Submission by the New South Wales Nurses and Midwives’ Association

 Elder Abuse Discussion Paper

Australian Law Reform Commission Inquiry into Elder Abuse

February 2017

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.

We welcome the opportunity to make a submission to this discussion 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.

Contact details

NSW Nurses and Midwives’ Association

50 O’Dea Avenue

Waterloo

NSW 2017

(02) 8595 1234 (METRO)

1300 367 962 (RURAL)

gensec@nswnma.asn.au

**Introduction**

This is the second submission to the ALRC on the subject of elder abuse. The NSWNMA also made a submission and gave evidence at the NSW Parliamentary Inquiry into Elder Abuse in New South Wales. To avoid duplication, we refer the committee to our previous submissions and papers and the recommendations contained therein[[1]](#footnote-1).

Our members continue to be concerned about the issue of elder abuse, particularly those working in residential aged care facilities. The prevalence of elder abuse in these workplaces is inextricably linked to staffing and skills mix. It is our view that to increase safeguards for older people there must also be laws securing: minimum safe staffing levels and skills mix; minimum standards of conduct for all aged care workers; minimum training expectations in elder abuse and employment security should workers raise issues of concern.

This submission will provide further comment on the proposals and questions relevant to our members. We would welcome the opportunity for further engagement regarding this important issue.

Judith Kiejda

Acting General Secretary

**Contents**

|  |  |
| --- | --- |
| **Page Number** |  |
|  |  |
| 4 |  List of abbreviations |
|  |  |
| 5 - 6  |  Recommendations |
|  |  |
| 7 - 16 |  Comment on the introduction to the Inquiry |
|  |  |
| 8 - 16 |  Responses to questions  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**List of Abbreviations**

AACQA Australian Aged Care Quality Agency

ACCC Aged Care Complaints Commission

ALRC Australian Law Reform Commission

ANMF Australian Nursing and Midwifery Federation

NSWNMA New South Wales Nurses and Midwives’ Association

RACF Residential Aged Care Facility

RN Registered Nurse

UK United Kingdom

**Recommendations**

|  |  |
| --- | --- |
| 1 | Legislative safeguards should be extended to all adults. Alternatively, legislation regarding elder abuse could be extended within its definitions to capture those younger adults who are vulnerable or dependent on others for their well being. |
|  |  |
| 2 | The development of national plan must consider the training needs of workers and community members and ensure that communication of national strategies is effective. |
|  |  |
| 3 | A national database should be established and maintained as part of the functions of any National Elder Abuse Department/Agency. This should inform policy development and benchmarking of national quality standards and performance indicators in relation to elder abuse. |
|  |  |
| 4 | There should be monitoring of reprisals against any person who reports elder abuse in good faith. There should also be an information/education campaign regarding such rights.  |
|  |  |
| 5 | Individual protection plans where actual or potential abuse is identified would assist in providing a supportive response to allegations and facilitate co-ordination of services and agencies. |
|  |  |
| 6 | Legislation should be extended to include regulation of independent care workers operating in the community as a means of reducing the risk of abuse. |
|  |  |
| 7 | Any agency identified to investigate allegations of abuse must have the legislative authority to initiate an immediate and impartial first response. |
|  |  |
| 8 | Proposal 11-2 (a) should include aged care provider unless this is explicitly covered within the category of staff to account for institutional abusive practices. |
| 9 | The definition of a reportable incident described in 11-2 should be extended to include institutional abuse and the use of chemical or physical restraint. Extortion and intimidation should also be considered. |
| 10 | Under proposal 11-3 we recommend that the same threshold of seriousness is met for all allegations, regardless of cognitive status, to reduce the risk of discretionary reporting. |
| 11 | The use of risk assessment processes should be overtly stated in legislation. This will promote the ongoing protection of staff and give due consideration to the ongoing applicability of restraint practices. |
| 12 | Legislation is required to secure: minimum safe staffing levels and skills mix; minimum standards of conduct for all aged care workers; minimum training expectations in elder abuse and employment security should workers raise issues of concern in good faith. |
| 13 | Under proposal 11-7 (c) the term ‘Senior Clinician’ should be clearly defined.  |

**Comment on the introduction to the Inquiry**

We note there is lengthy comment regarding definitions of abuse and abusive practices and discussion regarding classification of old age. We refer to our earlier submission which provided statistics regarding the prevalence of younger adults in RACFs. Our members care for adults as young as 20 years in their facilities. Members have previously highlighted their concerns about the inadequacy of arrangements for younger people residing in RACFs. This should be a marker for legislating protections for *all* adults and not just those classified as “old”. Alternatively, improved legislation that requires separate accommodation for younger adults whose needs are inconsistent with those requiring aged care.

We affirm our view that applying legislative safeguards to all adults would provide more appropriate safeguards for those younger people living in RACFs. Alternatively, legislation regarding elder abuse could be extended within its definitions to capture those younger people who are vulnerable or dependent on others for their well being. This would also enable better protections for vulnerable adults living in the community and reduce the potential for ageism within processes.

**Proposals and Questions (relevant to NSWNMA members)**

|  |
| --- |
| **Proposal 2-1 A National Plan to address elder abuse should be developed** |

The majority of our aged care members are employed in RACFs and therefore subject to Commonwealth legislation under the terms of the *Aged Care Act 1997* (*Cth)[[2]](#footnote-2)* and subsequent regulations and principles. We also have members who work across state borders and who find differences between state legislation and processes widens the risk of abuse. Therefore we are supportive of a National Plan which sets quality indicators, to ensure consistency.

In NSW an Elder Abuse Helpline has been established. Some regional elder abuse interagency collaboratives have also been developed and there are plans to extend these across other regional areas[[3]](#footnote-3). However, our aged care members tell us they have little knowledge of the purpose and functions of these; some are not aware they exist. This raises concerns regarding the effectiveness of strategies implemented to improve safeguards for older people. The development of National Plan must consider the training needs of workers and community members and ensure that communication of national strategies is effective.

|  |
| --- |
| **Proposal 2-2 A national prevalence study of elder abuse should be commissioned** |

We support the undertaking of a prevalence study. However, we perceive some difficulty in obtaining accurate data since it has been widely acknowledged that elder abuse is poorly recognised and widely under-reported. This might lead to significant areas of need being missed from any national strategy developed as a result of the findings. A more practical approach would be to ensure a national database is established and maintained as part of the functions of any National Elder Abuse Department/Agency. This should inform ongoing policy development and benchmarking of national quality standards and performance indicators in relation to elder abuse.

|  |
| --- |
| **Proposal 3-1 State and territory public advocates or public guardians should be given power to investigate elder abuse where they have reasonable cause to suspect that an older person:**1. **Has care and support needs;**
2. **Is, or is at risk of, being abused or neglected; and**
3. **Is unable to protect themselves from the abuse or neglect, or the risk of it because of care and support needs.**
 |

We support the increased powers of investigation and consider the extended criteria covered in the proposal adequately address the existing gap between recognised criminal activity and actual range of abusive practices. Implementation of this proposal would require an amendment to the *Aged Care Act 1997* *(Cth)* definition of a reportable offence to ensure protections are extended to those accommodated in RACFs. These currently only require action should they take the form of a physical or sexual assault[[4]](#footnote-4),[[5]](#footnote-5). Whereas evidence provided within our previous submissions suggests that neglect and institutional abuse are also commonplace.

We note the ALRC proposes to define care and support needs as arising from or relating to ‘*a physical or mental impairment or illness; or physical restraint’*. We would seek clarity as to whether the use of chemical restraint is implicitly captured within the classification physical restraint or whether this requires stand alone recognition. We also concur that care and support needs should capture *all* adults with such needs, as previously stated.

The ALRC refers to Safeguarding Boards in operation within UK. These provide governance over safeguarding procedures within their individual organisations and jurisdictions. A similar approach would be valuable with an independent statutory advocacy authority. Such an authority would be able to develop, implement and monitor individual protection plans[[6]](#footnote-6) where actual or potential abuse is identified would assist in providing a supportive response to allegations and facilitate co-ordination of local services and agencies.

|  |
| --- |
| **Proposal 3-5 Any person who reports elder abuse to the public advocate or public guardian in good faith and based on reasonable suspicion should not, as a consequence of their report, be:**1. **liable civilly, criminally or under administrative process;**
2. **found to have departed from standards of professional conduct;**
3. **dismissed or threatened in the course of their employment; or**
4. **discriminated against with respect to employment or membership in a profession or trade union.**
 |

We welcome this proposal and would suggest that aged care workers/employers and members of the public would benefit from an information campaign to ensure they are fully aware of such protections. We cannot over-emphasise the power imbalance between employer and employee in many aged care settings. The more protections are afforded in legislation the more security this offers our members. However, we suggest there is oversight of the operation of this protection. Not all reprisals are overt and our members have cited circumstances such as being given unfavourable shift patterns or ostracised by management as a result of raising matters with external agencies.

**Aged Care – General Comment**

The ALRC has acknowledged our previous concerns regarding the operation of the AACQA in relation to their responsibilities towards the regulation of RACFs. It is our members’ experience that the AACQA has a poor track record of fulfilling their responsibility to monitor compliance with other relevant legislation, despite this being listed as a requirement for compliance with legislation[[7]](#footnote-7). Similarly the AACQA perception of the adequacy of staffing in RACFs is at huge variance with that of our members working in those establishments and reports given to us from community members[[8]](#footnote-8).

We also have concerns regarding the ongoing monitoring of behaviour management plans designed to replace the requirement for mandatory reporting of abuse perpetrated by cognitively impaired residents. Our members often cite insufficient staffing levels and lack of RN oversight 24/7 as a major factor in their ability to implement effective behaviour management plans. We refer to our previous submissions and professional papers on this matter for evidence and suggested response.

There is also an emerging presence of *Uber* platform care agencies being established to meet the projected demands of a consumer based market. These agencies have seen huge growth over the past two years and provide an alternative care option for people seeking care services. With the introduction of consumer directed care funding this marketplace will likely increase. However, we have concerns that platform providers supply a largely peripatetic and unregulated workforce with few regulatory safeguards. Unless protective legislation is extended to all workers providing direct care (such as in operation in the UK[[9]](#footnote-9)), it is likely there will be gaps in safeguarding people from abuse.

|  |
| --- |
| **Proposal 11-1 Aged care legislation should establish a reportable incidents scheme. The scheme should require approved providers to notify reportable incidents to the Aged Care Complaints Commissioner, who will oversee the approved provider’s investigation of and response to those incidents.** |

Our previous submissions have highlighted the protracted process for resolution of complaints referred to the AACQA from the office of the Aged Care Complaints Commissioner. Matters deemed ‘non-urgent’ are often scheduled to be followed up by the AACQA at their next routine site visit, which can be over 12 months apart. Complaints are often indicative of wider systemic issues and therefore this process offers few safeguards for people living in RACFs. Considering the vulnerability of older people as they reach the end stages of life this is unacceptable.

The ACCC has preference for local resolution of concerns. Whilst local resolution is often a preferred outcome for addressing complaints, it would be an inappropriate first response for safeguarding allegations. Whilst supportive of a reportable incidents scheme our members are concerned about existing collaborations between the ACCC and AACQA and focus on local resolution. It is our view that any agency identified to investigate allegations of abuse must have the legislative authority to initiate an immediate and impartial first response.

|  |
| --- |
| **Proposal 11-2 The term ‘reportable assault’ in the *Aged Care Act 1997* (Cth) should be replaced with ‘reportable incident’.****With respect to residential care, ‘reportable incident’ should mean:**1. **a sexual offence, sexual misconduct, assault, fraud/financial abuse, ill-treatment or neglect committed by a staff member on or towards a care recipient;**
2. **a sexual offence, an incident causing serious injury, an incident involving the use of a weapon, or an incident that is part of a pattern of abuse when committed by a care recipient toward another care recipient; or**
3. **an incident resulting in an unexplained serious injury to a care recipient.**

**With respect to home care or flexible care, ‘reportable incident’ should mean a sexual offence, sexual misconduct, assault, fraud/financial abuse, ill-treatment or neglect committed by a staff member on or toward a care recipient.**  |

We support the increased protections that replacing this definition provides. However, we suggest that point (a) is amended to also include care provider unless they are covered by the legal definition of a staff member. We also ask that caution is given when identifying staff as the perpetrator without considering the institutional practices within the environment. Often our members are unwittingly complicit in omissions by virtue of reasons beyond their control, such as low staffing ratios or failure by aged care providers to provide appropriate equipment or supplies. We suggest institutional abuse and the use of chemical or physical restraint are also added as categories.

In relation to all categories our members report witnessing extortion and intimidation between residents in certain RACFs. We request the ALRC consider whether these should be included as acts of abuse since a power imbalance can also exist within the resident population.

We note the ALRC’s hesitance in recommending extending safeguards beyond the services covered by the *Aged Care Act 1997 (Cth)*. However, we consider that the aged care climate is changing. In relation to home/flexible care, we perceive a gap in the proposed provision as this does not account for independent workers providing home care services. These workers are not classed as employees and therefore not subject to ongoing training and supervision. Platform care services merely act as introduction agents and encourage individual care workers to establish independent contracts for service between themselves and the client, a practice that is not subject to any regulation. We consider this circumstance would need to be catered for with any legislative changes.

|  |
| --- |
| **Proposal 11-3 The exemption to reporting provided by s53 of the *Accountability Principles 2014* (Cth) regarding alleged assaults committed by a care recipient with a pre-diagnosed cognitive impairment on another care recipient, should be removed.** |

We fully support this initiative as indicated in our previous submissions and presented evidence following member consultation. It is only right that all Australians, regardless of health status are afforded equal rights in relation to protection against abuse. We note the ALRC suggestion that a higher threshold of seriousness is met before a notification is required to be made. We have concerns this will lead to under-reporting. Our members are extremely concerned that the daily resident-on-resident abuse they witness is already unreported. We must consider that people living in RACFs are unable to exit that environment and the impact of the abusive act is therefore much higher.

The aim of protective elder abuse legislation should not be a punitive exercise, particularly where residents are cognitively impaired. The intent must be to address the underlying causes, seek appropriate solutions and monitor their implementation for effectiveness. Once this process is established there should be a natural reduction in the incidence of abuse between cognitively impaired residents as the research evidence presented in our previous submission demonstrates.

|  |
| --- |
| **Proposal 11-4 There should be a national employment screening process for Australian Government funded aged care. The screening process should determine whether a clearance should be granted to work in aged care, based on an assessment of:**1. **a person’s national criminal history;**
2. **relevant reportable incidents under the proposed reportable incidents scheme; and**
3. **relevant disciplinary proceedings or complaints.**

**Proposal 11-5 A national database should be established to record the outcome and status of employment clearances.****Proposal 11-6 Unregistered aged care workers who provide direct care should** **be subject to the planned National Code of Conduct for Health Care Workers.** |

We refer to the ANMF response to this discussion paper and concur with their comments and recommendations in relation to points: 11-4; 11-5 and 11-6.

|  |
| --- |
| **Proposal 11-7 The Aged Care Act 1997 (Cth) should regulate the use of restrictive practices in residential aged care. The Act should provide that restrictive practices only be used:**1. **when necessary to prevent physical harm;**
2. **to the extent necessary to prevent the harm;**
3. **with the approval of an independent decision maker, such as a senior clinician, with statutory authority to make this decision; and**
4. **as prescribed in a person’s behavior management plan.**
 |

The use of risk assessment processes should be overtly stated in legislation. This will promote the ongoing protection of staff and give due consideration for the ongoing applicability of restraint practices.

The impact of low levels of staffing and skills mix on the prevalence of elder abuse and the use of restrictive practices in any form in residential aged care facilities cannot be underestimated. Our members working in aged care cite insufficient numbers of staff as the primary risk factor and many feel unable to report concerns for fear of reprisal from their employers[[10]](#footnote-10).

We are concerned that current legislation provides insufficient clarity to ensure safe staffing and skills mix. We refer to the recent *National Aged Care Staffing and Skills Mix Project*[[11]](#footnote-11) for guidance in relation to safe minimum staffing projections.

Legislation is required to secure: minimum safe staffing levels and skills mix; minimum standards of conduct for all aged care workers; minimum training expectations in elder abuse and employment security should workers raise issues of concern.

With regard to the proposal (c), it is submitted that there are a number of issues with the implementation of such a requirement. The phrase “*senior clinician*” lacks clarity. It is unclear as to whether the intent is for this to be a medical practitioner, registered nurse or other expert.

It is not feasible for such a senior clinician to be independent. The term independent implies that the clinician who approves the restraint is not a clinician that provides care to the person.

In most circumstances where a person needs to be subject to restraint or a restrictive practice, that restraint is required in a timely manner in order to protect the safety of other residents or staff. Access to senior clinicians in aged care is often very limited and the requirement that an approval occur prior to a restraint being implemented has the potential to place other residents and staff at risk of immediate harm.

1. NSWNMA (2016) *Submission to the ALRC Elder Abuse Issues Paper.* Sydney, NSW: NSWNMA ( August 2016); NSWNMA (2016*) Who will keep me safe? Elder Abuse in Residential Aged Care.* Sydney, NSW: NSWNMA. ISBN 978-1-921326-11-0 I Issued February 2016; NSWNMA (2016) *Solutions from the frontline: Practical approaches to reduce the risk of abuse in aged and disability services.* Sydney, NSW: NSWNMA. ISBN 978-1-921326-09-7 I Issued September 2016 [↑](#footnote-ref-1)
2. Commonwealth of Australia (1997) *The Aged Care Act*, Canberra: Commonwealth of Australia. [↑](#footnote-ref-2)
3. NSW Government (2017) Government response to the Legislative Council General Purpose Standing Committee No.2: Inquiry into Elder Abuse in New South Wales [↑](#footnote-ref-3)
4. Commonwealth of Australia (1997) *Op.Cit.* [↑](#footnote-ref-4)
5. Australian Government Department of Social Services (2007) *Compulsory Reporting Guidelines for Approved Providers of Residential Aged Care*. Canberra, ACT: Australian Government. [↑](#footnote-ref-5)
6. http://www.scie.org.uk/adults/safeguarding/policies/index.asp [↑](#footnote-ref-6)
7. AACQA (2014) *Results and Processes Guide* (p17) available at: http://www.aacqa.gov.au/assessors/copy\_of\_RPguideJan2015.pdf [↑](#footnote-ref-7)
8. ANMF (2016) *ANMF National Aged Care Survey: Final Report*. July 2016. [↑](#footnote-ref-8)
9. Care Quality Commission (2015) *The scope of registration: Registration under the Health and Social Care Act 2008*. London: CQC. [↑](#footnote-ref-9)
10. *NSWNMA (2016) Op.Cit.* [↑](#footnote-ref-10)
11. ANMF (2016) *National Aged Care Staffing and Skills Mix Project Report 2016: Meeting residents’ care needs: A study of the requirement for nursing and personal care staff*. ANMF SA, Flinders University, University of South Australia. [↑](#footnote-ref-11)