

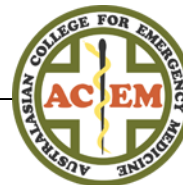
**Submission  
No 26**

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

**Organisation:** Australasian College for Emergency Medicine

**Date received:** 13/11/2015

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## Submission to the General Purpose Standing Committee No.2: November 2015

### INQUIRY INTO ELDER ABUSE

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide feedback to the General Purpose Standing Committee No.2 regarding its inquiry into *Elder Abuse in New South Wales (NSW)*.

ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians, and for the advancement of professional standards in emergency medicine, in Australia and New Zealand. ACEM, as the peak professional organisation for emergency medicine in Australasia, has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients across Australasia.

The below response refers to elder abuse detection and reporting in the setting of emergency departments (EDs).

#### Definition of older persons

ACEM notes that the scope of the inquiry relates to the prevalence of abuse experienced by persons aged 50 years or older in NSW. However, the term “elder” is not defined in the *2014 Interagency Policy Preventing and Responding to Abuse of Older People*. Definitions of elder persons vary in the literature, and are also dependent upon cultural background. However, in general, the literature defines this group as being comprised of those who are aged 65 years and older.<sup>1</sup>

With a rise in the retirement age and increased life expectancy, the age at which persons are considered “elders” could also increase, as has been documented in other cultures.<sup>2</sup> ACEM considers that one of the advantages associated with reducing the age at which a person is considered an elder to 50 years would be to include persons of differing cultural backgrounds, where vulnerabilities of ageing are documented to occur at an earlier time in life.<sup>3,4</sup> However, ACEM considers that this approach would also result in requirements to screen much larger populations, including those with a lower prevalence of elder abuse, with potential to adversely impact feasibility of screening. This may ultimately result in lower uptake of screening and disadvantage the frailest within the community.

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<sup>1</sup> Hajime Orimo, Hideki Ito, Takao Suzuki, Atsushi Araki, Takayuki Hosoi and Motoji Sawabe, “Reviewing the definition of “elderly”,’ *Geriatrics & Gerontology International*, 6 (2006): 149

<sup>2</sup> Ibid.

<sup>3</sup> Kate Senior, *Testing the ICDH-2 with Indigenous Australians: results of field work in two Aboriginal communities in the Northern Territory*, report prepared for the Australian Institute of Health and Welfare, ICIDH Collaborating Centre and the Department of Health and Family Services, (Canberra: Australian Institute of Health and Welfare, 2000) 18.

<sup>4</sup> Edward Strivens, *Indigenous Ageing in Australia*, position statement prepared for the Australian and New Zealand Society for Geriatric Medicine (ANZSGM), (Sydney: Australian and New Zealand Society for Geriatric Medicine, 2009) 2.

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In terms of assessing the effectiveness of the existing Policy, ACEM therefore suggests that a chronological definition of “elder”, that encompasses an increased age, as well as a functional aspect to the definition that promotes screening for chronologically younger persons as indicated, is also incorporated.

### **Definition of elder abuse**

ACEM considers that the definition of elder abuse applied in the *2014 Interagency Policy* is clear and encompasses the varying forms of abuse, including financial, psychological and physical. However, there are two significant gaps in the definition. These gaps include, as noted above, the lack of a clear definition of to whom the policy applies, as well as the exclusion of residents in aged care facilities.

ACEM notes that residents of aged care facilities who are subjected to neglect do not currently have their needs addressed by either the existing Policy, nor by mandatory reporting under the *Aged Care Act (1997)*. Furthermore, ED information systems have been documented to have poor accuracy in the identification of residents of aged care facilities.<sup>5</sup> This therefore results in the potential for abuse to go undocumented, as it is perceived to occur in the aged care setting, whilst many “aged care homes” are in fact private organisations which do not report under the Act.

ACEM considers the factors discussed above have significant potential to impact upon the reporting of elder abuse in the ED setting, and it is therefore recommended that these gaps be addressed.

### **Prevalence of elder abuse in emergency departments**

As noted, the true prevalence of elder abuse presentations in EDs is uncertain, however in NSW these presentations have been reported at between 1 to 5 percent of community-dwelling older persons.<sup>6</sup> The lack of comprehensive understanding of prevalence is contributed to by the lack of robust screening tools for elder abuse within in the ED setting. ACEM notes that existing tools, such as the Elder Assessment Instrument (EAI), whilst sensitive, lack specificity and are commonly not feasible in the time-constrained ED setting.<sup>7</sup>

ACEM considers that the constraints to reporting of elder abuse in the ED setting predominantly relate to the following:

- a) Lack of mandatory reporting of elder abuse;
- b) Common relationship of dependency on those perpetrating the abuse, with fears of further negative consequences to the elder patient if abuse is reported;
- c) Lack of ED staff awareness of elder abuse, its presenting features and risk factors;
- d) Lack of wide implementation of ED protocols for screening and reporting elder abuse; and
- e) ED overcrowding with resultant time constraints on staff.

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<sup>5</sup> Sharyn L Ingarfield, Judith C Finn, Ian G Jacobs, Nicholas P Gibson, C D’Arcy J Holman and George A Jelinek et. al, “Use of emergency departments by older people from residential care” a population based study,” *Age and Ageing* 38 (2009): 38.

<sup>6</sup> Patrick Livermore, Robert Blunt and Katrina Biscan, “Elder Abuse among Clients and Carers Referred to the Central Coast ACAT: a Descriptive Analysis,” *Australasian Journal on Ageing* 20, no.1 (2001): 44

<sup>7</sup> Terry Fulmer, “Elder abuse and neglect assessment,” *Journal of Gerontological Nursing*, 29, no.6 (2003): 4.

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ACEM therefore strongly suggests that the NSW government consider funding research into feasible, robust screening tools, supporting identification of elder abuse in the ED setting.

### **Identifying initiatives to empower older persons to protect themselves from risks of abuse**

ACEM notes that ED interventions may be contrary to elderly patients' wishes, however are undertaken due to the lack of an Advance Care Directive (ACD) or Advance Care Plan (ACP) which may detail preferences for or against treatment should a patient require end of Life (EoL) Care.

Clearly defined EoL care options such as ACDs, and documented discussions with family members, carers and GPs regarding realistic treatment and inappropriate transfers to the ED can support elderly patients to remain within their home or Residential Aged Care Facility (RACF) and receive EoL care. A clearly defined EoL care plan can also ensure that families and carers have an understanding of the patient's wishes as well as realistic expectations of treatment and its limitations.

ACEM therefore suggests that the NSW government more actively promote formulation of ACDs and ACPs as part of usual practice to support healthy ageing.

Furthermore, ED overcrowding has been demonstrated to be associated with disadvantage, particularly to older persons in terms of timely access to analgesia and mortality.<sup>8,9</sup> ACEM therefore also suggests that, as supported by the *Madrid International Plan of Action on Ageing*, existing ED quality indicators be reported in age-disaggregated format in order to ensure equity of access and performance for older persons in ED.<sup>10</sup>

### **Long-term systems and proactive measures to respond to increasing number of older persons**

ACEM considers that protocols for the screening and identification of elder abuse which address staff education and reporting, are required for EDs. These protocols should clearly define abuse within a framework of cultural sensitivity, and should also incorporate residents of RACFs in screening, especially for incidences of neglect. Reporting of elder abuse in EDs would therefore ultimately be optimized with the introduction of legal frameworks requiring mandatory reporting.

In the long-term, ACEM also considers that the introduction of models of care intended to reduce overcrowding, will assist in supporting the identification of elder abuse. These models will therefore also assist in mitigating the demonstrated disadvantages faced by older persons in the ED environment as a result of overcrowding.

### **Strategies for safeguarding older persons vulnerable to abuse**

In order to enhance existing strategies for safeguarding older persons who are vulnerable to abuse, ACEM also suggests that dedicated roles such as Aged Services in Emergency Teams should continue

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<sup>8</sup> Ula Hwang, Lynne D Richardson, Tolulope O Sonuyi and R Sean Morrison, "The Effect of Emergency Department Crowding on the Management of Pain in Older Adults with Hip Fracture, *Journal of American Geriatrics Society* 54, no.2 (2006): 270.

<sup>9</sup> Clair Sullivan, Andrew Staib, Rob Eley, Bronwyn Griffin, Rohan Cattell and Judy Flores et. al, "Who is less likely to die in association with improved National Emergency Access Target (NEAT) compliance for emergency admissions in a tertiary referral hospital?" *Australian Health Review*, (2015): 5

<sup>10</sup> United Nations, *The Madrid International Plan of Action on Ageing: Guiding Framework and Toolkit for Practitioners and Policy Makers* (Madrid: Department of Economic & Social Affairs, Division for Social Policy and Development, 2008), 11.

to be developed to facilitate care co-ordination for cognitively impaired elderly patients within the hospital and ED setting.

ACEM considers that these strategies could include advocating for the rights of the cognitively impaired, through including their requirements in policy and other initiatives, as well as permitting the implementation of the widespread screening of the cognitively impaired for potential elder abuse.

Thank you for the opportunity to provide feedback to the *General Purpose Standing Committee No.2 inquiry into elder abuse*. If you require any clarification or further information, please do not hesitate to contact the ACEM Policy and Advocacy Manager

Yours sincerely,



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