
TOTAL TIME	**7 hrs** (including 1 hour lunch)		

TRAINING GOALS AND OBJECTIVES



By the end of this training, participants will be able to:

1. Describe the purpose of accurate, complete and timely documentation.
2. Demonstrate the use of clear, concise, and objective language.
3. Identify four types of equipment and their uses.
4. Discuss the importance of accurate recall and identify at least three memory improvement techniques.
5. Discuss confidentiality as it relates to documentation.
6. Discuss documentation needed for court including statements, evidence, and language.
7. Analyze and rewrite an APS report.

EXECUTIVE SUMMARY

Course Title: *APS Case Documentation & Report Writing*

Outline of Training:
In this engaging and highly interactive introductory training, participants learn the necessary and essential components of effective documentation and report writing. Trainees will understand the purpose of competent documentation; demonstrate the use of clear, concise, and objective language; learn memory improvement techniques; understand confidentiality as it relates to documentation; and demonstrate written case documentation skills through an interactive skills practice exercise.

The following instructional strategies are used: lecture segments; interactive activities/exercises (e.g. small group discussion, experiential exercise); question/answer periods; PowerPoint slides; video clip; participant guide (encourages self-questioning and interaction with the content information); embedded evaluation to assess training content and process; and transfer of learning activity to access knowledge and skill acquisition and how these translate into practice in the field.

Course Requirements:
Please note that training participants are expected to participate in a variety of in-class and post- training evaluation activities. These activities are designed to enhance the learning experience and reinforce the skill acquisition of training participants as well as determine the overall effectiveness of the trainings.

An executive summary of each training and directions for post-training evaluation activities will be provided to training participants and their supervisors. Certificates of course completion will be awarded upon completion of ALL course activities.

Target Audience:
This course is designed for new APS social workers as well as Aging & Adult Service partners (e.g. APS/IHSS, IHSS). This training is also appropriate for senior staff that require knowledge and/or skills review.

Outcome Objectives for Participants:
Learning goals – Upon completion of the training, participants will be able to:

1. Describe the purpose of accurate, complete and timely documentation.
2. Demonstrate the use of clear, concise, and objective language.
3. Identify four types of equipment and their uses.
4. Discuss the importance of accurate recall and identify at least three memory improvement techniques.
5. Discuss confidentiality as it relates to documentation.

6. Discuss documentation needed for court including statements, evidence, and language.
7. Analyze and rewrite an APS report.

Transfer of Learning: *Ways supervisors can support the transfer of learning from the training room to on the job.*

BEFORE the training

Supervisors can encourage line staff to attend the training and help them identify particular strengths and/or challenges that they have had with documentation in the past. Training participants can share these experiences during training.

AFTER the training

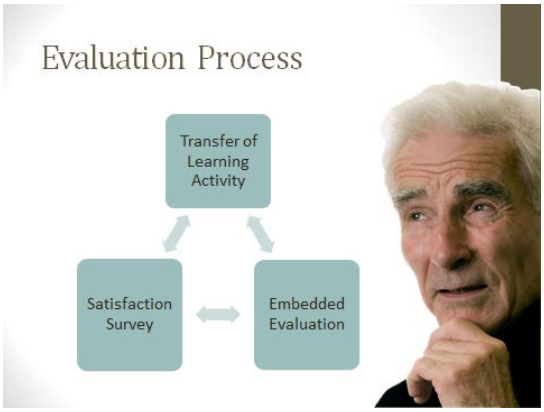
Supervisors can read the training executive summary and instructions for out-of-class transfer of learning activity. Supervisor and training participant will then schedule a time to complete the activity together – at this point trainee can share what specific skills they obtained from the training. If further staff involvement is available, trainee may present an overview of what was learned to other staff members to encourage collaboration and a culture of learning.

WELCOME, OVERVIEW & ICE BREAKER

TIME ALLOTTED: 30 minutes

Slide #3

Slide #4



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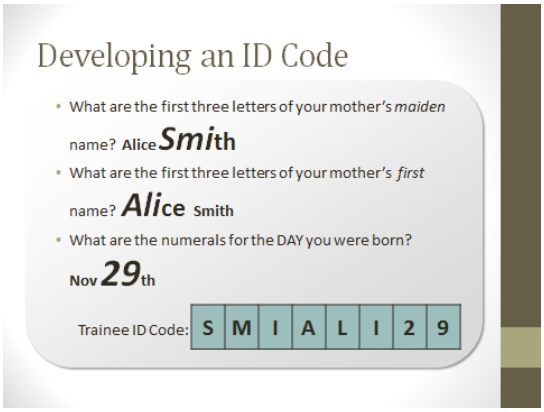


Dear Training Participant,

As a training program for the Academy for Professional Excellence at San Diego State University School of Social Work, we have begun a process of evaluating training delivered to Adult Protective Service workers. As part of this evaluation, we need your help.

At certain points during this training series, in addition to the usual workshop evaluation forms, you will be asked to complete various training evaluation activities.

These training evaluation activities have two main purposes:
1. To improve training effectiveness and relevance to your needs in helping you better serve adults and their families; and
2. To determine if the training has been effective in addressing the key learning objectives.

Our goal is to evaluate training, NOT the individuals participating in the training. In order to evaluate how well the training is working, we need to link each person's assessment data using a code. You will generate the code number using the first three letters of your mother's maiden name, the first three letters of your mother's first name, and the numerals for the day you were born. Please put this 8-digit ID code on each of your assessment forms, exactly the same way each time. ID code information will only be used to link demographic data to test data to ensure that the training is working equally well for all participants. Once this link is made, we will only look at class aggregate scores, not individual scores.

Only you will know your ID code refers to you. All individual responses to evaluation exercises are confidential and will only be seen by the Academy's training program and evaluation staff. Only group averages and percentages will be reported. Individual

results will not be reported to your employer. Aggregate data may be used for future research to improve training for Adult Protective Service workers.

If you agree to participate, you will fill out questionnaires administered before and after the training. The questionnaires will be coded with your ID code and all responses will be confidential.

There are no foreseeable risks to you from participating. There is also no direct benefit to you. Your responses will contribute to the development of a series of evaluation tools that will be able to accurately assess the effectiveness of adult protective service training. It is hoped that these tools will assist the Academy for Professional Excellence in improving training for adult protective service workers and therefore improve services to adults and families.

Your participation is voluntary and you may withdraw your consent and participation at any time. Participation or non-participation will have no effect on your completion of this training series.

By completing and submitting the questionnaire, you agree to participate. You further agree to permit us to use your anonymous responses in written reports about the training.

Your help with this evaluation process is greatly appreciated. Your feedback will be instrumental in helping to improve adult protective service training for future participants. If you have any questions about the evaluation or how the data you provide will be used, please contact:

James Coloma, MSW
Training & Evaluation Specialist
Academy for Professional Excellence
San Diego State University – School of Social Work
6505 Alvarado Road, Suite 107
San Diego, CA 92120
(619) 594-3219
jcoloma@projects.sdsu.edu

Trainee ID Code | | | | | | | | |

Date | | | / | | | / | | |
M M D D Y Y

YOUR IDENTIFICATION CODE:

In order for us to track your evaluation responses while maintaining your anonymity, we need to assign you an *identification code*. We would like you to create your own *identification code* by answering the following questions:

1. What are the first three letters of your mother's *maiden* name?
   Example: If your mother's maiden name was Alice Smith, the first three letters would be: **S M I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.

   ___ ___ ___

2. What are the first three letters of your mother's *First* name?
   Example: If your mother's maiden name was Alice Smith, the first three letters would be: **A L I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.

   ___ ___ ___

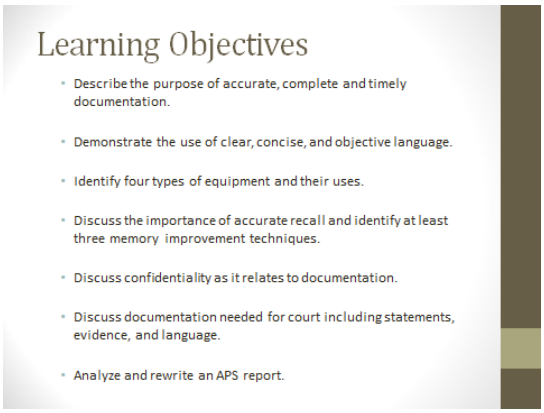
3. What are the numerals for the DAY you were born?
   Example: If you were born on November 29, 1970, the numerals would be **2 9**. If your birth date is the 1st through the 9th, please put 0 (zero) in front of the numeral (example **0 9**).

   ___ ___

Combine these parts to create your own identification code (example: **S M I A L I 2 9**). Please write your identification code in the space at the top right corner of all evaluation materials you receive.

Remember your identification code and write it at the top of every evaluation form provided to you throughout this training.

Slide #6



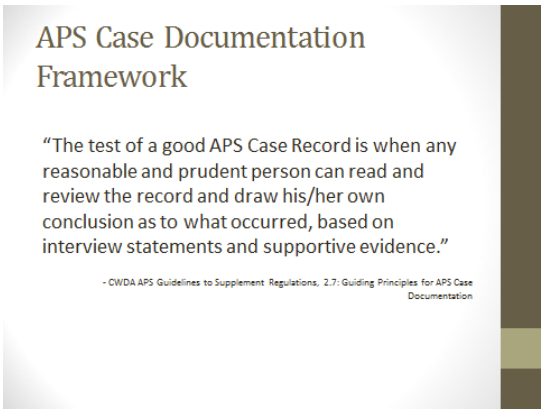
Slide #7

Slide #8

Documentation Overview

TIME ALLOTTED: 45 minutes

Slide #9



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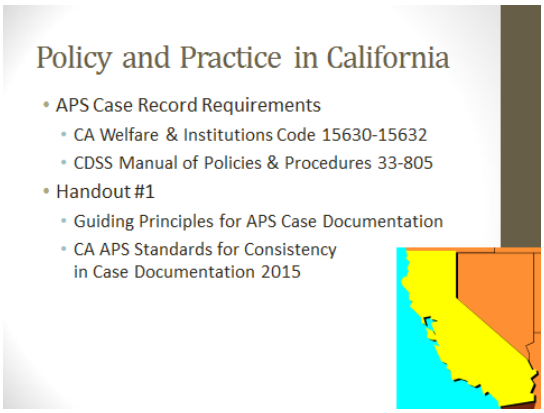


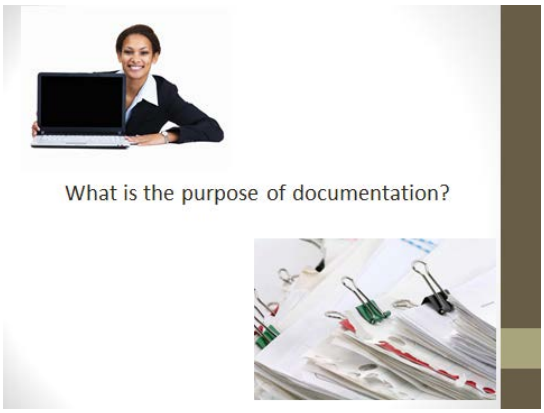
APS Case Record Requirements:

- CA Welfare and Institutions Code 15630-15632 – Requires any mandated reporter to document any incident that appears to be physical abuse (including sexual abuse), abandonment, isolation, abduction, financial abuse, or neglect (including self-neglect, which is defined under Neglect). See definitions under W&IC 15610 to 15610.70.

- CDSS Manual of Policies and Procedures 33-805 –Case Record Requirements:
  - SOC 341 Form – Report of Suspected Dependent Adult/Elder Abuse
  - All written assessments and reassessments.
  - The written service plan.
  - Any written visitation plan.
  - The chronological narrative of contacts made with, or on behalf of, the elder/dependent adult.
  - Documentation of any refusal of services including, if known, the reasons for refusal.
  - Copies of all documents, relating to the client, which have been received or sent by the adult protective services agency.
  - Case closure summary. Documentation of all supervisory approvals
  - Any other information or documents that APS believes necessary to maintain proper record of client's case.

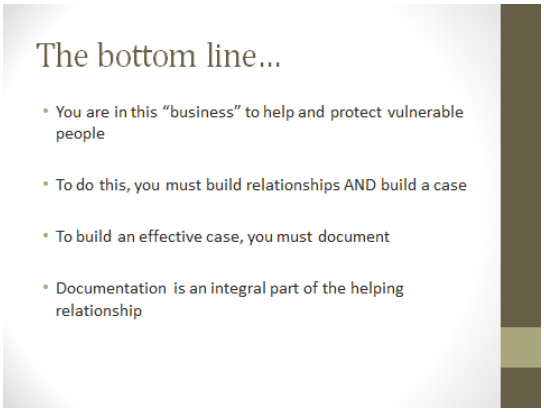
Source: CWDA APS Guidelines to Supplement Regulations, 2.7: Guiding Principles for APS Case Documentation - http://www.cwda.org/downloads/tools/adult/APS-Guidelines-to-Supplement-Regulations---Ver-6-1-15.pdf

Slide #11



Slide #12

Slide #13



Slide #14

Slide #15

Slide #16

Handout #2

Commonly Confused Words

Device (contrivance)
Devise (invent)

Precedence (priority)
Precedents (examples)

Disburse (pay)
Disperse (scatter)

Emersion (act of appearing)
Immersion (act of dipping)

Eminent (distinguished)
Imminent (about to happen)

Some time (period of time)
Sometime (point of time)
Sometimes (at times)

Stationary (not moving)
Stationery (writing paper)

New (recent)
Novel (unusual)

Leave (go away)
Let (permit)

Flaunt (display boastfully)
Flout (scoff at)

Perquisite (privilege)
Prerequisite (requirement)

Practical (useful)
Practicable (able to be used)

Complacent (self-satisfied)
Complaisant (eager to please)

Imply (hint)
Infer (take a hint)

Principal (chief)
Principle (tenet)

Raise (transitive)
Rise (intransitive)

Sewage (waste)
Sewerage (drain system)

Spacious (full of room)
Specious (misleading)
Species (classification)

Personal (individual)
Personnel (staff)

Track (course, path)
Tract (region)

Than (compares)
Then (refers to time)

Fortunate (lucky)
Fortuitous (accidental)

Lie/lay/lain (intransitive)
Lay/laid/laid (transitive)

There (place)
Their (possessive “they”)

Perspective (view)
Prospective (expectant)

Effective (producing desired effect)
Affective (arousing emotions)

Compliment (flattering remark)
Complement (goes well together)

Handout 3 - COMMON APS ABBREVIATIONS and ACRONYMS

Keep this hand out in your field book – there is room to add additional words.

A:)

AAA – Area Agency on Aging
AD – Alzheimer's Disease
ADD – Attention Deficit Disorder
ADA – Americans with Disabilities Act
ADC – Adult Day Care
ADHC – Adult Day Health Care
ADL – Activities of Daily Living
AIDS – Acquired Immune Deficiency Syndrome
ALANON – Alcoholics Anonymous Support for Families/Friends
ALS – Amyotrophic Lateral Sclerosis
AMA – Against Medical Advice
AP – Alleged Perpetrator
Approx. – Approximately
APS – Adult Protective Services
ASHD – Arteriosclerotic Heart Disease

B:)

B&C – Board & Care
BDI – Beck Depression Instrument
BP – Blood Pressure
BRO – Brother
bid/b.i.d – Twice Daily/Two Times a Day
bx - Behavior

C:)

CA – Cancer
CAD – Coronary Artery Disease
CAN – Certified Nursing Assistant
CCL – Community Care Licensing
CG – Care Giver
CHF – Congestive Heart Failure
CI – Court Investigator
COPD – Chronic Obstructive Pulmonary Disease
CVA – Cerebrovascular Accident (stroke)
CL – Client
CM – Case Manager/Case Management

D:)

DA – District Attorney
d/c – Discontinued
DD – Developmentally Disabled
DIL – Daughter-in-law
DJD – Degenerative Joint Disease
DM – Diabetes Mellitus
DNR – Do Not Resuscitate
DOB – Date of Birth
DPOA/HC – Durable Power of Attorney/Health Care
DSG – Dressing
DTR – Daughter
DV – Domestic Violence
DX or dx – Diagnosed/Diagnosis

E:)

EDRT – Elder Death Review Team
EMT – Emergency Medical Team
ESRD/ERD – Endstage Renal disease
ETOH – Alcohol

F:)

FA - Father
F.A.S.T. – Financial Abuse Specialist Team
FD – Fire Department
f/f – Face to Face
f/u – Follow Up

G:)

GDS – Geriatric Depression Scale
GI – Gastrointestinal
GP – General Practictioner
GSW – Gun Shot Wound
GRDDTR – Granddaughter
GRDS – Grandson
GYN – Gynecology

H:)

HA – Housing Authority
HBP – High Blood Pressure
HH – Home Health
HIPAA – Health Insurance Portability and Accountability Act
HIV – Human Immune Virus
HUSB – Husband

HOH – Hard of Hearing
HTN – Hypertension (High Blood Pressure)
HV – Home Visit
H&W – Health & Welfare
Hx – History

I:)

IADL – Instrumental Activity of Daily Living
IDDM – Insulin Dependent Diabetes Mellitus
IHSS – In-home Supportive Services
ILP – Independent Living Program
IM – Intramuscular
IV – Intravenous
IR – Incident Report
I&R – Information and Referral
IQ- Intelligence Quotient
INCL – Include/Including/Inclusive
INEL – Ineligible
INFO – Information
INIT – Initial

L:)

L – Left
LPS – Lanterman, Petris, Short
LTC – Long-Term Care

M:)

MC – MediCal
MCT – Mobil Crisis Team
MDT – Multi Disciplinary Team
meds – Medications
MH – Mental Health
MI – Myocardial Infarction
MMSE – Mini Mental Status Exam
MO – Mother
MOCA – Montreal Cognitive Assessment
MOW – Meals-on-Wheels
MR – Mentally Retarded
MS – Multiple Sclerosis
MSSP – Multi-purpose Senior Services Program
MVA – Motor Vehicle Accident

N:)

n/a – Not Applicable
NIDDM – Non-Insulin Dependent Diabetes Mellitus
NIFFI – No Initial Face-to-Face Investigation
NOS – Not Otherwise Specified
nv – Non-Verbal

O:)

O2 – Oxygen
OT –Occupational Therapy/Occupational Therapist

P:)

PA – Physician's Assistant
Para – Paraplegia
PCP – Primary Care Provider
PD – Police Department
PG – Public Guardian
PH –Public Health
PHN – Public Health Nurse
POA – Power of Attorney
PT – Physical Therapy/Physical Therapist
PTSD – Post Traumatic Stress Disorder
Psy – Psychiatric
PUD – Peptic Ulcer Disease
PVD –Peripheral Vascular Disease

Q:)

Q – Every
QD – Everyday
QH – Every Hour
QHS – Every Night
QID – Four times a day
QOD – Every other day
Quad – Quadriplegia

R:)

R – Right
RC – Regional Center
RCF – Residential Care Facility
RCH – Residential Care Home
RCU – Restorative Care Unit
RN – Registered Nurse
Rx – Prescription
RO – Restraining Order

ROM – Range of Motion
RP – Reporting Party
r/o – Rule Out

S:)

SA – Substance Abuse
SC – Subcutaneous
SED – Severely Emotionally Disturbed
SI – Suicidal Ideation
SIS - Sister
SNF – Skilled Nursing Facility
SOB – Shortness of Breath
SOC – Share of Cost
SRO – Single Room Occupancy (Hotel)
SSA – Social Security Administration
SSI – Social Security Supplement Income
SSNR – Social Security Number
ST – Speech Therapy/Speech Therapist
SW – Social Worker

T:)

t/c – Telephone Call
TIA – Transient Ischemic Attack
Thx – Therapy/Therapist
Tx – Treatment

U:)

UTI – Urinary Tract Infection
unk – Unknown

V:)

VA – Veterans Administration
VNA – Visiting Nurses Association
VW – Victim Witness Program

W:)

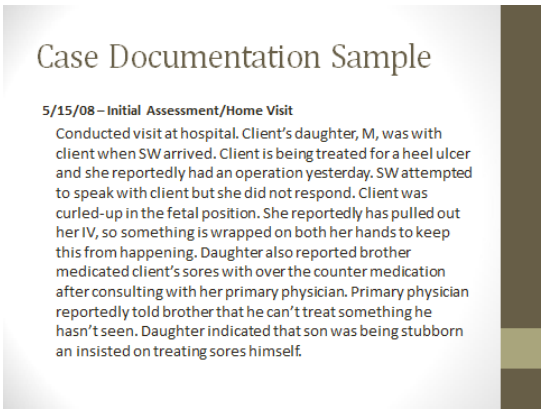
W&I Code – Welfare & Institutions Code
w/ - With
w/out – Without

Y:)

yo – Year Old

This document was created by the APS Training Project - Bay Area Academy/SFSU for the APS Case Documentation & Report Writing training – June 2008.

Slide #17

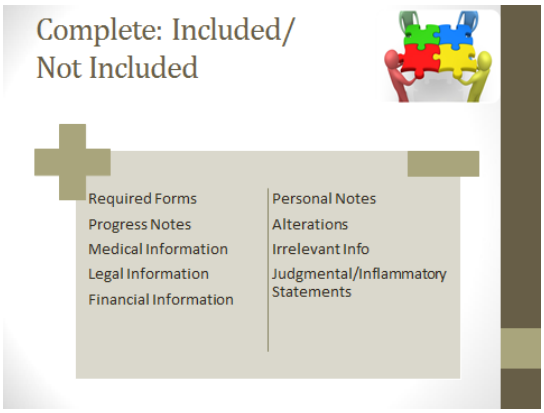


5/15/08 – Initial Assessment/Home Visit

Conducted visit at hospital. Client's daughter, M, was with client when SW arrived. Client is being treated for a heel ulcer and she reportedly had an operation yesterday. SW attempted to speak with client but she did not respond. Client was curled-up in the fetal position. She reportedly has pulled out her IV, so something is wrapped on both her hands to keep this from happening. Daughter also reported brother medicated client's sores with over the counter medication after consulting with her primary physician. Primary physician reportedly told brother that he can't treat something he hasn't seen. Daughter indicated that son was being stubborn an insisted on treating sores himself.

- **Is it accurate?**
- **Did the worker capture the necessary elements?**
- **What is missing or could be changed?**

Slide #18

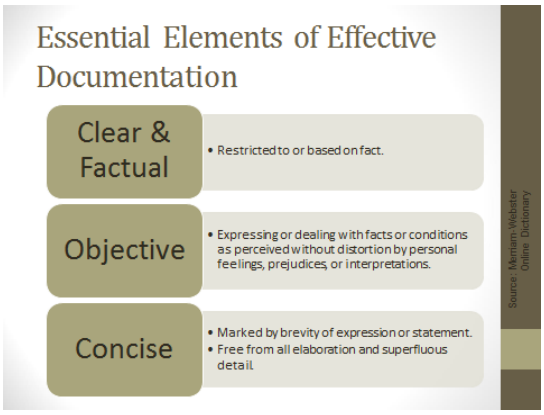


Slide #19

Clear, Factual, Objective & Concise Documentation

TIME ALLOTTED: 90 minutes

Slide #20



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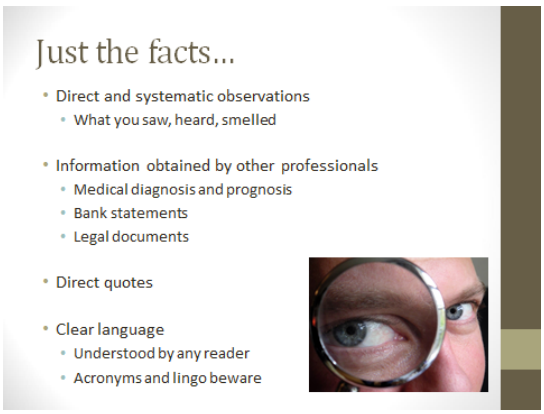
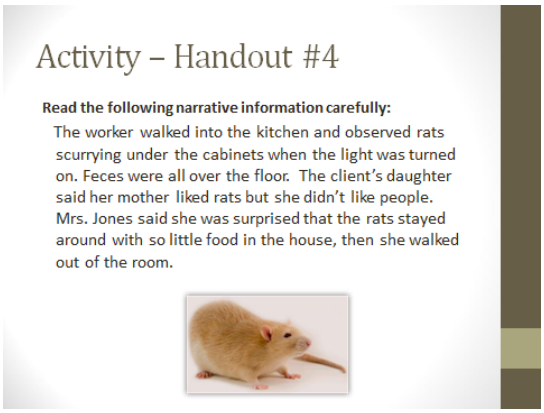


Slide #22

Slide #23



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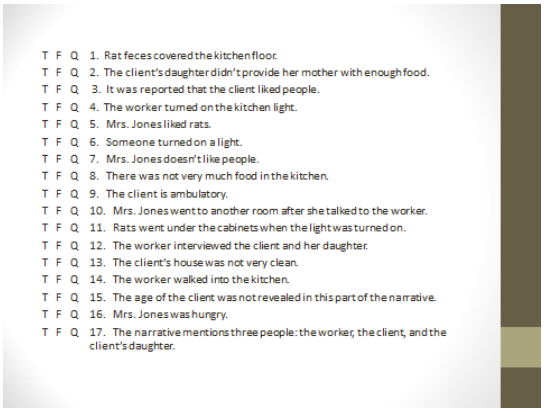


Handout 4 – Rat Feces Exercise

Read the following narrative information carefully:

The worker walked into the kitchen and observed rats scurrying under the cabinets when the light was turned on. Feces were all over the floor. The client's daughter said her mother liked rats but she didn't like people. Mrs. Jones said she was surprised that the rats stayed around with so little food in the house, then she walked out of the room.

Now read the following statements about the narrative. Circle "T" if the statement is true, "F" if the statement is false, and "Q" if you do not know if it's true or false.

T F Q 1. Rat feces covered the kitchen floor.
T F Q 2. The client's daughter didn't provide her mother with enough food.
T F Q 3. It was reported that the client liked people.
T F Q 4. The worker turned on the kitchen light.
T F Q 5. Mrs. Jones liked rats.
T F Q 6. Someone turned on a light.
T F Q 7. Mrs. Jones doesn't like people.
T F Q 8. There was not very much food in the kitchen.
T F Q 9. The client is ambulatory.
T F Q 10. Mrs. Jones went to another room after she talked to the worker.
T F Q 11. Rats went under the cabinets when the light was turned on.
T F Q 12. The worker interviewed the client and her daughter.
T F Q 13. The client's house was not very clean.
T F Q 14. The worker walked into the kitchen.
T F Q 15. The age of the client was not revealed in this part of the narrative.
T F Q 16. Mrs. Jones was hungry.
T F Q 17. The narrative mentions three people: the worker, the client, and the client's daughter.

Slide #25

Handout 5 – Video Observation Activity

Definitions

Facts – A piece of information presented as having objective reality (Merriam-Webster). Information that can be verified. Example – The client just had open heart-surgery.

Observations - The act of careful watching and listening; the activity of paying close attention to someone of something in order to get information (Merriam-Webster). Things the worker may see, hear, or smell.

Inferences – The act of passing from one proposition, statement or judgement. Considered true to another whose truth is believed to follow from that of the former (Merriam-Webster). Inferences beyond what is directly observed, conclusions which entail some degree of risk or uncertainty

Interpretations – The act or result of explaining or interpreting something; the way something is explained or understood (Merriam-Webster). Combination of facts, observations and inferences and what this means to the worker, i.e., a professional opinion.

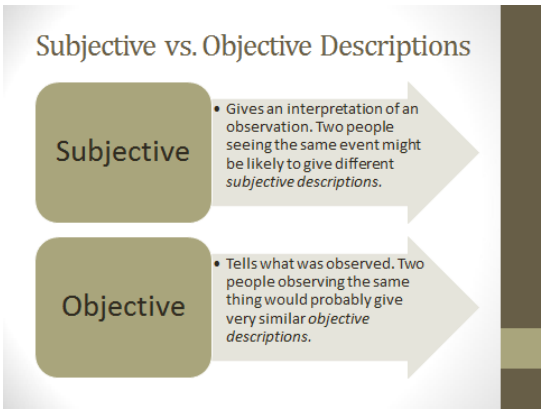
Activity

While watching the video, think about whether the impressions that you are receiving are facts, observations, inferences, or interpretations. Make notes below for each category.

What are the **facts**?

What are your **observations** (*appearance, behaviors, conversations, etc)?*

Slide #26



Handout #6 - Objective vs. Subjective Language

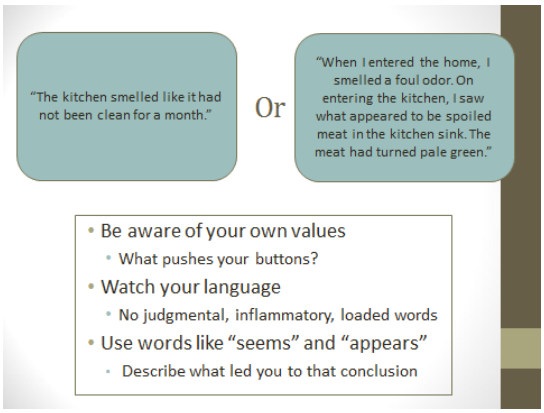
Subjective description gives an interpretation of an observation. Two people seeing the same event might be likely to give different *subjective descriptions*.

Objective description tells what was observed. Two people observing the same thing would probably give very similar objective descriptions.

Are the following words objective or subjective?

Depressed	**hostile**
frightened	**would not open door**
lonely	**hit**
acted crazy	**thin**
malnourished	**drooled**
nervous	**bruised**
abused	**sick**
sexually inappropriate	**touches other's genitals**
smiled	**disrespectful**
hot tempered	**developmentally delayed**

Slide #27



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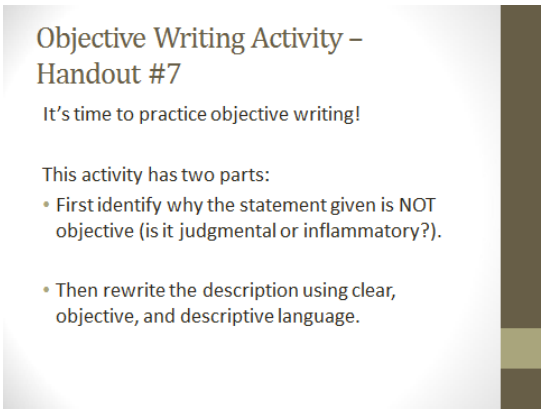


Handout #7 - Clear and Objective Language Exercise

Please read the following statements and rewrite them so they will be clear and objective. Be able to explain what was wrong with the original statement.

Example:

Client was filthy and disheveled. ⟶ *Client's arms, legs, and face were caked with dirt. His shirt was stained and unbuttoned. His trousers hung down to his knees. There were urine stains on his pant legs. He had no socks on and only one shoe.*

1. Visit to home of 86 year old double amputee, Mr. Williams. Neighbors complain that he has filled his home with trash which is attracting vermin. The client's behavior was inappropriate during the visit.

2. Client states her daughter, who is her primary source of care, worries a lot about everything. After interviewing the daughter, she is paranoid.

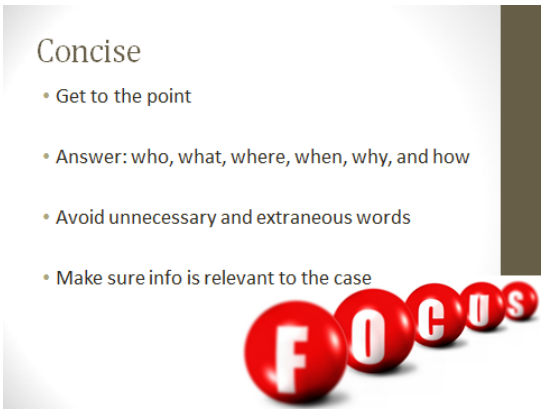
3. Case closure summary submitted by APS Social Worker: Despite all I have done for her over the months, the client is manipulative and is never satisfied.

4. After APS report from physician, visit to home of 92 year old woman who lives alone in the country. Client was inappropriately dressed.

5. Client states he gives his son money since his son was laid off six months ago. The son appears to be a drunk.

6. Home visit with client, her adult son, and adult daughter. Both adult children reside with the client. This is a dysfunctional family.

Slide #29



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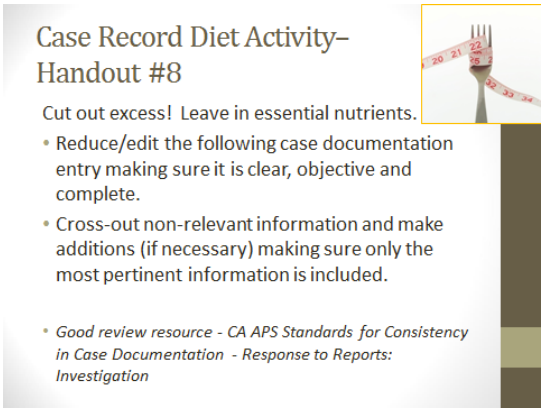


Handout 8 - Case Record Diet Activity

Cut out excess! Leave in essential nutrients. Reduce/edit the following case documentation entry making sure it is clear, objective and complete.

Directions: Cross-out non-relevant information and make additions (if necessary) making sure only the most pertinent information is included.

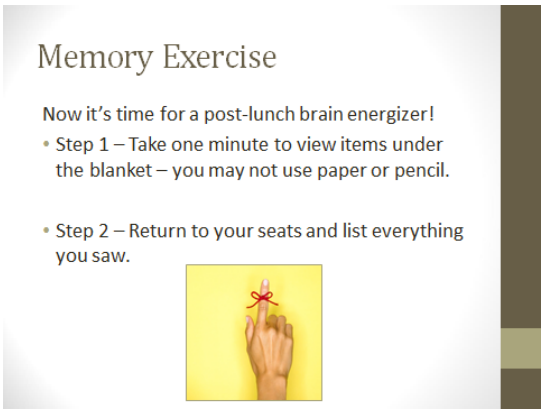
9/4/08

Home visit: It was a rainy day and I had a hard time finding the place because some of the roads were closed. Besides that, I got a late start because my supervisor wanted to see me, so that threw me off my schedule. Client opened the door and let me in. She told me to sit down but all the chairs were covered with stuff. I really didn't want to sit down, but I managed to find a spot where I was comfortable. Client was wearing a housedress that was a bit too long. It had a small stain on the right sleeve. She was eating a turkey sandwich on white bread with mayonnaise. It looked pretty good. She told me someone had brought it to her but she couldn't remember who it was. I asked her how she was feeling since her discharge from the hospital. She said she was feeling okay except that the top of her head was on fire and it was probably because of the people next door who put a spell on her. I looked in the refrigerator (which made me feel like a snoop) and found moldy, orange juice, a 6 pack of beer, eggs, bread, twinkies, cheese, a jug of wine, apples, and some things with mold on them. While I was there, the phone rang. It was a friend, checking up on her. I asked her if she needed anything. She said no and left.

Memory Tips and Documentation Equipment

TIME ALLOTTED: 30 minutes

Slide #31



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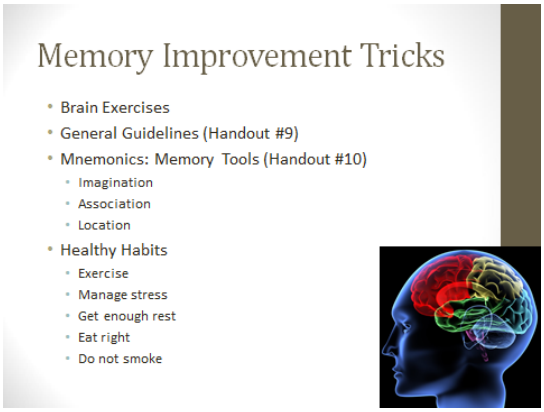


Handout 9 - General Guidelines to Improve Memory

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

1. **Pay attention.** You can't remember something if you never learned it, and you can't learn something — that is, encode it into your brain — if you don't pay enough attention to it. It takes about eight seconds of intent focus to process a piece of information through your hippocampus and into the appropriate memory center. So, no multitasking when you need to concentrate! If you distract easily, try to receive information in a quiet place where you won't be interrupted.

2. **Tailor information acquisition to your learning style and use as many senses as possible.** Most people are visual learners; they learn best by reading or otherwise seeing what it is they have to know. But some are auditory learners who learn better by listening. They might benefit by recording information they need and listening to it until they remember it. Even if you're a visual learner, read out loud what you want to remember. If you can recite it rhythmically, even better. Try to relate information to colors, textures, smells and tastes. The physical act of rewriting information can help imprint it onto your brain.

3. **Relate information to what you already know.** Connect new data to information you already remember, whether it's new material that builds on previous knowledge, or something as simple as an address of someone who lives on a street where you already know someone.

4. **Organize information.** Write things down in address books and datebooks and on calendars; take notes on more complex material and reorganize the notes into categories later. Use both words and pictures in learning information.

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

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

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

Handout 10 - Mnemonic Devices to Improve Memory

The three fundamental principles underlying the use of mnemonics are imagination, association and location. Working together, you can use these principles to generate powerful mnemonic systems.

Imagination: is what you use to create and strengthen the associations needed to create effective mnemonics. Your imagination is what you use to create mnemonics that are potent for you. The more strongly you imagine and visualize a situation, the more effectively it will stick in your mind for later recall. The imagery you use in your mnemonics can be as violent, vivid, or sensual as you like, as long as it helps you to remember.

Association: this is the method by which you link a thing to be remembered to a way of remembering it. You can create associations by:

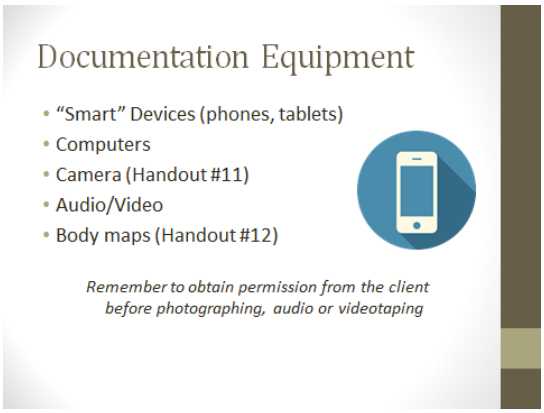
- Placing things on top of each other
- Crashing things together
- Merging images together
- Wrapping them around each other
- Rotating them around each other or having them dancing together
- Linking them using the same color, smell, shape, or feeling

As an example, you might link the number 1 with a goldfish by visualizing a 1-shaped spear being used to spear it.

Location: gives you two things – first, a coherent context into which you can place information so that it hangs together. Second, a way of separating one mnemonic from another. By setting one mnemonic in a particular town, I can separate it from a similar mnemonic set in a city. For example, by setting one in Wimbledon and another similar mnemonic with images of Manhattan, we can separate them with no danger of confusion. You can build the flavors and atmosphere of these places into your mnemonics to strengthen the feeling of location.
Common types of mnemonic devices include:

1. **Visual images**.
2. **Sentences** in which the first letter of each word is part of or represents the initial of what you want to remember.
3. **Acronyms**, which are initials that creates pronounceable words.
4. **Rhymes and alliteration**:
5. **Jokes** or even off-color associations using facts, figures, and names you need to recall, because funny or peculiar things are easier to remember than mundane images.
6. **"Chunking" information**; arranging a long list in smaller units or categories that are easier to remember.
7. **"Method of loci"**: You associate each part of what you have to remember with a landmark in a route you know well, such as your commute to work.

Slide #33


Documentation Equipment
• "Smart" Devices (phones, tablets)
• Computers
• Camera (Handout #11)
• Audio/Video
• Body maps (Handout #12)
Remember to obtain permission from the client before photographing, audio or videotaping

Handout 11

Photographing Evidence*

When to take photographs

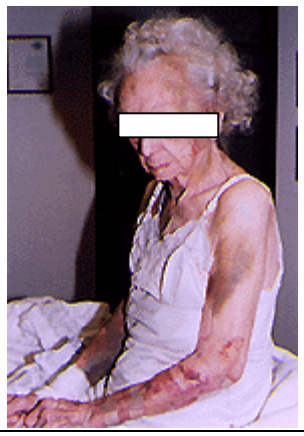
APS workers are encouraged to take photographs of their clients' injuries and adverse health conditions (e.g. severe weight loss due to malnourishment), or environmental conditions whenever:

Photographs will help document the client's lack of ability to provide self care for a probate conservatorship case.
A photograph can more accurately depict the client's injury or situation than can be stated in a brief narrative.
Requested to do so by law enforcement.
There has been a penal code violation that can be documented photographically.

APS workers may also take baseline photographs, with the client's permission.

Always take an identifying shot

Always take at least one photograph showing the whole person, the front of the home or an overview of the scene.
Rational: Without an identifying shot, it is often difficult to determine who was injured and exactly what part of the body was injured. It is also important to show that the interior shots are of the client's home and not another residence.

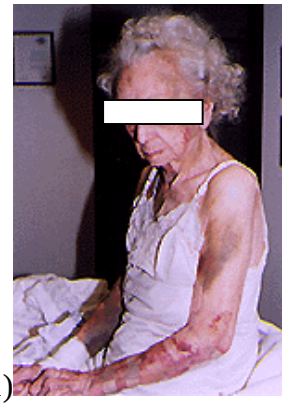
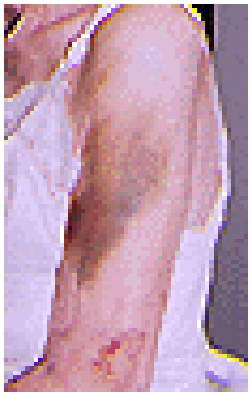


Continued on next page

Photographing Evidence, Continued

Use the rule of thirds

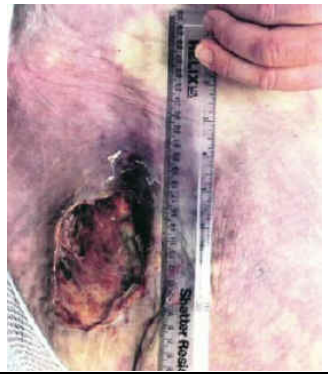
Using the identifying shot, move in by thirds to show the details of the injury or of an environmental condition (e.g. rat droppings, spoiled food, etc).

(1)  (2)  (3) 

(Notice how difficult it is to determine what extremity is being shown in picture (3) without looking at the identifying shot).

Use a "scale" in photographs

It is helpful to position an ordinary object of known size (e.g. a ruler, a coin or a pen) next to the object or injury being photograph to demonstrate the size of the item being photographed.



Photograph the injuring object

If the object that is believed to have caused the injury is identified, it is helpful to photograph the object next to the injury. For example, photographing a 1 inch wide leather belt next to a one inch wide bruise may help to demonstrate that the belt was the cause of the injury. (Please note that in some cases the size of the injuring object will **not** match due to swelling, movement of the victim when struck or other factors.)

Continued on next page

Photographing Evidence, Continued

Take sharp pictures

The following guidelines will help you produce sharp, detailed pictures:

1. Avoid backlighting the person or object as the resulting photograph will be a silhouette without any detail.
2. Use side lighting only if you need to show the texture or depth of a wound.
3. Almost all documentary photographs should be lit from the front if at all possible. However, it is advisable to take photographs in varying light levels.
4. Steady your camera against a table, the roof of a non-running car, etc. and squeeze the shutter slowly so as not to jerk the camera.
5. Make sure that your lens is clean, your batteries are charged and the camera has available memory.
6. Shoot most of your photographs from eye level as this makes it easier to judge the perspective of objects in the picture.

Downloading photographs

Photographs are to be (1) downloaded to the worker's computer or a CD and (2) labeled as soon as is practical after being taken.

Label electronic media and printed photographs

All photographs, electronic files, CD's or floppy discs must be labeled with, at a minimum, the client's name and the date the photographs were taken. In addition, it is desirable to include the name of the person taking the photographs and a description of what was photographed (e.g. the bruise on Mrs. M's left knee).

Only one client's photographs may be stored in any single electronic file.

All photographs should be stored in at least 2 places (e.g. CD and on paper, CD and in an electronic file on the worker's computer).

Continued on next page

Photographing Evidence, Continued

Maintain the "original" photograph

In some cases, photographs may need to be enhanced in order to clearly see some details. Enhancements include changes in lightness/darkness, sharpening the focus, cropping the photograph, etc.

Do not enhance the "original" photograph. Make a copy and then make any necessary enhancements. The changed photograph needs to be labeled as having been enhanced with notations of what changes were made. The notation should reference the original photograph and both photographs (the original and the enhanced version) should be kept in the same electronic file.

Releasing photographs to other agencies

Photographs are part of the APS case documentation and their release is regulated by the same policies as any other part of the case record.

*This document was created by Lori Delagrammatikas for APS Riverside County, CA. Permission granted for use in the *APS Case Documentation & Report Writing* training developed by the APS Training Project - Bay Area Academy/SFSU.

Handout #12 - Body Maps (see next page)

These body maps may be photocopied as required.

Please note on the body map any bruising, scars, injuries, red marks or the like, giving as much detail as possible under the prevailing circumstances as to size, colour and so on.

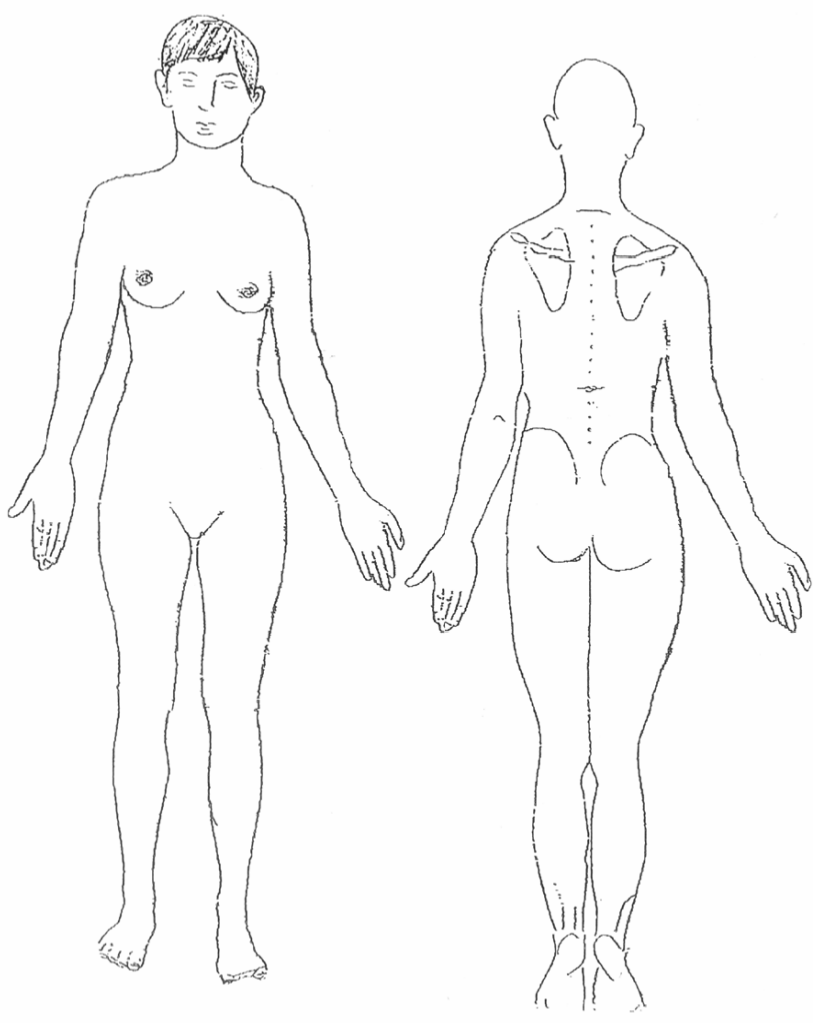
Only complete these if the injuries are clearly visible or shown to you freely.

4.1 Front and Back Views – Female

Details of service user:

Name:
Address:

DOB:



Completed by

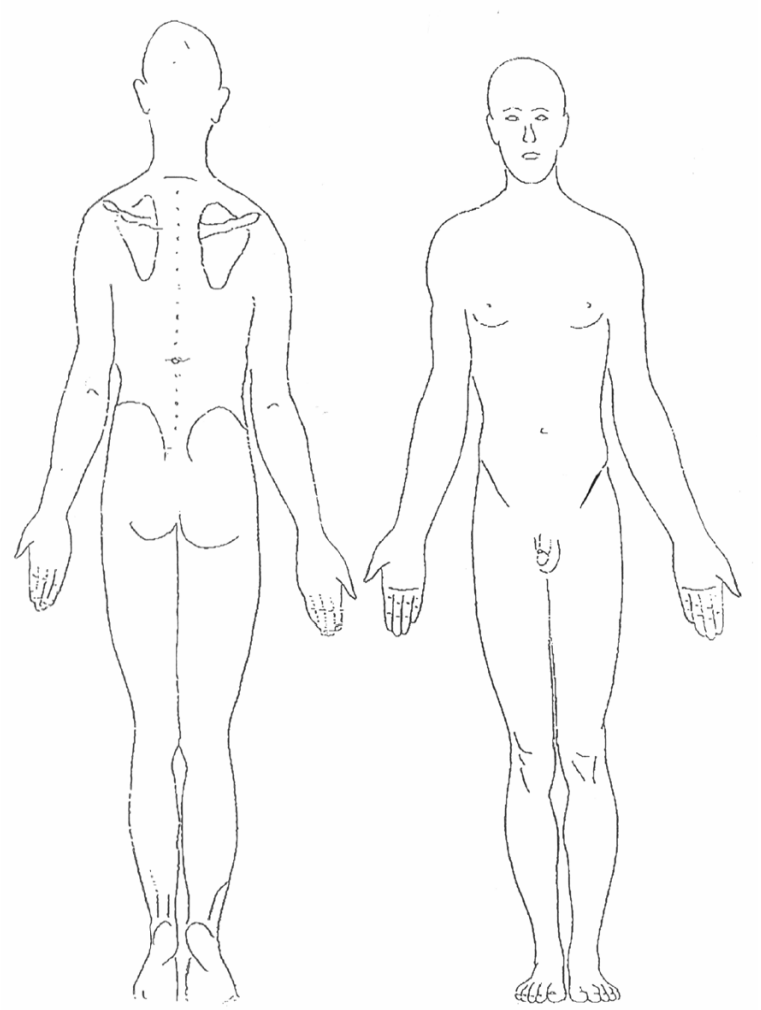
Name:
Designation:
Date:
Time:

4.2 **Front and Back Views - Male**

Details of service user:

Name:
Address:

DOB:



Completed by

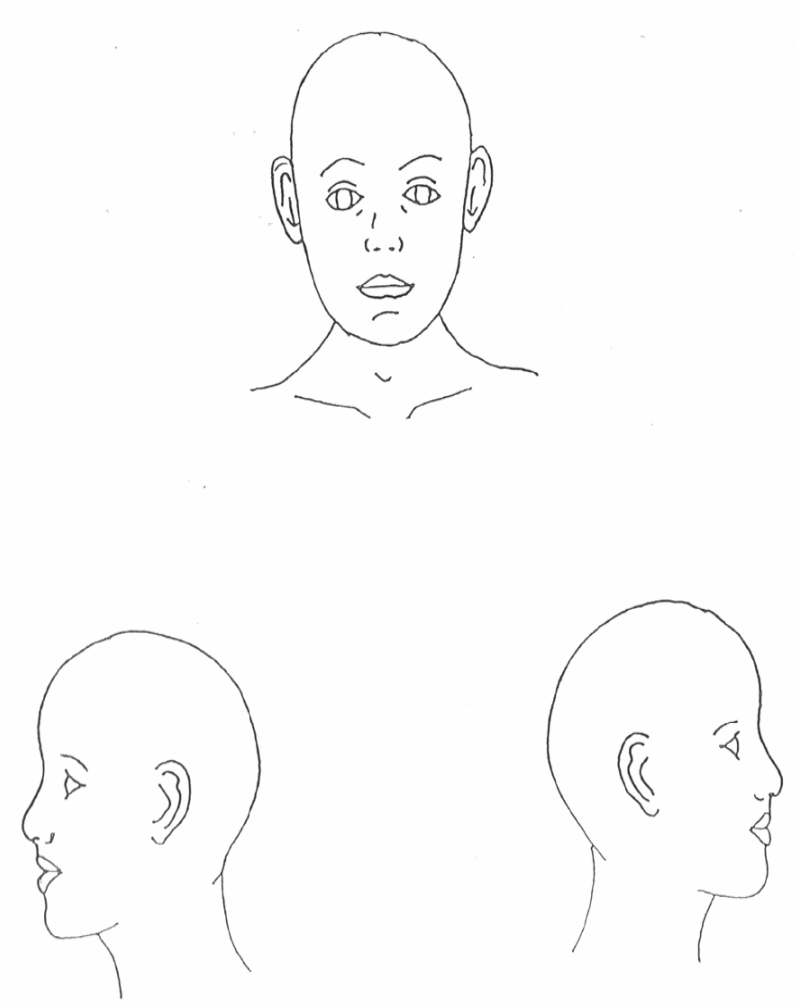
Name:
Designation:
Date:
Time:

4.3 **Front and Side Views - Head**

Details of service user:

Name:
Address:

DOB:



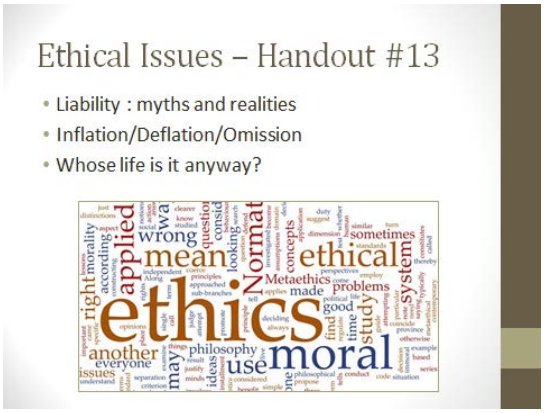
Completed by

Name:
Designation:
Date:
Time:

Ethical Considerations and Confidentiality Related to Documentation

TIME ALLOTTED: 30 minutes

Slide #34



Handout #13 - Ethics in Documentation

Have you ever:

Inflated (Exaggerated, Embellished, Amplified, Overstated, Overstressed, Embroidered),

Deflated (Minimized, Played down, Made light of, Underestimated, Underrated, Diminished) or

Omitted information in a narrative?

Possible reasons:

Liability issues

- Myth: "If I include this….. in the narrative, I could be sued."
- Reality: You are very protected as long as you perform the duties and responsibilities of your position accordingly. You could be held liable if you act out of the scope or neglected your duties and responsibilities.

Results

- Myth: "If I make the situation look a little worse than it is, maybe I can get the conservatorship approved… or maybe I can get that no-good son out of the house….."

Reality: These things can and will backfire on you, usually NOT getting the results you wanted and are not ethical practice. Analyze your intentions: make sure they are not for personal reasons ("I'll sleep better if she were in a nursing home"). Professionalism will yield the best results!

Slide #35


Confidentiality as Related to Documentation
• Confidentiality in the law
◦ Handout #14
◦ APS CA Cross-Reporting & Referral Guide 2014
◦ CA APS Standards for Consistency in Case Documentation - Response to Reports: Reporting Party
• With whom can you share documentation?
• Who needs to have what?
• Special concerns

Handout 14 - Client Confidentiality: Who, What & Why - California

Cross reporting to law enforcement

- SOC 341 form sent immediately – *Report of Suspected Dependent Adult/Elder Abuse.*

- SOC 343 form sent later - *Investigation of Suspected Dependent Adult/Elder Abuse* **or** equivalent form.

- Cross Reporting, as per CA Welfare & Institutions (W&I) Code section 15640. (a) (1) – *A county adult protective services agency shall also send a written report thereof within two working days of receiving the information concerning the incident to each agency to which it is required to make a telephone report under this subdivision.*

Working with Multi-Disciplinary Teams (MDT's)

- Mandates on confidentiality as per CA W & I Code 15633.2A & 15633.2B – *(A) Persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records that are relevant to the prevention, identification, or treatment of abuse of elderly or dependent persons.*

- *(B) Except as provided in subparagraph (A), any personnel of the multidisciplinary team or agency that receives information pursuant to this chapter, shall be under the same obligations and subject to the same confidentiality penalties as the person disclosing or providing that information. The information obtained shall be maintained in a manner that ensures the maximum protection of privacy and confidentiality rights.*

- Definition of MDT's - As per APS P&P manual section 33-130.3 – *"Multidisciplinary personnel team" means any team of two or more person who are trained in the prevention, identification, and treatment of abuse of elderly or dependent persons and who are qualified to provide a broad range of services related to abuse of elderly or dependent adults, as defined in Section 15753.5 of the CA Welfare & Institutions code.*

- Types of MDT's
  - Financial Abuse Specialist Teams (F.A.S.T.) – a multi-disciplinary group of public and private professionals who volunteer their time to advise APS, the Ombudsmen, law enforcement and private attorneys on matters of vulnerable adult financial abuse.

- Forensic Centers – typically staffed by professionals from legal, medical, social services, and law enforcement agencies who conduct case reviews; in-home medical and mental status, and evidentiary investigation; taped victim interviews; education; consultation; and research. This collaboration allows better understanding, identification and treatment of elder abuse and assists in more efficient ways to successfully prosecute elder abuse cases.

- Elder Death Review Teams (EDRT) – a team reviews closed cases of elder death that are suspicious or warrant further scrutiny.

❖ Who sits on MDT's – There are potential confidentiality issues if it includes community-based agencies, as community members may not be privy to confidential information.

Working with the District Attorney

- APS doesn't produce records under subpoena, only under court order.
- Court orders– information shared as per CA W & I Code 15633.5
- Refer to your county's policy for working with the DA as procedures may differ.

References:

California Welfare and Institutions Code Section 15640, Chapter 11, Article 5.
http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=15001-16000&file=15640

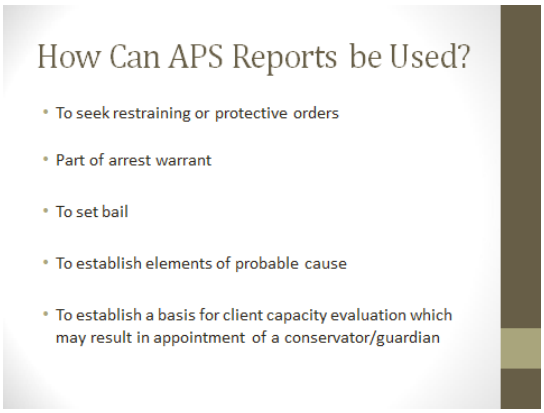
California Welfare and Institutions Code Section 15633-15637, Chapter 11, Article 4.
http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic&codebody=&hits=20

California Department of Social Services (2001). *Manual of Policies and Procedures: Adult Protective Services Program (No. APS-01-01).* Sacramento, CA, p. 22.

California Welfare and Institutions Code Section 15633-15637, Chapter 11, Article 4.
http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic&codebody=&hits=20

This document was created by the APS Training Project - Bay Area Academy/SFSU for the APS Case Documentation & Report Writing training – June 2008.

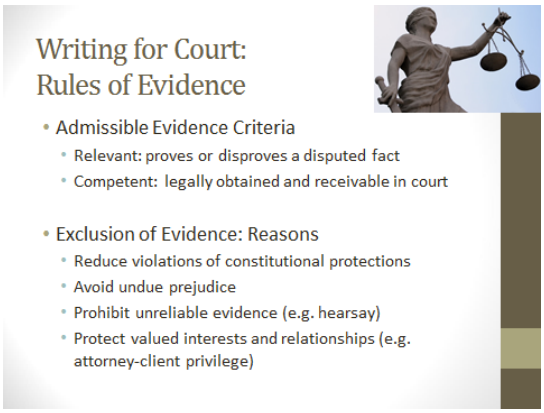
Slide #36


How Can APS Reports be Used?
• To seek restraining or protective orders
• Part of arrest warrant
• To set bail
• To establish elements of probable cause
• To establish a basis for client capacity evaluation which may result in appointment of a conservator/guardian

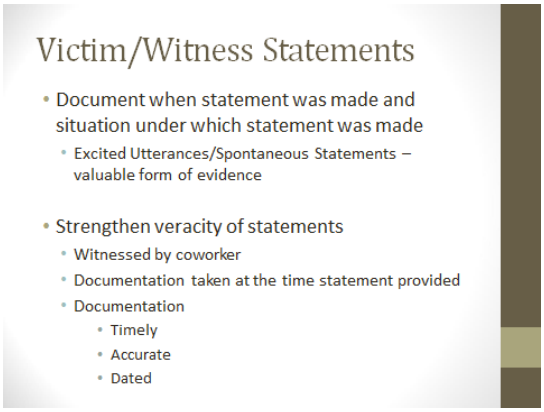
Report Writing for Court

TIME ALLOTTED: 30 minutes

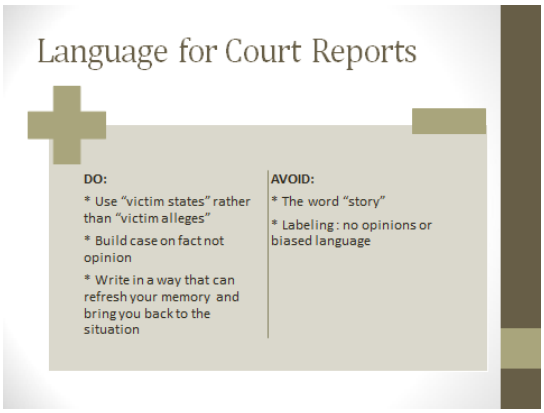
Slide #37



Slide #38



Slide #39



Slide #40

Applying the Rules of Evidence and Witness Statements Activity

Mrs. Gunther is a 78 year old woman whose son, Dave, hit her in the face with the telephone when she threatened to call the police on him. He had been threatening her with violence if she did not give him her car keys. Because Dave was drunk, Mrs. Gunther did not want him to drive. You are the APS worker called to interview Mrs. Gunther and you were first on the scene with the police. The police have now arrested Dave Gunther and you know that you may have to testify in court.

Let's consider what you would need to document. Applying the rules of evidence and witness statements, choose which statements you would include in Mrs. Gunther's case record and which you would trash. All statements were taken on December 12, 2012.

1. The police officer and I heard Dave shout at his mother, "I should have knocked you out cold."

2. Upon opening the door, Mrs. Gunther cried, "He tried to kill me. I am so happy you are here, can you help me?" Her hands were visibly shaking, her skin was ashen and there was a wound above her left eye that was bleeding. She stated she felt light-headed and I helped her to the nearest chair. Once seated, Mrs. Gunther began to cry and mutter to herself, "What did I do wrong? I raised him right."

3. Dave was practically falling down drunk.

4. Dave shouted at the police officer and me, "You have no business being here and you need to leave immediately." He was red in the face and his hands were clenched into fists. In my opinion, I was in serious danger.

5. Mrs. Gunther alleged that Dave had threatened to hit her if she didn't give him the car keys.

6. Mrs. Gunther's doctor stated she has arthritis and urinary incontinence.

7. Dave was angry enough to seriously hurt his mother.

8. Officer Brown stated that Dave's blood alcohol level was 2.5 when Dave was arrested.

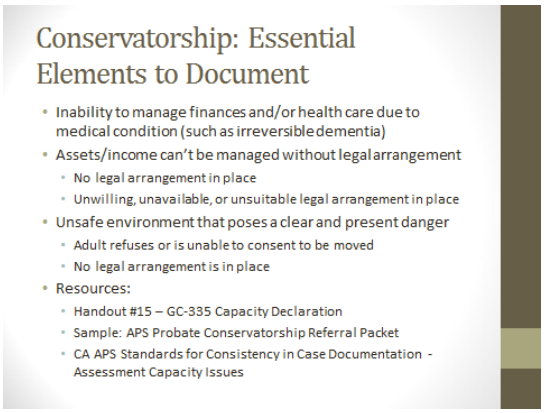
9. Mrs. Perry, the next door neighbor said, "I overheard Mrs. Gunther and her son shouting at each other at 7:30pm this evening."

Conservatorship Documentation & Report Writing Activity

TIME ALLOTTED: 60 minutes

Slide #41

Slide #42



County Health & Social Services Department

Mental Health Services
Public Health Services
Substance Abuse Services
Older & Disabled Adult Services

Eligibility Services
Employment Services
Children's Services
Administrative Services

Adult Protective Services

Probate Conservatorship Referral SAMPLE

Proposed Conservatee's Name	**Date**	
Social Security Number	**DOB**	**Age**
Permanent Address ☐ **California resident**	**Telephone**	
Present Address **Type of Residence**	**Telephone**	
Referring Social Worker **Telephone**		
Supervisor's Approval *(signature)*		
Need conservatorship of: ☐ Person ☐ Estate		
Need orders: ☐ Medical treatment ☐ Dementia ☐ Section 2900		
☐ Requesting temporary conservatorship		
☐ Requesting power to change residence		

Probate Conservatorship Referral
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Character and **estimated value of property** of the estate: (1) Personal property $ (3) Real property $ (2) Annual gross income from: (a) real property $ (b) personal property $ (c) pensions $ (d) wages $ (e) public assistance benefits $ (f) other $ Total of (1) and (2) $
Proposed conservatee ☐ is ☐ is not a patient in or on leave of absence from a **state institution** under the jurisdiction of the State Department of Mental Health or the State Department of Developmental Services. *(specify state institution)*
Proposed conservatee ☐ is receiving or entitled to receive ☐ is neither receiving nor entitled to receive benefits from the Department **of Veterans Affairs** *(estimate amount of monthly benefit payable):* $
Proposed conservatee ☐ is ☐ is not able to complete an affidavit of **voter registration**.
Proposed conservatee requires a **conservatorship (of person)** and is unable to provide for his/her personal needs for physical health, food, clothing or shelter because: *(list reasons, give specific examples, include what is relevant from medical diagnosis, cognitive status (i.e., dementia, MMSE), mental health history and diagnosis, substance abuse issues and criminal history)* Name(s) of suspected abuser(s):

Proposed conservatee requires a **conservatorship (of estate)** and is substantially unable to manage his/her financial resources or resist fraud or undue influence because: : *(list reasons, give specific examples, include what is relevant from medical diagnosis, cognitive status (i.e., dementia, MMSE), mental health history and diagnosis, substance abuse issues and criminal history)* Name(s) of suspected abuser(s):
Proposed conservatee ☐ is ☐ is not **developmentally disabled** as defined in Probate Code § 1420. *(specify the nature and degree of the alleged disability):*
Proposed conservatee ☐ will **attend the hearing** ☐ is able but **unwilling to attend** the hearing AND ☐ does ☐ does not **wish to contest** ☐ is **unable to attend** the hearing because of medical inability *(Attach affidavit or certificate of a licensed medical practitioner.)*
☐ Attached is a declaration executed by a licensed physician stating that the proposed conservatee **lacks capacity to give informed consent for any form of medical consent** and giving reasons and the factual basis for this conclusion. ☐ Proposed conservatee ☐ is ☐ is not an adherent of a religion that relies on prayer alone for healing, as defined in Probate Code § 2355(b).

Proposed conservatee is ☐ living in his/her **residence** and ☐ will continue to live there unless circumstances change ☐ will need to be moved after a conservator is appointed *(specify supporting facts in this section, or if a temporary conservatorship is requested, give reasons in the section below):* ☐ other *(specify and give supporting facts:* Proposed conservatee is ☐ not living in his/her residence and ☐ will return by *(date):* ☐ will not return to live there *(specify supporting facts):* ☐ other *(specify and give supporting facts):*
☐ request authorization to place in secured perimeter residential care facility ☐ request authorization to administer medication appropriate for care and treatment of dementia

☐ Need **temporary conservatorship** *(state reason(s) why temporary conservatorship is necessary)*

☐ Request that residence be changed to: *(type of facility needed and name, location, telephone number of the recommended placement options)*

The proposed conservatee will suffer irreparable harm if his/her residence is not changed as requested and no means less restrictive will suffice to prevent harm because: *(state precise reasons)*

☐ Take temporary possession or control of property pursuit to **Section 2900**.
Special powers requested or unusual circumstances requiring immediate court authority:
The names, addresses, telephone numbers and relationship of the **spouse and all known relatives** within the second degree of the proposed conservatee: ☐ none Relationship and name Address Telephone

The following **alternatives to conservatorship** have been considered and have been found to be unsuitable or unavailable to the proposed conservatee *(explain that each of the following alternatives were considered and the reasons each is unsuitable or unavailable):*

(a) Voluntary acceptance of informal or formal assistance

(b) Special or limited power of attorney

(c) General power of attorney

(d) Durable power of attorney for ☐ health care ☐ estate management

(e) Trust

(f) Other alternatives considered *(specify and give reason each is unsuitable or unavailable)*

During the past year
(1) **health services** ☐ were provided ☐ were not provided *(explain, give name of agency, contact person and telephone number)*

(2) **social services** ☐ were provided ☐ were not provided *(explain, give name of agency, contact person and telephone number)*

(3) **estate management assistance** ☐ was provided ☐ was not provided *(explain, give name of agency/firm, contact person and telephone)*

Describe informal support system. *(explain support provided or which is no longer provided, give name, relationship and telephone, e.g., relative buys groceries once a week, minister provides transportation to medical appointments, neighbor checks in every day, friend sorts bills to be paid)*

Medical/Mental Health Information
Medical Information Medi-Cal Number Insurance Coverage Medical Insurance Number Primary Care Physician's Name, Address, Telephone (FAX if known) Specialist(s) Name, Specialty, Address, Telephone (FAX if known) Mental Health and/or Other Case Managers: Name, Address, Telephone Other Health Care Providers
Medications/Dose/Purpose

Probate Conservatorship Referral
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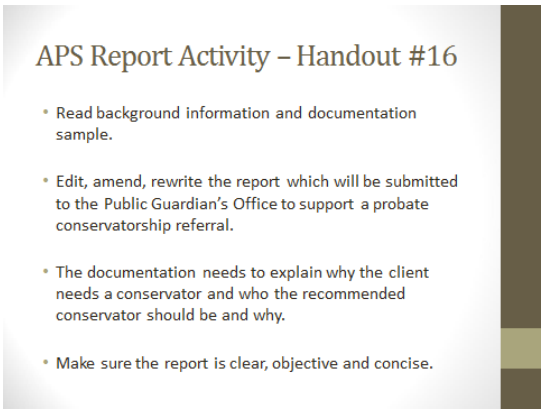
Assets
Financial Information Monthly income/source/how received *(include benefits such as VA, SSI, SSA)* Rent/mortgage payment amount/owed to Monthly utilities Debts/type/amount/owed to name, address and telephone
Financial Assets /Financial Institutions Type of asset/name of company/telephone/account number/value *(e.g. checking accounts, savings accounts, stocks, bonds, CDs)*
Life Insurance Type/name of company/beneficiary/value
Real Property Type/location/value
Automobile(s)/Boat/Mobile Home

Other Property
Burial arrangements/trust insurance
Other Important Information for Public Guardian's Office

Slide #43


APS Report Activity – Handout #16
Read background information and documentation sample.
Edit, amend, rewrite the report which will be submitted to the Public Guardian's Office to support a probate conservatorship referral.
The documentation needs to explain why the client needs a conservator and who the recommended conservator should be and why.
Make sure the report is clear, objective and concise.

Handout #16 - APS Documentation Activity

Activity Instructions:

1. **Read background information and documentation sample.**

2. **Edit, amend, and rewrite the report which will be submitted to the Public Guardian's Office to support a probate conservatorship referral.**

3. **The documentation needs to explain why the client needs a conservator and who the recommended conservator should be and why.**

4. **Make sure the report is clear, objective and concise.**

Background information:

Mrs. J is a German-born 89 year old widow who has severe dementia and has been hospitalized for 6 months. She has not been discharged because she cannot provide for her own care and nobody is available to help. Now that the application for Medi-Cal has been approved, she needs to be placed in a nursing home. An application for conservatorship is being processed and the request is that the Public Guardian be appointed, since neither the son nor the daughter is willing or appropriate to serve as their mother's conservator.

Family Situation

Mrs. J has 2 children. The son lives in Virginia and has POA for financial matters. The hospital social worker called him frequently asking for his help in completing the Medi-Cal, but he kept avoiding her. When he finally came to California, he refused to pay any of his mother's bills and wouldn't meet with the Public Guardian. He seems like a real loser and this worker suspects that he might have exploited his mother. It's possible that he used her credit card for motel stays in California, but he denies it. He said he cut up the credit cards but could not prove it.

The daughter isn't much better. She alleges that her brother is misusing her mother's money but she herself had credit cards in her mother's name, which she says she cut up. She says she really cares about her mother, but has not shown herself to be very responsible either. She is a long haul truck driver and is never home. She is also very jealous of her brother, since Mrs. J has always treated him very special and wanted him to handle everything. She is afraid of her brother and can't stand up to him. Worker observed that when they were interviewed in the hospital, he is a bully and she acted really submissively.

Assessment of Social Functioning

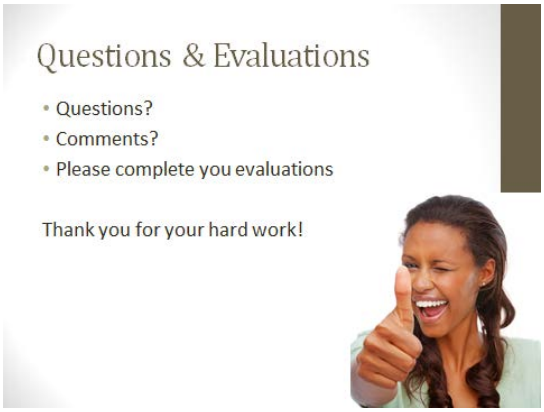
Mrs. J. was interviewed during her stay in the hospital. The first time she seemed okay but said it was too early to answer questions (it was 2 p.m.). She was probably trying to hide the fact that she didn't know the answers. She remembered some things about her childhood but said that she has 6 children. She has 2 children who are living and one who died a while ago. She talked about him as though he were still alive. Her short term memory is severely impaired. She seemed depressed and didn't care about the conservatorship.

At the second interview Mrs. J seemed really out of it but she wasn't depressed any more. She was inarticulate and needs help with all her ADLs.

Closing & Evaluations

TIME ALLOTTED: 15 minutes

Slide #44



Thank you for your hard work and for making this training day a success!

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Appendix

Handout #1 - Guiding Principles for APS Case Documentation

Purpose of this Guide:

The Protective Services Operations Committee's (PSOC) Consistency Sub-committee developed this Guide to provide assistance with documenting APS Casework in a consistent manner across the State.

This Guide focuses on the purposes and considerations of good report writing and properly maintaining a case record. In addition to this Guide, the accompanying Matrix focuses on the defining elements and standards that constitute appropriate documentation of an APS Case Record.

Elements of good report writing:

2. Accurate, factual, complete, and timely documentation.
3. Clear, concise, and objective language that will stand up in court, and provide a professional standard for APS casework.

What is a good APS Case Record?

The test of a good APS Case Record is when any reasonable and prudent person can read and review the record and draw his/her own conclusion as to what occurred, based on interview statements and supportive evidence.

APS Case Record Requirements:

CA Welfare and Institutions Code 15630-15632 – Requires any mandated reporter to document any incident that appears to be physical abuse (including sexual abuse), abandonment, isolation, abduction, financial abuse, or neglect (including self-neglect, which is defined under Neglect). See definitions under W&IC 15610 to 15610.70.

CDSS Manual of Policies and Procedures 33-805 –Case Record Requirements:

- SOC 341 Form – Report of Suspected Dependent Adult/Elder Abuse
- All written assessments and reassessments.
- The written service plan.
- Any written visitation plan.
- The chronological narrative of contacts made with, or on behalf of, the elder/dependent adult.
- Documentation of any refusal of services including, if known, the reasons for refusal.
- Copies of all documents, relating to the client, which have been received or sent by the adult protective services agency.
- Case closure summary. Documentation of all supervisory approvals
- Any other information or documents that APS believes necessary to maintain proper record of client's case.

Purposes of documentation

- Documentation to establish baseline data.
- Documentation as evidence of involvement - both justification for being involved and the importance of documentation for court.
- Documentation used to show that the case was handled properly.
- Documentation for purposes of consistency - to demonstrate that the case was handled efficiently and that all relevant leads were followed up on.
- To justify the need for staffing and/or funding - through documentation of the work required as well as the complexity of the work done on the case.

Considerations about documentation

- Who will read your documentation? (possibilities, among others, include: agency director, attorneys, auditors, judges, law enforcement, other APS staff)
- Where will it end up? (possibilities include: local Board of Supervisors or state officials, law enforcement agencies, conservatorship hearings, civil court actions, criminal court actions)
- Who benefits from good documentation? (possibilities include: the worker, their agency, the legal system, and the client)

Factual documentation should include:

- Date, time, duration of contact, type of contact (include who initiated the contact), with whom, who was present, and location.
- Direct and systematic observations
    - What you saw, heard, smelled
- Information obtained by other professionals
    - Medical diagnosis and prognosis
    - Bank statements
    - Legal documents
- Direct quotes, like spontaneous Statements
    - Carefully document spontaneous statements. A spontaneous statement is a statement made by a witness, including a victim, while under the stress of excitement caused by witnessing a startling event. It is considered truthful because little time has passed to allow the witness to “make-up” a story.
    - A spontaneous statement can only come from a first-hand witness, such as the victim.
    - Document the witness' physical and emotional demeanor, for example behaviors that show the stress level when making the statement.
    - Document the victim’s physical and emotional demeanor, including sounds and gestures, especially when the victim is non-verbal.
    - Save written interviews with non-verbal victims when done on paper.

  - Document the name of the person who heard the spontaneous statement.
  - Document what that person heard from the victim (in quotes), when they heard it, the circumstances in which they heard it.
  - Document spontaneous statements even when made by a person who may be found to be legally incompetent to testify or lack decision making capacity.
- Clear language
  - Understood by any reader
  - Uses limited acronyms and lingo

Definitions of Subjective and Objective

Subjective description gives an interpretation of an observation. AVOID Subjective descriptions! Two people seeing the same event might be likely to give different subjective descriptions. Example of subjective documentation:

Client was filthy and disheveled

Judgmental? Inflammatory?

- Two types of statements are inappropriate for good, objective documentation. *Judgmental statements*, or statements that make value judgments about clients and their behavior; and *Inflammatory statements*, that utilize negative stereotypes or paint a subjectively negative image of a client, family member, or contact.

Judgmental Examples - The following statements, unless they are quotes from clients or other relevant parties are judgmental and should not be a part of a legal record:

- The client is crazy
- The son is lazy
- The client is a redneck
- The daughter just wants to cause trouble

Inflammatory Examples - These statements, similar to the ones on the previous screen, are not objective and should not be a part of a legal record:

- The client's nephew is a druggie
- The client only wants pain meds to get high
- The client dresses like a hooker
- The client is milking the system
- The mother's relationship is toxic

Objective description tells what was observed. Two people observing the same thing would probably give very similar objective descriptions. This is APPROPRIATE documentation. Example of objective documentation:

Client's arms, legs, and face were caked with dirt. His shirt was stained and unbuttoned. His trousers hung down to his knees. There were urine stains on his pant legs. He had no socks on and only one shoe.

Case Disposition

The APS Case Record must justify the disposition of the case:

1. Findings – Determine whether the matter is confirmed, inconclusive, or unfounded using the Consistency in Findings Matrix and Guide, i.e. including reasons for the finding.
2. Actions taken on the case – Provide details on the actions you took or attempted to take to remedy the abuse (e.g. unsafe situation, exploitation, etc.).
3. Reasons for Closure – For example, services are completed, other agency or resource assuming responsibility, etc.

California APS Standards for Consistency in Case Documentation 2015

Key: **APS** = Adult Protective Services - **Vulnerable Adult** = elder and/or dependent adult, **Abuse** = all types of abuse and neglect/self-neglect.
W&IC (Welfare & Institutions Code), **MPP** (CDSS Manual of Policies & Procedures), **ACL** (CDSS All-County Letter)

Category	Defining Elements	Standard	What to Document	How to Document
Response to Reports – Immediate W&IC 15763(b) MPP 33-510.1	1. Immediate life threat. **or** 2. Imminent danger. **or** 3. Crisis on an existing case. **or** 4. Local law enforcement request.	Within two hours but no longer than 24 hours from the time the agency received the call.	a. That there was a response within two hours. b. Reasons for not responding within two hours.	a. Time of call and time of arrival. b. Assessment tool used (e.g. SDM) or explanation addressing the threat to life, danger, crisis or agreement from law enforcement.

Acronyms used in this document:

SDM – Structured Decision Making
NTD – No Ten Day
FTF – Face-to-Face (or in-person) meeting with victim
NIR – No In-Person Response
SOC – Designated prefix for forms or templates created by the California Department of Social Services
MDT – Multi Disciplinary Team
LE – Law Enforcement
LTCO – Long Term Care Ombudsman
PG – Public Guardian's Office
DA – District Attorney's Office
DCA – California Department of Consumer Affairs

Category	Defining Elements	Standard	What to Document	How to Document
Response to Reports – Ten Day W&IC 15763(b) MPP 33-510.1	Mandated response within 10 days.	Between 24 hours to ten calendar days from the time the agency received the call.	a. That there was a response within ten days. b. Reasons for a different response time, e.g. 2, 3, or 5 days.	a. Time of call and time of arrival. b. Assessment tool used (e.g. SDM) or explanation addressing the timeframe, e.g. reference to internal policies.

Category	Defining Elements	Standard	What to Document	How to Document
Response to Reports – NTD ACL 14-42 W&IC 15763(b)(2) MPP 33-510.1	No protection issue. **or** Clients receiving intervention form other agencies/resources. **or** Clients where the protection issue was resolved. **or** Clients placed in permanent facilities **or** Reports received from non-credible resources. **or** Reports received involving other circumstances.	Assessed as NTD within 10 days. Resolved and closed within 30 days. A FTF needed within 30 days if unable to resolve and close.	a. Evaluation of risk determining that the vulnerable adult is not in imminent danger. b. An immediate or ten day in-person response is not necessary to protect the health and safety of the vulnerable adult.	a. Time of call and time of arrival. b. Justification Assessment tool used (e.g. SDM) or explanation addressing the threat to life, danger, crisis or agreement from law enforcement.

Category	Defining Elements	Standard	What to Document	How to Document
Response to Reports – NIR ACL 14-42 MPP 33-505.1 MPP 33-510.1	1. Reports found to be outside APS jurisdiction or do not meet APS criteria. **or** 2. Inadequate information to contact or locate the vulnerable adult. **or** 3. Determination that the vulnerable adult has moved out of state or out of county. **or** 4. The vulnerable adult is deceased. **or** 5. A past occurrence that was investigated, and with no new allegations or present risks.	Assessed as NIR within 10 days. Resolved and closed within 30 days.	1. What jurisdiction they belong in, or what criteria they didn't meet. 2. Inability to find adequate contact information without assigning the case. 3. What jurisdiction they belong in. 4. Source of information, and there is no indication that another vulnerable adult is at risk. 5. Confirm there are no present risks.	1. Date and time of report, whether a cross-report was made, and where the caller was referred to receive the proper assistance. 2. That information could not be obtained from family or another individual with knowledge of the vulnerable adult's whereabouts. 3. To whom the cross-report was made, and/or where the caller was referred to. 4. Date of death, circumstances if known (e.g. suspicious), any collateral verification of the death. 5. Date of past occurrence, and information from other agencies that there are no present risks to the elder or dependent adult.

Category	Defining Elements	Standard	What to Document	How to Document
Response to Reports – Investigation W&IC 15610.40 MPP 33-110.8 MPP 33-510.4 SOC-343 *CWDA's APS Guidelines to Supplement Regulations	That activity undertaken to determine the validity of a report of elder or dependent adult abuse.	1. Interview of the alleged victim in private, unless he/she requests otherwise. 2. Interview the suspected abuser if available and if appropriate. 3. Interview others with knowledge of the abuse, e.g. agencies, professionals. 4. Other agencies/ professionals involved in the investigation. 5. APS Worker observations. 6. Document observations that place the worker at risk. 7. Document your findings per Consistency in Findings Guidelines.	1. Obtained consent to enter the residence if interviewing victim at home, and consent to speak privately. 2. Summarize suspected abuser's statement. 3. Summarize the individual statements made by others. 4. Agency name and telephone number of contact person. 5. Describe the victim and the victim's environment as seen by the APS Worker, i.e. living quarters, adequacy of care, financial arrangements, physical evidence of abuse (Clarify indicators* e.g. Physical Indicators, Behavioral Indicators, Sexual Abuse Indicators, Financial Indicators or any other tools used by your county). 6. Criminal activity, animal, filthy hazard, infectious disease, weapons, substance abuse, severe/history of psychological problems, homicidal/ suicidal ideation, violent behavior, sexual harassment. 7. All types of relevant and available evidence or facts gathered (whenever possible from more than one source), and as instructed in the *Consistency in Determining Findings Matrix and Guide.	1. Date, time, who was present, who left the room, victim's statement and willingness/ ability to cooperate with investigation, quote relevant statements, especially when made spontaneously and under strong emotion. 2. Date, time, who was present, relationship to the client, full name, contact info, role/ position, any consistency/inconsistency, and explanation of the events from the suspected abuser's point of view; quote relevant statements, especially when made spontaneously and under strong emotion. 3. Date, time, the relationship to the client, full name, contact info, role/position, and quote relevant statements. 4. Any findings, opinions, and quote statements made, e.g. the conclusion of a police report, fire department, or Public Health Nurse (PHN), etc. 5. Details of photos taken or obtained during the investigation, and source of information (e.g. documents) gathered by the APS Worker. 6. Details on the risky situation, and why it poses a risk. Include recommendations to mitigate the risk, e.g. don't go alone, go with law enforcement, etc. 7. Workers should document the specific reasons that led them to their findings for each allegation, not just state their conclusions.

Category	Defining Elements	Standard	What to Document	How to Document
Response to Reports – **Reporting Party** ACL 01-18 W&IC 15610.55 W&IC 15633 W&IC 15633.5 **NOTE:** Being an MDT member does not automatically grant access to APS confidential information. MDT member must be directly connected to the administration of the APS Program. * Review your County's Policy on how to treat confidential information, e.g. clearing requests with County Counsel.	Types of Reporting Parties (RP): 1. Non-mandated RP. 2. Victim/Client as RP. 3. Mandated RP. 4. RP is an agency listed under W&IC 15633.5, i.e. APS, local LE, LTCO, PG, DA, Bureau, Probate Court, and DCA Division of investigation. **Please Note:** All information retained on behalf of elders and dependent adults by county adult protective services agencies in the administration of the Adult Protective Services Program is confidential. All information contained in the case record as defined in the MPP Division 33, Chapter 8, Section 33-805, is also confidential.	1. May not receive Confidential Information, unless he/she is an MDT member directly connected to the administration of the APS Program. 2. May or may not receive confidential information based on County Policy.* 3. May not receive confidential information, unless he/she is an MDT member directly connected to the administration of the APS Program. 4. May receive confidential information when investigating a case of elder or dependent adult abuse.	• Include any information regarding expression of confidentiality or limitations of sharing information due to the type of RP. *** • Include a summary of the conversation, outcome, and any actions agreed to by either party. *** **Example:** The mandated reporter is the client's dentist. The dentist's services are not required by the client's service plan. Disclosure of confidential information, including acknowledging that the client is receiving adult protective services, is not directly connected to the administration of the Adult Protective Services Program. Therefore, the adult protective services agency may not release confidential information to the dentist. The adult protective services agency may, however, confirm receipt of the report of known or suspected abuse or neglect.	For every RP: • Date and time • Type of contact, e.g. call, email, etc. • Name, agency, title • Phone number/contact information • Purpose or reason of contact, call or email to APS For example: 2/28/14 at 3pm Telephone call from Capt. Jones with City Fire Dept (888-555-5555). He responded to the client's home. **IMPORTANT** Document the report of abuse in a timely manner, or as soon as practically possible based on your County's policy and procedure.

Category	Defining Elements	Standard	What to Document	How to Document
Assessment – Capacity Issues W&IC 15636 W&IC 15657.6 W&IC 15701.25 W&IC 10850(e) MPP 33-110.8 Probate Code 811, **812**, 813, 1821, 1881 Civil Code Sec 39 Probate Code 2250(a)(b) Objectives: Initiation and reason for involuntary case planning detailing how to remediate the unsafe situation; and when appropriate, to establish the facts of good cause for appointment of the temporary guardian or temporary conservator. [Probate Code 2250(b)].	Whether or not the vulnerable adult is incapacitated to the extent that he/she cannot give nor deny consent to protective services a) because of suspected mental impairment, **or** b) because he/she is an endangered adult.	a) Suspected mental incapacity: 1. Ability to understand relevant information, e.g. rights, responsibilities. 2. Ability to understand and appreciate a situation and its likely consequences. 3. Ability to manipulate information rationally, i.e. to reason and understand risks, benefits and alternatives. 4. Ability to evidence a choice by communicating verbally or through any other means. b) Endangerment: 1. The victim is at risk of serious injury or death due to abuse, or is substantially unable to manage his or her financial resources or to resist undue influence, **and** 2. The victim demonstrates the inability to take self-protective action.	a) Suspected Incapacity: 1. Information to be understood includes nature of client's condition and situation, nature and purpose of proposed remediation of the situation, possible benefits and risks of that remediation, and alternative approaches (including no intervention) and their benefits and risks. 2. Clients who do not acknowledge their abusive or precarious situation (often referred to as "lack of insight") are likely to remain in unsafe situations. 3. Focuses on the process by which a decision is reached, not the outcome of the client's choice, since clients have the right to make "unreasonable" choices. 4. Frequent reversals of choice because of psychiatric or neurologic conditions may indicate lack of capacity. b) To document endangerment: 1. Document the victim's refusal for protective services in light of whether the victim is an endangered adult or not. 2. Document the risk of serious injury or death, or the substantial inability to manage his or her financial resources or to resist fraud or undue influence. 3. Document how the victim demonstrates the inability to take action to protect himself or herself from the current and/or future consequences of remaining in that situation or condition.	a) Suspected Incapacity: 5. Document what the client said in his/her own words about: A. The problem with his/her situation now. B. The recommended remediation, and its possible benefits and risks. C. Any alternative remedies and their risks and benefits. D. The risks and benefits of no intervention. 6. Document what the client said about: A. Their view of their situation. B. There needing to be some type of assistance or intervention, and what is it likely to do. And his/her reasons. C. What clients believe will happen if there is no assistance or intervention? D. Why the clients think the recommendations have been made? 7. Document what the client said about: A. How did the client decide to accept or reject the recommendations? B. What makes the chosen option better than the alternative option(s)? 8. Document the client's responses to the following: A. Have you decided whether to follow the recommended remediation? B. Can you tell me what that decision is? C. [If no decision] What is making it hard for you to decide? b) How to document endangerment: 1. Document the worker's assessment of the risks and danger to the client. 2. Document the determination of whether or not to institute involuntary services.

Category	Defining Elements	Standard	What to Document
Service Plan – Development and Monitoring W&IC 15763 MPP 33-535 <u>Please Note</u>: If the client cannot consent to the Service Plan, please refer to your County's Policy on providing involuntary protective services.	A service plan is a set of activities developed with client input and acceptance to alleviate identified problems utilizing counseling, monitoring, followup, and reassessment. The purpose of a service plan is to give direction to efforts to alleviate or reduce identified problems or risks, by specifying actions to be taken and resources to be utilized, and bring about changes in the lives of victims and to provide a safety net to enable victims to protect themselves in the future.	a) To identify the problems to be alleviated based on the assessment. b) To develop the desired outcomes and strategies to be used in attaining those outcomes. c) To identify resources and supports to be used in order to attain the outcomes and stabilize the situation. d) The services identified in the service plan shall be delivered only with the consent of the elder or dependent adult. e) Monitoring and followup.	a) The client's perception of the problem and concerns and the APS Worker's perception of the problem and concerns. The adult protective services worker shall ensure the client's input in the development of the service plan and shall discuss with the client the voluntary nature of the adult protective services program. b) The specific goals and the steps to attain these goals, and how each step addresses the protective issue. Steps to attain these goals should include: • Documenting any counseling on protective issues by APS Worker. • Documenting any expert counseling (e.g. finances, psychotherapy, healthcare, insurance) for clients and significant others to alleviate the identified problems and to implement the service plan. c) Name of each resource (e.g. agency, service) and support (e.g. relative, friend, neighbor), and their role in stabilizing the situation. d) The adult protective services worker shall document in the case record the client's agreement to the service plan or shall request the client to sign a document that indicates the client's willingness to receive the services in accordance with the service plan. e) Document actions taken to monitor and evaluate the effectiveness of the plan in addressing the protective issues.

APS Guidelines to Supplement Regulations, Section 2.9: APS California Cross-Reporting and Referral Guide. Can be downloaded from: http://www.cwda.org/tools/adult.php

California Penal Codes Commonly Used in APS Case Documentation

PC 368 (a) through (k) – Crimes Against Elders or Dependent Adults:

368. (a) The Legislature finds and declares that crimes against elders and dependent adults are deserving of special consideration and protection, not unlike the special protections provided for minor children, because elders and dependent adults may be confused, on various medications, mentally or physically impaired, or incompetent, and therefore less able to protect themselves, to understand or report criminal conduct, or to testify in court proceedings on their own behalf.

(b) (1) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars ($6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

(2) If in the commission of an offense described in paragraph (1), the victim suffers great bodily injury, as defined in Section 12022.7, the defendant shall receive an additional term in the state prison as follows:

(A) Three years if the victim is under 70 years of age.

(B) Five years if the victim is 70 years of age or older

(3) If in the commission of an offense described in paragraph (1), the defendant proximately causes the death of the victim, the defendant shall receive an additional term in the state prison as follows:

(A) Five years if the victim is under 70 years of age.

(B) Seven years if the victim is 70 years of age or older.

(c) Any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions other than those likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care or custody of any elder or dependent adult, willfully causes or permits

the person or health of the elder or dependent adult to be injured or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health may be endangered, is guilty of a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars ($2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

(d) Any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or a dependent adult, and who knows or reasonably should know that the victim is an elder or a dependent adult, is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars ($2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars ($10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars ($950).

(2) By a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars ($950).

(e) Any caretaker of an elder or a dependent adult who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates Section 530.5 proscribing identity theft, with respect to the property or personal identifying information of that elder or dependent adult, is punishable as follows:

(1) By a fine not exceeding two thousand five hundred dollars ($2,500), or by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, or by a fine not exceeding ten thousand dollars ($10,000), or by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding nine hundred fifty dollars ($950).

(2) By a fine not exceeding one thousand dollars ($1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding nine hundred fifty dollars ($950).

(f) Any person who commits the false imprisonment of an elder or a dependent adult by the use of violence, menace, fraud, or deceit is punishable by imprisonment pursuant to subdivision (h) of Section 1170 for two, three, or four years.

PC 368 Definitions

Elder:

(g) As used in this section, "elder" means any person who is 65 years of age or older.

Dependent Adult:

(h) As used in this section, "dependent adult" means any person who is between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. "Dependent adult" includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

Caretaker:

(i) As used in this section, "caretaker" means any person who has the care, custody, or control of, or who stands in a position of trust with, an elder or a dependent adult.

(j) Nothing in this section shall preclude prosecution under both this section and Section 187 or 12022.7 or any other provision of law. However, a person shall not receive an additional term of imprisonment under both paragraphs (2) and (3) of subdivision (b) for any single offense, nor shall a person receive an additional term of imprisonment under both Section 12022.7 and paragraph (2) or (3) of subdivision (b) for any single offense.

(k) In any case in which a person is convicted of violating these provisions, the court may require him or her to receive appropriate counseling as a condition of probation. Any defendant ordered to be placed in a counseling program shall be responsible for paying the expense of his or her participation in the counseling program as determined by the court. The court shall take into consideration the ability of the defendant to pay, and no defendant shall be denied probation because of his or her inability to pay.

368.5. (a) Local law enforcement agencies and state law enforcement agencies with jurisdiction shall have concurrent jurisdiction to investigate elder and dependent adult abuse and all other crimes against elder victims and victims with disabilities.

(b) Adult protective services agencies and local long-term care ombudsman programs also have jurisdiction within their statutory authority to investigate elder and dependent adult abuse and criminal neglect, and may assist local law enforcement agencies in criminal investigations at the law enforcement agencies' request, provided, however, that law enforcement agencies shall retain exclusive responsibility for criminal investigations, any provision of law to the contrary notwithstanding.

Other Important Penal Codes:

PC 187 – Murder

PC 211 – Robbery

PC 237 (b) – False imprisonment; elder or dependent adult (apply to isolation situations)

PC 240 – Assault

PC 242; 243 – Battery

PC 243.25 – Battery against person of elder or dependent abuse; punishment

PC 243.4 (b) – Sexual battery of serious disabled or medically incapacitated

PC 245 – Felony Assault

PC 261 (a)(1) – Rape

PC 273.5 - Inflict corporal injury on current or former spouse or cohabitant

PC 288(a) – Oral copulation; lack of capacity

PC 289 (b), (c) – Forcible acts of sexual penetration; lack of capacity

PC 368(b); 368(c) or 368(f) - Lewd or lascivious acts (include forcing the elder to watch pornography, pose for pornography)

PC 459 – Burglary (also applies to entering a person’s home to defraud them)

PC 470-476 – Forgery

PC 484, 487, 488 – Theft; grand theft; petty theft

PC 530.5 – Identity Theft

PC 597 – Animal Abuse

PC 646.9 – Stalking (addresses a pattern of conduct, including following, badgering, calling, lurking - with a threat. It can vary from case to case, and typically requires some rather egregious conduct or pattern of conduct)

Other Codes to be Familiar With:

Family Codes

FC 4400 – Duty of adult children to support parents

FC 6250 (d); 6251 – Protective order for elder or dependent adult

Probate Code

PC 811 – Deficits in mental functions; incapacity to contract

Welfare & Institutions Code

W&I Code 5150- Involuntary psychiatric hold for an individual who is a danger to himself or others, or gravely disabled

W&I Code 15600, et. seq – Elder Abuse and Dependent Adult Civil Protection Act

W&I Code 15700, et. seq. – Protective Placements and Custody of Endangered Adults

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This document was created by the APS Training Project - Bay Area Academy/SFSU with research assistance by Lori Delagrammatikas; APS, Riverside County; Candace Heisler, JD; and Tristan Svare, DDA, Elder & Dependent Adult Abuse Prosecution Family Violence Unit, San Bernadino County and the CA District Attorney's Association. Ju. PC