66. M Agllias

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Question 1

All the elements of intended or unintended & resultant physical and/or psychological harm, distress, pre-meditation, pricing & payment for goods & services and profiteering from elders of any kind should be included in the description of abuse.

The settings of these abuses can be institutional (including academic research, medico-legal), private enterprise, public sectors, not-for-profit and domestic.

eg

- inflated prices of aged care goods & services in order to get greater government subsidies and not benchmarket to other industries.

- academic research conducted on or about older persons which could be deemed distressing to an elder without adequate debriefing and supervision

- elder person's lawyers compromising their advocacy for that person by simultaneously acting on behalf of said person’s beneficiaries, POA, or other family members.

-evaluation of capacity to understand & sign POAs, wills, advanced care directives & family agreement documents should include a medico-legal team not just one lawyer or at the very least two lawyers. And the evaluation of capacity should be over extended timeframe with cooling off periods and enforced reviews.

- government assigned substitute decision makers should not use elder's funds to get third party reports to go against a person's wishes.  If the report goes against a person’s wishes then government should pay for the resultant report to justify their decision.

- all breaches of abuse (including profiteering, negligence) should be flagged by a professional (health, legal) as well as a member of the public.

Question 2

Legal responses to elder abuse should focus on preventative measures primarily (and punitive measures should be swift with suspensions or criminal proceeding applied)

For example - all POAs and Guardians must sit in a training course where the ethics, values and best practice is learned not assumed as known.

Diaries either audio video, verbal or written should be required for reasoning behind all financial & lifestyle decisions and called upon if needed as evidence if an abuse of rights of these roles are suspected.

Question 3

Institutional bullying by ethno-specific aged providers which leaves a disabled elder from a NESB with very limited choice to no choice and place to go.

An example of which is currently occurring with my mute father who resides in XX XX Nursing Home where the nursing home management has threatened to exclude or limit visitation right of his only relative because of advocacy for reasonable nursing care. Where the said Nursing Home then appears to be using a loophole created by government initiative (where there is no distinction between high and low care) and appears to be changing their 'model of care' to create a higher turnover of high care recipients with preference for lower care to keep their labour costs low. And as such if any issue is raised the brutal answer is “you can leave”.  Thus bullying the care recipient and their representative citing demand for ethno-specific services and dodging the issue of dignity, aging in place, integrity and original care contracts.

Institutional bullying by public hospitals.

The right to life, hope and dignity of elderly people is not valued in many hospital environments.  Cost pressures are seeing the elderly faced with being denied the full spectrum of medical services and constant repeated abusive demands of doctors for advanced care directives in front of ill patients. These services should be provided by a combination of mobile rapid response teams supporting mandatory doctor/s in aged care facilities to triage and deal with patients according to an understood advance care directive plan.  Not to be bullied by hospital staff.

Question 4

There needs to be a Royal Commission into the financial, physical, psychological and emotional abuse of the elderly in government and private institutional care.

Further research needs to be conducted in cross-cultural attitudes to care and boundaries of abuse.

Better research into the forensic markers of abuse and this is to inform mechanism to train people to identify abusers and create preventative training courses for eg POAs, guardians etc

More research into the conduct of Public Guardianship & Public Financial Management which is bureaucractic and by that very nature not timely or cost effective.

Question 5

High risk Centrelink recipients are those with a disability - loss of one or more senses.

Special forensic training of staff to identify those at risk.

Question 6

Question 7

Question 8

Social security should be able to call upon a POA rationale for decisions if abuse suspected.  Including non-action or denial rights to be consulted.

Question 9

Question 10

Social security laws that prevent a person from a minority NESB background for returning to homeland for care needs to be explored.  Leaving a person in a culturally and linguistically foreign environment makes them more vulnerable to exploitation and abuse.

Question 11

Whole aged care system/act, accreditation and funding model needs complete overhauling after a Royal Commission & valid international research.

Use of tax payers funds, and individual's funds to pay for care requires better management of such funds within NFP & for profit Aged care providers; so government should provide teams to service providers free of charge to overhaul their processes to ensure care processes are efficient and quality of life driven.

Forensic analysis of abuse claims should carry greater weight than paper reporting which can lead to cover-ups, omissions & inaction.

More root cause analysis and wider cross hospital statistical analysis required of deaths in aged care to determine gaps in care/abuse identification.

For example if one particular nursing home consistently is sending elderly to Emergency with sepsis, or body shutting down or dehydration or malnutrition or infected pressure sores etc. This generates an alarm to investigate that facility. Or conversely they aren’t sending people at all.

Question 12

Aged care assessments should not be carried out by a social worker, they are completely inadequate.

Centres for the Protection of the Elderly should be set up where elders can visit and have access to allied health, medical or legal services as well as be assessed inobstrusively overtime as needs may change. A community approach is healthier, safer and a one stop shop for those no matter their social or financial status.

Question 13

As recommended above all decisions made on behalf of a care recipient should have a reasons for decision recorded verbally or in writing regardless if a public or private decision maker is appointed.

Question 14

Consumer directed aged care models can be safeguarded from abuse if there is full disclosure on what a provider cannot provide. There is a major gap between the marketing and what is actually provided.  Expectations of care and the realities can be very far apart. If there will not be enough staff with the knowledge of the individual preferences and witnessing changes then care recipients and their representatives need to know.

A safeguard would be to provide standardised forms, processes and systems to facilities to use to capture information to tailor care and effectively review and promptly review changes in care.

But the law needs to change in that any one being an aged care provider must have have increased government representatives onsite protecting & refining against abuse. (similar to FDA overseers in the food production industry in the US)

Question 15

A prescriptive description of quality in aged care is absent.  Hallmarks of quality, ratings/rankings are present in say hotels but what constitutes care?  But there are none in aged care for the consumer.

Aged care providers, specifically nursing homes, should not be left alone to map their customer experience from entry to death & post-death experience in nursing homes.

Government intervention is seriously required now in modelling care processes. Market forces will not create change in this area because of the serious nature in which people finding themselves in need of 24/7 nursing care.

Question 16

Question 17

My father was in X Nursing Home and it was not reported that an obvious assault had occurred.  It was reported that he slipped on his own urine however a community dementia nurse specialist reported that she thought this unlikely.  His bruising clearly looked suspicious. However the Public Guardian didn't investigate further on his behalf because the Nursing Home's paper-trail said otherwise.

Often Nursing Homes make out that relatives or friends of the care recipient are not of sound mind and cover up abuse this way. Playing the health professional card to protect their reputation against suspicion and cover-ups such as the example mentioned and others I have seen.

Chemical handcuffing by a doctor was practiced in that same facility and this doctor boasted on how much he could use on my father.  Despite my own protestations to the  NSW Public Guardian not to consent to the use of the drug as it was contraindicative to his disease & to investigate the truth around the need for use; the doctor went ahead and used the drug which made my father incontinent of bowel overnight. A psychogeriatrician several months later pronounced that the drug was contraindicative to my father's disease and still the Public Guardian did not seek any kind of compensation or suit against the doctor nor sought forensic advice upon pictures I took of his bruising.

Mandatory quantitative and qualitative reporting of all bruising & pressure sores in aged care, as well as resident on resident physical & verbal abuse reported.

Question 18

Aged care complaints mechanisms are basically pointless when nursing homes can fabricate paperwork to support their view of events or pass assessments.

A paper reality as opposed to an observed reality.

Not admitting they have any deficiencies or saying sorry for gross errors causing pain, suffering and stress. They generally prefer to find fault in the care recipient or their representative to create a diversion to their negligence.  A very common pattern and strategy observed.

Any other customer service complaint environment the customer would get their money back or some kind of compensation.  But not in Australia, we pay for the privilege of being neglected, suffering infected pressure sores and having to have amputations.

Do away with complaints bureaucracy and have a Fair Trade Tribunal for aged care matters where claims can be made against providers.

Question 19

With repeated offenders, sanctions need to be immediate and far reaching.  No new residents for two years and a team of government officials onsite observing / guiding for several months 24/7.

Question 20

Forensic elder abuse observation skills course for all aged care advocacy services and community visitors.

Question 21

Question 22

Adoption of expensive equipment (like a motorised wheelchair) bought before the scheme having only a 5 year age limit.  These pieces of equipment cost more than an automobile yet support for costs for repairs should be available to those on a full pension.

Provision of alterations to equipment as disability worsens.

Question 23

Question 24

Question 25

Question 26

Question 27

Family agreements should be part of a written elder law package which is undertaken by two independent lawyers. Package should include will, advance care directive, guardianship, power of attorneys & family/support network agreements/identification.

Family members opting out of providing any hands on care or alternative financial support within family agreements should be

(The definition of Family Agreements could include Significant Support Network for those with no family and persons responsible included & updated. In case of those with no networks a Community Care Advocate could be set-up with a pool of trained volunteers much like Foster Parenting.)

Question 28

Question 29

POAs who stand to inherit curb spending money on the elder or may hasten their demise through inaction.

They are insufficiently trained as to their obligations and the rights of the individual elder.  Rationale for decisions, need to be recorded.

Public Advocates as a last resort advocate should never act alone.  Every elder person deserves the right to swift yet considered substitute decision making.  A public advocate cannot do this effectively.  More joint private guardianship and financial management arrangements should be made between a voluntary public member/guardian mentor with a person responsible in order to avert long delays in decision making which ultimately causes distress, harm and abuse.

Reasons for decisions duly collected. Technology enabled and where stakeholders can register to place comments against decision rationale.

Question 30

Question 31

If preventative measures such as training and a register with reasons of decisions for all POAs were created this would largely prevent a lot of unintentional abuse however intentional abuse needs to a reporting mechanism and investigated within criminal laws.

Question 32

Public Guardians and Public administrators are negligent because of their very bureaucratic nature.  They do not have the ability to be briefed by an elder who has lost capacity to fully investigate or prosecute any abuse.  So that in itself is abusive.

There should be no public guardian or public administrators only guided guardianship and guided public administrators.  Saving time, tax payers and individual’s money as a person responsible will always be more proactive than a government officer in seeking timely and appropriate substitute decision making.

In the event of long term family breakdowns the person who is actually onsite doing the caring should be awarded guardianship along with a civil guardian or mentor who can liaise with other family members in order to get their views. If this joint guardianship relationship breakdowns then a single public advocate will be last resort.

Guardianship laws need to change because so many families have people who do not communicate with each other and thus there is an automatic application of guardian of last resort. This is not in the best interest of the elder person and perpetuates a cycle of abuse including institutional & bureaucratic management which inevitably leads to unintended harm & powerlessness of the individual against the state.

Question 33

Public Advocates are not adequately trained in the forensic investigation of abuse.  Have no powers to investigate and raise charges of abuse. They rely too much on 'paper realities and vested interests.

Question 34

People with profound sensory & cognitive disabilities are most at risk special legislation should be enacted to protect these people.

Question 35

Health care professionals can be part of the elder abuse cycle.  Valuing the elders contribution past, present and future is not fully part of their curriculum.  Elder abuse training needed in all health professional courses.

Question 36

Professional development should include mandatory forensic skills in identifying elder abuse and reporting mechanisms identified.

Question 37

I don't think health justice partnerships are a useful model.  Some professionals can be the perpetrators of such abuse.

Valuing elders contribution in society, valuing hands-on carers, sound forensic skills to identify abuse and POA & Guardian registers & training will go a long way.

Enshrining these in a Human Rights law, legal practice law and curricular is better that creating more bureaucratic agencies.

Question 38

Question 39

Question 40

Question 41

Question 42

Question 43

Question 44

Question 45

Question 46

Question 47

Question 48

Question 49

Question 50

Other comments?