The voice of aged care

ELDER ABUSE ISSUES PAPER

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Leading Age Services Australia (LASA)

Leading Age Services Australia (LASA) is the national peak body representing all age service providers. LASA is the only industry peak body acting on behalf of private sector and not-for-profit providers delivering retirement living, home care and residential aged care services. On behalf of its members, LASA works with government, health and community services and other stakeholders to improve standards, equality and efficiency within age services.

LASA's state and national offices work together to ensure Australia's age services industry is economically viable, sustainable and able to meet the growing demand – today and in to the future.

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Introduction

Leading Age Services Australia (LASA) is a strong advocate for the delivery of safe, quality care and welcomes the national dialogue regarding elder abuse being undertaken by the Australian Law Reform Commission. We look forward to the final report following the inquiry.

Thank you for the opportunity to comment on the *Elder Abuse Issues Paper*. LASA has commented on a number of the questions posed, but significantly focussed on the section from pages 22 through to 26. A comment in relation to this section is that it predominately focusses on residential aged care, rather than the full spectrum of the aged care industry.

Given the most common form of elder abuse is financial, and research shows that sons and daughters are most likely to be responsible for the abuse of older people[1], LASA recommends that focus should also be directed to the general community.

Should you have any questions regarding this submission, please do not hesitate to contact Ms Kay Richards, LASA National Policy Manager on 02 6230 1676.

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?*

LASA suggests that the elements above are important aspects to consider, however some actions perpetrated by people may not necessarily be considered as 'criminal' and the law has little impact when those actions are taken. For example, intentionally leaving a person in a position they cannot get out of, say a reclining chair, following an incontinence episode, may not be criminal, but it is the *lack of appropriate action* which detracts from a person rights and impacts on their dignity. It can certainly harm and distress the person. This simple example can occur in a range of settings and by a range of people, and may go undetected in certain circumstances.

The question of intent raises a number of issues. One is identifying abuse, where an older person is affected. A further issue concerns the development of appropriate responses. Elder abuse may include criminal and non-criminal conduct. In some of these, such as responses involving the criminal law, matters of intention may be crucial. In others, where the abuse arises for example through ignorance rather than, say, malevolence or greed, the response may be to provide better understanding to those undertaking roles like carers or attorneys.

There is support for the inclusion of the Tasmanian guidelines definition – *the focus should be on the effects on the older person, rather than the intention of the perpetrator.*

Question 4

What further research is needed and where are the gaps in evidence?

There is an obvious gap in what is reported and to whom, given that the only reporting requirements, relevant to this discussion in the aged care environment, is in relation to reportable assaults in residential settings and is confined to the definition in the Aged Care Act (section 63-1AA) as:

- unlawful sexual contact with a resident of an aged care home; or
- unreasonable use of force on a resident of an aged care home.

The legislation requires the Approved Provider to:

- report to the police and the Department of Health incidents of alleged or suspected reportable assaults within 24 hours of the allegation, or when the approved provider starts to suspect a reportable assault;
- take reasonable measures to ensure staff members report any suspicions or allegations of reportable assaults to the approved provider (or other authorised person), to the police and the Department; and
- take reasonable measures to protect the identity of any staff member who makes a report and protect them from victimisation.

Therefore, there are a range of gaps in understanding other forms of abuse and in what setting.

Having said that, LASA would contend that despite the above requirements the reporting regime imposed on the industry has had little positive effect, very few convictions and only concentrates on

a limited area of aged care and does not include other forms of abuse. Other data sources should be used rather than expecting an approved provider to undertake reporting that does not have positive outcomes for the service or the care recipient.

In instances where approved providers have identified abuse, such as financial abuse, they do not necessarily have avenues to pursue action.

Aged Care

Question 11

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

As mentioned above, there are reporting requirements that residential services have a legislative responsibility to adhere to. These requirements do not extend across the spectrum of aged care settings and may in fact not be able to be undertaken in areas such as home and flexible care settings or through the Commonwealth Home Support Programme (CHSP).

In 2014–15, the Department received 2,625 notifications of reportable assaults. Of those, 2,199 were recorded as alleged or suspected unreasonable use of force, 379 as alleged or suspected unlawful sexual contact, and 47 as both. With 231,555 people receiving permanent residential care in 2014–15, the incidence of reports of suspected or alleged assaults was 1.1 per cent.[2]

What is not known is the outcome of these reports and whether they were found to be true, especially as they include suspected cases, where evidence is not necessarily available.

Home care and flexible care settings do not have *mandatory reporting* requirements, and instances of elder abuse (especially when perpetrated by family members) would obviously go unreported.

Assessment of care needs

Question 12

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

Many older people are very wary of assessment processes as they fear it may lead to the removal of autonomy and independence. Not all assessments are undertaken face to face and therefore the identification of potential or actual abuse might not be evident.

Some groups of people, for example the LGBTI community, may fear family retribution if they are open within the assessment process. Many may not identify as LGBTI for this reason. There is a strong case for ensuring confidentiality and privacy are respected.

Decisions about care

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?

There are formal and informal processes that can identify a *decision-maker* and many people have not undertaken the formal process. Even where the formal processes do occur, it does not necessarily protect the person from abuse. As the Issues Paper identifies, such decision-maker may still take advantage of the role to facilitate abuse.

For example, a person may require admission to a residential setting, and the family block such a move, in order to keep the family home, rather than pay an accommodation payment following the sale of the house. In the home care setting, and following an income assessment, families may choose not to receive a home care package due to the costs of the income tested care fee and the basic daily care fee, despite the older person requiring such assistance.

Also decisions about end of life care may impact negatively on the older person. It is known that, although many people prefer to die at home, in some cases, their wishes are not respected and are admitted to hospitals and other settings.

Documents such as Advance Care Plans and Advance Care Directives should be widely promoted and their use made as simple as possible. Having state differences to the legal status of these documents only causes confusion and often prevents a person from completing them.

The role of and scope of the Public Guardian and Trustee (or equivalent) should be expanded to support vulnerable people in the community.

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?

As *My Aged Care* (www.myagedcare.gov.au) suggests, Consumer Directed Care (CDC) means:

- the person has more say in the care and services they access, how it is delivered and who delivers it
- the person will have conversations about their needs and goals
- the person will work in partnership with a service provider to develop a care plan
- the person agrees to the level of involvement they will have in managing a care package
- the person will have a greater understanding about how a package is funded and how those funds are spent through an individualised budget and monthly income and expense statement
- the service provider will monitor and provide a person with ongoing formal reviews to ensure that the package still meets their needs.

CDC allows a person and their carer more power to influence the design and delivery of the services they receive. It also allows a person to exercise a greater degree of choice in what services are delivered and where and when they are delivered.

Therefore, providing care on a CDC basis, should not impact any further on the chance that elder abuse occurs.

Similar to the points made above, with greater financial transparency and control sitting with the consumer (or their assigned decision maker), there is the potential for decisions to be made for financial reasons that might conflict with the consumer's lifestyle decisions. Where an Enduring Power of Attorney is in place, there is the opportunity that, although the older person may not be legally able to make decisions, their wishes may not be considered or enacted.

In line with a CDC approach, while a provider is required to determine who has the authority to make decisions, where possible, there should continue to be shared decision-making with the provider, the consumer and their appointed representative.

Under CDC, it is important to ensure transparency and fairness with any fee structures is maintained, as family members may form an opinion that there are financial improprieties occurring.

Quality of care

Question 15

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

There are a range of responsibilities that are required to be met for providers of residential care, home care and Commonwealth home support programme. There is also a review of the current standards which will eventually be applicable across the aged care spectrum of services. These standards are developed to improve the quality and safety of care and services provided to care recipients.

While this review is underway, no further changes to the requirements concerning quality of care should be undertaken.

Education and training are vital to ensure staff and volunteers are aware of and alert to elder abuse signs including the sensitives in dealing with various cultural and family dynamics.

Restrictive practices

Question 16

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

As discussed in the Issues Paper, a *DECISION-MAKING TOOL: Supporting a Restraint Free Environment in Residential Care* guidance document is available to support providers understand their duty of care[3]. LASA agrees with the document that any decision to restrain a resident carries significant ethical and legal responsibilities and that the use of restraint should always be the last resort.

In-fact, LASA has recently been involved with the 'Reducing Use of Sedatives' (RedUSe) project, funded by the Australian Government Department of Social Services, which aimed to promote the quality use of antipsychotic and benzodiazepine medication in residential aged care.

The project involved residential service staff, General Practitioners, the pharmacist providing Quality Use of Medicines services for the organisation and their supply pharmacist. The RedUSe project was multi-strategic, including customised IT audits and feedback of sedative use, educational sessions for nursing staff, 'good practice' guidelines and academic detailing for GPs attending the facility.

What this project highlighted was the importance of a multi-disciplinary approach to support the person, their family and friends and the staff of services to have positive outcomes from the appropriate use of medications. It highlighted, consistent with the *Decision Making Tool*, that consultation should take place with the resident or their legal representative, the resident's family or other close associates, the medical officer and other relevant health professionals prior to a decision to apply restraint.

Of concern, and relevant to this Issues Paper, is the confusing information about the status of a guardianship order or an enduring power of attorney where they may cover a limited range of matters not including decisions about restraint. In addition, legal requirements for consent to the use of restraint where the resident is not mentally competent may vary in different States and Territories. A family member who does not have a relevant guardianship order or enduring power of attorney may not have the legal capacity to consent on behalf of the resident to the use of restraint.

LASA agrees, as identified in the *Decision Making Tool* that it is the responsibility of all individual care staff e.g. nurses, personal care assistants, medical practitioners and allied health professionals, to ensure a restraint free environment in residential settings, however there seems to be varying requirements (or care practices) in other settings, such as a person's home, or in a hospital.

Consistent legislative requirements, for any setting, and across borders, should be identified in the same case as discussed above for advance care planning and advance care directives.

Reporting alleged and suspected assaults

Question 17

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

As commented above, with 231,555 people receiving permanent residential care in 2014–15, the incidence of reports of suspected or alleged assaults was 1.1 per cent[2] in the residential setting. A vigorous debate is required to review the reporting requirements currently expected of providers in the residential setting, as it could be contended that those requirements have made little or no difference to the safety of residents. There are strong legislative requirements to ensure the safety and quality of care delivery across the spectrum of age services. Reporting under the current regime in itself has very limited impact with protecting or guarding against elder abuse.

LASA supports an industry that respects and provides safe quality care and services to those that need them. However, the current requirements of reporting appear to only support red tape and bureaucratic processes, rather than promote safe quality care.

Complaints and sanctions

Question 18

What changes to aged care complaints mechanisms should be made to improve responses to elder abuse?

With the new role of the Aged Care Complaints Commissioner commencing 1 January 2016, with a vision that:

> 'people trust that making a complaint is worthwhile; that it will lead to resolution for the individual and improve care for others' and

through objectives of Resolve, Protect and Improve, the current mechanisms in place should be left as is. Only once an evaluation of the new processes is undertaken, should further changes (if any) be considered.

Question 19

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

The current sanctions process is rigorous, dictated by legislation, and respected by Approved Providers. LASA contends that the current process does not need changing, however might be reconsidered once the new aged care standards are introduced.

Support Services

Question 20

What changes to the role of aged care advocacy services and the community visitors scheme should be made to improve the identification and responses to elder abuse?

Advocacy services and the Community Visitors' Scheme play an important role to protect and support age care recipients. Better advertisement and promotion of such services should be provided to ensure the general community and service providers are more aware of and better use such services.

Other issues

Question 21

What other changes should be made to aged care laws and legal frameworks to identify, provide safeguards against and respond to elder abuse?

Often when providers are reporting alleged assaults to the police (under the mandatory reporting framework) there are inconsistent responses to elder abuse concerns in different states and territories.

In the residential setting, unless the abuse is carried out by a nurse, there is no mechanism for stopping someone from working in another aged care service. A nurse can be reported to AHPRA, however there is no governing body for aged care workers. However, even in the nurse example, while the AHPRA processes are undertaken there may be nothing stopping the nurse working in another setting while the process is undertaken.

Likewise, an aged care worker can move between services, even following termination or resignation. However, one would hope good recruitment strategies, such as reference checking

might assist in positive recruitment. However, this should not be the only avenue to ensure people working with older people have the right attitude and attributes to do so. Police checks are also not necessarily going to identify staff who may abuse the older person.

A registration process for age care workers may assist in improving standards, however, how such a system would be introduced, how it would function and who would pay for such a process would need to be considered before such a system was to be introduced.

There are also concerns that elder abuse may not be identified if such treatment of an elder is seen to be the 'norm' (especially in the home setting). Identification of such abuse is very difficult to uncover, let alone actions to alter the behaviours that may be occurring.

Financial Institutions

Question 25

What evidence is there of elder abuse in banking or financial systems?

Evidence suggests that financial abuse is the most common form of elder abuse. Banking staff could have a greater understanding of dementia and the link to financial abuse. Education of banking staff, the legal profession and the community should be encouraged.

Appointed Decision Makers

Powers of Attorney, appointed decision-makers

As mentioned above the role of and scope of the Public Guardian and Trustee (or equivalent) should be expanded to support vulnerable people in the community.

Health Services

Health Professionals

Question 35

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

Forming a relationship with a General Practitioners (GP) is important for the older person. GPs have a role to play, not only in identification and reporting abuse, but in assisting an older person to connect with the community and peers to reduce their vulnerability. Additional resources and information for both GPs, and older people, on how they may best engage should be considered.

Primary care nurses, specialist doctors, nurse practitioners, volunteers, and pharmacist also have a role to play not only in identification and reporting, but in assisting older people to connect with others and to reduce vulnerability.

The role of Primary Health Networks (PHNs) should include the identification and management of those people at risk of elder abuse.

Other General Comments

Clear guidelines to appropriately manage and report incidences of elder abuse - in a range of settings, are required for persons likely to encounter and support older people.

Consistent with the LASA NSW & ACT response to the *Inquiry into Elder Abuse in New South Wales*, issues crucial to identifying and preventing elder abuse need to be dealt with through a robust risk assessment process, ongoing mainstream education, and the ability to report to the police and Guardianship Tribunal, with appropriate management and follow-up.

Support and funding is also required for local communities in early intervention work, including for persons from cultural and linguistically diverse (CALD) background ATSI communities, as well as for those people living with dementia.

A suggestion has included a review of child protection models from across Australia should be undertaken and applied where appropriate to the older person.

References

1. University of Western Australia, 2011, ‘An Examination of The Extent of Elder Abuse in WA’
2. https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/11_2015/final_final_typeset_version_-_sent_to_printer_20_nov_2015.pdf
3. https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2014/residential_aged_care_internals_fa3-web.pdf