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| ALRC Elder Abuse Discussion PaperSubmissionFebruary 2017 |
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About HammondCare

Established in the 1930s, HammondCare is an independent Christian charity specialising in dementia care, palliative care, rehabilitation and older persons' mental health services. HammondCare is acknowledged as Australia’s leading dementia-specific service provider and is dedicated to research and supporting people who are financially disadvantaged. HammondCare’s mission is to improve quality of life for people in need, regardless of their circumstances.

We currently operate 960 residential aged care places across New South Wales and Victoria, 70 per cent of which operate in expert designed dementia-specific cottages. We also provide Special Care Programs for people displaying severe behavioural and psychological symptoms of dementia. On any given day, HammondCare provides community aged care to more than 2,000 people. Our HammondCare At Home services support older people, people with dementia and people requiring respite. HammondCare’s Dementia Centre is recognised in Australia and internationally for its high quality research, consultancy, training and conferences in the area of best-practice dementia care.

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# Introduction

HammondCare strongly supports and strives to uphold the rights of all people using aged care services to feel safe and live free from abuse, while respecting and promoting their individual rights and freedoms. As an aged care provider with a particular focus on providing tailored support to people with dementia, we are committed to providing high quality, individualised care based on getting to know the person and understanding their needs. Underpinning our commitment to quality services is a robust framework for monitoring and managing risks to aged care clients and residents.

We welcome this Discussion Paper and the opportunity to provide comment on it. This submission draws on our experience and expertise as a service provider and focuses on the recommendations made in Chapter 11 of the Discussion Paper which relates to elder abuse in Aged Care. We note that a significant proportion of the proposals outlined in the paper (11 of 43) are devoted to aged care and, in a number of cases they refer specifically to residential aged care. Yet despite this, Australian and international research has found that most reported elder abuse is caused by family members with only a minority caused by someone outside the victim’s family (NARI 2015, 14).

In responding to the Discussion Paper’s proposals, it is important to consider the goals of any regulation or recommended practice relating to abuse in aged care. We believe that the aim of regulatory policy must be to:

* Minimise the likelihood of abuse occurring.
* Ensure that where an incident does occur, appropriate action is taken.
* Assure aged care service users, their family and friends, along with the general public, that they can be confident about resident safety.

Before any new regulations, processes or schemes are developed or introduced, it is imperative to consider:

* The extent to which existing systems can be used to meet those goals.
* Whether the proposed additional requirements will increase the likelihood of those goals being met.

It is also necessary to ensure that additional requirements for reporting and investigating incidents of abuse do not reduce the time and resources dedicated to caring for aged care residents and clients, without achieving significant benefits for them.

# The exemption for reporting assaults be people with a cognitive impairment

As a leading provider of dementia-specific aged care services, HammondCare has a particular interest in Proposal 11-3. Eleven of the 15 residential aged care services we provide in NSW and Victoria are dementia-specific homes and more than two thirds (69 per cent) of the 960 residential aged care places we offer are dedicated dementia-specific places.

Under the existing reportable assaults arrangements, HammondCare logs any alleged or witnessed incident of unreasonable force between two or more residents in an electronic risk management system. Such incidents are automatically escalated to senior managers and a structured decision making process about whether to report the incident or not begins. If the incident involves a significant injury, we report it regardless of the alleged offender’s cognitive ability.

The nature of the types of incidents where the provider can use their discretion not to report varies significantly. This is seen in the following examples of the types of incidents that occur in HammondCare’s dementia-specific services which do not require reporting:

*Example 1*

*Mary always carries a handbag with a few items including tissues when she is up and about in the aged care home. While eating breakfast she placed her handbag on the table between herself and another resident, named Joan. Joan took hold of Mary’s handbag and Mary slapped the back of Joan’s hand and pulled the handbag onto her lap.*

*Example 2*

*Alf enjoys spending time in the garden and he often walks quickly along the outdoor paths. One day, two other female residents were walking arm in arm along the garden path. Alf was walking quickly when he approached the two residents and pushed his way past them. This caused the other two residents to stumble off the path into a bush. They did not fall but one sustained a skin tear on her lower leg.*

*Example 3*

*Joe was helping the care staff in the aged care cottage to unpack the dishwasher in the cottage kitchen. David approached him yelling, “What are you doing in my home?” As Joe looked up, David came towards him and pushed him. Joe fell to the floor but was not injured.*

*Example 4*

*Staff heard a commotion in the sitting area at the end of an internal corridor. They ran to attend and found two male residents on the floor punching each other. The residents were not able to indicate what had happened to prompt the disagreement. One resident had a small laceration on his cheek and later developed a bruise but there was no major injury.*

All of the residents involved in these examples had dementia. As there were no significant injuries as a result of the unreasonable uses of force, the provider would be able to exercise discretion not to report these incidents under the existing scheme if they had put a behavioural management plan in place.

In our experience, the number of incidents caused by residents that do not need to be reported is much higher than the number of those that do. The table below shows the number of reported and non-reported assaults in HammondCare’s residential aged care services over the past three complete calendar years.

***Table: Reported and non-reported assaults in HammondCare’s residential aged care services 2014-2016***

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|  | **2014** | **2015** | **2016** |
| Reported assaults  | 9 | 55 | 54 |
| Assaults not reported due to cognitive impairment | 448 | 668 | 646 |

We note that the ALRC proposes a ‘higher threshold of seriousness’ be met before requiring that resident-to-resident incidents are reported in the proposed reportable incidents scheme. These include sexual offences, incidents causing serious injury, incidents involving the use of a weapon and incidents that occur as part of a pattern of abuse. In practice, we believe the vast majority of providers already report these types of incidents, regardless of the cognitive status of the residents involved in such incidents.

Like the ALRC, we acknowledge the need to focus on ‘managing and reducing risks’ in response to incidents caused by residents. However, it is unclear how exactly an external oversight body without specific expertise in dementia and behaviour management would assist in managing and reducing risks.

Given this focus, there should be a strong emphasis on producing high quality behaviour management plans in residential aged care services in response to incidents. The Discussion Paper noted that some stakeholders are concerned about the appropriateness of plans implemented by residential aged care providers. In addressing this concern, we believe there is a key role for existing programs designed to build capacity in the aged care sector regarding behaviour support for people living with dementia.

The Australian Government already funds a number of programs to provide education and expert advice to aged care services to support people with dementia including:

* The Dementia Behaviour Management Advisory Service (DBMAS):[[1]](#footnote-1) which provides tailored support to informal care and professional staff caring for people with dementia where a change in behaviour impacts on their care.
* The Severe Behaviour Response Teams (SBRT):[[2]](#footnote-2) which provide support to aged care homes caring for residents with the most severe and extreme behavioural and psychological symptoms of dementia; and
* Dementia Training Australia (DTA):[[3]](#footnote-3) which provides accredited education, upskilling and development for staff providing care to people living with dementia.

These existing programs provide tailored, on-the-ground support to assist with challenges involved with behaviour management related to dementia. By continuing to support and promote these programs to residential aged care providers, the Australian Government will ensure that support is available to improve the quality and effectiveness of behaviour management plans in response to incidents by residents with a cognitive impairment.

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| ***HammondCare position****The primary focus of resident-to-resident incidents – particularly those involving residents with cognitive impairment – in residential aged care must be managing and reducing risks. Existing programs providing advice and education should continue to be supported and promoted to build capacity within the aged care sector in responding appropriately to those incidents.* |

# Compulsory incident reporting and treating all incidents as complaints

Rather than creating a reportable incident scheme to monitor and oversee the response to incidents in residential aged care (Proposal 11-1), existing frameworks such as accreditation and quality reporting should be used to monitor the processes that aged care services have in place for responding to assaults and other inappropriate incidents in aged care.

## Responding to incidents

The Discussion Paper claims that under the existing framework an approved provider is not required to take any ‘action’ in response to a reportable assault, apart from maintaining a record of the incident. In saying this, the Discussion Paper downplays the role of the Australian Aged Care Quality Agency (AACQA) and the quality standards they use to monitor and assess aged care services. The paper states that the existing residential aged care standards “focus more broadly on quality of care provided”, rather than the way that providers respond to incidents.

It is true that the existing Accreditation Standards for residential aged care services do not explicitly refer to the management of incidents.[[4]](#footnote-4) But before dismissing the quality standards as irrelevant to incident management, it is important to consider existing plans for the aged care quality framework. As the Discussion Paper acknowledges, aged care in Australia is going through a period of reform, and this process will have a significant impact on the quality standards for all aged care services.

In its 2015 Budget, the Australian Government announced that it would work with the aged care sector to consider the development of a “single quality framework” for aged care (DSS 2015, 1). Work has progressed in this area and the Government is now partnering with a range of stakeholders, including aged care service users and providers, as it creates a single set of aged care standards, that will apply to a broad range of residential and community based home care services (DoH 2016).

HammondCare supports the implementation of a single quality framework in aged care with a focus on meeting outcomes for service users. We believe this represents an excellent opportunity to ensure that the quality standards for all aged care services consistently address the appropriateness of the way in which aged care providers manage and respond to incidents.

A suggestion for how this may occur is found in the current Home Care Common Standards, which already have an expected outcome around Risk Management (1.6). Under this outcome, it is expected that home care services that meet the quality reporting requirements must demonstrate that they: “actively work to identify and address potential risk, to ensure the safety of service users, staff and the organisation” (AACQA 2015, 26).

The practice and processes guide for expected outcome 1.6 states that the quality review process should consider whether the service provider has a framework “that assists it to identify, assess, respond [to] and manage risks” (AACQA 2015, 26). It goes on to explain that this includes “evaluation of practices and processes, incidents, policies and procedures, complaints and other feedback”. While this guide should not be seen as prescriptive, aged care consumers should be confident that a service that meets this outcome has appropriate frameworks in place to identify and respond to particular incidents.

Rather than creating a reportable incident scheme to monitor and oversee the response to incidents in residential aged care (Proposal 11-1), existing systems such as accreditation and quality reporting should be used to monitor the processes for responding to assaults and other inappropriate incidents in aged care.

The Australian Aged Care Quality Agency can also continue to promote strategies for identifying and managing risks and incidents through its conferences and education programs, helping to raise awareness and drive improvement among service providers. If providers are supported and encouraged to identify and manage risks, there is a strong likelihood that this will prevent numerous potential incidents from occurring.

## Treating all reportable incidents as ‘complaints’

The Discussion Paper also claims that the response to specific incidents should be treated as complaints and monitored by an external party. However, if all aged care services demonstrate that they have a thorough risk management approach in place through the accreditation and quality review process, this obviates the need for each reportable incident to be subjected to particular oversight.

HammondCare believes that managing risks and incidents ought to be ‘core business’ for aged care providers. They should develop this expertise themselves and the accreditation and quality review process provides an opportunity for external review of performance in incident management.

Under this approach, the Australian Aged Care Quality Agency would monitor a service’s framework for, and performance in, identifying and responding to risks and incidents. At the same time, the Aged Care Complaints Commissioner would continue to respond to complaints about particular incidents where a provider’s processes for responding to incidents are found to be inadequate.

The scheme proposed in the Discussion Paper has the potential to duplicate existing reporting responsibilities, with little evidence to demonstrate it will improve outcomes for people living in residential care or using home care services. It also appears that little consideration has been given to the increase in workload, both for the Complaints Commissioner and residential aged care providers, with the introduction of such a scheme. A requirement to treat reportable incidents as complaints would mean that providers would need to spend increasing amounts of time justifying their response to individual incidents to external bodies, potentially reducing the amount of time dedicated to care and managing complex situations involving the safety of residents.

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| ***HammondCare position****HammondCare does not support the establishment of a reportable incidents scheme for residential aged care. Instead, the Australian Aged Care Quality Agency should monitor the approach that providers use in identifying and responding to risks and incidents as part of the accreditation process. The Complaints Commissioner should continue to respond to complaints about individual cases as they arise.* |

## A broader definition of ‘reportable incidents’ and restrictive practices

As HammondCare does not support the introduction of a reportable incidents scheme, we do not believe there is justification for a broadened range of ‘reportable incidents’.

We are also concerned that the proposed requirement to include mandatory reporting of any “incident resulting in an unexplained serious injury to a care recipient” could have unfortunate unintended consequences for aged care residents. If, for example, providers were required to notify an external body about every incidence of an unexplained physical injury, this could lead to an increase in the use of restraints for people who are at risk of falling.

For the same reason, HammondCare does not support the Discussion Paper’s proposal to regulate the use of restrictive practices in residential aged care. The proposed conditions for permitting restraint in residential aged care could establish an unfortunate loophole permitting inappropriate restraint. Under proposal 11-7, restraint would be justified “when necessary to prevent physical harm”.

This regulation could unintentionally enable providers to justify the restraint of residents who are at risk of physical harm from falling, without considering other risks such as the emotional or psychological harm a resident may experience as a result of being restrained. We believe restraint in residential aged care should only be used as a matter of last resort following comprehensive assessment and evidence that alternative strategies have been exhausted.

The guidelines outlined in proposal 11-7 fail to address all the factors that should be considered before implementing restraint. Any decision to restrain a resident should be informed by the expressed wishes of that resident, and their representative where appropriate, to ensure that measures to promote safety do not unnecessarily curb personal autonomy.

Instead of simply employing additional regulation to minimise restrictive practice, it is critical to promote strategies that minimise the use of restraint.[[5]](#footnote-5) Many of these strategies rely on a deep understanding of the individual, including their particular needs and preferences. It is equally important to promote a sophisticated risk management approach in aged care that seeks to manage and respond to risks in a tailored, person-centred manner, rather than simply attempting to eliminate risk.

The inadequacy of the guidelines outlined in Proposal in 11-7 highlights the difficulty in attempting to change practice by creating new rules. Despite their intention to add precision and certainty, regulations such as these have a tendency to unintentionally sanction poor practice.

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| ***HammondCare position****HammondCare does not support the proposal for regulating the use of restrictive practices through the Aged Care Act because:** *The proposed requirements for justifying restraint are, on their own, inadequate.*
* *Promotion of sound risk management and appropriate strategies for minimising restraint would be more effective in promoting resident safety.*
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# Other matters

## Employment screening in aged care

HammondCare strongly supports the need to ensure that people who work in aged care are fit to work with older people. In recruiting care staff, HammondCare prioritises a person’s fit with our mission and values, and their affinity for working in a caring capacity.

We support efforts to review and update the current requirements for screening aged care staff in order to exclude inappropriate people from working in aged care. However, any new or revised system to screen potential aged care workers must be practical. The Discussion Paper notes that the screening process it proposes will have a number of ‘implementation issues’. We suggest that if the Australian Government does decide to review the current requirements around employment screening, that it should investigate more efficient solutions.

## Community Visitors Scheme

As a Community Visitors Scheme (CVS) auspice, HammondCare believes that if the Department of Health decides to develop national CVS guidelines, they should consult extensively with auspice organisations. This would mean that elements of existing internal policies are incorporated into an overarching document, while ensuring that any proposed guidelines are readily implemented.

## Official visitors

HammondCare does not support the proposals for an ‘official visitors’ scheme as existing arrangements provide safeguards for residents. At the moment, all residential aged care services have one unannounced visit from the AACQA each year. The Agency can also conduct review audits when there are concerns about a home’s performance, while other external visitors such as the staff of the Complaints Commissioner and Aged Care Funding Instrument (ACFI) reviewers can also make referrals to the AACQA.

The Discussion Paper notes that plans for aged care reform include a move towards co-regulation and earned autonomy. However, it must be recognised that to achieve autonomy and co-regulation, aged care services will be required to demonstrate a strong quality record and robust systems and processes. Any transition to earned autonomy or co-regulation should occur following a robust risk-management approach, providing consumers with confidence about the safety of aged care services.

# References

Australian Aged Care Quality Agency (AACQA), 2014. *Results and processes guide: October 2014*, Australian Government: <https://www.aacqa.gov.au/providers/residential-aged-care/resources/other-resources/copy_of_Resultsandprocesses.pdf> [Viewed 25 January 2017]

Australian Aged Care Quality Agency (AACQA), 2015. *Practices and processes guide: August 2015*, Australian Government: <https://www.aacqa.gov.au/providers/home-care/practices-and-processes-guide> [Viewed 25 January 2017].

Department of Health, 2016. ‘Single quality framework: focus on consumers’, Ageing and Aged Care: <https://agedcare.health.gov.au/quality/single-quality-framework-focus-on-consumers> [Viewed 25 January 2017]

Department of Social Services, 2015. *Aged Care Quality Agency: 2015 Budget*, Fact sheet, Australian Government, Canberra.

National Ageing Research Institute (NARI), 2015. *Profile of elder abuse in Victoria: Analysis of data about people seeking help from Seniors Rights Victoria, Summary Report*, Seniors Rights Victoria.

1. <http://dbmas.org.au/what-we-do/> HammondCare leads the consortium that provides DBMAS nationally. [↑](#footnote-ref-1)
2. <http://www.sbrt.org.au/about> HammondCare leads the consortium that provides the SBRT service nationally. [↑](#footnote-ref-2)
3. <https://www.dementiatrainingaustralia.com.au/> [↑](#footnote-ref-3)
4. However, the Results and Processes Guide, which broadly outlines the steps assessors may use in assessing aged care homes, does mention the identification of trends around incidents relating to staff, collecting information on behavioural incidents and managing ‘challenging behaviours’. (See AACQA 2014, 24; 54; & 57.) [↑](#footnote-ref-4)
5. Depending on the circumstances, these could include the use of appropriate furniture, modifications to equipment or the environment, appropriate footwear, exercise programs, physical and occupational therapy, individualised rest periods, increased supervision, anticipation of needs, appropriate lighting, personal alarms, bed sensors, medication assessment, floor mats and bed protectors among many others. [↑](#footnote-ref-5)