

Supplementary Questions General Purpose Standing Committee No 2 Inquiry into Elder Abuse in New South Wales

- (A) What kind of behaviour management strategies would an aged care facility put in place to manage violent behaviours of a resident?
1. Review by a psychogeriatrician / geriatrician
 2. Review by a behaviour management team such as DB Mass
 3. Policies and Procedures crafted on
 - “Aged Care - Working with People with Challenging Behaviours in Residential Aged Care Facilities” – NSW Health Document, 2014
 - Joanna Briggs “Management of physical aggression in the dementia resident in an 18 bed secure dementia unit: A best practice implementation project”
 - “Pain management in RACF” by the RACP
 - “Managing challenging behaviours” Alzheimer’s Australia
 4. Education provided by – Alzheimer’s, HammondCare, other behaviour management experts
- (B) Is the industry concerned that the inclusion of physical restraint in the voluntary quality indicator program may lead to an increase in chemical restraint?

No, absolutely not. Restraint is taken very seriously by every Residential Aged Care Services (RACS) and the use of restraint is always viewed as a last resort after exhausting all other avenues of behaviour management.

In both instances of restraint, authority is required not only from the care recipient’s general practitioner but from the care recipient’s person responsible.

RACs have detailed and robust behaviour management policies and processes that support staff in managing behaviours without the need for any type of restraint. A summary of the type of alternative strategies used are:

- Environmental – improved lighting, lowered bed height, safe areas for wandering, reduced noise etc
- Activities and programs – rehabilitation or exercise, regulation ambulation, individual and group activities
- Alterations to nursing care – personalised care, regular evaluation and monitoring, individualised routines
- Physical strategies – comprehensive physical check ups, pain management, comprehensive medical management review
- Psychosocial programs and therapies – companionship, visitors, familiar staff, relaxation programs

This list is not exhaustive and RACs employ many more interventions and strategies than those listed above.

Additionally, where restraint is used, it is used as a short term measure and is the least restrictive form available. Restraint, where necessary, is used until the prevention of the behaviours is successful by identifying the triggers causing the behaviour.

- (C) Would the industry support better collection of data on the use of chemical restraint? Would the industry support the inclusion of chemical restraint in the voluntary set of quality indicators?

RACS already collect data on chemical restraints under standard 2.7 of the accreditation standards. The Australian Aged Care Quality Agency (AACQA) conducts announced and unannounced visits of government subsidies RACS. The Agency triangulates information gathered through a process of documentation review, direct observation, resident/representative and staff interview.

How would 'better' collection be achieved? What constitutes 'better' collection? 'better' is a subjective term and would need qualification and definition.

As with physical restraint, if chemical restraint was included as a quality indicator it would not necessarily be indicative of the quality of care being provided. As stated above at (B), restraint is taken very seriously by every RACS and the use of restraint is always viewed as a last resort after exhausting all other avenues of behaviour management

The collection methodology for the physical restraint indicator is collection of data over a quarter using 9 observations – 3 observations per day for 3 days – for all residents. Restraint is defined as an **intentional** restriction of movement or decision. Again, if the observation is occurring during a time where other interventions have failed but is in use until the prevention of the behaviours is successful by identifying the triggers causing the behaviour then this is not the best indicator of quality. It is recognised that, in the next quarter, when other strategies have been implemented and there is no longer the need for restraint, the indicator data number will be less. However, by that time, the potential clients who are reviewing the data will have placed their loved one into care elsewhere.

It is important to remember that with behaviour interventions, it is a matter of trial and error and, as new behaviours occur over the course of the residents length of stay, the data will peak and trough. It will also peak and trough as residents enter and exit services.

- (D) Would the industry support aggregation of resident-on-resident assaults and staffing data to explore whether there is a relationship between staffing and resident on resident abuse?

The Industry is already required to keep consolidated records of resident-on-resident assault. The requirements under the Aged Care Act 1997 and Accountability Principles 2014 mandate that an Approved Provider record resident-on-resident assaults and, if the perpetrator of the assault has not been assessed as cognitively impaired then it is a

reportable assault under the Act 1997. Moreover, the requirement under the Accountability Principles 2014 is that “the approved provider puts in place arrangements for management of the care recipient’s behaviour” within 24 hours.

The accreditation standards, and in particular outcome “2.13 Behaviour Management” requires an approved provider to ‘demonstrate’ its behaviour management strategies and ‘confirm’ that the care recipients and/or their representatives are satisfied with the homes approach to managing challenging behaviours. Accreditation outcome ‘1.6 Human Resource Management” requires an approved provider to have sufficient numbers of appropriately skilled and qualified staff and that “the development and maintenance of appropriate staff skills and knowledge are addressed”. It can be seen that under the Aged Care Act 1997, Accountability Principles 2014 and the Australian Aged Care Quality Agency Standards, this data is already being collected and analysed to inform best practice behaviour management strategies. Adding another layer of reporting would not add any value.

(E) Do aged care providers train their staff in supported decision making to ensure that the legal capacity of those they care for are recognised?

The Attorney General’s Department has released the publication:”Capacity toolkit” which has been developed to provide information for government and community workers, professionals, families and carers in New South Wales.

In general, a person’s capacity to make day-to-day decisions is not subject to the type of assessment discussed in the Toolkit. Decisions about when to get up, what to wear or what to eat, for instance, are usually supported or made when required by family, friends or other carers, with the person closely involved. However, carers or staff may need to seek an assessment of, a person’s capacity when the decision in question is about something significant or has legal consequences.

RACS have policies and procedures in place to guide staff regarding supporting a person to make day to day decisions and procedures regarding how to obtain an assessment by qualified individuals such as solicitors, medical practitioners, social workers or members of the Aged Care Assessment Team. This is not an exhaustive list, merely indicative of those types of professions who may be required to make a decision regarding a person’s capacity.

(F) The NSW Interagency Policy ‘Preventing and responding to abuse of older people’ does not apply to residential aged care facilities however, it appears to apply in home care settings. Do aged care providers train their home care staff on the Interagency Policy?

Each home care provider is required to have policies and procedures that govern the conduct of staff and uphold the rights of care recipients including care recipients safety and well being.

Home Care providers would have their own internal policy developed on best practice guidelines for identifying and reporting abuse of older people in the community. This policy would form part of the training on orientation and induction. It would also form a part of the ongoing training and development of staff.

Home Care Providers are aware of the resource “ Model policy – Preventing and responding to abuse of older people” which is closely aligned to the *Preventing and responding to abuse of older people NSW interagency policy 2014*.

Home Care Providers can tailor this model policy to their local circumstances and train staff to its use.

(G) How do aged care facilities assist residents who wish to report a crime to the police (specifically a crime that falls outside of the mandatory reporting requirements)?

RACS have many robust systems and processes to assist residents in a variety of ways to exercise their civil rights. Staff can assist a resident in a number of ways dependent upon the preferences of the resident. As examples, staff can provide

- the phone number of the police
- the phone number of clergy
- call the police on the residents behalf
- call a representative of the resident

RACS work hard at creating environments of trust and transparency. Staff at all levels encourage residents to seek assist when it is needed, in whatever form it is needed and then work with the resident to provide the assist in the way the resident wants the assistance to be delivered. Staff support the resident through the process to ensure that the resident feels espoused.

(H) Would you support whistleblower protections for aged care staff reporting all forms of abuse and neglect of aged care residents, not just those covered by mandatory reporting provisions?

There would need to be very strict and clear guidelines on the forms of abuse and neglect as these terms are quite broad and subjective.

The current legislated requirements for approved providers surrounding whistleblower protections under the Aged Care Act 1997 are very specific and include amongst other requirements that the:

- person making the disclosure has reasonable grounds to suspect that the information indicates that a reportable assault has occurred
- person making the disclosure does so in good faith.

However, even with these provisions, there have been many cases of vindictive and nuisance reports made. In each instance these vindictive and nuisance reports have

been made by discharged staff with a complaint against the approved provider. In most of the cases leading up to the discharge of the staff, the discharge has been instigated due to the approved provider becoming aware that the discharged staff member provided less than the standard of care and service expected and set by the approved provider. These vindictive and nuisance claims against the approved provider, are rarely substantiated, and are time consuming and costly for key personnel who are required to deal with the matter.