ELDER CARE WATCH

Submission to Australian Law Reform Commission Elder Abuse Inquiry

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This submission contains a response to the following questions in the Issues Paper:

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

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

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

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.

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

Operation Home Truths: the evidence

The following material relates to residential care settings. The evidence collected and published by Elder Care Watch consists of first-hand accounts of poor quality care provided to residents. Most of the accounts are given by a resident's close relative who visited the nursing home frequently.

These contributions were sought by Elder Care Watch in a project called *Operation Home Truths* which is on-going. The project was advertised in *The Senior* newspaper, a Melbourne radio station and in the Elder Care Watch newsletter. The advertising was purposefully directed to those who had concerns about care. Contributors were guaranteed anonymity in publication. Some wish to preserve this anonymity, others are willing to be identified and three have already featured in the mainstream media (respectively ABC Lateline; The Age; and Sunday Age). A hard copy of the primary source material has been provided to the Commission.

The idea for the project came from listening to people in distress talking at length about their experiences with the health care that their relative or friend was receiving in a nursing home. If these experiences could be captured in writing then the insights into the realities of day to day care might be a trigger for confronting the need for change at the bedside. This submission provides a limited number of extracts from the cases to illustrate different aspects of abuse.

Failure to take timely action in relation to an acute health episode

Twenty nine of the 60 cases published to date included *a failure to take timely action in relation to an acute health episode* either a fracture or a serious infection. Case 52 illustrates the latter.

> ***"There was severe infection between her toes on both feet and both heels were black from pressure sores. My sister immediately notified the RN in charge and Mum was admitted to hospital that day. The hospital doctor advised that the matter needed to be reported to the authorities because of neglect. Mum was barely able to walk at all for several months while her feet healed"***
>
> *Operation Home Truths, case 52*

Possible explanations for failure to act are (i) insufficient staff with nursing knowledge and (ii) unsafe staffing levels (excessive workloads). Both are exclusively management responsibilities as there is no public regulation of specific staff numbers or skill profiles in private nursing homes. A third possible explanation, and it is a disturbing one, is staff complacency towards acute health episodes of our institutionalised elders.

Nutrition and hydration

Problems with *nutrition and hydration* were cited in 26 cases. They included: inedible food, rotten food; food out of reach; not enough food; 'shovel' feeding; forced eating; and most commonly, insufficient assistance with eating. An example of abuse is provided by case 44.

> ***"When I visit at meal times, I often notice other residents struggling to feed themselves. On Sunday 6 October the resident who is legally blind was having difficulty getting the lids off bowls and containers so I asked if I could help him. A nurse refused to allow me to assist him. Instead to my horror, she began shovelling …. food into the resident's mouth. She continued without allowing him to chew the food adequately, until the plate was empty. Shortly after, he brought up the food onto the table in front of him. My father witnessed this and of course was upset. The nurse then gave the blind resident an injection and put him to bed"***
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> *Operation Home Truths, case 44*

Medication management

Twenty three cases cited problems with *medication management*. They included: use of anti-psychotics; incorrect medication; over medication; failure to medicate; doctor's orders not followed; and a PCA ignorant of the drug she was administering. Case 59 provides an example.

> ***"My husband has Parkinsons and the medication was a constant problem. I used to have to chase it up all the time because it was not being given when it should have been. I wonder what would have happened if I had not been there every day"***
>
> *Operation Home Truths, case 59*

Behavioural management

Only ten of the 60 cases cited deficiencies in managing resident behaviour but many were disturbing. They included those cited in cases 1 and 53.

> ***"The staff left him to crawl on the floor begging for someone to take him home, how degrading this was for him and upsetting for me to see. I will never forget it until the day I die. ……. I found Dad's wheelchair and took him back to his room. When I approached staff about this I was told 'we find him sooner or later'"***
>
> *Operation Home Truths, case 1*

> ***"My husband was aged 63 and he was shackled like a wild dangerous animal day and night. The shackles went around his groin and were knotted to the base of a princess chair, so tight that if he tried to move in any way he was obviously in excruciating pain around his groin. I wrote to management and begged and pleaded with them not to terrify and dehumanise him in this way"***
>
> *Operation Home Truths, case 53*

In the above case, the resident had been admitted to a nursing home as a consequence of a brain injury sustained when attacked by a group of youths while out walking with his wife.

Privacy and dignity

In 39 cases, the contributor believed that the resident's privacy or dignity or both had not been ensured. Two examples are from cases 23 and 58.

> ***"When my mother needed assistance to go to the toilet she would have to wait so long it was too late. This was upsetting for my mother as it would be for any of us. How can we expect our parents, and eventually, ourselves, to maintain their dignity in these circumstances?"***
>
> *Operation Home Truths, case 23*

> ***"I saw both nurses and PCAs go in and pull the blankets off my mother and leave her naked with the door open"***
>
> *Operation Home Truths, case 58*

Some, especially provider associations, may say these are only isolated cases, that most care is good. It is impossible to know for sure. The public monitoring, primarily in the form of accreditation processes is not forensic enough to tell us what the quality of care generally really is.

The cumulative evidence that too much care is of poor quality continues to build however: from previous government inquiries; from coroners' cases, from media stories and letters to newspaper editors. The above cases are part of that cumulative evidence.

The key point is that the health care described here and which is provided by government subsidised institutions, should not be acceptable for any patient whatever the incidence of poor quality aged care Australia wide.

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

TRANSPARENT STAFFING

The quality and quantity of staff is surely the most critical input affecting quality of care outcomes. 'Hands-on' staff top the priority list but the skills of management staff are also vitally important as this group makes the decisions concerning the 'hands-on' staff.

The current position is that staffing decisions are almost universally an unfettered management prerogative. Management decides how many staff will be employed on each shift and what the skill mix will be. There are pockets of exceptions, such as the Victorian provision mandating ratios in the handful of metropolitan public nursing homes and in the scores of small country public nursing homes. The ratios can be found in the *Nurses and Midwives (Victorian Public Health Sector) (Single Interest Employers) Enterprise Agreement 2012 - 2016, Schedule C, page 119),* pending their transfer to legislation next year in the *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015.*

Previous State-based regulation

There has been public regulation of nursing home staffing in the past. Prior to the 1997 *Aged Care Act*, staffing requirements existed for nursing homes. The public regulation took the form of State regulations specifying hours of nursing care per resident per 24 hours. In some States, hours of non-nursing care were also specified. Government funding was directly linked to the nursing hours stipulated. Attempts to develop a uniform (national) set of staffing hours' requirements during the 1980s failed as States asserted their independence *(Senate Select Committee, Private Nursing Homes in Australia: their conduct, administration and ownership, AGPS, Canberra, 1985, paras. 2.145 & 2.146).*

The usual argument against mandatory staffing levels

The argument used by a number of government ministers for aged care, by nursing home providers and public servants is that residents' circumstances are so different and complex that general staff:resident ratios are not feasible. This point is amplified in the following statement from a senior public servant.

> ***"I just make the observation in relation to ratios …….. the way the instruments*** [the laws] ***work at the moment, the provider should have the staff of the qualification necessary to deliver the care to the individual, recognising that the needs of individuals vary quite significantly.***
>
> ***A lot of people make a comparison with child care. I actually think that it is a very poor comparison myself because you know that three babies, five toddlers will have a fairly constant need for care; it is a significant need, obviously. But in this particular case*** [nursing homes], ***where people's circumstances can be quite different, someone who is dementing may need a lot of actual supervision, not a lot of instrumental assistance. Someone who is bedbound will often need quite a lot of technical nursing. So this is actually quite a complex space"***
>
> Jane Halton, Secretary, Department of Health and Ageing, responding to question from Senator Nick Xenophon, Senate Estimates, 4 June 2009 *(emphasis added)*

Question 15 continued

The Secretary's argument overlooks the fact that nurse:patient ratios do operate, as noted above in the acute health sector and some nursing homes in Victoria. Further, the variation in patient dependency levels (their care needs) will likely be as pronounced in the acute sector as in any nursing home and the patient turnover will be markedly greater than the relatively stable patient profile in the nursing home practice setting.

Given the prominence and longevity of the argument against public regulation as put forward by the senior public servant, it needs to be addressed directly and by those best qualified to respond, namely, members of the nursing profession, and in particular by its collective voice the Australian Nursing and Midwifery Federation.

Introduce mandatory disclosure of management decisions on staffing

The staffing ratios which operate in practice are based on management decisions. There is anecdotal evidence of an industry staffing standard. If one does exist, it damages the potency of the argument opposing a national standard of public regulation. However, the ratios in operation and the frequency with which they change, are a mystery. They are shrouded in secrecy. Anyone visiting a nursing home on an open day will likely receive an evasive or limited answer should they be bold enough to ask a direct question about staffing. There is too little transparency in aged care. In addition to opaque staffing there is no identification of homes which have transgressed and been penalised under the complaints scheme and there is no public disclosure of the Quality Agency reports on unannounced visits *(see below)*.

Elder Care Watch advocates the introduction of a regulation mandating disclosure of staffing levels and skill mix. Specifically, all approved providers should be required to display in the foyer of the facility:
(1) the classification and the name of the person in charge of clinical care on the current shift;
(2) the number of 'hands-on' staff on duty and their classification;
(3) the number of residents in each dependency category;
(4) the number of supernumerary nursing staff on duty.

The transparency requirement could be introduced into the *Quality of Care Principles*.

The Quality Agency audit reports could also be required to include a home's staffing figures (numbers and skill mix) and the resident dependency levels at the time of the audit.

This proposal leaves the management prerogative on staffing decisions untouched but introduces transparency in staffing numbers and skills. Shining a light on actual numbers and skill levels seems a reasonable requirement given the high percentage of providers' incomes derived from the public purse and the growing body of evidence from diverse sources, highlighting poor quality health care so often linked directly to staffing.

TRANSPARENCY IN THE MONITORING OF THE QUALITY OF CARE

The public has access to the Quality Agency re-accreditation site audit reports. These reports result from announced visits, with the provider typically given weeks of advance notice. The Agency is required to publish these reports on its website *(see Quality Agency Principles, s.2.26 (2))*. There is a good deal of scepticism among relatives regarding the veracity and usefulness of these reports.

The Agency also conducts unannounced visits for various reasons. Each home is required to have at least one unannounced visit per year. They are referred to colloquially as 'spot checks' and in the *Quality Agency Principles* as *assessment contacts.* One important purpose of *assessment contacts* is *"to assess the approved provider's performance, in relation to the service, against the Accreditation Standards" (Quality Agency Principles, s. 2.30 (c)).* These are in effect mini-audits.

Reports on these unannounced 'mini-audits' have a better chance of capturing an accurate picture of the quality of day-to-day care. The reports are given to the provider but they are not available to the public. There appear to be two reasons for this. First, there is no requirement in the *Quality Agency Principles* for the Agency to publish these reports. Secondly, the *Protected Information* provisions of the *Aged Care Act (section 86)* operate to thwart a Freedom of Information request for a copy of an *assessment contact* report.

In 2013, Elder Care Watch lodged a Freedom of Information request for a copy of any *assessment contact* reports relating to the Lilley Lodge Nursing Home in Bendigo, Victoria during 2012 and 2013. The request was denied because the report contained *personal information* and *information relating to the affairs of an approved provider* as revealed below.

> ***"Personal information***
> ***14. The document contains***
> - ***The name and position of a Lilley Lodge staff member***
> - ***The name and other details relating to a Lilley Lodge resident***
> - ***The names and positions of Accreditation Agency staff***
>
> ***15. I am satisfied that this information comprises personal information, and is therefore 'protected information' under sub-section 86-2(1) of the Aged Care Act***
>
> ***Information relating to the affairs of an approved provider***
> ***16. The phrase "relating to the affairs of" are words of wide import, and can include anything relating to an approved provider's business.***
>
> ***17. The assessment contact report relates to the performance of the Lilley Lodge Nursing Home against the Accreditation Standards …… I am satisfied that the document as a whole comprises information relating to the affairs of an approved provider, and is therefore 'protected information' under sub-section 86-2(1) of the Aged Care Act"***
>
> Department of Social Services, Freedom of Information Request No. 13/14-057 - Internal Review, 11 March 2014.

The *personal information* could easily have been redacted and it is notable that the names of Agency assessors who conduct the announced site audits appear in the published reports on the Quality Agency website. The legal barrier of *'information relating to the affairs of the approved provider'* remains.

Provide public access to audit reports arising from unannounced visits (assessment contacts) and increase resources directed to unannounced audits

There would be less community scepticism about the public monitoring of the quality of residential aged care if the public could access the reports on unannounced visits. Further, nursing home managements would have a greater incentive to monitor the quality of care at all times.

Public trust in the regulation of aged care would also be enhanced if a greater percentage of Quality Agency resources were directed to unannounced audits and the results were transparent.

A trial conducted in a group of South Australian nursing homes in recent years (the SA Innovation Hub Trial) is relevant here. The trial was established by the then Minister responsible for aged care, Kevin Andrews (Minister for Social Services) in 2014, and was primarily concerned with reducing red tape for providers (K. Andrews*, 'Launch of the South Australian Innovation Hub Trial',* BioSA Conference Centre, Adelaide, 10 October 2014). To date, more than 40 South Australian homes have had the frequency of announced re-accreditation site audits reduced from once every 3 years to once every 5 years. It is understood there has been no increase in the number or frequency of unannounced audits.

In the interests of balance between provider needs and resident needs, the unannounced audits, which examine only a limited number of accreditation standards and involve no dedicated preparation time for providers, should be increased.

Elder Care Watch advocates an amendment to the *Quality Agency Principles* to require the Quality Agency to publish on its website audit reports on *assessment contacts* conducted under *section 2.30 (c)* of the *Principles.*

There should be a re-allocation of resources from announced site audits to unannounced site audits *(assessment contacts).* The latter require fewer resources both from a Quality Agency perspective and a provider perspective. The shift to a greater emphasis on unannounced audits would also be to the benefit of residents in terms of more accurate monitoring of the care they actually receive.

The annual report of the *Quality Agency* should include dedicated reporting on those assessment contacts which assess a provider's performance against the Accreditation Standards.

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

CLARITY IN PROCESS OPTIONS FOR COMPLAINANTS

The history of the complaints mechanisms is that reforms introduced in 2007 shifted the focus to investigations of complaints and away from mediation. Further reforms were introduced in 2011 which included a shift back to a reliance on mediation. This is the current position. Significantly, it was providers and their organisations who sought the shift away from investigation *(Walton Review: Department of Health and Ageing, Review of the Aged Care Complaints Investigation Scheme, Canberra, 2009)*. The shift was not sought by organisations speaking for those receiving aged care services. At its worst, mediation can become a 'talk fest' which works to the advantage of the more powerful party. Typically it is the provider who has greater resources than the complainant when dealing with a complaint.

Heavy use is made of the *'quick resolution'* option by those operating the complaints mechanism. Yet this option is not given prominence in the structure of the relevant law *(Complaints Principles 2014,s. 7(b))* and is not easy for the non-lawyer to find and understand. When complaints are resolved in this way there is *ipso facto* no right of appeal and there is no written record of the substance of the complaint. This could work to the disadvantage of the complainant who may have preferred something on the written record. It certainly minimises the official data on complaints.

It has been apparent to Elder Care Watch in discussing the handling of individual complaints with relatives, that often they are not aware they can reject this option and they can ask for mediation or an investigation. The discretion on whether to meet the complainant's request then rests with the delegated Complaints Resolution Officer (CRO).

Entitle a complainant to a full explanation of options for handling a complaint

The reasonableness of the *'quick resolution'* option will depend greatly on the discretionary explanation of the processes available provided to the complainant by the Officer. This is not ideal and it would be fairer to complainants if the *Complaints Principles* included an express obligation on the Officer to carefully explain all the options and to explain where the complainant has a choice concerning how the complaint is handled.

> Elder Care Watch advocates an express requirement in the *Complaints Principles* that the Officer handling the complaint explain fully the alternative processes available for dealing with the complaint and the consequences of accepting the *'quick resolution'* option.

STRENGTHEN THE PENALTIES

The *Complaints Principles (section 15)* contain weak penalties with too many chances for providers who transgress. An example of the limitations of the penalties was evident in the case of a complaint concerning physical restraint *(Department of Social Services Case 149477, Decision 15 April 2014)*. This is provided in *case 53 of Operation Home Truths.*

> ***"The decision stated: 'The staff failed to ...obtain the necessary restraint orders and complete the documentation including noting the time*** [the resident] ***spent restrained in the wheelchair. Given the sensitivities around the issue of restraint previously raised*** [by the resident's spouse] ***it is of concern that the staff did not follow their own procedures'.***
>
> ***The Scheme referred the case to the Quality Agency because of the nature of the issue and the possibility that other residents may also be affected.***
>
> ***The Scheme did not penalise the nursing home. The Scheme's decision just said senior staff would remind staff of their obligations and the home had addressed the issue to the satisfaction of the Complaints Resolution Officer"***
>
> *Operation Home Truths, case 53*

It seems generous to give providers a chance to explain how they will deal with the substance of a complaint that has been upheld before there is any direction to comply with their legal responsibilities. There is another barrier to the imposition of penalties to be found in the requirement to first issue a *notice of non-compliance* and give the provider an opportunity to make a submission on the issues raised in the complaint. This seems like a *de facto* right of appeal.

Impose a penalty immediately when a provider is found to have breached its legal responsibilities under the *Aged Care Act*

Once a provider has been found to be in breach of their legal obligations there should be some form of penalty imposed for example, a system of demerit points could be applied. Sanctions could then be imposed once a specified number of demerit points is accumulated over a defined time period. Any appeal right would need to be separate.

> Elder Care Watch advocates the automatic imposition of a penalty once a provider is found by the Aged Care Complaints Commissioner to have breached their responsibilities under the *Aged Care Act.* Any right of appeal should be a separate matter.
>
> One form of penalty could be a demerit points system with a specified number of demerit points in a defined time period attracting a sanction such as a reduction in the period of accreditation or a fine.
>
> The names of homes and the providers who have incurred penalties should appear as part of the reporting on the operation of the complaints mechanisms in the annual report of the Aged Care Complaints Commissioner

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.

EXTERNAL ENGLISH LANGUAGE SKILLS TEST FOR PERSONAL CARERS

Effective communication in English, specifically the components of listening, reading, writing and speaking, is regarded by the Australian Nursing and Midwifery Board as essential for safe patient care.

> ***"The English language registration standard is part of best practice regulation to protect the public. …… The standard aims to make sure that nurses and midwives can communicate effectively in English to provide safe patient care in Australia"***
>
> Australian Nursing and Midwifery Board, 2011

Nurses must provide evidence that they have completed 5 years' full-time secondary, vocational or tertiary education in one of the following countries: Australia; Canada; Ireland; New Zealand; South Africa; United Kingdom; or the United States. If they cannot do so, then they must demonstrate English language proficiency according to one of two tests (1) International English Language Testing System (IELTS) with a minimum score of 7 in each component, or (2) Occupational English Test (OET) with an overall pass and with grades A and B only in each component. *(Australian Nursing and Midwifery Board, Fact Sheet - Registration standard in English language skills, Revised 29 November, 2011).*

Most of the patient care in residential aged care is provided by personal carers who are not subject to registration or licensing and so not subject to public regulation of practice standards as are nurses. The core qualification for personal carers is *Certificate III in Individual Support - Aged Care.* The training package does include a communication module but no external language test.

In 2013, the Australian Skills Quality Authority published a report *Training for aged and community care in Australia* which found high levels of non-compliance with core training standards by registered training organisations (RTOs) and the worst non-compliance was with the assessment standard.

In its 2011 report *Caring for Older Australians*, the Productivity Commission discussed the importance of English language skills for nurses and carers from overseas but made no recommendation *(pp. 380-381)*. Importantly, the Commission expressed its approval of the increasing scope of practice of personal carers. This involves the adoption of some work practices previously restricted to nurses *(pp. 375-378).*

In the 60 personal accounts of inadequate health care cited in *Operation Home Truths (see response to Question 11 above)* 26, or 46 per cent, identified problems with the English language skills of staff, mostly with personal carers. The problems included limited English comprehension skills leading relatives to doubt they had been understood by the staff member and strong accents which the relative, and more so, the resident, found difficult to understand. One example is from case 56.

> ***"My husband found it difficult to understand staff with strong accents. He was accused of not liking Asians, Indians or Africans but I also found their accents difficult. Some did not have a good command of the English language: one of them did not know what the word 'deaf' meant"***
>
> *Operation Home Truths, case 56*

An external language test for personal carers where English is not the first language

The importance for resident safety of competency in English language skills, the shortcomings in the training standards of many RTOs, and the expanding scope of practice of personal carers, warrants an external language test to be passed by personal carers before they are awarded the *Certificate III in Individual Support-Aged Care.*

Elder Care Watch advocates that personal carers who have not received five years' secondary or vocational education in countries where English is the first language, should undertake a mandatory English test, either the International English Language Testing System or the Occupational English Test, and meet a standard set by the Australian Nursing and Midwifery Board, before they are awarded the relevant Certificate III qualification.