



Aged & Community
Services NSW & ACT

Illana Halliday and Paul Sadler - Aged and Community Services NSW
and ACT - Received 5 April 2016

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The Director
General Purpose Standing Committee No. 2
Parliament House
Macquarie St
Sydney NSW 2000
Fax: (02) 9230 2981

Dear Sir / Madam

**RE: General Purpose Standing Committee No. 2
Inquiry into Elder Abuse In NSW - Post-hearing responses**

Following my appearance before the General Purpose Standing Committee No. 2 on 7 March 2016 for the inquiry into elder abuse in New South Wales, please find attached:

- Response to Questions on Notice taken during the hearing issued to - Ms Illana Halliday, Mr Paul Sadler - Aged and Community Services NSW/ACT; and
- Response to Supplementary questions on notice issued to - Ms Illana Halliday, Mr Paul Sadler - Aged and Community Services NSW/ACT.

Thank you for the opportunity to review the transcript – we offer no corrections to the transcript provided.

Yours sincerely

Illana Halliday
Chief Executive Officer
31 March 2016

**General Purpose Standing Committee No. 2
Inquiry into Elder Abuse In NSW**

**Response to questions on Notice taken during the hearing issued to:
Ms Illana Halliday, Mr Paul Sadler - Aged and Community Services NSW/ACT**

1. Australian Aged Care Quality Agency - Unannounced visits:

The Australian Aged Care Quality Agency's website says "assessment contact visits may be announced or unannounced. Each home receives at least one unannounced assessment contact every year". http://www.aacqa.gov.au/for-providers/residential-aged-care/copy_of_processes/assessment-contacts/assessment-contacts

ASSESSMENT CONTACTS (from: AACQA Annual Report 2014 -15, Pg 32-33)

An assessment contact is a visit where we assess performance against the Accreditation Standards.

In 2014-15 we conducted 3,704 assessment contacts.

There are two types of assessment contacts:

Announced. This is usually a follow-up visit where we are monitoring a home's progress against a timetable for improvement, or where we have given notice that we want to assess the sustainability of improvements made;

Unannounced. This can be where we have information which would indicate concerns about a provider's performance, or where we wish to conduct an 'in-between monitoring visit' to ensure the aged care service provider is maintaining services in accordance with standards, or where we want to assess the sustainability of improvements made.

It is an Australian Government policy requirement that every aged care home receive at least one unannounced visit each year. Unannounced means unannounced and no notice is given.

Assessment contacts, whether announced or unannounced, are usually conducted over a full day by a team of assessors. The time on-site and number of assessors assigned is determined on a case-by-case basis taking into account the size and configuration of the home and information we have about the circumstances of the home.

Assessment contacts are usually focused on certain aspects of care and services and may involve:

- a targeted review of specific expected outcomes.
- a thematic review eg care assessment, planning and action; or staffing management systems; or complaints, comments and suggestions.
- or a combination of the above.

Assessment contacts may also involve an overview of the home's performance against all the Accreditation Standards.

Following an assessment contact, a report is given to the home setting out the findings of the assessment team. The home has the opportunity to provide a response before a decision is made. A decision as to the home's performance is made separately by a decision-maker appointed by the CEO. The decision may also include information about areas in which the

home needs to improve and whether the home's assessment contact arrangements need to be varied or whether a review audit is necessary.

Tracey Clerk, NSW Manager, AACQA was contacted and confirmed that whilst the AACQA conducts most of its assessment contacts during the day, after hours assessment contacts can and have been conducted when it was deemed appropriate.

2. Copy of *Preventing and Responding to Abuse of Older People Policy* from Presbyterian Aged Care NSW & ACT

Attached.

Presbyterian Aged Care
POLICY



Policy Name: Preventing and Responding to Abuse of Older People Policy	
Policy Level: Governance	
Policy Group: Organisation, Structure and Management	
Policy Reference No: GP2007/16	Revision Reference No: 1.5
Commencement Date: March 2016	Review Date: March 2018

PART ONE: POLICY STATEMENT:

1.1 Policy Declaration:

Presbyterian Aged Care is committed to the provision of safe, caring and inclusive environments and communities for our residents and clients. As part of that, we are committed to prevent abuse of older people wherever possible, and to respond promptly where it does occur.

1.2 Policy Objective:

- Promote an environment that supports the safety of the older people who live in our residential aged care facilities.
- Promote an environment that supports the safety of the older people who are our clients in community programs and who contract our services.
- Promote an environment that provides for residents/clients, their families and staff at all levels to feel free to raise any concerns they may have about the abuse or possible abuse of residents/clients and to have those concerns dealt with appropriately.
- Report all "reportable assaults" in residential aged care in accordance with Australian Department of Health guidelines.

1.3 Related Legislation:

Aged Care Act 1997
Crimes (Domestic and Personal Violence) Act 1997 (NSW)
Dept of Social Services, *Commonwealth Home Support Programme Manual*, July 2015
Dept of Social Services, *Home Care Packages Programme Operational Manual*, December 2015
Guardianship Act 1987 (NSW)
Guardianship & Management of Property Act 1991 (ACT)
Privacy Act 1988

Related policy and procedures:

PAC Complaints Policy
PAC Critical Incident Policy
PAC Police Records Checks Policy
PAC Prevention of Harassment and Bullying Policy
PAC Privacy Policy

1.4 Policy Provisions:

Definitions:

Abuse: Elder abuse can be defined 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.

World Health Organisation at http://www.who.int/ageing/projects/elder_abuse/en/

Reportable assault: According to the Aged Care Act (Section 63-1AA), a reportable assault means:

- Unlawful sexual contact with a resident of an aged care home; or
- Unreasonable use of force on a resident of an aged care home.

PART TWO: RESPONSIBILITIES:

PAC Committee: Overall responsibility to ensure policies and procedures relating to the prevention of resident/client abuse are in place.

Chief Executive Officer/Executive Management Team: Responsible for ensuring that policies and procedures, systems and processes to assist identification and appropriate action are developed, in place and observed by staff.

Facility/Program Managers: Responsible for ensuring that staff are aware of policies and procedures, systems and processes and that staff observe them.

Facility/Program Staff Members: Responsibility to comply with organisation's policies, procedures, systems and processes. If unclear, staff should seek immediate clarification from their immediate supervisor.

PART THREE: PROCEDURES:

3.1 Duty of Care Guidelines:

PAC maintains a strong commitment to our duty of care to our residents, clients and staff. Staff members who work for PAC are required to support and promote our duty of care principles and act accordingly in our workplace and our communities. It is considered a breach of duty of care if:

- A staff member is aware of an alleged abusive situation and does not act in accordance with the organisation's policy and reporting requirements, or
- A staff member provides advice to an older person that is outside their scope of competence or beyond what is required and expected in their position.

3.2 Staff Training:

PAC is committed to ensuring that all staff have access to comprehensive training relating to resident/client abuse. Facility/Program Managers are responsible for ensuring that training sessions are provided to all staff in accordance with the information and guidelines in this policy. Additionally, training will be provided in:

- Developing skills and approaches for dealing with abuse cases;
- PAC Policy and Procedures relating to allegations of resident or client abuse;
- Legislative requirements re compulsory reporting of allegations or suspicions of abuse;
- Confidentially discussing abuse cases, and debriefing sessions as and when required;
- Evaluation of the case, including information relating to progress of any identified abuse cases; and

- Input into the organisation's continuous improvement processes for dealing with abuse cases.

3.3 Reporting Responsibilities:

3.3.1. Processes for identifying and reporting incidents:

- A procedure will be displayed at all residential aged care facilities and community care offices that outlines the process for reporting all or any incidents.
- Some elder abuse situations may be reportable to the police and the Department of Health – see Section 3.3.4 and the PAC Critical Incident Policy.

3.3.2 Privacy and Confidentiality:

- Any staff, resident/clients and concerned others who make a report to the organisation will have their identity and privacy protected by the organisation.
- Information, documentation etc completed as part of the reporting process will be managed and maintained confidentially by each Facility/Program Manager.
- All staff, resident/clients and concerned others who make a report to the organisation will not be unfairly treated as a result of making such a report.

3.3.3 What incidents should be reported?

Care staff should report a situation of abuse, or alleged abuse to their supervisor in any of the following circumstances:-

- If the older person states that they are being harmed by another person
- Another person states they are harming an older person
- Another older person, or significant other states they have observed abusive acts
- Someone is not responding to the financial/medical needs of the older person
- They observe an action or inaction that may be considered abusive
- When there is clear evidence that an abusive situation is occurring.

3.3.4. Organisational Responsibilities relating to alleged and suspected assaults in Residential Aged Care:

Compulsory reporting obligations require providers of residential aged care to report suspected sexual and serious physical assault of residents, known as "reportable assaults". The report must be made within 24 hours of being reported to PAC key personnel to both the police and to the Department of Health.

If a responsible manager receives an allegation of, or starts to suspect on reasonable grounds, a reportable assault, this information must be reported, within 24 hours to:

- PAC Executive Management Team immediately – using the processes outlined in the PAC Critical Incident Policy and Critical Incident reporting requirements;
- The local police station commander or delegate officer at the local police station; and
- The PAC EMT or, under delegation, the Facility Manager will report the information to the Department of Health.

Under the legislation, there is a discretion not to report instances of:

- Alleged assaults that are perpetrated by residents with an assessed cognitive or mental impairment; and
- Subsequent reports of the same or similar incident to that already reported.

A decision to report or not is made by the PAC EMT, in consultation with the Facility Manager. Where it is decided that a report is not required because the assault was perpetrated by a resident with an

assessed cognitive or mental impairment, PAC will review the behaviour management plan for the perpetrator within 24 hours of notification of the incident to key personnel.

To make a report in relation to a suspicion or allegation of assault or an unexplained absence, approved providers can complete a notification form and email it to the Department of Health (NSW/ACT: agedcarecompulsoryreports.NSW.ACT@health.gov.au), or call the compulsory reporting line on **1800 081 549**, Monday to Friday between 9.00am and 5.00pm local time. Voicemail is available for reporting purposes outside these operating hours, on weekends and on public holidays. Reports made via the voicemail service meets provider's reporting obligations and are responded to the next business day.

3.3.5 Record Keeping:

The appropriate and accurate recording of facts can have legal implications and is a requirement of our organisation. Recording is essential in the development of a well thought out, positive action plan to address abusive practices. Recording demonstrates that we have met accountability requirements under Quality Standards and records actions that have been carried out.

The purpose of recording information related to the abuse of an older person by family or friends is to create a picture of what is occurring, to keep care staff on track and to:-

- Identify all the issues and factors involved
- Identify informal supports that exist in the older person's life
- Form the basis of communication between all those involved
- Assist in formulation of a plan of action
- Support any legal intervention that may be required e.g. application to the Guardianship Tribunal
- Protect care staff who are intervening an abusive situation
- Develop a positive outcome for the older person.

3.3.6 Documentation Guidelines:

Documentation of strategies is an important aspect of any care plan. In cases involving abuse, or alleged abuse, it can also have legal ramifications. The Facility/Program Manager and/or Supervisors will need to ensure:-

- Older people are aware that the information recorded in their file is confidential and only available to those who have an appropriate role to assist the older person in this matter.
- Accurate recording of any consent given by the older person for any decisions, actions or discussions being held in relation to the abusive situation.

3.3.6 (i) Statutory Reporting Requirement:

In accordance with Section 8 of the Records Principles 2014, consolidated records must be kept that include the following details:

- Record or file number – indicating where the original record is held.
- Date of receipt of allegation – date that PAC received an allegation or started to suspect a reasonable assault.
- Description – Brief description of the allegation or of the circumstances that gave rise to the suspicion.
- Information on reports made – date reported, to whom it was reported, (e.g. Police and DSS) and any record/report number give by the Police or DSS.

- Information on why reports were not made – Should include a brief description on the reasons as to why a report was not made.
- Action Date and Brief Description – record of the date on which the incident or suspicion was resolved as well as brief description of the outcome and/or actions involved.

3.3.6 (ii) General Documentation Guidelines:

The documentation in the file needs to:-

- Be legible, dated and signed
- Contain well organised factual descriptions of what has been said and by whom or observed e.g. What is happening, when, the severity of the behaviour or act and how often this situation occurs, who is involved, relationship with the alleged abuser
- Include clear and concise history/background of the alleged abusive behaviour and whether the behaviour is intentional or unintentional (Information gained can assist in determining the intent of actions)
- Describe behaviours and avoid judgements e.g. the "older person was pacing back and forth and raised his or her voice rather than "the older person was angry"
- Use verbatim statements (word for word) that the older person or family/friends uses to describe the situation e.g. " I am so cross, she took all my jewelery"
- Provide details of any meetings held, with whom and the issues discussed
- Provide factual details of logical explanations, supporting details or documentation e.g. medical reports, financial statements
- Ensure that the recorded directives or actions to resolve the abuse are consistent with the identified issues.

Information must be recorded in a professional and accurate manner. Do not include statements that are irrelevant, judgmental, hearsay, malpractice, defamation, or negligent.

Storing of information needs to uphold the older person's rights to confidentiality and access to information needs to be on a need to know basis, e.g. care staff will only be required to access information which provides them with direction or actions related to the care of the older person.

3.3.7. Organisational Responsibilities relating to alleged and suspected assaults in Home Care or Independent Living Units:

Although there are no legislated compulsory reporting obligations for providers of Home Care/Home Support or Seniors Housing, PAC takes any report of suspected abuse seriously. Any allegations or reasonable suspicions of abuse must be raised with an EMT member within 24 hours of being reported to PAC key personnel to determine the need to report the information to either a family carer, the Police, or both. A report may also required to a funding body. A decision to report or not is made by the PAC EMT, in consultation with the local Service Manager. Where it is decided that a report is not required, PAC will review the situation and ensure the client has details regarding their options for seeking further assistance and support consistent with the NSW Interagency Policy on Preventing and Responding to Abuse of Older People.

3.4 Managing Staff involved in abuse, or alleged abuse:

Any staff member who has been identified as alleged to have committed an abusive act will:

- Not have any contact with residents or clients until a thorough investigation has occurred.
- Have the right to have the allegation put to the staff member and be informed of the details of any allegations
- Have the right of reply to the allegation
- Have the right to representation if they choose

- May be suspended from duty during the investigation.

3.5 Managing staff reporting abuse, or alleged abuse:

PAC will provide a positive environment that supports and promotes quality care outcomes. Should any staff member report an incident relating to alleged resident/client abuse the organisation will:

- Protect staff who report allegations
- Maintain the privacy and confidentiality of staff who report allegations
- Ensure that reported allegations are investigated and, if and where possible, provide feedback to the reporting staff member.

A staff member who makes a disclosure in good faith of a “reportable assault” in residential aged care is given protection under the Aged Care Act from action being taken against them under criminal or civil law, including defamation actions. They are also provided with protection against detrimental action from their employer on the grounds of their disclosure.

3.6 When to report an abusive situation, or alleged abusive situation involving an older person:

3.6.1 Care Staff Checklist

The following checklist is to assist care staff if they suspect or identify that an older person is being abused by family or friends.

- Discuss suspected cases of abuse immediately with their supervisor
- Offer the older person the opportunity to speak to the supervisor directly
- Report incident as soon as possible via the Accident and Incident Report form.
- Record any direct observation, information or discussions with (or concerning) the older person that might indicate that abuse is occurring. See **record keeping** for further details.
- Follow the organisation protocols when responding to an older person experiencing abuse
- Assure those involved that the older person's rights will be upheld
- Follow the actions recorded in the care plan
- Report back to supervisor of any changes or concerns about the directives or action steps recorded in the care plan which care staff are required to follow.

3.6.2 Supervisor’s Checklist

The following checklist is to assist supervisors when they are aware/suspect that family members or friends are abusing an older person. Their role is to ensure that all principles are followed.

In particular:

- Place the interests of the older person first
- Check the PAC policies and guidelines for assistance and make a report to the Facility / Program Manager / PAC EMT via the Critical Incident report form.
- Assess the situation for initial response and appropriate intervention
- Ask yourself: is it urgent or non-urgent?
- Investigate and gather all relevant facts.
- Consider all possible intervention strategies to stop abuse - from supportive to restrictive

- Consider positive and negative outcomes of all intervention strategies
- Respect confidentiality and understand its limitations. Inform the older person of your concerns
- Inform the older person of their right to an independent advocate of choice (for example Seniors Rights Service)
- Inform the older person of your duty of care and obligations towards older people in the facility
- Establish the wishes and mental capacity of the older person to make decisions and/or to self advocate
- Encourage and assist the older person to make their own decisions if they have mental capacity.
- Focus intervention strategies on what the older person wants
- Record actions to be undertaken by care staff in the older person's care plan.
- Complete any documentation required under the organisation's policy
- Provide support to the care staff involved in implementing any action plans.

3.7 Initial response to an abusive situation

All staff, once they are aware of an abusive situation, will need to take steps to respond (link to initial response) to it. When staff suspect or know that an older person is at risk of/ or are being abused by family or friends they should base their response on knowledge of the situation and principles of intervention.

IF YOU ARE PRESENT during an abusive incident you will need to determine if the situation is:

Urgent or an Emergency:

Is the situation one that poses an immediate threat to the safety or wellbeing of an older person or other people?

- Your first priority is to remain calm
- Consider whether can you safely take immediate action to stop the abuse occurring
- This may be a time when you have to escalate your response
- If safe to do so ask for the abuse to stop
- If need be, remove yourself from danger and seek assistance of others (e.g. staff or police).

Non urgent:

If you become aware of, observe, or are told by others about an abusive situation you need to discuss the situation with your supervisor with the aim of planning the next steps.

If an older person discusses abuse with you, whether the abuse has happened previously or is happening presently, incorporate all of the identified intervention principles into your response. Regardless of the older person's ability to make decisions you will need to:

Listen to the older person

- Create an environment that has privacy and is respectful

- Enable them to tell their story
- Remain calm
- Do not jump to conclusions
- Pass no judgement
- Affirm you have heard them
- Acknowledge their wishes.

Reaffirm they have rights

- Confirm with the older person that abuse of any kind is not OK and they have a right to safety, dignity and to have their concerns addressed
- If the older person is mentally competent, explain if appropriate, if confidentiality needs to be broken, or that their concerns are confidential within the organisation and will not be discussed with others outside without their permission
- If the older person is mentally competent assure the older person that no action will happen without their explicit permission
- If the older person is **not** mentally competent assure them you have a responsibility i.e. duty of care to assist them to resolve their concerns and aim for positive outcomes. Refer to intervention principles.

Help is available

- Let the person know you will need to inform your supervisor
- Let the person know the supervisor will need to gather facts about the suspected abuse
- Assure the older person the supervisor will seek information about who could help them
- Let them know care staff and the supervisor are there to support and assist them
- With your supervisor, identify a full range of strategies to stop the abuse
- Assure the older person they will be able to choose the strategy which best suits them.

Related Documents, Forms and Attachments:

Department of Health (2016): Compulsory Reporting Guidelines for Approved Providers of Residential Aged Care (for residential aged care services) at <https://www.dss.gov.au/ageing-and-aged-care/ensuring-quality/aged-care-quality-and-compliance/guide-for-reporting-reportable-assaults>

NSW Government: Family & Community Services (2015): Preventing and Responding to Abuse of Older People: NSW Interagency Policy (for community care services or ILUs) at <http://elderabusehelpline.com.au/for-professionals/nsw-state-government-policy-tools>

PAC Critical Incident Report Form

Policy Attachment Part 4: Preventing and Responding to Abuse of Older People: Guidelines and Information

Resources:

PAC Preventing and Responding to Resident Abuse: Power Point Education & Training Program

REVISION HISTORY:

Last edits	March 2016	Previous Edits	October 2013 ,June 2015
Responsible	Executive Management Team	Approved By:	PAC Committee
Date for Review	March 2018	File Ref:	1.5
Previous Titles	PAC Preventing & Responding to Resident Abuse in Aged Care programs V1.1 Issued May		

	<p>2007, Rescinded March 2009 PAC Preventing & Responding to Resident Abuse in Aged Care Programs v1.2 Issued March 2009, Rescinded October 2013 PAC Preventing & Responding to Abuse of Older People v1.3 Issued October 2013, Rescinded June 2015 PAC Preventing & Responding to Abuse of Older People v1.4 Issued June 2015, Rescinded March 2016</p>
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**PRESBYTERIAN AGED CARE
PREVENTING AND RESPONDING TO ABUSE OF OLDER PEOPLE
POLICY ATTACHMENT: PART FOUR
GUIDELINES AND INFORMATION**

The following information is provided as a resource and guide to assisting staff of Presbyterian Aged Care in the management of abuse or alleged abuse situations. This section describes the different forms of abuse and exploitation that can occur and the signs that may indicate that an older person has been abused.

4.1 PHYSICAL ABUSE

Physical abuse is a non-accidental act which results in physical pain or injury, and which may include physical coercion and physical restraint.

Signs of physical abuse include:

- Bruises
- Lacerations or abrasions
- Welts or rashes
- Broken or healing bones
- Burns
- Weight loss
- Facial swelling or missing teeth
- Pain or restricted movements
- Cringing or acting fearful
- Agitation
- Drowsiness
- Unexplained hair loss
- Noticeable decline in physical well being
- Unexplained accidents or injuries
- Conflicting stories between resident/client and staff or family members about the cause of injuries.

4.2 PSYCHOLOGICAL/EMOTIONAL ABUSE:

Psychological or emotional abuse is language or actions designed to intimidate another person and is usually characterised by a pattern of behaviour repeated over time, intended to maintain a 'hold of fear' over them. Forms of psychological abuse include:

- Intimidation, humiliation and harassment – e.g. threats, calling a resident/client names, treating a resident/client like a child, shouting at a resident/client
- Withholding of affection
- Refusing a resident/client access to family members or close friends
- Depriving a resident/client of sleep
- Inappropriate removal of a resident/client's decision-making powers.

Signs of psychological/emotional abuse include:

- Loss of interest in self or environment
- Passivity

- Helplessness
- Withdrawal
- Apathy
- Insomnia
- Fearfulness
- Reluctance to talk openly
- Huddling or nervousness round a particular person
- Paranoid behaviour or confusion not associated with illness.

4.3 SEXUAL ABUSE (ASSAULT):

Sexual assault is the general term used for a broad range of unwanted sexual behaviour, whether through physical force, emotional intimidation or any type of coercion. Sexual assault is a crime. Sexual abuse is a form of sexual assault. Abuse and assault are mainly about violence and power over another person, rather than sexual gratification or pleasure.

Sexual abuse includes rape, indecent assault, sexual harassment and sexual interference. Sexual activity with an adult, who is incapacitated by a mental or physical condition (such as dementia) that impairs his or her ability to grant informed consent, is defined as sexual assault/abuse.

Sexual abuse can be overt and obvious (rape, penetration, oral-genital contact) or more subtle (inappropriate comments or interest in the older person's body). It can also include practices such as the inappropriate, and possibly painful, administration of enemas or genital cleansing.

Signs of sexual abuse include:

- Unexplained sexually transmitted disease or infections
- Bruising in genital areas, inner thighs or around the breasts
- Unexplained vaginal or anal bleeding
- Increased anxiety and/or other emotional changes
- Fear of certain people or places
- Fingertip bruising on upper arms
- Torn, stained or bloody underclothing, continence pads or bed linen
- Difficulty in walking or sitting
- Use of sexually explicit language or references by a resident/client
- Changes in sleep patterns, sleep disturbance, recurring nightmares.

4.4 NEGLECT:

Neglect is the failure of a carer to provide the necessities of life to a person for whom they are caring. Neglect can be intentional or unintentional.

Unintentional neglect occurs when a carer does not have the skills or knowledge to care for a dependent person, although this is a situation that is unlikely to occur in the residential care setting. The carer may not be aware of the types of support that are available, or they may be ill themselves and unable to provide care.

Neglect is considered intentional when an older person is abandoned or not provided with adequate food, clothing, personal items, medical or dental care. Inappropriate use of medication (overuse, under-use or misuse), not providing adequate hygiene and personal care, and not allowing other people to provide adequate care are also forms of neglect.

Signs of neglect include:

- Poor hygiene or personal care
- Unkempt appearance
- Lack of personal items
- Absence of health aids
- Inappropriate or lack of clothing
- Weight loss
- Secretiveness or agitation.

4.5 SOCIAL ABUSE:

Social abuse involves preventing a person from having contact with friends or family or access to social activities. Forms of social abuse include discouraging or stopping a resident/client from seeing other people, including family or friends, and preventing them from joining in activities in or outside the residential/community aged care environment.

Signs of social abuse include:

- Sadness and grief because of people not visiting
- Anxiety after visits by particular person
- Withdrawal, lack of interaction with others
- Appearing ashamed
- Passivity (not wanting to participate)
- Low self esteem, sadness
- Listlessness.

4.6 FINANCIAL ABUSE:

Financial abuse involves the illegal or improper use or mismanagement of a person's money, property or resources. Stealing, fraud, forgery, embezzlement, forced changes to a will, inappropriate removal of a resident/client's decision making powers and misuse of power of attorney are all forms of financial abuse or exploitation.

Signs of financial abuse include:

- Unpaid accounts
- Unwillingness to provide or purchase items for a resident/client
- Withholding of funds from a resident/client
- Resident/client lacks money for items needed or to pay for outings
- Loss of jewellery or personal belongings
- Removal of cash from a wallet or handbag
- Money missing from resident/client's bank accounts, unprecedented transfer of funds
- Resident/client is fearful and anxious when discussing finances
- Resident/client frequently changes her/his mind about their power of attorney
- Management of a competent resident/client's finances by another person when not asked to do so.

4.7 WHEN TO REPORT AN ABUSIVE SITUATION:

It is important to always search for the cause of a change in a resident/client's behaviour or unexplained physical symptom. If a resident/client shows one or more of the possible signs of abuse, it does not automatically mean she or he is being abused, but it must be reported.

You must report to your supervisor (or next most senior manager) if:

- A resident/client shows a change in behaviour or mood or any of the signs described above.
- You observe someone behaving towards a resident/client in a way that makes you feel uncomfortable.
- A resident/client tells you that they are being abused by another person.
- A person tells you that they are abusing a resident/client.
- A resident/client, staff member or visitor tells you that they have observed abusive acts.
- You observe an action or inaction that may be considered abusive.

Note: Do not dismiss what a resident/client with dementia tells you as merely 'dementia talk'.

Failure to report an abusive situation may result in disciplinary action.

4.8 HOW TO RESPOND TO AN ABUSIVE SITUATION:

Procedures for Care Staff – Any form of abuse

If there is an immediate threat to a resident/client

- Remain calm.
- Consider whether you can safely take immediate action to stop the abuse occurring, without endangering the resident/client, yourself or other people.
- Alert other staff by using call bell or alarm systems.
- Report to, or get someone else to contact, your supervisor immediately.
- Reassure and comfort the resident/client.

After taking the necessary immediate action:

- Complete an incident form.
- Record your observations or discussions with (or concerning) the resident/client that might indicate that abuse has occurred.
- Do not attempt to ask extra questions or to investigate in any way. That is not your role.
- Do not disturb the area or remove any items involved in the incident.
- Report to your supervisor any additional changes or concerns that you think of or observe later.

If there is no immediate threat to the resident/client

- Reassure and comfort the older person.
- Report directly to your supervisor.
- Complete an incident form.

- Record your observations or discussions with (or concerning) the resident/client that might indicate that abuse has occurred.
- Do not attempt to ask extra questions or to investigate in any way. That is not your role.
- Do not disturb the area or remove any items involved in the incident.
- Report to your supervisor any additional changes or concerns that you think of or observe later.

Procedures for Supervisors - Physical or Sexual Abuse:

If you suspect that abuse has occurred, or abuse or suspected abuse is reported to you

- Place the interests of the resident/client first.
- Determine whether the situation is urgent (happening now). If yes, consider whether you can take immediate action to stop the abuse occurring, without endangering the resident/client, yourself or other people.
- Call for the police if necessary.
- Call for an ambulance if necessary.
- Report to your Facility or Program Manager or Senior Manager/Team Leader
- Seek medical treatment if necessary.
- Treat the area as a crime scene until advice is given otherwise.
 - Do not remove any articles or items from the area
 - Ensure the older person does not wash or shower
 - Do not allow others to enter into the area.
- Ensure that there is no risk of exposure to or contact with the alleged perpetrator (i.e. the person who is alleged to have carried out the abuse) by the resident/client.
- Reassure the resident/client.
- Provide support to the care staff involved.
- Counsel the resident/client and document the events.
- If the abuse is of a sexual nature, seek immediate advice from the nearest Sexual Assault Service.
- Establish if the resident/client has the capacity (is competent) to understand their circumstances and make decisions. If unsure, seek a medical assessment of this.

If the resident/client is competent to make their own decisions

- Raise your concerns with the resident/client and discuss their wishes. (Remember that an older person who is capable of making an informed decision has the right to make his or her own choices, including the right to refuse assistance.)
- Determine if confidentiality may need to be overridden due to safety issues for the person or others (e.g. where the rights of other resident/clients are endangered by the suspected abuse), or where a criminal act may have occurred.
- Inform the resident/client of her/his right to an independent advocate of their choice.
- Ensure that the resident/client is aware of her/his rights to make a complaint through the facility's internal complaints system or through the Aged Care Complaints Resolution Scheme. Ensure that they are aware of how to do so.
- Complete incident forms and document on the resident/client's file.
- If the abuse is of a sexual nature, report it to and seek guidance from the local Sexual Assault Service.
- Seek guidance from the resident/client about notifying family or friends as support.

If the resident/client is not competent or you are unsure of their competency

- Seek a medical assessment of the resident/client's competency if this is in doubt. Remember there is an assumption of mental capacity unless there is evidence of incapacity.

If the person is not competent:

- Notify the resident/client's family and any appointed substitute decision maker.
- If medical treatment is needed seek consent from their 'person responsible'.
- If the person has no family or substitute decision maker (or there are concerns about them as they are suspected of the abuse) contact the Civil & Administrative Tribunal for advice about substitute decision-making.
- If the abuse is of a sexual nature, seek guidance from the local Sexual Assault Service.
- Contact the Guardianship Tribunal for advice if consent is required to gather forensic evidence from a resident/client's body (e.g. tissue samples) or to release a sexual assault kit to police. (Family members cannot give consent in these circumstances).
- Determine if confidentiality must be overridden due to safety issues for the person or others (e.g. where the rights of other resident/clients are endangered by the suspected abuse) or where a criminal act may have occurred.
- Complete incident forms and document on the resident/client's file.

4.9 GUIDELINES FOR FACILITY AND PROGRAM MANAGERS:

Responding to the alleged abuser

The Senior Manager may need to respond to the alleged abuser, especially in cases where the alleged abuser is a member of PAC staff. Care must be taken to ensure procedural fairness when doing so.

- Do not jump to conclusions or make assumptions.
- Plan what you are going to say.
- Record all facts.
- Explain to the alleged abuser that you have a responsibility to resolve the concerns expressed.
- Assure the alleged abuser that you want to involve them in finding a resolution to the concerns.
- Ensure that your language and approach is non judgmental, calm and relaxed.
- Do not escalate the situation by using confronting behaviour, challenging actions or words.
- Have a witness present during all conversations with the alleged abuser.

If the alleged abuser is a member of staff:

- Assure the alleged abuser that their rights as an employee will not be compromised while the incident is under investigation.
- Depending on the severity of the incident, a process involving counselling, disciplinary action, or suspension will proceed.
- Report the incident to the next line of management.

Support for Staff who are Assisting Older People Experiencing Abuse by Family or Friends

To provide a quality service for older people, care staff need the opportunity to receive skills training, strategies, support and supervision to enhance their abilities to respond to abusive situations. Care staff who observe, hear, or respond to a situation of abuse involving an older person may find that it is stressful and feel that they need support to deal with a complex situation. One of the supports that care staff can use to gain guidance and direction is to debrief with their supervisor.

Debriefing needs to occur as soon as possible after identification of the alleged abuse that has been reported or witnessed. Care staff need regular opportunities to:

- Discuss the problem and issues relating to the case
- Discuss these issues in a climate of trust and confidentiality
- Share feelings such as anger, frustration, sadness fear etc and concerns relating to the case
- Evaluate the nature and quality of the organisation and / or care staff input into the case
- Determine the progress of the case to date and explore future directions
- Learn and share new ideas, skills, and techniques for dealing with abuse
- Decide how to continually develop and improve workers' response to abuse

Three things should be discussed during a debriefing session

Facts: What actually happened, what was seen and heard?
What was said and done by the care staff?
What documentation/reporting is required under organisational policy?

Feelings: How did the care staff feel about his/her actions, words, and inaction at the time?
What emotions are still affecting the care staff?
What does the care staff need to do and say to process these emotions and feelings?

Future: What do you think the older person wants?
What follow up is appropriate?
How will this situation be handled now?
Are any referrals necessary?

4.10 ADDITIONAL RESOURCES

Sexual Assault Services

There are Sexual Assault Services in all Local Health Districts in NSW, contactable 24 hours a day and based at major hospitals or community health centres. There is a full list of services at <http://www.health.nsw.gov.au/sexualassault/pages/default.aspx>.

NSW Civil & Administrative Tribunal (Guardianship Division)

Ph (02) 9556 7600 (day time and after hours)

Website

http://www.ncat.nsw.gov.au/Pages/guardianship/gt_matter_about/matter_guardianship.aspx

The NSW Civil & Administrative Tribunal (Guardianship Division) operates a free enquiries service during business hours which can be contacted for information and guidance about whether the Tribunal can assist in cases of abuse.

The Tribunal can:

- Appoint a guardian for a person with a cognitive disability, such as dementia. The guardian can be a private person or the Public Guardian.
- Consent to medical treatment if there is no other person who can legally consent to medical treatment on behalf of a person who cannot give consent themselves.

- Review the appointment of an enduring guardian or an enduring power of attorney if there are concerns that these arrangements are not working in the best interests of the person with a disability.
- Provide brochures and information sheets about substitute decision-makers for medical decisions for people who are unable to provide consent themselves.

In the ACT, guardianship and property matters are the responsibility of the ACT Civil and Administrative Tribunal.

Website: <http://www.acat.act.gov.au/>

Other sources of information, advice and referral:

Sources of information, advice and referral that may be helpful in cases of abuse or suspected abuse include:

NSW Elder Abuse Helpline

Ph 1800 628 221

Website: <http://www.elderabusehelpline.com.au/>

The NSW Government has established a helpline and resource unit to provide practical assistance to older people, family members and frontline service, and support staff and provide them with ways to respond and reduce abuse of older people. The service also promotes community education and collects data. The helpline focuses on the abuse of older people who are living in the community.

ACT Older Persons Abuse Prevention Referral and Information Line (APRIL)

Ph (02) 6205 3535

Website:

http://www.communityservices.act.gov.au/wac/ageing/elder_abuse_prevention_and_assistance

The Abuse Prevention Referral and Information Line (APRIL) is a confidential telephone service for callers who want to discuss elder abuse issues and seek advice and referral on options. The service operates during business hours.

Community legal centres:

Website <http://www.clcnsw.org.au/>

Community Legal Centres provide confidential free information and advice and assistance on a range of issues. Anyone needing legal advice or assistance who cannot afford the services of a private solicitor can contact a Community Legal Centre. Community Legal Centres may be a source of information and assistance for resident/clients (with decision making capacity) in cases of financial abuse.

Advocacy Services:

NSW - Seniors Rights Service

Website <http://seniorsrightsservice.org.au>

Ph (02) 9281 3600

Country callers 1800 424 079

The Seniors Rights Service (TARS) is an advocacy service for older people in aged care facilities and retirement villages and using community care services. It incorporates the Older Person's Legal Service.

ACT: A.C.T. Disability, Aged and Carer Advocacy Service (ADACAS)

Website www.adacas.org.au

Ph (02) 6242 5060

An independent, not-for-profit, advocacy organisation helping people with disabilities, older people and their carers in the ACT.

Domestic Violence Line (24 hour service)

Ph: 1800 65 64 63

Website: www.domesticviolence.nsw.gov.au/home

Provider Support:

Aged and Community Services (NSW & ACT)

Ph (02) 8754 0400

Website www.acs.asn.au

Acknowledgements:

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General Purpose Standing Committee No. 2
Inquiry into Elder Abuse In New South Wales

Response to supplementary questions on notice issued to:

Ms Illana Halliday, Mr Paul Sadler - Aged and Community Services NSW/ACT

(a) What kind of behaviour management strategies would an aged care facility put in place to manage violent behaviours of a resident?

In the first instance the provider would ensure everyone was safe and would do whatever is needed to prevent recurrence of resident violence – close monitoring of the resident (including 1:1 specialising if necessary), assessment of circumstances leading to an incident, determination of possible triggers for the behaviour, informing all staff of possible triggers and ensuring avoidance / limitation of those triggers.

Providers work closely with the resident, family and staff to learn from their experience of interacting with the resident, about what things or ways of doing things are pleasurable and calming for the resident.

Providers develop and document a behaviour management plan which includes the identified triggers and strategies to be implemented for the resident which enables this information to be shared with staff so they can incorporate these into their practice with this resident.

There are a number of resources available to assist providers such as the *ReBOC (Reducing Behaviours of Concern) Guide*
http://dbmas.org.au/uploads/resources/SA_DBMAS_REBOC_Guide_2012.pdf
and *Behaviour Management: A Guide to Good Practice*
http://dbmas.org.au/uploads/resources/DBMAS_Guide_21_05_12.for_USB_pdf.pdf.

Providers will arrange assessment or reassessment by a psycho-geriatrician or The Dementia Behaviour Management Advisory Services (DBMAS) / Severe Behaviour Response Team (SBRT) if needed.

(b) Is the industry concerned that inclusion of physical restraint in the voluntary quality indicator program may lead to an increase in chemical restraint?

No – monitoring the use of both forms of restraint has been in place in residential care for some time. The Australian Aged Care Quality Agency (AACQA) monitors all restraint used including use of psychotropic medication prescribed for the purpose of restraint (see appendix 1 Expected Outcome 2.13 Behaviour Management – and information from *Results and Process Guide* attached).

Most services would also be collecting benchmarking data on use of physical and chemical restraint as part of their internal quality programs already.

The Decision –Making Tool, *Supporting a Restraint Free Environment in Residential Aged Care* (<https://www.dss.gov.au/ageing-and-aged-care-publications-and-articles-training-and-learning-resources-decision-making-tool-supporting/decision-making-tool-handbook-supporting-a-restraint-free-environment-in-residential-aged-care>) has been widely recognised as best practice guidelines since 2012

(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?

Yes. The industry has been supportive of the establishment of an appropriate suite of indicators which would allow for improved benchmarking. The industry was surprised that physical restraint was the indicator chosen for the Quality Indicator Program as there has been a lot of work done in this area and most facilities have moved away from all forms of physical restraint, whilst there is still room for improvement with chemical restraint.

(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 acknowledges that there can be a link between staffing levels and behavioural issues, but would question the value of further data collection in this area unless there were the potential for additional funding to address the issue. Therefore, we do not believe aggregation of resident-on-resident assaults and staffing data would add significantly to this area and therefore do not support it.

This link is why the sector was disappointed to lose the Severe Behaviour Supplement which enabled the increase of staffing numbers to work with people with behavioural issues. It is also one of the major concerns that has been raised with the proposal for 24/7 RNs in all facilities – to introduce 24/7 RNs in facilities which have not previously required them, will be a costly exercise and may result in a reduction in staffing in other areas. This reduction in other staff hours will limit staff and resident interaction and reduce programs designed to meaningfully engage residents a result of which is likely to be an increase in incidents.

(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?

Providers, in residential aged care and the community, train their staff in working with people with dementia and in understanding the different levels of decision making someone can make. They have training to understand that dementia is a progressive disease and that loss of capacity is progressive - rather than assuming a diagnosis of dementia means that a person is unable to make any decisions.

This assists them to support residents and clients to make decisions within their capacity, which may vary over time.

Providers have systems in place to ensure staff are aware when a resident or client has appointed an advocate, representative or substitute decision maker and how to involve them to support decision making for the person.

Some providers arrange training for their staff from Seniors Rights Service (previously TARS) and the CMSA (Case Management Society of Australia) which covers supported decision making.

(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?

Some community providers include training for their staff on the NSW Interagency Policy 'Preventing and responding to abuse of older people', and some have their own policies outlining their procedures for dealing with suspected abuse if identified.

There was limited promotion of the NSW Interagency Policy 'Preventing and responding to abuse of older people' when it was released and it is only recently that the NSW Elder Abuse Helpline and Resource Centre (EAHRU) commenced running training courses and working with local areas to develop local collaborations to advance work in this area.

Whilst the Policy fosters coordination and may be seen as a best practice, there is no requirement for all providers to conduct training for their home care staff on the Policy. Despite this, most providers do provide training on elder abuse.

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

Residents and families are able to contact the police directly if they wish to report a crime and many residents have their own phone in their room which would enable them to do so.

If a resident identified that they believed a crime had been committed and wished to report it to the Police, the facility staff would assist them to do so.

If a provider became suspicious that a crime may have been committed, they would report this to the police.

In all instances, a provider would document that an incident had been reported and investigate it as they would any other incident.

Residents and their families are also provided with information about how to make a complaint or provide feedback to the organisation, and are also given information about the Aged Care Complaints Commissioner and Seniors Rights Service. This information is available in their Agreement, their handbook and also around the facility.

(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 the mandatory reporting provisions?

No, we do not support additional whistle-blower protections. However, we do want to encourage staff to report any suspected abuse and we do support the principle of no retribution for staff who report abuse. It is standard practice that investigations of any allegations, be it of abuse, neglect or any disciplinary matter or crime would be handled according to standard human resource practices in the workplace.

Providers would follow steps so that natural justice and procedural fairness were followed. This would ensure the rights of the resident / client to whom the allegation relates, the rights of the person who made the allegation and the rights of the person whom the allegation was made against were balanced and protected, whilst allowing the matter to be investigated fully.



Expected outcome 2.13 Behavioural management

This expected outcome requires that:
The needs of care recipients with challenging behaviours are managed effectively.

The focus of this expected outcome is 'results for care recipients'.

Results

- Management demonstrates its approach to behavioural management is effective in meeting care recipients' needs.
- Care recipients/representatives confirm they are satisfied with the home's approach to managing the causes which prompt challenging behaviours.

Processes

Consider:

- How does the home ensure regular behavioural management assessments are conducted and communicated for care recipients with challenging behaviours? For example, how does the home ensure:
 - consultation with care recipients/representatives and others (medical officers and health professionals) about behavioural management needs and preferences
 - following completion of the assessment process the results are used to plan necessary referrals to gain a diagnosis and/or appropriate treatment
 - an individually tailored approach is taken
 - assessment of the home's environment to determine how this should influence behavioural management practices and strategies
 - the use of appropriate behaviour and cognitive assessment tools?
- How is behavioural management carried out and communicated to the relevant staff as per the general care process? For example, how does the home ensure:
 - assessment of the presenting behaviour, causes and triggers to the behaviour and ways to avoid the behaviour
 - staff are educated on appropriate methods for managing care recipients with challenging behaviours
 - strategies to reduce the behaviour, including alternative therapies as appropriate are sought
 - the need for physical and chemical restraint (if used) has been assessed, has been deemed to be the last resort, is authorised and administered at a minimum form and level required, and in accordance with strict safety standards?
- How does the home ensure practices are consistent with the planned behavioural management strategies?
- How does the home evaluate and review behavioural management practices to determine their effectiveness in meeting the needs of care recipients? For example:
 - Are staff practices monitored and improved where indicated including in relation to the use of assessment tools, equipment, and methods of facilitating behavioural management?
 - Is each care recipient's behavioural management reviewed regularly in consultation with the care recipient/representative and appropriate health professionals?



- Is information collected and reported on behavioural management strategies and incidents?
- Are assessment tools monitored for effectiveness and appropriateness?

Links to related expected outcomes

- *Expected outcome 2.1 Continuous improvement*
Behavioural management data (which may include prevalence of aggression or other challenging behaviours) may be used by the home to identify opportunities for improvement within the home in relation to behavioural management and linked expected outcomes.
- *Expected outcome 2.2 Regulatory compliance*
The Accountability Principles 2014 require the reporting of unexplained absences of care recipients.
- *Expected outcome 2.7 Medication management*
When using pharmacological interventions, the aim is to settle distress, without affecting clarity of consciousness or compromising quality of life. Chemical restraint should only be used when all other options have been exhausted.
- *Expected outcome 2.16 Sensory loss*
Loss of eyesight or hearing may contribute to confusion or distress. Sensory stimulation should be used only to decrease the distress or behavioural agitation of care recipients.
- *Other expected outcomes of Standard Two*
Various expected outcomes relating to health and personal care may involve the management of care recipients with challenging behaviours, for instance, in relation to encouraging care recipients to use mobility aids, or in relation to the management of psychotropic medications. Likewise, poor behavioural management may indicate gaps in other systems, for instance, challenging behaviours may be the result of pain, side effects of medication, infections, anaemia, respiratory disease, hunger, dehydration, fatigue or a need to go to the toilet.
- *Expected outcome 3.4 Emotional support*
A care recipient's diagnoses may have an impact on their emotional health and behaviour.
- *Expected outcome 3.7 Leisure interests and activities*
Leisure interests and activities should be provided to each care recipient based on their assessed cognitive needs and abilities. An environment in which care recipients are restless may also indicate an inadequate recreational activities program, boredom or social isolation.
- *Expected outcome 3.9 Choice and decision-making*
Before any medical treatment or procedure is carried out, staff must obtain consent from the care recipient/representative. The consent must be informed, competent, un-coerced and continuing.
- *Other expected outcomes of Standard Three*
Poor and inappropriate behavioural management may affect the provision of other care recipients' rights such as in relation to independence, privacy and dignity, and choice and decision-making.



- *Expected outcomes 4.4 Living environment and 4.5 Occupational health and safety*

The environment should be safe, calm and comfortable for all care recipients, including those who are inclined to become agitated, who wander, or who are inclined to display other intrusive behaviours such as aggression, moving care recipients' belongings and taking other objects in the home. The management of care recipients with challenging behaviours can also be seen to affect the experience of other care recipients, as well as the safety of staff. Areas which present danger to the care recipient should be managed, including in relation to care recipients at risk of absconding.

Homes should be able to demonstrate all other options and alternatives for managing a resident's behaviour have been exhausted before any form of restraint is employed.