Submission by the New South Wales Nurses and Midwives' Association

Elder Abuse Issues Paper

Australian Law Reform Commission Inquiry into Elder Abuse

August 2016

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises of those who perform nursing and midwifery work at all levels including management and education. This includes registered nurses and midwives, enrolled nurses and assistants in nursing (who are unregulated).

The NSWNMA has approximately 64,000 members, of which 10,000 work in aged care or disability services. Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation. Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and aged care services.

As part of our preparations for this submission we consulted our members and the community through a survey and a national aged care telephone dial-in. Their testimonials and responses are included in this document and serve to highlight the frontline issues affecting the aged care workforce and recipients of aged care services. This followed an initial survey and report on elder abuse in residential aged care facilities conducted in late 2015, which we submit as an appendix.

We welcome the opportunity to make a submission to this issues paper and the opportunity for wider discussion that this provides.

This submission is authorised by the elected members of the New South Wales Nurses and Midwives' Association.

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“It is always so heartbreaking to visit my parents in different facilities and see the neglect they put up with.”

Aged-care caller no. 52

Introduction

Statistics show that the population is ageing and although most Australians aged over 65 consider themselves to be in good health[1] living longer does not always equate to living better. 40% of hospitalisations in 2013–14 were for people aged 65 and over[1] and over 650,000 people aged over 65 are currently living with a severe disability[2]. These figures will inevitably rise as people live longer with chronic and complex age related illnesses.

Longevity can also increase the chances of dementia related illnesses and frailty both of which can increase vulnerability to abuse[3]. Elder abuse is already acknowledged as a global public health problem which affects all levels of society[4.] Figures from the United States suggest that as many as one in ten older people have experienced elder abuse in some form[5]. If this statistic is applied to Australia where the population aged over 65 is already at 3.5 million[2], as many as 350,000 Australians could have experienced the effects of abuse in one way or another. This is a shocking statistic that only serves to highlight the urgency of action required to ensure safeguards are implemented.

There will be increasing reliance on registered nurses, enrolled nurses and assistants in nursing to meet the needs of the ageing population. This means that strategies to reduce the incidence of elder abuse must be aligned with wider government reform within the aged care sector as a whole. Consumer directed care; increasing use of community based care services and workforce planning within the aged care sector will all impact on the ability of frontline staff and the wider community to ensure adequate protections are in place for the most vulnerable elderly.

Many of our older population, particularly those aged over 85 live in some form of supported living, including residential aged care. A recent survey of aged care workers highlighted that elder abuse issues pose daily challenges for staff employed in residential aged care facilities. Inadequate staffing, poor skill mix and fear of reprisals within reporting mechanisms were identified as key barriers to reducing the

incidence of abuse. The survey highlighted the need for an urgent review of safe staffing; comprehensive commonwealth elder abuse strategy and an effective regulatory system for aged care facilities to reduce the risk[6].

Despite this evidence the 2016/17 Federal budget announced major cuts to aged care funding particularly for those people requiring a high level of complex healthcare[7,8], prompting many aged care providers to indicate that they would be likely to make further cuts to the numbers of registered nurses and care workers they employ[9]. This is in addition to the already declining number of registered nurses employed in the direct aged care workforce from 21% of total staff in 2007 to 15% in 2012[10]. Since almost 90% of all people entering aged care facilities are assessed and funded as having high care needs[11] logic tells us there should be more, not less skilled nurses within the aged care workforce. The combined evidence would also suggest that the risk climate for elder abuse is greater than it has ever been.

The NSWNMA made a submission and gave evidence at a recent NSW Parliamentary Inquiry into Elder Abuse in New South Wales. To avoid duplication, we refer the committee to our submission which we have attached as an appendix. We request that due consideration is given to the contents, including the testimonies by our aged care sector members which form part of our evidence for change. We would welcome the opportunity for further engagement regarding this important issue.

Brett Holmes
General Secretary

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List of Abbreviations:

AACQA	Australian Aged Care Quality Agency
AiN	Assistant in Nursing
ANMF	Australian Nursing and Midwifery Federation
EN	Enrolled Nurse
NSW	New South Wales
NSWNMA	New South Wales Nurses and Midwives' Association
RACF	Residential Aged Care Facility
RN	Registered Nurse
UK	United Kingdom
US	United States (of America)

Recommendations

1 A full review of both National and International literature on elder abuse is required, so that elements of best practice can be used to formulate a comprehensive and practical definition of abuse.

2 The development of a comprehensive commonwealth evidence based adult abuse strategy is required. This should include: local safeguarding officer(s) to offer specific training and support for staff; 24 hour access to a helpline and support for workers with substitute decision making.

3 Legislation should require the reporting of safeguarding concerns as a neutral act and should enable workers to raise concerns without fear of reprisal.

4 Legislation should be amended so that all instances of actual or suspected abuse, regardless of the cognitive capacity of the perpetrator can be reported as a neutral act.

5 Any protective legislation must ensure impartiality in the identification of abuse by ensuring there is legal accountability on the organisation for raising concerns, even in circumstances where the organisation itself may be implicated.

6 A comprehensive review of safe staffing levels in aged care facilities and disability services is required in order to establish mandated staffing ratios and skill mix.

7 All assistants in nursing (however titled) should be licensed and subject to regulation to ensure a minimum standard of qualification for assistants in nursing (however titled) and to increase accountability within the aged care sector workforce.

8 The regulation of independent care workers operating in the community as a means of reducing the risk of abuse.

11 A review of the current system for monitoring and regulating quality in residential aged care facilities, including improving the availability of information about the performance of a service.

12 Consideration of the provision of a safeguarding lead in all healthcare settings to provide a link between external agencies and health professionals and ensure best practice in safeguarding responses. For large organisations or health districts, organisational governance could be secured through implementation of local safeguarding boards.

13 The establishment of an Ombudsman to assist staff when assisted decision making is required and for power of attorney failures.

14 The commissioning of further research to investigate under-reporting of abuse with a view to empowering recipients of aged care services and their advocates to raise concerns.

Questions

In responding to this issues paper we have selected the questions that are relevant to respond to on behalf of our members.

(Please also refer to the NSWNMA submission to the NSW Elder Abuse Inquiry, ANMF National Aged Care Survey and NSWNMA staff survey attached as appendices)

What is elder abuse?

Question 1 To what extent should the following elements, or any others, be taken into account in describing or defining elder abuse:

- ***harm or distress;***
- ***intention;***
- ***payment for services?***

We consider that any definition of abuse should be comprehensive enough to capture the full range of abuse practices, yet be simple enough for workers and potential reporters to understand. Using a definition of abuse that focuses on the experience of the victim may be helpful in formulating an appropriate legal response and identifying which support services will be required by the victim.

"What is important is the impact of the harm on the vulnerable person, not who did it or what the intent was. By keeping impact as central, we keep the safeguarding effort focused on protecting and working with the person being harmed, not on judging the person who has harmed them. Disabled people tell us that we should also use inclusive terminology: for instance to refer to theft or fraud not "financial abuse" and to rape, if someone has been raped, not "sexual abuse"."[12]

In forming a definition consideration should be given to poor care in institutions and also contemporary issues which may be found within modern Australian society such as: discrimination; modern slavery and forced marriage. It should also apply to those people living in 'aged care' services who are under 65 years. Useful references in this regard include the UK Office of the Public Guardian Safeguarding Policy[13] and Victoria's 2009 Elder Abuse Strategy[14]. The latter also offers comprehensive guidelines which have been used to formulate various local prevention strategies

around Victoria. However, little has been done to develop a commonwealth strategy that can be applied across state boundaries and which can form the basis for common benchmarking and good practice. We suggest that a full review of both National and International literature occurs, so that elements of best practice can be used to develop both a comprehensive definition of abuse and a commonwealth strategy.

Question 2 What are the key elements of best practice legal responses to elder abuse?

A system exists within childcare services for the protection of younger people against abuse. Family and Community Services within Australia offer a caseworker to those who are either at risk of abuse or are alleged to be the victim of abuse. This system ensures that cases are discussed within a multidisciplinary team and the most appropriate response is established. A similar system operates in the UK for adult protection[15]. Reporting systems allow for investigation of concerns as a neutral act within a multi-disciplinary framework, thereby reducing the risk of fear of reprisal which is a major concern for our members[6].

"Everyone including myself are reluctant to report to anyone other than our own management due to fear of reprisals from our management."

Registered Nurse - RACF

Question 3 The ALRC is interested in hearing examples of elder abuse to provide illustrative case studies, including those concerning:

- ***Aboriginal and Torres Strait Islander people;***
- ***people from culturally and linguistically diverse communities;***
- ***lesbian, gay, bisexual, transgender or intersex people;***
- ***people with disability; or***
- ***people from rural, regional and remote communities.***

We draw your attention to the documents attached as an appendix which provide further anecdotal evidence from aged care workers and community members. The

following responses are taken from recent consultations. We admire the honesty of aged care workers and relatives in relaying their stories. We make no judgement in relation to these statements. However, what is apparent is the lack of any training, or safeguarding framework which would have enabled workers and relatives to respond appropriately to the situations they describe. Failure to do this not only places people receiving care at further risk, but also creates unresolved psychological distress as staff and relatives seek to reconcile the situations they are witnessing and/or experiencing.

"My father was a high care patient due to Lewy Body Disease. He had a urinary catheter in place. On a public holiday there was one qualified nurse for 85 people. The catheter had fallen out the nurse was unable to replace it. The hospital phoned for an ambulance to take dad to hospital. It was 8 hours before an ambulance arrived to transfer him to a hospital emergency department. On arrival he was diagnosed with septicemia from the poor catheter care and obstructed bladder. He was only in the aged care facility for 2 weeks as we thought they would offer higher care than we could offer him at home. We felt they were not able to offer him very high care as they were so busy and understaffed. This was in 2010. My mother now also has dementia and I am very concerned about her moving to an aged care facility in the future due to the ratio of staff to patients."

Aged-care caller no. 67

"Took Aboriginal family to financial guardianship because resident was a smoker and they would always be late providing cigarettes. They were also spending the residents money on their own requirements - alcohol and nail salons. Now the daughter no longer visits her mum - which is very sad."

Manager -RACF

"I worked for nearly 8 years in Aboriginal aged care in central Australia. I have seen countless times the elderly seen as a commodity to take whatever the family can get off the resident..... Residents taken out by family members to have their accounts cleared and then they are dumped in town to fend for themselves until the RACF can locate them or the hospital rings the RACF because they have been admitted. Visitors taking residents out into the car park, taking their money and leaving them there in 40 degree heat."

Care worker - RACF

"I was quiet shocked with the reaction of some staff when a male resident showed his love of wearing extravagant female jewellery. This resident has a mental illness among other disabilities which do not have any bearing on his ability to direct his care, his choices and decisions. The attitude of because he has a mental illness it has to be recorded that it is his choice to wear the jewellery. The thought process of some staff is that "It might be considered that staff are pushing this decisions on him" is very sad. It reminds me of the dark old days when homosexuality, cross dressing etc. was considered a sexual perversion and need to be treated as a mental illness in the medical profession."

Care worker - RACF

"We have a transgender resident in our facility & staff make awful remarks about her & call her 'him'."

Assistant in Nursing - RACF

Question 4 The ALRC is interested in identifying evidence about elder abuse in Australia. What further research is needed and where are the gaps in the evidence?

71% of our recent member survey responses confirmed that there was not enough information about elder abuse to inform their practice. Gaps in evidence exist due to the fact that there is confusion over the definition of abuse and underreporting. If these issues are addressed it will provide a much clearer platform to develop research around the area. Once systems are established which ensure abuse is reported, this will produce useful statistical data. However, there should be a common legal and organisational framework to enable effective benchmarking. Also to ensure that workers and services crossing state boundaries do not have the added risks associated with inconsistent policies and procedures.

There are certainly gaps in the evidence surrounding marginalised communities and it is hoped that this Inquiry will attract expert opinion in this regard.

It would also be useful to examine power imbalance issues relative to the underreporting of abuse by relatives of people in aged care. There is anecdotal evidence to suggest that this group feel powerless to raise concerns or have their concerns dismissed by aged care providers. Relatives live with feelings of guilt associated with putting their loved ones into care. They not only witness the physical and often, mental decline of the person but must live with the knowledge that they are powerless to control what happens to their loved one once they have left the building. The Adelaide aged care facility featured in the ABC's 7.30 program aired in July saw the relative's complaints about the care of her very ill father countered by the threat of legal action by the aged care provider.

Raising concerns or being seen as a whistle-blower is not a decision taken lightly since there is the constant fear of reprisal against their relative who has to remain in the care of the alleged perpetrators. The post traumatic stress these people suffer must not be under-estimated. It is a very under-researched area yet is one which has a significant influence on a person's ability to raise issues of concern about abuse.

Often once a person has died, relatives prefer to seek closure by not prolonging their involvement with an aged care facility due to feelings of guilt at not being able to care

for them at home, or trauma through association. As a consequence, they are unlikely to raise concerns retrospectively. All these factors are worthy of further research to inform policy direction, reporting systems and increase protections for adults accessing care services.

Aged care

Question 11 What evidence exists of elder abuse committed in aged care, including in residential, home and flexible care settings?

Our members consider that neglect due to a failure to provide adequate staffing is a major contributor to institutional abuse in aged care. This can lead to over-medicating and failure to provide adequate supervision, nutrition or hygiene. Legislation must ensure that it recognises inadequate staffing and institutional neglect as contributory factors to abuse, whether intentional or unintentional. It should also consider whether regulatory systems, aged care policy and more recently, aged care funding cuts announced in the 2016/17 Federal budget need to be considered in a broader contextual sense when seeking to develop meaningful strategies to reduce the risk of abuse.

Some public hospitals and childcare facilities have mandated staffing ratios. It is difficult for our members to understand why the same level of protection is not afforded to older people living in residential aged care services. Many have restrictive physical disabilities and even more are unable to communicate effectively due to cognitive decline. Unable to vocalise and/or totally dependent on a largely unregulated workforce for their every day care, these people should be considered more, rather than less in need of protection through prescribed staffing ratios .

Residential aged care facilities are not places that people can leave at 5pm and weekends, nor are they a lifestyle choice. People are there 24 hours a day, 365 days a year and are often terminally ill. We cannot emphasise enough the importance of meaningful legislation to ensure minimum staffing and skill mix ratios in residential aged care.

"Lack of staffing in aged care facilities opens the window to abuse. Aged care clients can be left unattended for periods whilst personal care is being attended. It is imperative that adequate staffing is made available."

Registered Nurse - RACF

"Lack of staffing and /or resources can lead to instances of inadvertent abuse of elders. E.g. when residents unable to speak up for themselves are left for hours in wet/ soiled beds or continence aids because staff are busy attending to other, more vocal residents.

Assistant in Nursing - RACF

"My father who was 66 years old was an inpatient at a facility where his cognitive and physical abilities declined drastically until he passed away from a brain tumour. I witnessed many, many situations that he was put in which were totally inhumane. All situations were due to a lack of staff numbers. I am a registered midwife working for NSW Health and I see every single day services offered to the public that unable to be delivered effectively due to a lack of staffing. My father suffered as a direct result of poor staffing and a lack of funding and this standard of care provision is unacceptable. The Government must prioritise funding for healthcare across the scope of services including aged care."

Aged-care caller no. 12

"Where I work NEGLECT would be without a doubt the main form of Elder Abuse in residential aged care. The cause is time constraints, inadequate training and lack of resources (registered nurses and assistants in nursing) I have seen people who may have difficulty walking soon become wheelchair bound because the nursing and care staff do not have time to walk the resident often enough. This is despite having a visiting physiotherapist one day per week. Our two facilities are adjoining and total 99 residents majority of the time. It is a rural setting. Also I have seen far too many residents developing a rash in the groin due to having a wet or soiled incontinence pad on for too long without being changed. I have seen far too many skin tears occurring due to care staff rushing because of time constraints."

Registered Nurse - RACF

Question 12 What further role should aged care assessment programs play in identifying and responding to people at risk of elder abuse?

Nurses working in Aged Care Assessment Teams are in a unique position to identify elder abuse as they often have access to information about the persons' family situation. The nature of their role means there is an element of trust which might lead to disclosure. However, teams should have a common tool available to identify risk of abuse and triggers, similar to those used to identify child or domestic abuse. They should also have access to an agency or department in their local health district to report concerns to.

Recently, our members working in assessment have raised concerns that their services are due to be reviewed and that contracts may be awarded to private providers. There is the risk of a conflict of interest situation if abuse allegations are levied at other services that the same provider delivers. Any protective legislation must ensure impartiality in the identification of abuse by ensuring there is legal accountability on the organisation for raising concerns, even in circumstances where the organisation itself may be implicated.

Question 13 What changes should be made to aged care laws and legal frameworks to improve safeguards against elder abuse arising from decisions made on behalf of a care recipient?

Around a third of our members who completed our survey had either witnessed, or were unsure about witnessing financial abuse of a person by relatives who held Power of Attorney. This is a significant figure considering the number of people receiving aged care services. Our members are in a unique position to identify financial abuse, yet their responses indicate they lack the knowledge and skills to be able to pursue these areas effectively.

The uncertainty of some aged care workers as to whether they had witnessed abuse further highlights the need for legal frameworks to ensure safeguards are in place. 73% of all members completing the survey said that training would assist them in relation to this area. The development of aged care laws must ensure that all workers providing direct or indirect care to people, including volunteers receive adequate training. Over 60% of members completing the survey also told us that quality audits by the AACQA should focus more heavily on financial abuse.

Aged care laws, and those for adults who lack capacity must ensure adequate protections against the risk of exploitation by those making decisions on their behalf. This relates not only to relatives and significant others but also care givers and organisations charged with upholding the person's best interests. Members often struggle with decision making on behalf of the people they are caring for either because the person has fluctuating capacity, or as a result of unclear guidelines about where their decision making boundaries lie. The NSW Capacity Toolkit[16] is an excellent resource but there is no requirement in the *Aged Care Act, 1997* for staff to have any mandatory training in this regard. Having Independent legislation covering mental capacity and specialist workers to assist staff to make decisions on behalf of people is something our members consider important to enable them to safeguard people effectively[17,18].

The NSW Elder abuse inquiry recently investigated this matter in depth and made recommendations regarding power of attorney decisions, which we would encourage this Inquiry to reference[19].

"A couple of years ago I cared for X in an aged care facility. X liked to attend the hairdresser weekly for a set; she liked to go to the kiosk for coffee and to buy snacks. X initially had a mobile phone. X's family began to reduce the activities that they would fund for X. The family asked that X stopped attending the hairdresser weekly instead to attend 4-6 weekly for a trim. X was no longer left with cash to visit the kiosk for coffee and snacks. X's family removed X's mobile phone stating that she was making too many calls and it was too expensive. X expressed her anger and frustration to staff. I felt at the time as did many of my colleagues that it was financial abuse but our hands were tied, we had no one to report this to so X just went without unless staff went and bought a snack or a coffee from the kiosk for her. Her family did supply chips and biscuits but weren't regular visitors so for lengthy periods of time X was without these."

Registered nurse - RACF

"Refusing to pay bills or provide things such as clothing or other items not provided by the RACF. It seems to me that there are a lot of children out there not wanting to spend their inheritance!"

Care worker - RACF

"Financial abuse by family leaving the resident with little financial means, unable to attend outings as they could not afford to, reluctant to have medications as the family always complained about the pharmacy account, lack of necessary clothing due to family controlling the finances, in fact staff bought and paid for underwear and other necessary items from their own pockets."

Assistant in Nursing - RACF

Question 14 What concerns arise in relation to the risk of elder abuse with consumer directed aged care models? How should safeguards against elder abuse be improved?

The latest available figures show that there are over 900,000 older people receiving some form of community based care service[20] and admissions into community based care have grown by 23% over the past five years, compared to 6% growth in take-up of residential aged care[21]. 60% of members completing our survey for this paper thought that the risk of financial abuse was greater with the introduction of consumer directed care.

"I am also a Service Coordinator with a Community Care service provider in rural remote areas & I believe in this new world of service provision more abuse will occur as accessing services for aged & disability clients will be very limited by travel costs leaving clients vulnerable & open to abuse as less visible in our society. Most service providers won't provide service if not cost effective in these areas. People have a right to live where they choose without being disadvantaged one would hope."

Assistant in Nursing -RACF

The move to consumer directed care opens a new care scenario which is a potential disrupter to the care industry as a whole. The operational system as it is proposed allows consumers more freedom to spend their personal budget on bespoke services. This opens up the market to a largely peripatetic, unlicensed and potentially unregulated workforce for both the elderly and those living with restrictive disabilities in the community. Those people receiving commonwealth funding will have some degree of security since there will be a level of oversight within the accountability of funding allocations. However, as means-testing of funding becomes increasingly restrictive more people will opt to receive private care services operated by 'Uber' style platform care agencies.

There are already a growing number of care workers and registered nurses operating in this way. Platform care agencies currently have no control over the way care is delivered. They remove themselves from contractual care obligations following introduction of the worker to the client. These 'private arrangements' leave great potential for exploitation of the care recipient by the care giver. We would suggest that the regulatory model in operation in the UK is examined as a potential way to legislate for this emerging group of individual private care givers[22].

Question 15 What changes to the requirements concerning quality of care in aged care should be made to improve safeguards against elder abuse?

Many residential aged care providers operate a quality service and take all appropriate action to reduce the risk of abuse in their facilities. However, the law must offer a safety net for people living in aged care, or receiving aged care services. Currently our members feel this is an area which is lacking and allows for some providers to make cuts to service provision in an attempt to improve profitability within their service.

Quality in aged care must be considered in relation to aged care policy concerning residential aged care. Historically aged care places have been ring-fenced in an attempt to control public spending on aged care. This resulted in the licensing of a finite number of aged care places and effectively removed the open market from residential aged care services. Providers historically carried few vacancies and most had waiting lists. This system does not support the natural evolution of market driven quality improvements, since competition between providers is low. Whilst the introduction of consumer directed care may be a driver for quality, unless the restriction on aged care places is removed completely it is unlikely this will make any significant impact.

In addition, our members have told us that the AACQA who are the regulatory body for residential aged care services have not proven themselves to be effective in improving quality in aged care. They tell us that site visits conducted by the AACQA are often announced and therefore do not reflect the true picture of the operation of the home on a day-to-day basis. The inspection methodology is based around audit of systems and paperwork.

Our members working in RACFs feel unable to be open with assessors about perceived care failures due to fear of reprisal from their employers. Few systems exist for reporting on the operation of the home between inspections, which are often over a year apart.

"Our elderly deserve much better care. The accreditation agency visit and staff from 'head office' come to the facility and talk their way out of problems that are identified. Staff feel intimidated to speak freely about their concerns because they need a job and are in fear of reprisal by management. Management are more concerned about being sued than providing hands on meaningful care."

Registered Nurse - RACF

Empowering the community could drive quality in this area and therefore reduce the risk of abusive practices. However, detailed information about the outcome of AACQA quality audits is largely unavailable to the general public. Government aged care reforms have resulted in the creation of a 'one stop shop' for all aged care services through the 'My Aged Care' portal. However, many older people seeking aged care services are unable to navigate the complex online system. This lack of transparency and information must be addressed to reduce risk factors for abuse.

(see also Q19)

Question 16 In what ways should the use of restrictive practices in aged care be regulated to improve safeguards against elder abuse?

and

Question 17 What changes to the requirements for reporting assaults in aged care settings should be made to improve responses to elder abuse?

One of the main concerns of our members is the lack of a legal framework for reporting abuse that falls outside the definitions of physical or sexual assault. They

are also concerned that people with cognitive impairment are exempt from reporting requirements; despite evidence to suggest that resident on resident violence is commonplace[16]. Providers are expected to put into place a behaviour management plan as an alternative to reporting in these circumstances. However, our members tell us that there are often inadequate staffing ratios to fulfil the requirements of a robust behaviour management plan and little monitoring of this process by the AACQA. Whilst our members would not wish to criminalise people with cognitive impairment, it is essential that external agencies review any behaviour management plan operated by the aged care provider and ensure sufficiency of staffing.

Failure to provide therapeutic interventions and adequate supervision can increase the use of physical or chemical restraint used to control undesired behaviours. Therefore any re-design in relation to the legal definition of abuse should be replicated within the Aged Care Act 1997 reportable assaults legislation[25,26] so that adequate safeguards are maintained in residential aged care.

"I have observed a steady decline in care given to Residents in the Facility I work at due to inappropriate skill mix of Staff, decreased RN staffing levels consequently less supervision of Residents suffering severe cognitive impairment and increased incidents of Resident to Resident Elder abuses."

Registered Nurse - RACF

Question 19 What changes to the aged care sanctions regime should be made to improve responses to elder abuse?

A recent national aged care dial-in attracted over 2000 calls from aged care staff and community members[25]. 78.1% of workers said that in their experience staffing in RACFs was inadequate to meet acceptable standards of care. Workers highlighted unacceptable staffing ratios such as one registered nurse responsible for over 100 residents. 81.7% of community callers (including care recipients) also said that

staffing levels were inadequate, citing lack of time to assist people with meals and bathing as some of the consequences. This is hardly surprising since the acuity of people entering aged care is now greater than ever[11]. These neglectful and potentially abusive practices caused by institutional failures must be considered in relation to the current regulatory framework in which residential aged care providers operate, as part of this inquiry.

The Commonwealth *Aged Care Act 1997*[23] and associated *Quality of Care Principles 2014*[26] set out legal requirements for residential aged care providers in relation to the quality of services they provide. The Australian Aged Care Quality Agency (AACQA) was established to monitor compliance with this legislation, using prescribed service standards to interpret compliance[27]. However, the primary legislation affords little guidance for enforcement of staffing standards since it does not prescribe minimum staffing ratios and skill mix in the delivery of direct care to recipients. As a consequence the poor care outcomes that consumers and frontline workers attribute directly to poor staffing ratios and skill mix[6,25] are not reflected in the level of legislative non-compliance reported by the AACQA following site visit audits.

As of 30 June 2015 there were 2,681 residential aged care facilities in Australia providing 195, 953 places[28]. During the three year period to end March 2016 the AACQA reported that even as one of the highest areas of non compliance there was still an incidence of less than 0.5% of non compliance found with staffing outcomes[29]. Around 5,000 site visits are conducted each year by the AACQA and records show that over the past 15 years, only 0.4% have resulted in the issue of a non-compliance notice or sanction in *any* area[30].

Comparing these figures to the UK where similar residential aged care services exist, the UK aged care regulator found 40% of adult care services required improvement during the year 2014/15, of which 7% required regulatory action[31]. This led the UK care regulator to voice its concerns about safety within healthcare citing inadequacy of staffing numbers and mix alongside poor skills, training and lack of support for workers[31]. This evidence suggests there is scope for the development of

a more robust protective regulatory framework for Australian aged care services to reduce the risk of institutional abuse due to neglect caused by insufficient staffing. A meaningful framework for prevention of abuse must ensure that these issues are addressed and that protective legislation is both developed and enforced in relation to the staffing of residential aged care.

"Management of RACF not following mandatory reporting requirements, and accrediting agency not picking up on it / paperwork: " in place for reporting - appears to be correct." No transparency seen in process. Both staff and resident / families unable to take any further action because they don't have access to the relevant information about the incident / abuse- even when directly involved.

Registered Nurse - RACF

"When the facility is inadequately staffed to care for high care residents, those resident's needs are not met, therefore, they are being neglected. The assessment team turns a blind eye to such issues and there is no hope for poor elderly who can't speak for themselves."

Assistant in Nursing - RACF

"Our facility recently passed accreditation! Many of the staff cannot understand why this was the case? One of the facilities was a "Hostel" with less staffing levels. Now we have residents being admitted to that area with high care needs but with the same low staffing levels!! This is elder abuse. The staff are very stressed and because of this are unable to care for the residents adequately."

Registered Nurse - RACF

"One area of concern that I have come across in recent times is in the facilities that are ostensibly considered Hostels. It is extraordinary that providers administering these facilities can hide under the guise of low care facilities and yet agree to care for people with high care. As such, they lack policies and systems to support the appropriate care. While employing Registered Nurses, these employees lack the basic tools for which they were employed. In the organisation to whom I refer, the RN is prevented from administering Nurse-initiated medications because the organisation had not developed a policy. RNs, therefore, can fulfill their roles of assessment and first line care if they are prevented from administering immediate pain relief and comfort. In the same way, RNs in aged care facilities are still, in this day & age, from administering appropriate pain relief for people requiring palliative care. In my recent experience, I had to ask the GP to provide regular S8 medications to guarantee a more appropriate response to the residents' needs. Accreditation agency visits do not really investigate to this level and thus standards of care are not being maintained. It's no wonder that the general public lack faith in our palliative care services when one observes what's occurring in places where care & comfort should be done well. I've worked as a RN and manager in aged care for over thirty years. I'm not sure that standards have improved greatly over this time."

Registered Nurse - RACF

The National Disability Insurance Scheme

Question 22 What evidence exists of elder abuse being experienced by participants in the National Disability Insurance Scheme?

And

Question 23 Are the safeguards and protections provided under the National Disability Insurance Scheme a useful model to protect against elder abuse?

Many people participating in the National Disability Insurance Scheme are younger than 60 years therefore any safeguards and protections should apply to all adults. Our members are rightly concerned that the transfer of people from large group facilities to the community increases the risk of abuse. Currently these facilities are staffed using a nursing model which affords people a level of professional oversight.

The transfer of their long term care to the private sector where staffing models do not include registered nurses means the care will be provided by an unlicensed and unregulated workforce. This is a big concern since community care is largely unsupervised.

Another consequence is that those registered nurses who have developed long term therapeutic and trusting relationships with the individuals will be lost. There is the potential that people will not have the same level of advocacy as a result. Whilst we would wholly support the ideology around the relocation of services, this must not be at the loss of the safety net that professional oversight of registered nurses provides.

"As working as support worker in disability the person I was supporting signed over a huge amount of compensation money to his family he was taken by his family several times to the solicitor to sign over his funds until he finally gave in."

Assistant in Nursing - RACF

Appointed decision-makers

Question 29 What evidence is there of elder abuse committed by people acting as appointed decision-makers under instruments such as powers of attorney? How might this type of abuse be prevented and redressed?

Our members are frequently faced with situations that make them feel uncomfortable and powerless to act. They have told us that they need: more training on how to keep people safe when power of attorney/assisted decision making arrangements are required; a 24 hour helpline to help them to assist people with decision making and better regulation of this area by the AACQA. Many members also considered that an ombudsman to deal with concerns and monitor decisions made on behalf of people would be beneficial.

"Financial abuse by family leaving the resident with little financial means, unable to attend outings as they could not afford to, reluctant to have medications as the family always complained about the pharmacy account, lack of necessary clothing due to family controlling the finances, in fact staff bought and paid for underwear and other necessary items from their own pockets."

Assistant in Nursing - RACF

Public advocates

Question 34 Should adult protection legislation be introduced to assist in identifying and responding to elder abuse?

5 % of people living in residential aged care facilities are under 65 of which, over 200 people are aged below 49 years[32]. 3.5% of all first admissions to residential aged care between 2014-15 were under 60 years totaling 943 people[21]. More live with disabilities in the community and supported living settings and there are an even greater number of adults who are vulnerable due to factors such as: mental illness; poverty, ethnicity and/or homelessness. Although some groups in society are more at risk of abuse than others, no-one is immune to the potential for abuse. Therefore if protective legislation is to be enhanced, this should extend to protect all adults.

Health services

Question 35 How can the role that health professionals play in identifying and responding to elder abuse be improved?

and

Question 36 How should professional codes be improved to clarify the role of health professionals in identifying and responding to elder abuse?

There are provisions in the *Aged Care Act 1997*[23] that ensure staff working in aged care facilities report suspicions of abuse. However, as previously stated there is concern about reprisals should they raise concerns. In addition Registered Nurses

and Enrolled Nurses are required to report concerns about poor practice they witness being carried out by other healthcare professionals.

A large percentage of direct care, particularly in the community is provided by assistants in nursing and personal care workers (however titled) who do not have the same level of accountability. The NSWNMA has been calling for the licensing of all direct care workers for a number of years. Our members working in these roles have identified the benefits to themselves that this would provide in terms of recognising their training, skills and years of experience. Bringing this group of staff into a licensing framework would ensure greater accountability and responsibility for raising concerns and acting upon these.

This would also ensure this staff group achieve minimum standards of training prior to commencing direct care work, as was recommended in the well-publicised 2013 UK Mid-Staffordshire Inquiry[33]. Currently this large section of the aged care workforce have no minimum training requirements imposed on them and our members tell us that some receive as little as a basic five week online training course prior to commencing work. Currently the AACQA use industry-set standards to assess sufficiency of staff training. This is not a safe or appropriate benchmark, nor one which offers safeguards for the most vulnerable. Legislated minimum staff training and licensing of unregulated care workers would improve this.

"All direct care staff need to be licensed so that they can be reported to APRHA and never work in the industry again if they are found guilty of elder abuse."

Service Manager - RACF

"Need to see licensing and regulation of AiNs. Too many quickie training courses around. Staff need to be trained properly. We are looking after frail elderly they deserve properly trained staff."

Assistant in Nursing - RACF

"Care staff need to be on some kind of register to monitor the whereabouts of 'dubious' care staff."

Educator - RACF

Question 37 Are health-justice partnerships a useful model for identifying and responding to elder abuse? What other health service models should be developed to identify and respond to elder abuse?

This has not been trialled in NSW therefore we are unable to comment with any degree of insight as none of our members have any direct experience of this project. However, we are aware that pilot projects on health-justice partnerships have been subject to a 12 month evaluation. The project evaluated well in its first year and has raised staff awareness of abuse[34]. We note there will be attempts to produce a screening tool for abuse and we hope that a nationally applicable tool will be considered.

The provision of a safeguarding lead for all healthcare settings would be useful. This role could ensure that staff are suitably trained to respond to issues and provide a link between external agencies and health professionals. For large organisations, or health districts, organisational governance could be secured through implementation of local safeguarding boards.

Criminal law

Question 45 Who should be required to report suspected elder abuse, in what circumstances, and to whom?

The reporting of suspected abuse is highly emotive and we would wholly support the mandating of local safeguarding teams and a safeguarding lead in each organisation so that workers were supported to raise issues as a neutral act, in an impartial way. However, the reporting of abuse should be open to all members of the community and all services with a point of contact to vulnerable adults and older people. The recent NSW Elder Abuse Inquiry[19] made recommendations in this area which we would refer this Inquiry to.

“How do we get politicians to understand that aged care is not the same as a retirees independent living…and that some residents have horrible lingering lives and become desperately depressed by poor pain management because facilities can't maintain staff? My mother in law was a tiny woman but resistant to pain meds for her whole life. She suffered needlessly because she was different and didn't conform to the usual patient profile. Despite knowing that there is no reason to withhold pain medication, she was always in pain. It was really very traumatic for her.”

Aged-care caller No. 58

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