Supplementary Submission No 10a

INQUIRY INTO INQUIRY INTO ELDER ABUSE IN NEW SOUTH WALES

Organisation: NSW Nurses and Midwives' Association

Date received: 11/02/2016

NSW NURSES & MIDWIVES' ASSOCIATION

NEW SOUTH WALES NURSES AND MIDWIVES' ASSOCIATION
In association with the Australian Nursing and Midwifery Federation

ABN 63 398 164 405

IN REPLY PLEASE QUOTE: BH:HM
Ref:15/1206
11 February 2016

The Director
General Purpose Standing Committee No. 2
Parliament House
Macquarie St
Sydney NSW 2000

Dear Sir/Madam

RE: INQUIRY INTO ELDER ABUSE IN NEW SOUTH WALES

Please find attached our supplementary submission in relation to the inquiry into elder abuse in New South Wales.

We look forward with interest to the findings of the Committee

Yours sincerely

BRETT HOLMES
General Secretary

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Who will keep me safe?

Elder Abuse in Residential Aged Care

NSW NURSES & MIDWIVES' ASSOCIATION

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INTRODUCTION

In October 2015, the NSW Nurses and Midwives' Association invited members to complete a survey regarding elder abuse.

The majority of respondents were staff working in residential aged care. Their responses have implications for the aged care sector at both State and Federal level.

This report highlights areas of good practice, but it also raises concerns about the prevalence and management of elder abuse in residential aged care settings.

The findings are intended to inform government and policymakers about the issues affecting our older population and their caregivers.

Who we are

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes assistants in nursing (who are unregulated), enrolled nurses, registered nurses and midwives at all levels including management and education.

The NSWNMA has approximately 62,500 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving the standards of patient care and quality of services in the health and aged care sectors.

The NSWNMA currently has over 10,000 members who work in aged care. We consult regularly with them in matters that are specific to their practice. We wish to acknowledge the contributions made by our members in relation to this important issue.

This report is authorised by the Elected Officers of the NSWNMA.

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Background

The World Health Organisation (WHO) defines elder abuse as *"a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person."*[1]

Generally, abuse occurs where there is a power imbalance between the perpetrator and victim. However, in residential aged care facilities (RACFs) this power imbalance, or who the perpetrator might be, poses a dilemma.

The NSWNMA survey found most people who suffer abuse in RACFs are staff and residents, caused by acts perpetrated not by people who yield power over them, but those who lack power and are most at risk of abuse themselves. For example, people with cognitive impairment who, in a legal context, are unlikely to be held accountable for their actions.

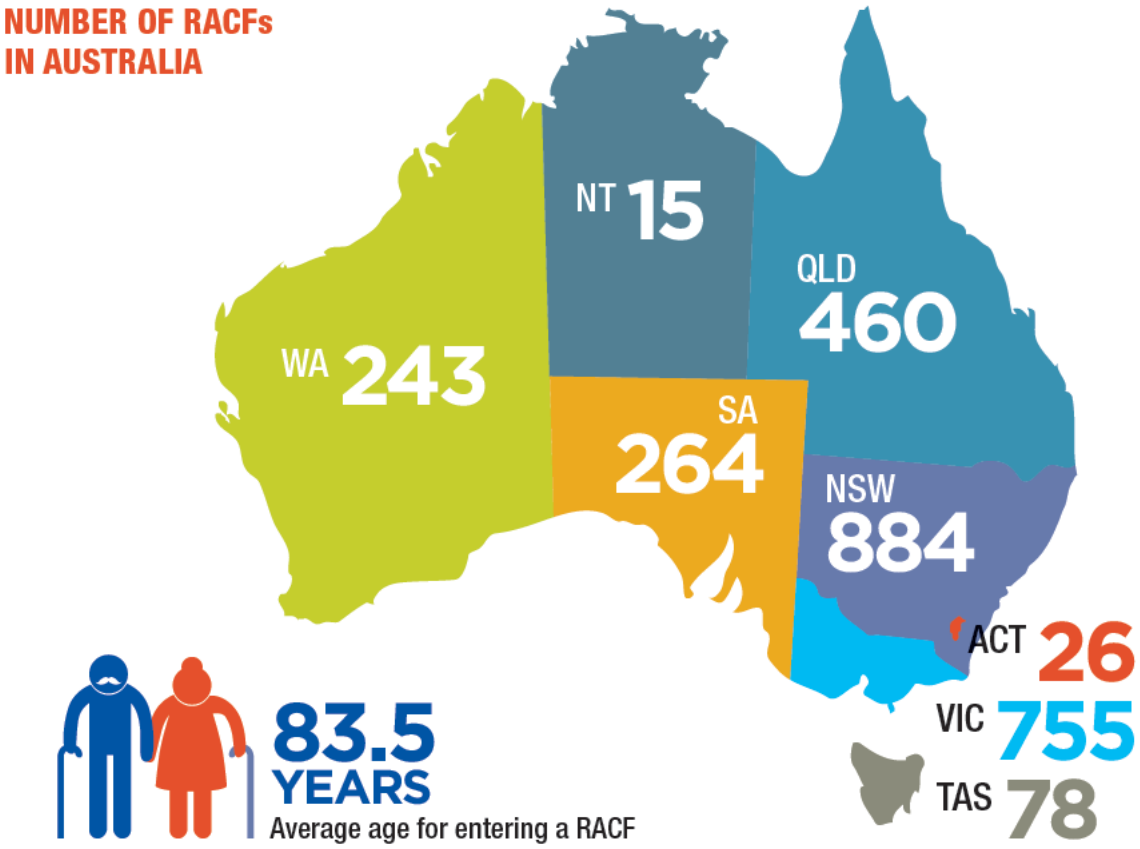
So who should take responsibility for these acts of violence against another person and what strategies are available to assist carers and aged care providers to keep people safe? This report explores these topics and is intended to prompt further debate around this important issue for our older society.

When defining elder abuse in relation to people residing in long term residential care settings it is necessary to place this within a legal context, since RACFs operate within the prescribed elements of the *Aged Care Act 1997*[2] and associated reporting guidelines[3]. This legislation and guidance define reportable abuse as being when a person has committed an act leading to "*unlawful sexual contact, unreasonable use of force, or assault*."[4] Generally, these refer to acts that can be criminalised. However, abuse can extend beyond physical or sexual assault to include neglect, emotional, psychological and financial forms of abuse.

The WHO also recognises that serious loss of dignity and respect is a form of abuse[5]. Increased awareness and acceptance that abuse is not merely a physical or sexual violation suggests that the terminology used to protect people in RACFs is poor and warrants urgent review.

NSW has the highest number of RACFs across all Australian states, with a total of 884 sites accommodating 59,252 people[6]. The average age for entering a RACF is 83.5 years. It is projected that the number of Australians aged 65 years and over will more than double by 2054-55; with 1 in 1000 people projected to be over 100 years old[7]. Within that timeframe the number of people with dementia will triple, rising to around 900,000 by 2050[8]. This will impact significantly on both RACFs and the staff employed in them.

In 2009–10, figures indicate 53% of permanent residents in RACFs had dementia. Residents with dementia were more likely than those without dementia to require high care[8]. Since 80% of people entering RACFs have high care needs it is reasonable to assume that people with dementia-type illnesses already account



for a significant proportion of the total population within residential aged care, regardless of the setting.

Dementia is the umbrella term used to describe several diseases affecting the brain, where a person's memory, reasoning, mood and behavior are adversely affected[9]. People living with dementia experience varying degrees of cognitive impairment. The incidence of dementia-type illnesses doubles every five years for people aged over 65 years and evidence suggests that this continues in people aged over 90 years[10]. Aggression is not always an outcome of dementia[24], but can be exhibited in up to 30% of people with the disease and is more common in people with dementia than non-dementia groups[11].

It is therefore unsurprising that staff have noted a high incidence of challenging behaviour in the resident population of RACFs. Whilst there is general debate about what constitutes challenging behaviour, for the purpose of this report we have used the term to describe physical and verbal aggressive behaviours such as hitting, pushing, kicking and shouting.

Resident-to-resident abuse

NSWNMA members report that resident to resident abuse accounts for a large percentage of the total observed incidents (see Figure 1). A recent analysis, undertaken by the Canadian Provincial Coroner's office, of 13 deaths occurring mainly in aged care homes and involving assaults between residents during 2013-14 highlighted that violence had become a normalised part of long term care and that resident-to-resident violence is an urgent and persistent issue[12]. Sadly, in Australia there has also been a number of cases reported in the media following incidents of resident-to-resident violence in RACFs, some with fatal consequences*.

The lack of urgency to find a solution to this well recognised problem goes to the heart of the issue around ageing: what value does society place on our older population? The WHO recognises that older people often experience violation of their rights at a societal and institutional level simply due to their age[5]. Quite simply, by ignoring this issue we are devaluing our older population and subjecting them to a life where fear of attack becomes an acceptable part of daily life.

The *Aged Care Act* (1997) exacerbates this situation by providing an exemption from the requirement to report incidents which involve residents affected by an assessed cognitive or mental impairment and where there are repeated allegations of the same assault. Yet it is recognised that cognitive impairment is one of the main barriers to reporting elder abuse[13, 14].

Figure 1
HAVE YOU WITNESSED ELDER ABUSE IN YOUR WORKPLACE (e.g. hitting, pushing, kicking, verbal)

	Every shift	Once or twice a week	Once or twice a month	Less than monthly	Never
Resident to resident	8.09% 22	20.22% 55	18.38% 50	45.59% 124	7.72% 21
Resident to staff	22.71% 62	29.67% 81	21.25% 58	19.78% 54	6.59% 18
Relative/visitor to resident	1.12% 3	8.96% 24	9.33% 25	32.46% 87	48.13% 129
Resident to elderly relative/visitor	1.88% 5	7.14% 19	10.15% 27	37.59% 100	43.23% 115

(NSWNMA survey)

* http://www.abc.net.au/news/2015-02-16/bundaberg-nursing-home-assaults-prompt-aged-care-review-call/6119456
http://www.brisbanetimes.com.au/queensland/woman-89-dies-after-nursing-home-assault-20130603-2nmpq.html
http://www.adelaidenow.com.au/news/south-australia/south-australian-nursing-home-death-85-year-old-quizzed/story-e6frea83-1226376970258

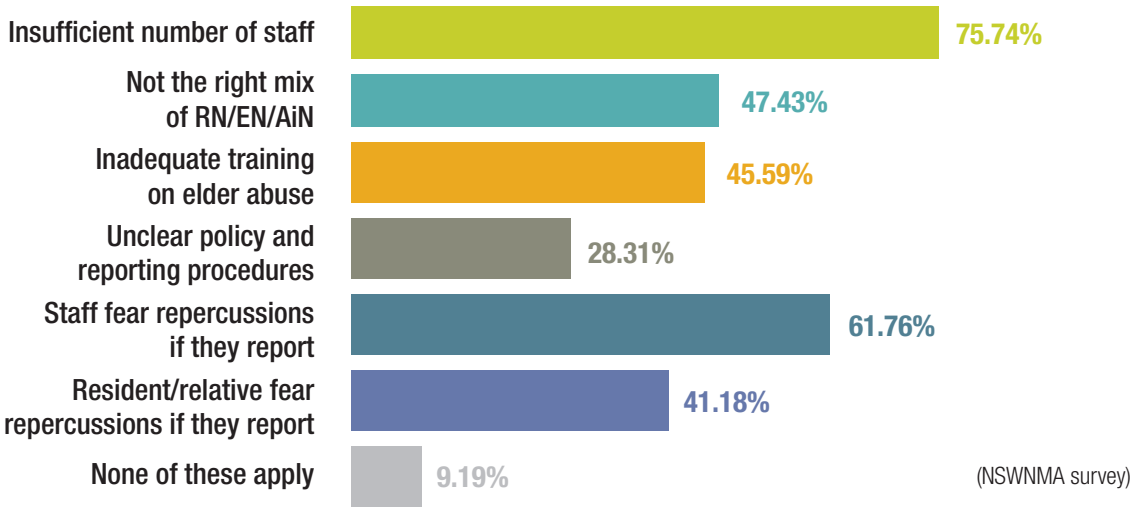
The legislation justifies this by requiring aged care providers to effectively manage peoples' behaviours and to provide adequate staffing to prevent recurrence.

It would be inappropriate to criminalise people with cognitive impairment for committing acts of physical or verbal violence as they are essentially 'blameless' being affected by a brain disease rather than carrying out intentional ill will[15]. However, there must be an effective system in place to keep both aged care residents and staff protected from physical or verbal attack. It is suggested that failure to protect a person from an assault by another could be seen as a form of neglect[15] and that failure to protect is abusive by nature as it fails to uphold a person's dignity and respect[5].

The Canadian research found that resident-to-resident mistreatment was the most prevalent reason for police attending a facility where this was reported[15]. Removing the requirement to report incidents which involve residents affected by an assessed cognitive or mental impairment does reduce the burden on the police. However, without additional safeguards that reporting to an external agency provides the responsibility for identifying trends in abuse and managing behaviour lies with those who seek to gain the least out of providing solutions, such as extra staffing and staff training.

It would be inappropriate to consider aged care providers solely responsible for the prevalence of abuse in RACFs since managing challenging behavior is a complex care issue. However, the law requires them to provide adequate staffing to manage people's behaviours effectively. A responsibility which our member survey suggests they fail to deliver on. In fact, almost 76% of respondents cite inadequate staffing as a precursor for elder abuse (see Figure 2). Therefore, some collective responsibility must lie with aged care providers and the aged

Figure 2
WHICH OF THE FOLLOWING DO YOU THINK INCREASES THE RISK OF ELDER ABUSE IN YOUR WORKPLACE? (tick all that apply)



(NSWNMA survey)

care regulator, whose remit is to ensure adequate staffing arrangements are in place. This raises the question of whether responsibility should be transferred to the managers or organisation charged with keeping a person safe and well cared for, and whether the law needs to reflect this in cases of neglect or failure to maintain dignity and respect.

Resident-to-resident aggression can have a significant impact on both the people involved and the staff caring for them. However, it is argued that there is a lack of framework for dealing with people who commit acts of aggression who are cognitively impaired[15]. It is acknowledged that managing aggression is one of the most challenging areas for staff and many RACFs lack guidance in this area due to a lack of other evidence-based options[5]. There is no doubt that this is an area that requires urgent attention and further research has been called for in numerous studies and reports[5, 9, 15, 16, 17]. The existing evidence base available however does offer a foundation to build a body of knowledge and inform this area.

It is clear that more people are entering RACFs with dementia type illness[11] and resident-to-resident aggression is likely to occur where people are co-located in the same building[15, 18] often because they lack control over their lives, leading to frustration which exhibits itself in aggressive behaviours[9, 19]. Aggression often presents when people first move into a facility[11] and is more frequent in larger facilities[17]. However, this is commonly underreported due to a focus on reporting staff-to-resident abuse[6] and the assumption that reporting conflicts with the caring role or belief it is part of the job[20].

There is also evidence to suggest that screening tools have value in the identification of the risk of aggression[11, 16, 20]. These could have the most value when undertaken as part of the admission process, since the first few weeks post admission are a known trigger for aggressive behaviours associated with loss of control and resistance to care[11]. However, there is little evidence of such tools currently being used to inform staffing and skill mix within RACFs.

Reducing the risk

The WHO calls for an integrated approach to the prevention of elder abuse, through the development of a comprehensive assessment framework for older people using an integrated care framework[5].

In NSW, older people now benefit from an Elder Abuse Helpline and a Dementia Behaviour Management Advisory Service delivered by HammondCare. The latter scheme aims to provide 24 hour short term support and case management for people, including staff in RACFs, who require advice regarding the management of people who are experiencing behavioural and psychological symptoms of dementia**. Although early indications about this service are

** http://dbmas.org.au/contact/nsw/

positive, there are no evidence-based evaluations of its effectiveness in reducing the incidence of challenging behaviours in NSW RACFs. In the absence of any legal requirement to report incidents of abuse involving people with cognitive impairment it is unlikely that there would be sufficient data to enable any significant evaluation for this vulnerable group within our RACFs in the near future.

Whilst the Elder Abuse Helpline is a positive initiative and valuable resource, it needs to be part of a wider protective system for older people. A helpline relies on a person's ability to make the call, yet the most vulnerable people may either be reliant upon their abuser to contact a helpline on their behalf or lack the capacity to access it altogether.

> "The training provided deals mostly with mandatory reportable incidents and although it may name other forms of abuse, does little about recognising and what to do about reporting things like neglect and psychological abuse."
>
> **REGISTERED NURSE – AGED CARE**

The NSWNMA survey results appear to show a relatively confident and well educated workforce in relation to the identification and reporting of elder abuse, with 93% stating they had read an abuse policy in their workplace (see Figures 3 and 4). Despite this, 45% of respondents still considered inadequate training on elder abuse increased the risk.

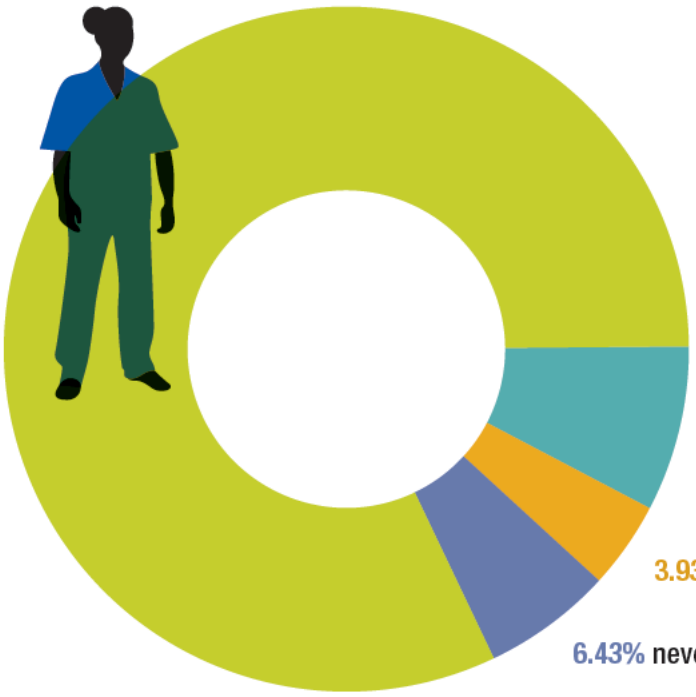


Figure 3
WHEN DID YOU LAST RECEIVE ELDER ABUSE TRAINING IN YOUR MAIN AGED CARE JOB?

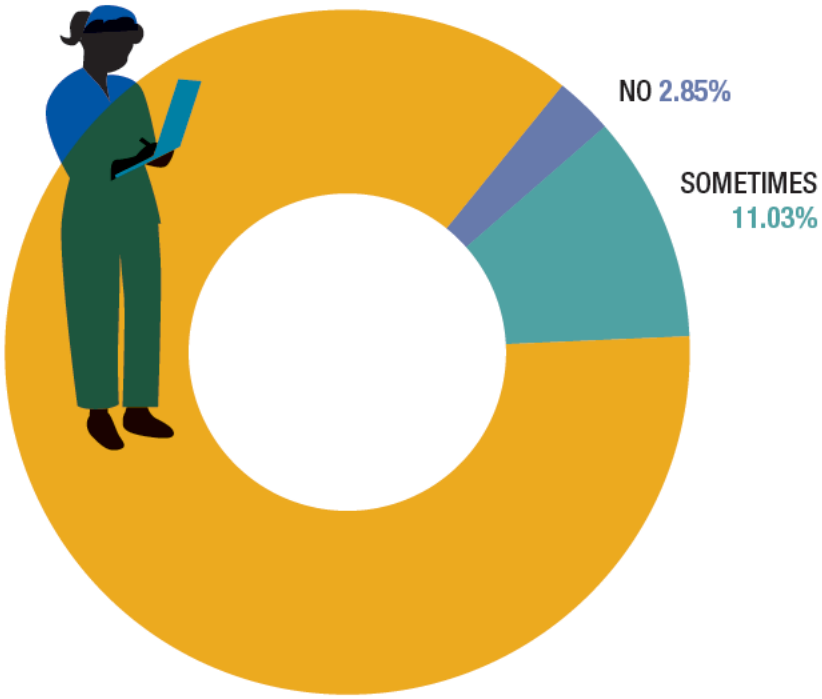
81.79% in the last year

7.86% in the last 3 years

3.93% more than 3 years

6.43% never

Figure 4
DO YOU FEEL CONFIDENT TO RECOGNISE AND REPORT ELDER ABUSE?



> "Staff are often unable to answer calls for care promptly due to insufficient staff especially on evening shift."
>
> **ENROLLED NURSE – AGED CARE**

Research suggests that care workers often deal with aggression without considering the causal factors such as pain[21, 22], lack of control and frustration[19, 20] and it often occurs when personal care is being delivered[23]. These factors could be alleviated through better staff awareness and training[24]. Therefore, it is reasonable to conclude that staff not only require training to identify and report abuse, but also better training on precursors for aggression and evidence-based strategies to effectively manage it.

Research has also found there are more reported incidents of physical or verbal abuse in RACFs than in community dwellings[15]. This is likely attributable to the fact that people in community living arrangements have lower care needs than those in a RACF. However, it is recognised that the environment, practices and rules in RACF's can exacerbate aggressive behaviours[15] and that low staff-patient ratios and high staff turnover increase the risk[17, 23, 25, 26].

Typically RACFs have lower staffing levels and less registered nurses than in public hospitals. This means staff often lack the time to engage with residents[17] and to properly assess behaviour which means triggers to resisting care can be missed[11]. Because of a lack of staff to adequately supervise the high numbers of people with dementia type illnesses in RACFs who present with symptoms such as wandering, they can inadvertently end up 'in harms way' and at the receiving end of an act of aggression[15].

Staffing and skill mix levels in RACFs present a challenge for those wishing to implement effective strategies to manage challenging behaviours, since most are reliant upon close supervision of a person and an individualised assessment and care management. This may lead to over-prescribing of antipsychotics to control behaviours and/or a tendency to manage challenging behaviours through antipsychotic medication alone, where increased staffing and better training might be more appropriate forms of management[22, 26, 27].

> “There is a need for much higher level of staff in aged care…. This is a speciality area that requires highly trained staff.”
>
> **REGISTERED NURSE**

One UK study estimated that at least 50% of people living with dementia were likely to be prescribed antipsychotic medication[28]. This is concerning since evidence suggests this type of medication can cause accelerated cognitive decline, sedation, chest infection and even death[29, 30]. Use of medication in this way could be considered an abusive practice and is sometimes referred to as chemical restraint, yet little is mentioned of its significance in elder abuse strategies.

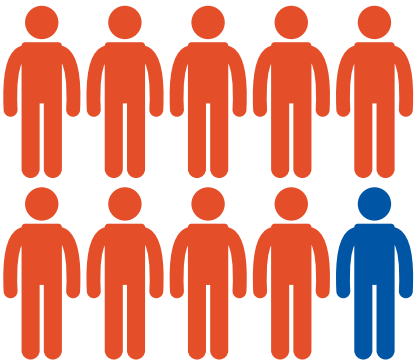
> “Staff take shortcuts and skip care duties to get duties completed within a certain timeframe. There are not enough staff to deliver quality care.”
>
> **ASSISTANT IN NURSING – AGED CARE**

Abuse of staff

Unfortunately, it has become somewhat accepted that caregivers will experience high levels of aggression from people in long term care facilities[21, 31] despite research highlighting awareness of this problem spanning more than a decade[9, 15, 23, 32]. Sadly, for some staff it has become an acceptable part of the job[11, 20, 33].

Staff who are constantly at risk of abuse from residents can become emotionally distressed[11, 23] and, more concerning, detached from residents, reducing their ability to provide person-centred care which is essential in the management of challenging behaviour[33]. It is therefore unsurprising that settings with a high number of abusive episodes produces a lower quality of care environment[17].

The NSWNMA survey found that over 90% of staff had been subject to some form of aggression from residents. It is recognised that incidence is a subjective matter and dependent on staff perception of what constitutes aggressive behaviour[26]. To address this our member survey gave examples of what might constitute abusive behaviour by giving the examples of hitting, kicking, pushing or verbal. Allowing for differences in interpretation, this figure remains significant and highlights the extent of the issue in residential aged care within NSW. Our findings are also consistent with rates reported in research undertaken in Europe[17, 27, 31] and Canada[9], suggesting the phenomena is not unique to Australia and highlights the need for further research to address this important area.



90% OF STAFF

had been subject to some form of aggression from residents

> "In the residential aged care facility where I work, there is a lot of abuse of staff from residents with dementia. They are the ones that kick, hit and bite us."
>
> **ASSISTANT IN NURSING – RACF**

> Management seem to take a negative approach when approached by staff, yet publically they inform us to report.

REGISTERED NURSE – AGED CARE

61%
OF STAFF FEAR REPERCUSSIONS
if they report an incident of assault

In addition, 61% of survey respondents admitted they feared repercussions if they reported an incident of assault. This finding is consistent with previous research undertaken with assistants in nursing, which found they lacked confidence to report for fear they would be blamed for the incident[24] or found management unresponsive to their concerns[9]. It is suggested that rather than apportioning blame, workplaces should focus on addressing the issues of workplace aggression[9].

Similarly, the survey found that where staff had reported concerns they often considered management to be unresponsive.

The reporting of elder abuse requires urgent change. This can only be brought about through better staff training and the establishment of a Federal regulatory framework, offering aged care providers clarity in what constitutes elder abuse and outlines expectations for staff training and reporting systems.

> I have experienced elder abuse in RACF within the past three years. I have lost all hope and confidence in managers that are in a management position as nothing ever is dealt with.

REGISTERED NURSE – AGED CARE

A protective response for aged care

The NSWNMA survey highlighted a far-reaching and complex issue within aged care that is unlikely to be resolved unless there is a co-ordinated approach at both a Federal and State level. It is clear that staff working in aged care facilities face daily challenges trying to meet the needs of people in their care, whilst ensuring other residents and themselves are adequately protected against assault.

It is without question that aged care providers lack a robust framework for dealing with elder abuse. Federal law needs to change to ensure it offers not only a more comprehensive definition of what constitutes elder abuse but also to ensure it effectively monitors the strategies providers are asked to implement to manage challenging behaviours. This includes the provision of adequate staffing and skill mix in RACFs. Effective procedures are also required to ensure older people and staff are not in fear of reprisal when they report incidents.

At a fundamental level, under what circumstances should aged care providers be required to report? It is clear that a good starting point for any further research would be to ensure the effectiveness of strategies can be monitored through the collection of statistical data. Requiring providers to report, through legislation, *all* incidents of elder abuse would enhance the body of knowledge that we have about the prevalence of abuse in RACFs regardless of perpetrator or blame. This data would enable preventative strategies to be developed. It would also assist external agencies to more effectively monitor quality of care and assess whether systems to manage challenging behaviour are effective.

Where systems are failing to safeguard, consideration must be given as to whether there is a need to extend the current Federal legislation so that those failing to protect are penalised. The current systems for regulating RACFs must be strengthened to ensure that where aged care providers fail to manage behaviours effectively, or fail to provide adequate staff numbers and skill mix, this is acted upon and recognised as elder abuse.

Initiatives such as the Dementia Behaviour Management Advisory Service add value in this area however, more can be done to identify, assess and manage complex behavioural issues associated with dementia within the workplace. Increased staff awareness through the development of specialist training and support roles within RACFs and through peripatetic services could have value in assisting aged care providers and staff to manage challenging behaviours. However, good care comes at a cost and appropriate staffing resources are required to ensure strategies are effective and residents are adequately assessed and supervised.

To value our older society we must protect not only those who receive care, but also those who deliver it.

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Who will keep me safe?

Elder Abuse in Residential Aged Care

NSW NURSES & MIDWIVES' ASSOCIATION