

**Submission
No 18**

**INQUIRY INTO ELDER ABUSE IN NEW
SOUTH WALES**

Name: Name suppressed
Date received: 15/11/2015

Partially Confidential

Inquiry into Elder Abuse – submission from

This submission is relevant to Numbers 7, 8 and 9 of your Terms of Reference:

7. The effectiveness of NSW laws, policies, services and strategies, including the 2014 Interagency Policy *Preventing and Responding to Abuse of Older People*, in safeguarding older persons from abuse

8. The possible development of long-term systems and proactive measures to respond to the increasing numbers of older persons, including consideration of cultural diversity among older persons, so as to prevent abuse, and

9. The consideration of new proposals or initiatives which may enhance existing strategies for safeguarding older persons who may be vulnerable to abuse.

Confidentiality

If you publish this on your website please remove the details about my parents.

Summary

Poor institutionalised systems put stresses on families. Such stresses could easily lead to abusive situations.

Elderly people require social interaction with their families that involves more than toileting, showering, washing, cleaning and doing other chores. If all the time is taken with doing chores, there is little time left for positive interaction – talking, going for a walk, going for a ride on the ferry, visiting friends and family, going to the movies and so on.

Lack of support services results in neglect despite the best of intentions.

I have identified a number of issues in the official support for the elderly that could be improved as explained below.

Background

My father is 89 and had a major stroke 2 years ago. Prior to that he was fitter and more mentally alert than most people twenty years younger. He was the primary decision maker in the family up until that time and managed the family finances. On leaving the hospital his written assessment stated that he had “moderate cognitive impairment” and we were told he did not have the capability to make a sandwich. Fortunately that has proved inaccurate, however that is the official information that various people are working from. He also lost his driver’s licence.

My mother is 87. She has had a pacemaker for ~20 years and recently developed early stages of dementia. She lost her driver's licence in 2014. Since Dad's stroke her condition has deteriorated significantly.

They live in a purpose-built home adjacent to one of my brothers. My two brothers and I all have full-time jobs. One lives next door, one lives at least an hour's drive away, and I live about 4 hours' drive away. Collectively we have been supporting our parents with the help of HACC, and for the last 6 months, Level 1/2 home care. Mum has recently been assessed as eligible for Level 3/4 care but this has yet to begin.

Issue 1: ACAT Assessments

My local state member said Aged Care is a Federal responsibility, however **access to aged care** is managed by NSW Health which plays the gatekeeper.

Explanation

My mother's condition had deteriorated significantly since the previous assessment 18 months previously: she had a stroke, lost ~ 20 kg and was very weak and unsteady on her feet, had incontinence and worsening dementia. This meant she required encouragement to do normal activities including getting out of bed to go to the toilet.

I rang the local Aged Care Assessment Team in March 2015 to try and get my mother re-assessed. I was told that if she was physically able to get out of bed by herself and feed herself she would not be upgraded to the higher level of care. The HACC provider considered that my mother's condition was worse than a number of her other clients who were receiving the higher level of care. I rang ACAT again in May 2015 and was told that Level 1/2 residential deals with incontinence and she was not ready to be re-assessed. Level 1/2 support allows for 3 visits/week to assist with showering, changing and washing sheets and clothes. This is not appropriate for someone with incontinence.

She had 2 falls, one requiring stitches in the hospital emergency department, with follow-up visits by a community nurse to dress the wound. I'm not sure if it was the GP or the community nurse who finally achieved the ACAT re-assessment and she has now been assessed for the higher level 3/4 care. That assessment was done in September, seven months after my initial call. She is now on a waiting list for a place – basically waiting for someone else to die or move into a nursing home.

This is institutionalised neglect.

Recommendations

There needs to be:

- a better checklist to do phone assessments of people's condition.
- a system where the professional care providers can request an assessment.
- more staff allocated to doing the assessments, which may mean a bigger budget.
- remove the quota system for care packages: we don't have quotas for people getting the aged pension: someone doesn't have to die before the next person in the queue is eligible for a pension; unemployed people don't have to wait for someone else to get a job before they're entitled to unemployment benefits. Why should people have to wait for the care they have been assessed as needing? I realise that this is a Federal responsibility, however as I noted earlier, NSW is the gatekeeper responsible for doing ACAT assessments. The NSW government can lobby the Federal government for care for its citizens.

Issue 2: Holistic approach:

The current system applied by NSWHealth and support agencies which may be mandated in their contracts is to be "client" centred. Theoretically this is a worthy goal, however in practice, it results in a hole-istic outcome.

Example 1:

The person who did my father's assessment when he left hospital asked him a number of questions. My brother and mother were present and tried to correct his answers, but were told it was the client's answers they were interested in. Dad answered most of the questions in relation to Mum, not himself, because he had been trying to get Mum assessed before he was hospitalised after a stroke.

Example 2:

My mother was in hospital and had a very minor stroke. She was discharged with no warning to the family, and no intermediate rehabilitation, which had been the plan the previous day when we visited. We were told that she was discharged because she said she wanted to go home. If you ask most people in hospital if they'd rather be in hospital or at home, they'd say they'd rather be home, but they aren't discharged on this basis.

Mum described the house to the social worker who deemed it safe to go home. However she described the house she'd left 15 years ago, not her current house.

The stroke also resulted in urinary incontinence. This had previously been minor and Mum managed it with small pads. The problem had been exacerbated by the stroke. She was sent home with no incontinence products. When I rang and asked the Nurse Unit Manager I was told there wasn't a problem. This indicates poor observation, record-keeping and possibly care during her stay in hospital. It also denied her access to appropriate support at the time.

Asking questions of people with dementia does not always get a current answer. The outcome of this was urine-stained clothing, furniture and bedding, which is difficult, time-consuming and expensive to rectify, and was totally preventable. It is also embarrassing and difficult for families to deal with. This is institutionalised neglect that was caused partly by pressure to empty beds and insufficient notes on transfer between wards, and partly by not involving the family. Anywhere that dementia is involved needs an extra level of checking and not just asking the person.

There also needs to be training and education of the family or carers in support services, products and strategies for dealing with various problems. This applies to all aging-related health issues, not just incontinence.

Recommendation:

A holistic approach involving the whole family, or group supporting the elderly person needs to be involved in developing care programs.

Issue 3: Practical support for carers

Much of what has happened to my mother is predictable to the medical profession as each disease, condition or event has a relatively standard trajectory. Looking things up on the internet is time-consuming and not necessarily useful. The GP gave us a lot of advice, but that was often well down the track because we did not realise immediately the consequences. It would have been much better to anticipate issues up front. I can give more specific examples if you require.

Recommendation:

Simple fact sheets could be developed listing likely behaviours and signs; consequence of these; and outlining practical ways of dealing with them. I am happy to provide examples if required.