Elder Mistreatment Screening and Response Tool (EM-SART)

The EM-SART is a tool intended for use in the emergency department for identification of suspected elder mistreatment. Users should undergo training regarding the administration of the tool as well as the content areas of elder mistreatment and geriatric medical syndromes. It is important to ask the screening questions privately while the patient is unaccompanied.

**PRE-SCREEN**

**Brief Screen**

Positive response to one or more questions and/or concerns based on observations?

**Yes**
- Proceed to Full Screen

**No**
- ED Care as Usual

**Ask the Patient**

- Has anyone close to you harmed you?  
  - YES  
  - NO
- Has anyone close to you failed to give you the care that you need?  
  - YES  
  - NO
- Has anyone tried to force you to sign papers or use your money against your will?  
  - YES  
  - NO

**Look for Red Flags**

*If available, the patient’s medical history includes:*

- Repeated visits to the ED  
  - YES  
  - NO
- Frequent or unexplained injuries  
  - YES  
  - NO
- History or signs of cognitive impairment  
  - YES  
  - NO
- Delayed attention to or unmet health needs  
  - YES  
  - NO

*The patient appears to:*

- Have physical signs of mistreatment (e.g., suspicious wounds, concerning personal hygiene, malnutrition or dehydration)  
  - YES  
  - NO
- Have unmet mental health needs or problems with substance use  
  - YES  
  - NO
- Lack access to needed resources  
  - YES  
  - NO
- Feel uncomfortable with their caregiver(s)  
  - YES  
  - NO

*If present, the caregiver appears:*

- Unengaged, inattentive, or to lack knowledge of the patient’s medical needs  
  - YES  
  - NO
- Dismissive of, frustrated with, or hostile towards the patient  
  - YES  
  - NO
- Overly concerned or anxious about the patient  
  - YES  
  - NO
- To have unmet mental health needs or problems with substance use  
  - YES  
  - NO
- To lack access to needed resources  
  - YES  
  - NO

**Record Additional Notes and Recommendations**

- I recommend the EM-Full Screen.
- I recommend ED care as usual.

**Notes:**

Adapted from DETECT Screening Tool¹

The National Collaboratory to Address Elder Mistreatment is supported by grants to Education Development Center from The John A. Hartford Foundation, The Gordon and Betty Moore Foundation, and The Health Foundation for Western and Central New York.
Initial Cognitive Assessment (AMT4)

Indicate whether the patient answers the following questions correctly.

- What is your age?
- What is your date of birth?
- What is this place?
- What is the year?

Elder Mistreatment Questions

Ask questions when patient is alone, and indicate the patient’s response. Preface each question with “In the last 6 months…”

- Have you needed help with bathing, dressing, shopping, banking, or meals?
  - *If yes, have you had someone who helps you with this?
  - *If yes, is this person always there when you need them?
- Has anyone close to you called you names or put you down?
- Has anyone told you that you give them too much trouble?
- Has anyone close to you threatened you or made you feel bad?
- Has anyone tried to force you to sign papers or use your money against your will?
- Has anyone close to you tried to hurt you or harm you?

Observational Screen/Red Flags

Indicate the proper response.

The patient appears to:

- Have physical signs of mistreatment (e.g., suspicious wounds, concerning personal hygiene, malnutrition or dehydration)
- Have unmet mental health needs or problems with substance use
- Lack access to needed resources
- Feel uncomfortable with their caregiver(s)

If present, the caregiver appears:

- Unengaged, inattentive, or to lack knowledge of the patient’s medical needs
- Dismissive of, frustrated with, or hostile towards the patient
- Overly concerned or anxious about the patient
- To have unmet mental health needs or problems with substance use
- To lack access to needed resources

Adapted from DETECT Screening Tool²
Judgment of Patient’s Ability to Report (Confident/Not Confident)

- Confident
- Not Confident

Clinical Judgment: Suspect Elder Mistreatment?
Based on all information available including the answers the patient provided, the patient’s chief complaint, and any observations you have made, do you suspect elder mistreatment?

- Uncertain

Physical Assessment

- Susicion
- No suspicion but need for additional services
- No Suspicion

ED Care as Usual
 Proceed to Response

Judgment of Patient’s Ability to Report
Based on the information gathered, do you feel confident that the patient was able to honestly and accurately report mistreatment?

- Confident
- Not confident

Indicate the proper response.

Elements Highly Suggestive of Abuse

- Bruising in unusual location, multiple bruises, or large bruises?
- Burn patterns suggestive of intentional injury?
- Patterned injuries?
- Abrasions or lacerations suggestive of intentional injury?
- Evidence of neglect?

Elements That May Suggest Abuse

- Evidence of malnutrition?
- Evidence of dehydration?
- Swollen or tender area on palpation?
- Evidence of poor control of medical problems?

Specific Circumstances

- Genital trauma or infection concerning for sexual abuse?
- Fractures concerning for abuse?
- Current problem has been present for a long time—unusual delay in seeking medical attention concerning for abuse or neglect?

Clinical Judgment: Suspicion of Elder Mistreatment

- Suspicion
- No suspicion but need for additional services
- No suspicion

Notes:


2 Detect Screening Tool is incorporated into this screening protocol with permission from Michael Bradley Cannell, University of Texas.
**Judgment of Situation**
Is the patient in immediate danger?

- No Suspicion but Need for Additional Services
  - Does not meet APS criteria

- Suspicion of Elder Mistreatment
  - No Immediate Danger
  - Meets APS criteria

- Suspicion of Elder Mistreatment & Immediate Danger
  - Consider:
    - Contacting hospital security
    - Notifying law enforcement

**Report**

- **Indicate where patient currently lives:**
  - Own residence
  - Residential care community
  - Nursing home
  - Other: ___________________________

- **Indicate whether a report was made to:**
  - Adult Protective Services (APS)
  - Other: ___________________________

**Document**

- **Indicate whether physical assessment findings were documented in health record**
  - Physical assessment findings
    - (e.g., written descriptions, diagrams, photos)

- **Indicate the type(s) of mistreatment and whether there is concern for immediate danger in the table below**
  - Level of concern

<table>
<thead>
<tr>
<th></th>
<th>Physical Abuse</th>
<th>Sexual Abuse</th>
<th>Emotional Abuse</th>
<th>Financial Abuse</th>
<th>Undue Influence</th>
<th>Neglect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspicion of EM &amp; Immediate Danger</td>
<td>●</td>
<td>●</td>
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<tr>
<td>Suspicion of EM No Immediate Danger</td>
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</tbody>
</table>

- No suspicion of mistreatment but need for additional services

**IMMEDIATE DANGER:** **STOP**
Do not discharge to previous living situation if:

- **Check all that apply**
  - Sexual assault with ongoing risk
  - Threat: concern for or stated threat of physical injury
  - No access: neglect with ongoing risk for insufficient access to shelter, food, medication, or medical care
  - Physical abuse with injury and ongoing risk

**Assess decision-making capacity if appropriate:**
If a patient wishes to return to an unsafe living situation, assess capacity to make this decision

**Response to Positive Screen (continues on next page)**
Referral

- Care/case management services
- Emergency assistance and material aid services
- Legal services
- Housing and relocation services
- Substance use services

Safety Planning

- Develop safety plan that aligns with patient’s values

Discharge Patient

Immediate Danger: Do not discharge to previous living situation. Consider:
- Hold in ED
- Inpatient
- Skilled nursing facility
- Emergency housing
- Shelter
- Other:

No Immediate Danger:
- Inpatient
- Skilled nursing facility
- Long-term care facility
- Emergency housing
- Home with safety plan
- Other: