



Submission to the Australian Law Reform Commission

Inquiry into Elder Abuse

August, 2016

Queensland Nurses' Union
106 Victoria St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
P (07) 3840 1444
F (07) 3844 9387
E qnu@qnu.org.au
www.qnu.org.au

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The primary function of nurses is to provide early surveillance and to detect problems that could lead to death and other complications. If there aren't enough nurses at the bedside with visual contact with patients, nurses don't have a chance of making those decisions.

Linda Aiken, Professor of Nursing, Pennsylvania State University

Introduction

The Queensland Nurses' Union (QNU) thanks the Australian Law Reform Commission (ALRC) for providing the opportunity to make a submission to the Inquiry into Elder Abuse.

The QNU represents all categories of workers that make up the nursing workforce in Queensland including registered nurses, registered midwives, enrolled nurses and assistants in nursing who are employed in the public, private and not-for-profit health sectors including aged care. The QNU also retains specialist lawyers to assist its members in their dealings with the Nursing and Midwifery Board of Australia (NMBA) and Australian Health Practitioner Regulation Agency (AHPRA).

Our more than 53,000 financial members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNU and our membership continues to grow.

The QNU has provided answers to the relevant questions set out in the discussion paper (ALRC, 2016). Changes to legislation alone will not prevent the incidence of elder abuse. We preface our answers with an overview of the aged care workforce, a factor that has a significant impact on the prevention, identification and reporting of elder abuse.

Changes to the Aged Care Workforce

The QNU has almost 7,000 members working in aged care. The anecdotal evidence they have provided in member meetings indicates that the models of care in residential aged care have changed significantly over recent years.

QNU officials often meet with representatives of approved providers to discuss workload matters or employment conditions. In many of those meetings, facility managers have stated that their models of care have changed because of the difficulty in attracting registered nurses

to the aged care workforce. However, those models appear more tailored towards meeting business needs rather than residents' needs.

The changes to models of care that have been forced upon providers due to their unwillingness or inability to attract registered nurses have resulted in the registered nurses who remain being restricted to completing non-direct care duties, such as reviewing care plans and completing Aged Care Funding Instrument (ACFI) documentation, while the unregulated workers and enrolled nurses take on greater responsibility for resident care, often with inadequate assessment or supervision.

These changes to the composition of the aged care workforce and their increasing workloads provide the potential for incidents of elder abuse to occur and to go unreported. Therefore the general theme of our submission centres on the concept of 'unintentional neglect'. We point out that the issues we have identified here are systemic and must not be attributed to individual staff already working to maximum capacity in a notoriously under-resourced sector.

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?**

The QNU agrees that all of these should be taken into account in defining elder abuse. The World Health Organization (WHO) (2002) defines elder abuse as "a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person". Elder abuse can take various forms such as physical, psychological or emotional, sexual and financial abuse. It can also be the result of intentional or *unintentional neglect*.

The QNU finds particular relevance in the effects of 'unintentional neglect' which incorporates 'missed cares'. These are situations where, for various reasons, mostly inadequate staffing numbers and/or skill mix, residents in aged care facilities do not receive the type or level of care required. Missed nursing care is a global phenomena linked to the rationing of health care (Willis, Blackman, Henderson, Xiao & Toffoli, 2015).

The employment of unregulated health workers such as Assistants in Nursing (AiNs) has implications for patient/resident safety such as missed care. Nearly all states in Australia now employ unregulated levels of workers who perform various nursing tasks in hospitals and residential aged care settings (Willis et al., 2015).

These workers are part of the secondary labour market where work is not recognised as skilled, workers often lack formal qualifications and where wages and working conditions are less favourable than those provided to higher skilled professionals such as nurses. There is some evidence that the secondary labour market has a number of 'new migrants' employed as AiNs or Personal Care Workers (PCWs), particularly in residential aged care (Australian Survey Research Group, 2011).

The QNU continues to stress the need for regulation of AiNs who assist registered and enrolled nurses in the provision of care according to clearly defined education standards and skill competencies which encapsulate relevant professional standards and accountability through the Australian Health Practitioner Regulation Agency (AHPRA) and the Nursing and Midwifery Board Australia (NMBA).

Primary health, aged care and social service sectors need to be well resourced to identify and deal with elder abuse so that it is effectively diagnosed and acted on. Our analysis of Department of Health (2012) and aged care (Aged Care Financing Authority 2015) data shows a disturbing trend in aged care:

- In 2008-2009, aged care providers spent **66%** of government revenue on staffing costs;
- Three years later in 2011-2012 this had dropped to **60%**;
- In 2014-2015 it was **55%**.

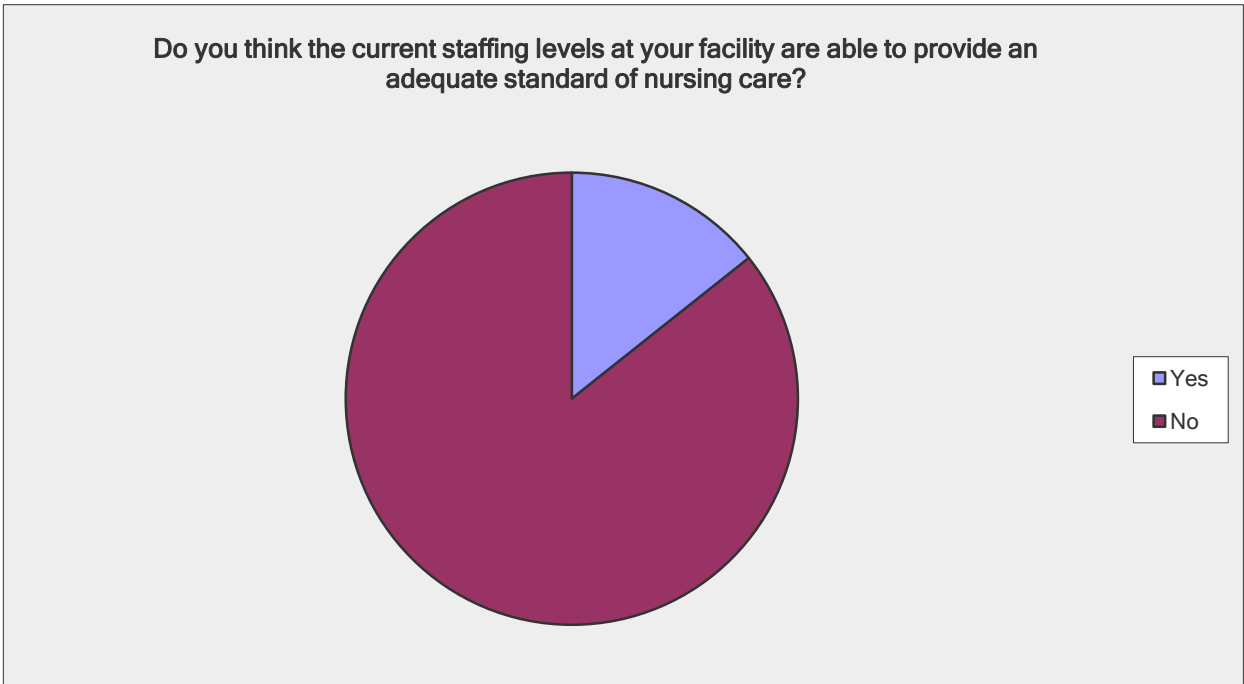
Assuming no wage increases,

- if staffing expenditure had stayed at 60% of government funding we estimate there could be an extra 3.3 registered nurses per facility.
- if staffing expenditure had stayed at 66% of government funding we estimate there could be an extra 7.25 additional registered nurses per facility.

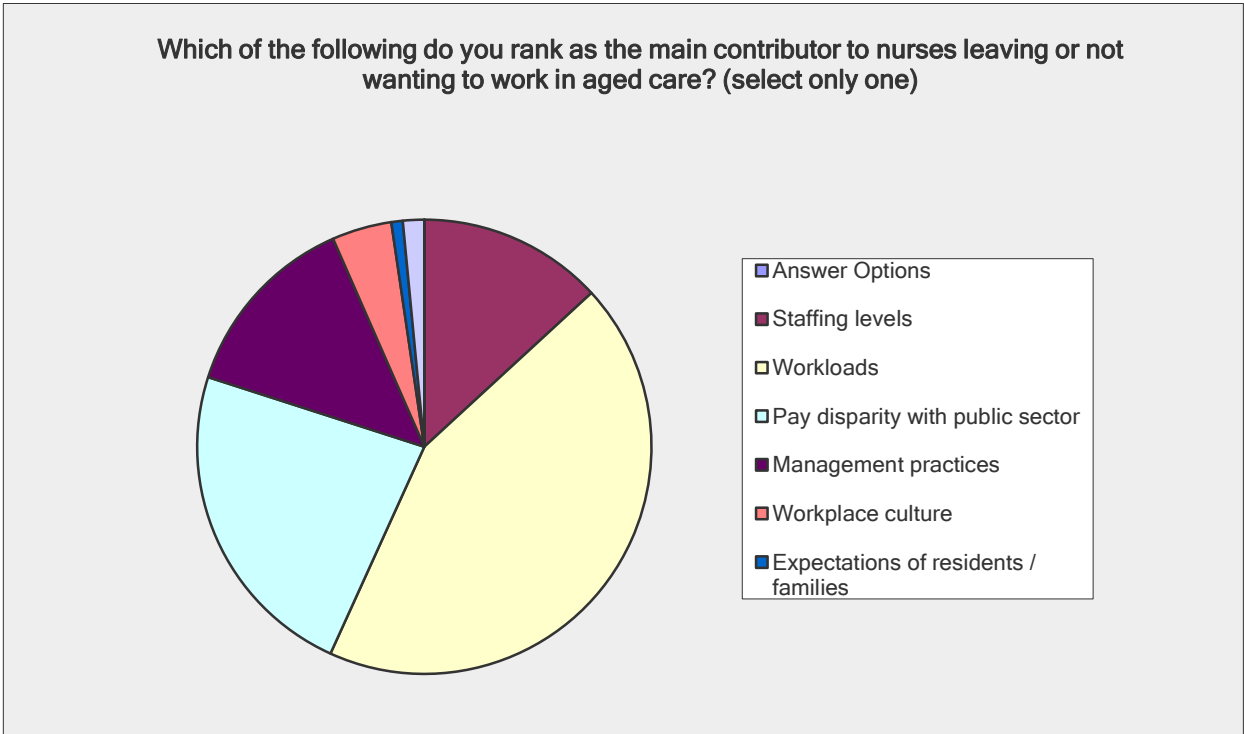
These figures indicate that aged care providers have continued to decrease funding spent on nursing staff, particularly registered nurses. This will inevitably have an adverse impact on the quality and safety of care being provided.

National Aged Care Call-in Survey Data

The QNU took part in a recent national aged care call-in survey where 86% of Queensland respondents indicated the current staffing levels at their aged care facility (either as an employee or relative or friend of someone in aged care) were not adequate.



The survey data indicated excessive workloads, inadequate staffing levels and significantly less pay are the major reasons why nurses leave aged care.



These factors demonstrate how the aged care environment is one where elder abuse through 'unintentional neglect' can occur simply because there are inadequate nurses available to keep surveillance on those in their care.

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

We suggest prevention and remedial practice are the first responses with prosecution as a last resort.

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.

Approaches to define, detect and address elder abuse need to be placed within a cultural context and considered along side culturally specific risk factors (WHO, 2002).

It is imperative that approved providers ensure their facilities engage fully with local cultural and inclusive groups including Aboriginal and Torres Strait Islander (ATSI) Cultural and Linguistically Diverse (CALD) and Lesbian, Gay, Bisexual, Trans and/or Intersex peoples.

Many aged care facilities will have a cohort of residents who identify with those groups and will require their needs incorporated into daily resident care. This is essential for spiritual and cultural well-being, an important component of holistic care and person-centred aged care.

Insensitivity to the needs of these groups can cause them isolation and stress.

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?

The Australian Nursing and Midwifery Federation (ANMF) is currently engaged in a research project with Flinders university to determine the effects of staffing shortages and inadequate skill mix in aged care. The 2016 budget changes to ACFI cut the indexation for Complex Health Care domain by 50 per cent which will impact not only on providers, but will also reduce the funds available for care genuinely being provided to frail older people. The impact of these changes warrant further research.

Our own modelling of data from a recent report (Bentley, 2015) indicated:

Residential Aged Care Staff Hours –

- 40.03 hours per resident per fortnight (prpf) = 2.86 hours per resident per day.

This means nurses have just 2.86 hours per day for each resident's showering, lifting, dressing, turning, feeding, toileting, observations, charting, wound care, medication rounds, assessment, evaluation, care planning, progress notes, medical reviews, handover, etc.

Resident Categories –

- 70% of all residents are in the top four categories (high care)

When nurses are required to undertake the duties outlined above in just 2.86 hours per day and 70% of the residents are likely to require high levels of care, it is possible that care could be unintentionally missed with the likelihood of an adverse outcome for such a vulnerable cohort.

In summary, the data (Bentley, 2015) indicated aged care providers who make the most profit do so by:

- Having a higher % of high care residents; and
- Spending less money on staffing; and
- Having less staff hours overall.

The combination of these factors alert us to the possibility of missed care through minimal staffing for high care residents.

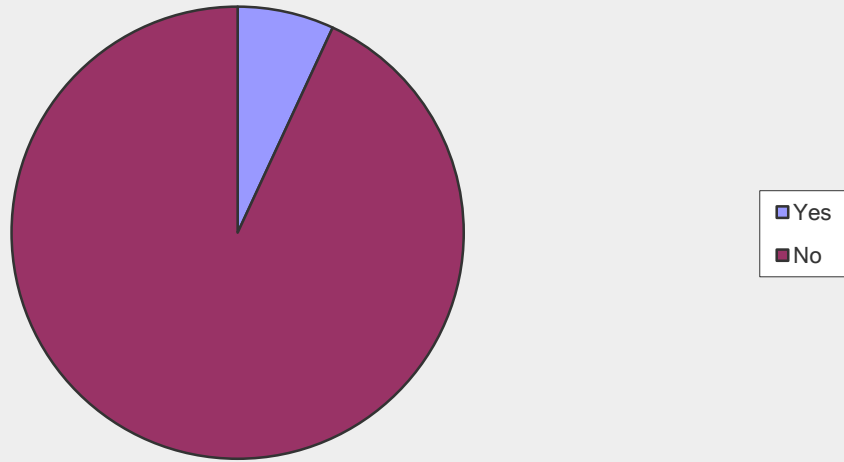
Question 11. What evidence exists of elder abuse committed in aged care, including in residential, home and flexible care settings?

According to the WHO, prevalence rates or estimates of elder abuse exist only in selected developed countries - ranging from 1% to 10%. Although the extent of elder mistreatment is unknown, its social and moral significance is obvious. It therefore demands a multifaceted response, one which focuses on protecting the rights of older persons through legal and social means.

In our experience, aged care providers have responded to the federal government's reduction of funding through changes to the ACFI by reducing assessed care hours to residents and employing AiNs or PCWs as substitutes for more highly paid registered and enrolled nurses. As AiNs must work under the direction of a registered nurse, this serves to increase their workload and reduce their capacity to oversee the provision of adequate care. This can result in unintentional neglect through missed care.

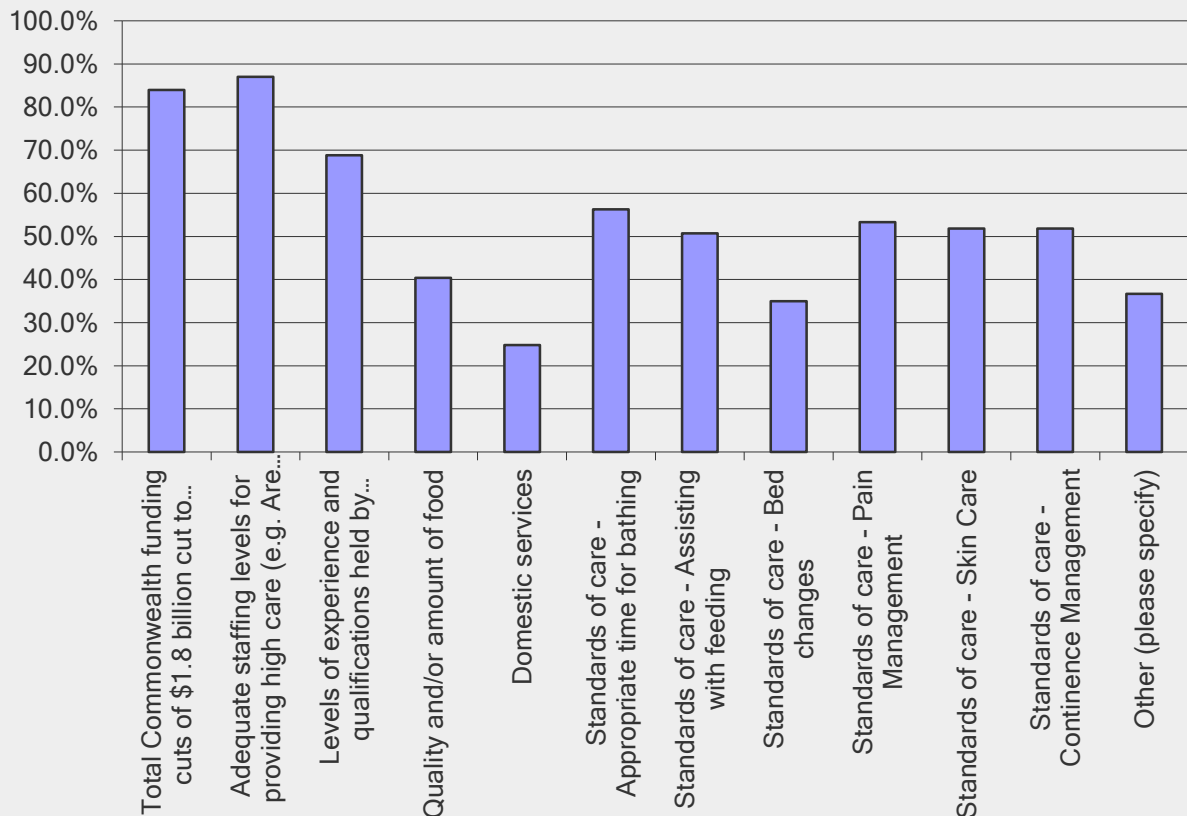
Respondents to the national phone-in survey came from all types of nursing positions in aged care across all areas of the state. The majority of respondents (93%) thought the current funding for aged care is inadequate (see graph below).

Do you think the current funding of aged care is adequate to meet the needs of the aged care residents?



The following graph indicates the issues of most concern to residents, staff and relatives.

What are the issues you are most concerned about? (you can select more than one)



The QNU continues to advocate for:

- amendment to the *Aged Care Act 1997* to ensure there is a registered nurse on duty at all times and for industrial instruments to provide minimum nurse-to-patient ratios in aged care facilities;
- proper “acquittal” of government funding provided for care services and the formal linking of dedicated funding to the provision of care services.

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

The QNU supports an elder abuse awareness campaign to educate the community and to empower older people. This should provide sources for reporting elder abuse and for obtaining information to assist the elderly make important decisions concerning their own welfare.

The Australian Aged Care Quality Agency (AACQA) has a role to play in assessing aged care providers under its accreditation standards that should include criteria for determining how a provider identifies and reports elder abuse.

Aged care assessment Teams (ACAT) should be focused on matching the needs of the individual to a suitable package of care rather than determining the care that is available and matching the individual to it. To that end, ACAT could play a role during the assessment process in identifying and responding to elder abuse.

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?

The QNU seeks amendment of the *Aged Care Act 1997* and its subordinate *Aged Care Principles* to include provisions for identifying and protecting against elder abuse.

The Department of Health and Ageing (2016) has developed a guide to aged care law that could be more widely promoted through providers and community groups so they are more aware of the individual’s rights in this area.

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 Department of Health expects Consumer Directed Care (CDC) packages to increase from around 75,000 to over 100,000 by 2017 (Department of Health, 2016b). Under CDC the

consumer can choose their care needs from a range of providers, many of whom are not registered health practitioners. There are risks with this model, particularly to vulnerable elderly.

The *Aged Care Act 1997* and the *Aged Care Principles* fail to address the practical differences between personal and nursing care, despite these two types of care being by far the most common provided to home and residential aged care recipients.

The Department of Health is well aware that the expansion of home care packages in recent years has resulted in recipients being cared for in their own homes for longer periods who have increasing dependency and more complex health care needs.

Where in former years much of the home care could be provided by unregulated carers, this situation has changed dramatically with many recipients now requiring complex nursing care. However, we find that registered and enrolled nurses employed by aged care approved providers to deliver care in the home are few and far between. The current situation, in our view, is at least in part a product of the suite of legislation's failure to differentiate between nursing care and personal care and prescribe that nursing care must be provided or supervised and evaluated by a registered nurse.

This failure has allowed some providers to deliver aged care in the home without being required to engage registered and enrolled nurses. As a result the care provided is not "fit for purpose" and healthcare costs are then shifted to the State through unnecessary referrals or admissions to public sector health services.

Nursing

Nursing takes a holistic rather than task oriented approach to health care and includes the physical, mental and emotional care of the person. The 'choice in home care' packages establish the framework for non-regulated carers to perform tasks that may fall within the nursing scope of practice and which must be undertaken by a qualified, regulated professional. There needs to be a clear understanding of who is responsible for co-ordinating and monitoring care plans.

Not all persons with a direct or implied obligation or responsibility for caring for individuals or groups are necessarily engaged in nursing. For example care by an unpaid carer or relative in the home environment is not considered to be nursing.

Nursing practice is undertaken by registered nurses, enrolled nurses and nurse practitioners who are regulated to practise as nurses. AiNs are delegated aspects of nursing care by registered nurses and provide that care under the direct or indirect supervision of registered nurses. Current nursing regulation also requires that the outcomes of any nursing care

provided by AiNs or employed carers, whether in the home or the residential setting, must be evaluated by a registered nurse.

Individuals practising nursing should undertake relevant education and possess the required qualifications for registration. Registered and enrolled nurses must comply with the NMBA National Standards for Practice.

The provision of personal care to individuals enables them to live independently and facilitates their integration and participation in the community. Decisions about whether personal care should be provided by a nurse or another level of worker should only be made by a registered nurse. A registered nurse assesses the characteristics of the person requiring care, the activities to be performed, and the competence, education and authority for practice of the person providing the care.

It is important the consumer has a role in directing the care provided, is aware of the different types of workers who will be providing their personal care and is empowered in the knowledge that any nursing they receive must be delivered, or supervised and evaluated, by a registered nurse.

As health care workers have a range of different qualifications and experience, consumers will need education and support in making decisions related to the type of care they receive and who delivers it.

The QNU opposes the erosion of aged care nursing positions and/or services in any setting by the employment of other staff categories (however titled) to manage or provide nursing.

Example

We use the following example of the management and administration of medicines to demonstrate why the qualifications and responsibilities of a 'carer' are important and how missed or incorrect care is a form of unintentional elder abuse.

In the nursing sense, a carer is any person who is not registered to practice as a registered or enrolled nurse. Two risks arise from this. The first is a service provider's engagement of carers to administer medicines with no nationally accredited qualifications in pharmacology or in the administration of medicines. Current Australian Qualifications Framework certificate courses have an elective unit which teaches carers how to assist with the administering of medicines, particularly with those clients who self-administer, but they do not provide those students with the necessary pharmacology knowledge to administer medicines safely.

Secondly, registered nurses who are directed or coaxed into allowing carers to administer medicines in contravention of the national professional nursing standard risk liability for disciplinary action by the NMBA.

It cannot be assumed that a person receiving a health service in their own home is mentally competent. In fact, an ever increasing number of aged care home packages are for persons with dementia or cognitive decline. If the care recipient is not mentally competent to self-administer their medicines, they will require a registered health practitioner (with qualifications in medicines recognised by their National Board) to manage and administer their medicines.

The QNU seeks more rigorous transparency and accountability for public funding provided to all health and aged care services through improved public reporting including nursing staffing numbers, skill mix and quality outcomes.

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

Providing choice in home care must not come at the expense of safe, quality care. Any service that provides health care invokes a duty of care. The standard of that health care will vary depending upon the circumstances.

The QNU recommends the Australian Aged Care Quality Agency (AACQA) Standards should be amended to include a definition of elder abuse and the required action in residential and community care. This will need a common understanding of elder abuse acceptable to the community, providers and health practitioners so that ethical standards in care are balanced with sufficient protections for practitioners against vexatious or unsubstantiated allegations.

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

The QNU contends that regulation of the use of restrictive practices should be nationally consistent and cover all aged care settings and services. Professional standards of practice should be taken into account.

We support the ALRC (2014) in its call for the Australian Government and the Council of Australian Governments (COAG) to facilitate the development of a national or nationally consistent approach to the regulation of restrictive practices. In developing such an approach, the following should be considered:

- (a) the need for regulation in relation to the use of restrictive practices in a range of sectors, including disability services and aged care;
- (b) the application of the ALRC's National Decision-Making Principles; and
- (c) the provision of mechanisms for supported decision-making in relation to consent to the use of restrictive practices.

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

The QNU seeks amendment to the *Compulsory Reporting Guidelines for Approved Providers of Residential Aged Care* to include approved Providers of Community based aged and disability care services including the National Disability Insurance Scheme (NDIS) and CDC. Employers must set out a process for identifying and reporting elder abuse. Nurses can report any suspected or actual cases directly to the police or relevant government department for investigation.

The QNU has endorsed the *Compulsory Reporting of Abuse in Aged Care Settings for Nurses and Assistants in Nursing* position statement of the ANMF to which we are affiliated. In part this states -

In order for compulsory reporting to be effective, clear policies and protocols at the work place level must specify and support the process to be followed by the person making a report of any alleged abuse.

Registered nurses, enrolled nurses and assistants in nursing are required to report any suspected or actual abuse of an older person. They must report to their employer or directly to the Police or the Department of Social Services.

The person to whom the report is made has a legal obligation to investigate and take action, and to advise the person making the report that action has been taken, and in what manner.

If the person making the report is not satisfied with the action taken, they have an obligation to make the report to a higher authority.

The person making the report must not be subject to any victimisation or discrimination in the workplace as a result of making the report.

Question 18. What changes to aged care complaints mechanisms should be made to improve responses to elder abuse?

The ANMF position statement (2015) above makes it clear that a process for reporting and a follow up mechanism is necessary.

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

CDC now dictates that aged care sanctions must include community providers in aged care and the NDIS. Any sanctioned providers must be publically identified.

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?

It is our experience that the working environment in many aged care facilities is more authoritarian than those with a shared governance model such as Queensland's public hospitals. Engaging in industrial activism is frequently discouraged by employers and individuals who take part in such activities are often singled out for adverse action.

Direct care staff are often too busy to engage in meaningful dialogue with employers regarding working conditions and workloads. Many members report coming in an hour before their shift starts or staying back late after their shift to ensure residents obtain their nursing needs. These additional hours are not on paid time.

From one of our members, a registered nurse in a not-for-profit residential aged care facility:

I remember on one occasion I did mention that there was just too much to do. I was told to stop complaining and just get on with the job. On that shift I was supposed to finish at 2200 hrs, I finally left at 0100 hrs.

No thanks, no mention, no nothing (and no paid overtime).

Some members have even reported that their facility requires residents to be roused at 4.00am so that the showering of residents can be completed in good time.

Members in aged care regularly describe a culture of fear and intimidation with regard to their working environment. QNU Officials are often required to meet with members away from their worksite due to their fear that managers will become aware of who is attending the "union meeting".

Therefore it is not only the elderly who need legal protection, but also aged care health workers when they report abuse.

Legislation should consider the role of the 'third party' i.e. representative organisations such as unions or other advocacy groups when members report elderly abuse directly to them.

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