NSW Nurses and Midwives' Association

PROFESSIONAL ISSUES | 2

Solutions from the frontline

Practical approaches to reduce the risk of abuse in aged and disability services

Solutions from the frontline

Practical approaches to reduce the risk of abuse in aged and disability services

Contents

NSW Nurses and Midwives' Association

PROFESSIONAL ISSUES | 2

Introduction

The scale of abuse of older people and those living with disabilities is only now emerging; widely acknowledged, yet largely ignored by successive governments. Recent media attention regarding abusive practices in aged care and pressure from consumer advocacy groups have prompted state and federal inquiries[1,2]. Small scale projects at state level have barely scratched the surface in reducing risk of abuse and there has been no concerted effort to develop an overall Commonwealth strategy that is meaningful and practical. This inaction has cast frontline workers adrift, without adequate tools to respond to incidents of concern.

In 2015, we consulted the nursing workforce about the prevalence of abuse. Findings were published in '*Who will keep me safe? Elder Abuse in Residential Aged Care*'[3], highlighting the nature and extent of abuse as seen and experienced by nurses.

This document reports on a second consultation in 2016, which sought solutions so that patients and clients can be better protected by workers. The findings provide a unique insight into the frontline issues affecting the aged-care and disability workforce and suggest practical solutions to enhance safeguards for the aged and people with disabilities.

Focusing attention on abuse has highlighted many concerns the nursing workforce have about the lack of safeguards within disability and aged care services. However, it is likely that many people receiving care are afforded a fair level of protection by staff. Nevertheless, protection is a key responsibility for direct care workers and they require adequate resources, knowledge and tools for this.

323 survey responses were received during the consultation. Just under half were completed by registered nurses; about a quarter by assistants in nursing (including care workers and disability support workers, however titled) and the remainder by enrolled nurses, managers and clinical educators with nursing qualifications. The breadth of direct experience and cumulative nursing knowledge revealed in this consultation gives strong credence to its findings. We commend its usefulness in relation to elder abuse policy and workforce planning in disability and aged care services.

We would like to thank all those who took the time to share their stories.

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 is comprised of those who perform nursing and midwifery work at all levels, including management and education. This includes registered nurses and midwives, enrolled nurses and assistants in nursing (who are unregulated).

The NSWNMA has approximately 62,000 members and 7,000 associate members, of which 10,000 work in aged care or disability services. 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 standards of patient care and the quality of services in health and aged care services.

This report is authorised by Brett Holmes of the New South Wales Nurses and Midwives' Association.

Contact details

NSW Nurses and Midwives' Association
Australian Nursing and Midwifery Federation NSW Branch
50 O'Dea Avenue
Waterloo, NSW 2017

(02) 8595 1234 (METRO)
1300 367 962 (RURAL)
gensec@nswnma.asn.au

Background

Healthcare is constantly evolving to adapt to the changing needs of our society and keep pace with advances in modern medicine and technology. Billions of dollars are invested each year developing the most appropriate and evidence-based treatment options. Yet the very essence of good care is based on human contact. Health services are overwhelmingly provided and delivered by registered nurses, enrolled nurses and assistants in nursing.

Healthcare workers must be afforded the same level of investment as that given to pharmaceuticals and technology. In the same way that scientific research relies on adequate government and private funding, so does the provision of safe staffing in disability and aged care services.

Recent reforms within the aged care and disability sectors have sought to promote individualised care and enhance consumer choice through the National Disability Insurance Scheme (NDIS) and Consumer Directed Care funding models.

There are around 460,000 Australians under the age of 65 with a permanent and significant disability[4]. The NDIS is aimed at keeping people out of large group facilities so they can live within their community with the reasonable and necessary supports they need to live an ordinary life. Whilst supportive of the ideology of the NDIS, the nursing workforce has concerns that the movement of people with complex disabilities into the community will separate them from workers with whom they have a long established relationship. Former arrangements ensured people with profound disabilities had care provided by registered nurses who have specific skills in the ongoing clinical management of such long term conditions. Many community services are provided by unregulated care workers. There are real concerns that people will be more at risk without the level of professional oversight they currently receive.

Aged care reforms are similarly focused around the provision of care to people in their own homes. For many older people, remaining at home in their familiar surroundings would be the optimal outcome in their final years. However, there are inherent risks associated with community-based aged care. Like community disability services, these are largely provided by an unlicensed and peripatetic workforce. The isolated nature of community care means there is more, not less, need to ensure older people and those living with disabilities receive professional health care delivered by registered nurses and enrolled nurses to keep them safe. This will require adequate resourcing to ensure people receive safe care from sufficient numbers of skilled registered nurses and care workers.

Recommendations

1. A Commonwealth funded and coordinated Adult Protection Agency should be established to enable workers to seek independent support and advice regarding abuse.
2. A single piece of legislation covering the range of potentially abusive practices against *all* adults is required.
3. Legislation must require aged and disability service providers to ensure: Workers have the necessary skills to identify and act on actual or potential abuse; workers' concerns are taken seriously and acted upon; reporters are not at risk of reprisal from employers.
4. Legislation and policy that provides clear guidelines for the aged and disability sector workforce in relation to substitute decision-making and power of attorney is required.
5. Staffing and skill mix in residential aged care and disability services must be reviewed as a matter of urgency to ensure safe care. Minimum ratios of registered nurses, enrolled nurses and assistants in nursing (however titled) must be provided to prevent neglect.
6. All Assistants in Nursing (however titled; including disability care workers) must be licensed and subject to regulation to increase protections.
7. Aged care funding must be sufficient to enable minimum safe staffing ratios and skill mix to be provided in aged and disability services.
8. An urgent review of the Australian Aged Care Quality Agency (AACQA) guidelines regarding behaviour management must be undertaken so that: It is evidence based; promotes safe practice and recognises the role of adequate staffing in the prevention of abuse and implementation of protective behaviour management programs.
9. The role of the AACQA must be strengthened to ensure:
    - a more proactive role in securing safe staffing in residential aged care facilities and community care as a means of preventing abuse.
    - Effective monitoring of substitute decision-making and power of attorney arrangements within regulated services.
10. Additional safeguards are required with the introduction of Consumer Directed Care (CDC) and the National Disability Insurance Scheme (NDIS). These include: strengthening of regulation, support for consumers with budgeting and enhanced advocacy.
11. Immediate action must be taken to initiate research that aims to quantify the cost of providing registered nursing services to people under CDC.
12. Commonwealth funding of community care packages delivered under CDC and NDIS schemes must extend to a level required to secure the services of registered nurses in the community and intense home care packages, including psychological support for those with dementia-related illness.
13. Research must be undertaken to develop best practice approaches to the identification and prevention of abuse, particularly in relation to LGBTQI, CaLD, Aboriginal and Torres Strait Islander peoples and other marginalised communities. This must be initiated as a matter of urgency and national benchmarks set.
14. Domestic violence, including against older people and those living with disabilities, must be included within a Commonwealth adult abuse strategy.

Recognising the scope of protective legislation

BETWEEN 2014-15

3.5%

of all first admissions to residential aged care were **UNDER 60 YEARS,**

totalling 943 people[6]

In NSW, five percent of people living in residential aged care facilities are under 65, of which over 200 people are aged below 49 years[5]. 3.5% of all first admissions to residential aged care between 2014-15 were under 60 years, totalling 943 people[6]. Many more adults live with disabilities in the community and supported living settings and there are an even greater number who are vulnerable due to factors such as: mental illness; poverty, ethnicity and/or homelessness. The overwhelming need for a safeguarding strategy that extends to all those receiving direct care services is reflected in our survey responses, with over 80% of the nursing workforce agreeing that this would be the most appropriate solution.

Fragmenting safeguarding policy by separating adult and older aged policies can lead to duplication and confusion amongst workers as they attempt to navigate potentially conflicting systems. There is already a variance in the agreed age at which 'old age' is reached[7] and to avoid potential for error, a single piece of legislation covering the range of potentially abusive practices against *all* adults would assist the workforce to keep people safe.

Almost three quarters of the nursing workforce completing the survey said there is insufficient knowledge around abuse and further research should be undertaken. In particular very little is known about the extent of abuse affecting people from culturally and linguistically diverse populations, Aboriginal and Torres Strait Islander peoples and marginalised communities such as LGBTQI and people classed as homeless. Whilst legislation needs to be applicable to all communities, there may be additional safeguards needed to protect these groups.

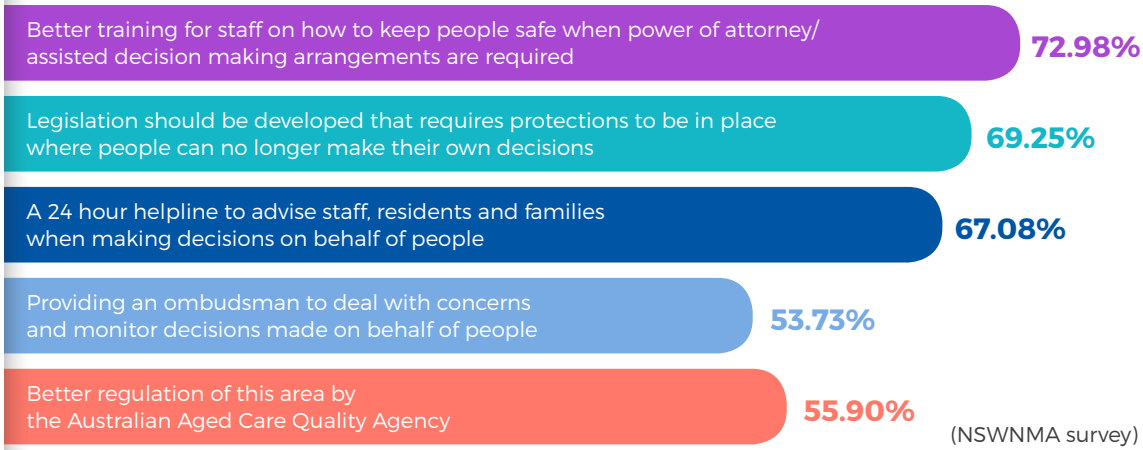
There has been progress in relation to identification of domestic violence and Commonwealth strategies to minimise risk and provide support to victims. However, they do not fall within an overall adult protection strategy. Aged care and disability workers encounter circumstances of domestic abuse which only emerge once the perpetrator or victim enters long term care. Many victims have lived in silence within abusive relationships for years and this is only identified when it has been necessary through illness to separate the perpetrator from the victim.

As community-based care increases, so is the likelihood that direct care workers will be the ones identifying potential domestic violence. It also means that workers themselves are more at risk. This area has been largely omitted from domestic violence intervention and support projects and is a largely under-researched area. Including domestic violence within a Commonwealth adult abuse strategy would assist in: raising awareness of domestic violence affecting older people and those with disabilities; provision of targeted training for workers and planning of support services for victims.

> Elder abuse is rife in the community but there is no mandatory reporting and no agency responsible for investigation or intervention. I once had a client that was experiencing domestic violence but she had dementia and could not press charges. The police would do nothing. ACAT couldn't do anything because the husband wouldn't consent to assessment. The adult children couldn't do anything because the husband was the person responsible. Neighbours, family, health care professionals all had grave concerns but there isn't a FACS (Family and Community Services) for old people.
>
> **Registered Nurse RACF**

Safeguards when decision making capacity is diminished

What protections are needed for older people when decisions are made on their behalf e.g. by a family member?



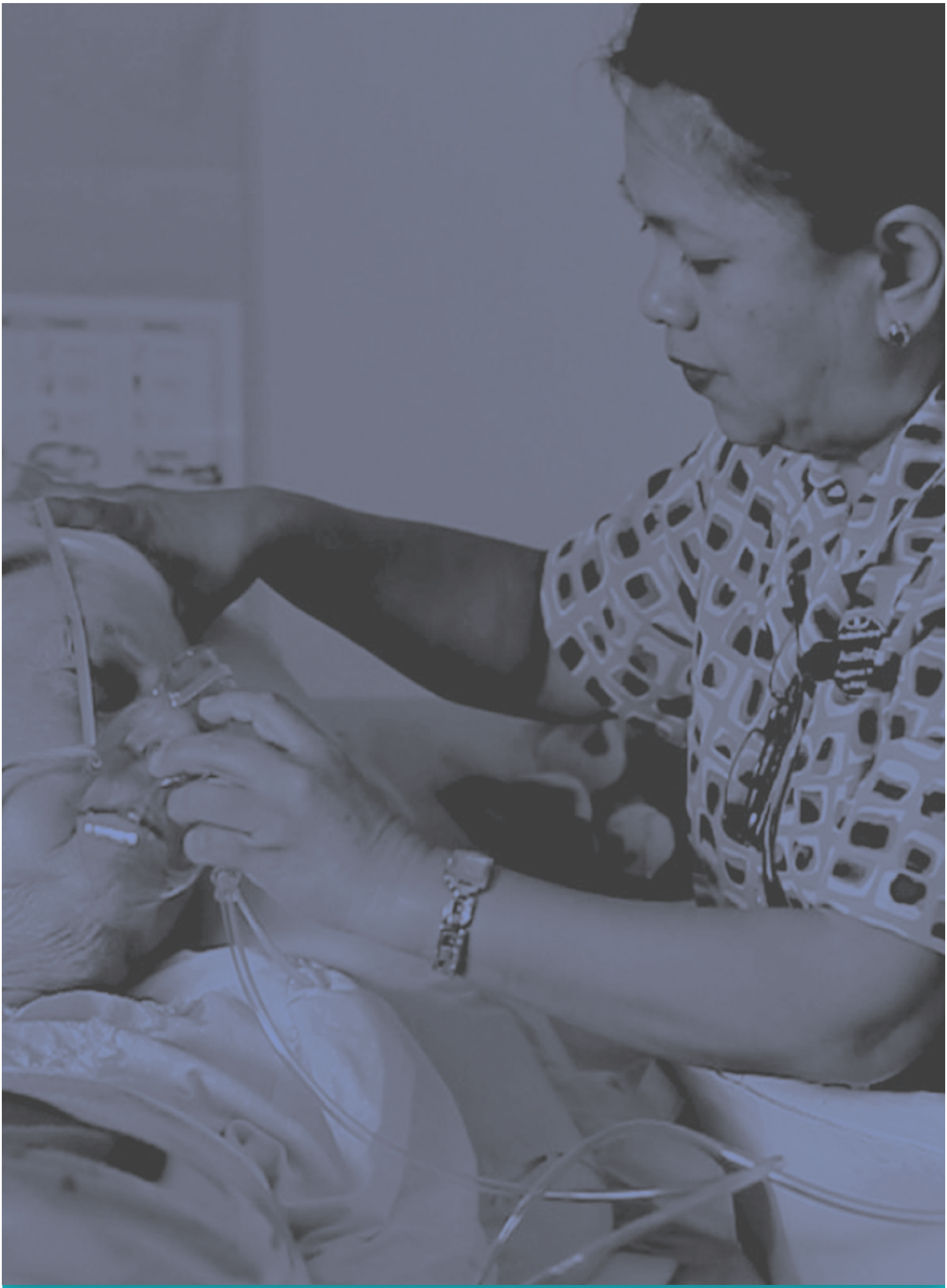
(NSWNMA survey)

The fairly even distribution of responses shows there are a range of protections required in circumstances where substitute decision-making is required. A formal substitute decision-maker (SDM) is described as:

> *"A person that is either appointed or identified to make health care decisions on behalf of a person whose decision-making capability is impaired. Depending on the situation an SDM may be either: chosen by the person informally; formally appointed by the person under the legal framework that exists in the relevant State or Territory where they live or assigned to the person or appointed for the person by a court.*
>
> *It is important to remember that if the person is competent, then the substitute decision maker does not have a role".*[8]

Whilst nurses consider that an enhanced legislative and regulatory response would be useful for families and other appointed decision-makers our survey highlights that nurses also require support when they become substitute decision-makers in their capacity as care-giver.

> Staff generally need to be better educated on the potential/actual risk in this area.
>
> **Registered nurse and nurse educator**



Direct care workers are often required to make decisions on behalf of people receiving aged care and disability services. This is often an informal arrangement arising from the unique ongoing and personal relationship between care giver and recipient in long term care arrangements. It is also increasingly prevalent as the number of people living with dementia-related illnesses and cognitive impairment rises.

Most recent figures show that 50% of people aged under 65 with severe or profound disability had mental health conditions[9]. Of these, many will require assistance to make everyday decisions. In addition, 89,000 people living in residential aged care facilities are assessed as having a dementia-related illness[10]. Given the total number of people with diminished capacity due to dementia, the nursing workforce need more support to manage this complex area.

The survey highlighted that aged and disability care workers often face dilemmas when relatives are making poor choices and decisions on behalf of people. Their testimonies clearly indicate that they face ethical challenges balancing the rights of the family and the rights of the individual they are caring for. Many spoke about people being left without sufficient funds to pay for trips out, hairdressing, sundries and items of clothing. The nursing workforce clearly lack clarity on when it is appropriate to advocate in someone's best interests in order to keep them safe. This is an issue that will require immediate legislative attention and more stringent monitoring by the aged care regulator.

Almost 56% of those surveyed said better regulation by the Australian Aged Care Quality Agency (AACQA) is required to ensure aged care providers maintain good practice in relation to assisted decision-making. Although the ability

> I've seen cases of families helping themselves to the bank books and accusing staff of interfering.
>
> **Assistant in Nursing RACF**

> The person I was supporting signed over a huge amount of compensation money to his family; he was taken by his family several times to the solicitor to sign over his funds until he finally gave in.
>
> **Assistant in Nursing RACF**

> There are middle aged sons 'caring' for parents when they're clearly unable to cope, because if they were to put them in a home the son would lose the carer's pension and entitlements and would then have to go on the dole and look for work.
>
> **Registered Nurse – Community**

> I work in an emergency department and looked after a man physically and emotionally abused by his brother who is also a power of attorney.
>
> **Registered Nurse, Public Hospital**

> A grandson of a resident accessed his grandmother's account and took a large amount of her money.
>
> **Assistant in Nursing RACF**

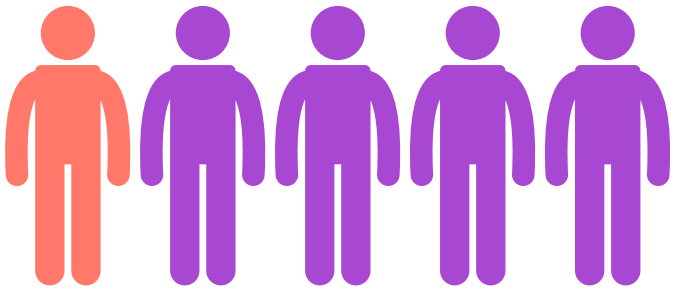
> Families disregard nursing advice and manhandle residents by forcing food into them.
>
> **Registered Nurse RACF**

of aged care providers to ensure residents are supported to make decisions is a key outcome to be tested by the AACQA[11], 72% of workers said they need more training on how to keep residents safe when power of attorney/assisted decision-making arrangements are required. This suggests that existing regulation does not ensure aged care providers adequately train staff to support decision-making and therefore leaves the people in their care vulnerable to abuse.

Around 20% of the nursing workforce said they had direct experience of power of attorney failures, leading mainly to financial abuse of older people by relatives. This is a significant figure which indicates that direct care workers are well placed to identify financial abuse. This is possibly attributable to the ongoing and personal nature of the care they deliver.

A recent inquiry into elder abuse held in NSW explored power of attorney failures in depth and recommended that laws be enhanced to provide additional safeguards where such arrangements are made[12]. However, our survey highlighted that as likely identifiers of financial abuse, direct care workers at all levels also need greater knowledge and support regarding this issue. Failure to require aged and disability service providers to implement mandated training in this area will further diminish their staff's ability and authority to pursue these issues and provide necessary safeguards.

Have you ever witnessed/ experienced elder abuse committed by people acting as appointed decision-makers under instruments such as powers of attorney?



YES: 1 in 5 (21.51%)

(NSWNMA survey)

I had seen numerous occasions where family members who have nothing to do with someone for decades turning up and pushing aside a long term partner, then denying the patient their wishes.

Registered Nurse, Public Health

A nephew (power of attorney) cut off a resident to family members, refused to speak to her and took control of all her financial and material possessions.

Assistant in Nursing RACF

Relatives will bully or forcibly move elderly parents into nursing homes and retirement villages — kicking them off their own farms that they then take over once they are given power of attorney or allowed to share the homes.

Registered Nurse, Public Health

The impact of Consumer Directed Care (CDC)

CDC gives consumers greater choice over their own lives by allowing them to decide what types of care and services they access and how those services are delivered[13]. People will be able to choose to hold their own budget to pay for care services. Over 60% of the nursing workforce said that this will increase the likelihood of financial abuse due to the vulnerability of people living with complex health conditions. People will need even greater support from aged care providers to support decision-making about choice of services and budgeting.

People will have much greater autonomy to manage their own finances but many may lack the necessary skills to organise and monitor their care and how their funds are being used. There will be 'hidden' administrative charges for setting up services, which may be shrouded by complicated business language. Many older people are already disadvantaged due to physical disability and sensory loss and often do not have family support nearby. Additional safeguards will be required including: strengthening of regulation, support with budgeting and enhanced advocacy.

> As well as financial exploitation, bureaucracy ensures that the system becomes more and more complicated, making it very difficult to understand what it is that an individual is actually 'agreeing to'. In fact, they have no real grasp of the ramifications and their exposure in written 'agreements'. At a time when life should be more straightforward, convoluted legal and government arrangements make life very complicated.
>
> **Assistant in Nursing RACF**

> The elderly may be unable to make the correct decisions regarding financial matters.
>
> **Registered Nurse RACF**

> Each case needs to be managed on an individual basis, depending on the cognitive capabilities of the resident, with an impartial 3rd party adviser.
>
> **Assistant in Nursing RACF**

> I don't think consumer driven care is working for older people in the community. Decisions are made on financial circumstance and a lot of older people are not utilising the services as they find it too expensive. Therefore, we have older people missing out on services that they require to stay in their own homes. Many older people are worse off than ever before.
>
> **Care Manager RACF**

Aged care reform

CDC was introduced as part of the Government's aged care reforms. These aim to keep people living in their own home and out of residential aged care for as long as possible[14]. This is viewed as a cost-effective long term solution to meet the needs of an ever ageing population. Whilst there can be little doubt that people would prefer to remain at home, there must be sufficient government funding to enable people to both remain at home and receive quality health care.

Traditional community care models for older people focus around the provision of domiciliary and personal care services. These are largely provided on an informal basis by unpaid volunteers, family and community members. In addition, people also receive 'formal' care services provided by unlicensed peripatetic care workers, who often receive low wages and poor training. It naturally follows that community-based services delivered by care workers will be a cheaper option than residential aged care where services are often delivered by registered nurses, enrolled nurses and assistants in nursing (however titled).

However, what has not been adequately recognised is the growing level of complex healthcare needs that people choosing to stay at home may have. People electing under CDC to purchase home care packages will run the risk that these will not be delivered or overseen by registered nurses.

We must learn lessons from other countries where this model of funding has been in operation for some time. Shortfalls in care and premature admissions into long term residential care have occurred. This is due to failure to provide adequate funding to resource community staffing models and also a lack of clearly defined boundaries between informal and formal caregivers in relation to the monitoring of health within community disability services[15,16].

A further concern is that the assessment of needs and allocation of funds are traditionally based around physical health needs and tasks to be undertaken, rather than recognising the cost of increased supervision, clinical oversight and psychological support for people living with mental illness and dementia. Registered nurses not only deliver direct care, but also assess and monitor complex healthcare needs. Often these duties are difficult to quantify and therefore funding often overlooks these essential elements of care that are pivotal in reducing the risk of abuse.

Evidence suggests that research should be conducted to 'map' the activities that registered nurses and assistants in nursing perform when nursing a person in the community[17]. Only then will appropriate allocation of funding be achieved. The Government must address this as a matter of urgency. Current funding models for Commonwealth funded packages may not extend to a level required to secure the services of intense home care packages from registered nurses in the community, which includes psychological support.

> "Carer stress is the major concern I have seen in the community – families unable to afford community care and financially/emotionally abusing clients due to high stress levels – they are unable to have a break because community services (home care packages) have increased their costs."
>
> **Registered Nurse, Aged Care Assessment**

Regulation of aged care

The AACQA is the responsible organisation for monitoring quality of care in residential aged care facilities and is also responsible for approving aged care providers to run a facility through an accreditation system. They do this by asking aged care providers to self-report on their service and also by undertaking announced and unannounced site visits. Aged care providers are often given advance notice of site visits and these may occur at intervals of more than a year apart, so the AACQA is not always in a position to assess how a service is operating between site visits or following accreditation.

How can the regulations governing aged care be improved to offer people better protections?

(NSWNMA survey)

There was a fairly even distribution of responses indicating that a 'one size fits all' approach to regulation would not be appropriate to safeguard people effectively. Many nurses consider that the AACQA site audits could focus more on the areas of abusive practices that are not so easy to identify, such as neglect. Nurses were keen to see assessors focusing on identifying causal factors behind abuse, such as low staffing ratios and poor education programs for staff. They used this section to voice their justified concerns about safe staffing in aged care.

The 2016/17 federal budget announced major cuts to aged care funding, particularly for those people requiring a high level of complex healthcare[18], prompting many aged care providers to indicate they would be likely to make further cuts to the numbers of registered nurses and care workers they employ[19,20]. This is in addition to the already declining number of registered nurses employed in the direct aged care workforce, from 21% of total staff in 2007 to 15% in 2012[21]. Since over 80% of all people entering aged care are assessed and funded as having high care needs[22], logic tells us there should be more, not fewer, skilled nurses within the aged care workforce. Aged care funding must be sufficient to provide minimum staffing ratios in aged care services.

As of 30 June 2015, there were 2681 residential aged care facilities in Australia providing 195,953 places[23]. Aged care workers continually cite insufficient staffing and skill mix as a major cause of concern for them and one which impacts on their ability to provide quality care. Despite this, during the three year period to end March 2016, the AACQA reported that even as one of the highest areas of non-compliance, there was still an incidence of less than 0.5% of non-compliance with staffing outcomes in residential aged care facilities[24]. Around 5000 site visits are conducted each year by the AACQA and records show that over the past 15 years only 0.4% visits have resulted in the issue of a non-compliance notice or sanction in *any* area[25].

The Aged Care Complaints Scheme received over 3,700 complaints during

> "Visits must be unannounced and rosters must be checked to analyse adequacy of staff and skill mix."
>
> **Registered Nurse RACF**

> Audits should focus on the staffing shortfalls and the resident to staff ratio – more so for the high care residents (in facilities). Management should also be made responsible for the continuation of staffing shortfalls and issues. There should be a governing body where AiNs, RNs etc. can report the ongoing and unresolved staffing shortfalls. If management of the aged care facilities continue to ignore these issues or refuse to put measures in place to resolve these then a governing body should be able to intervene somehow. These shortfalls are directly linked with poor resident care and subsequently, elder abuse. How are we expected to do our jobs successfully and efficiently with the highest standard of care when all the facility is focused on is cost cutting?
>
> **Assistant in Nursing RACF**

> Spot checks are known about well in advance. So many more staff are on the floor on the day.
>
> **Assistant in Nursing RACF**

2014/15, of which almost a third were related to health and personal care. Poor quality care, staffing levels, skills mix and mismanagement of medications were among the top five areas for concern. 809 complaints were referred to the AACQA for action. However, almost 90% were deemed non urgent and matters that could be addressed through routine contact with the service[26]. With site visits occurring at intervals of over a year for some services it is of little surprise that the nursing workforce is not confident in the ability of the aged care regulator to ensure adequate staffing safeguards are maintained. It also raises questions in relation to the role of the Complaints Commissioner in the prevention of abuse.

Over 60% of the nursing workforce identified that standards and outcomes used by the AACQA should be focused more towards the prevention of neglect, financial and psychological abuse and over-medicating rather than focusing solely on reportable assault.

The AACQA *Results and Processes Guide*[27] provides practical guidance to interpret legislative compliance within the residential aged care sector. This document specifies that although a last resort, in some circumstances the use of physical or chemical restraint would not be considered an area of non-compliance. Surprisingly, this section omits the lack of staff availability as a possible contributory factor for ineffective behaviour management which may predispose the use of chemical and physical restraint. Research shows that if root causes for undesired behaviours are determined and corrected, the need for restraints can be ameliorated and alternatives can be implemented[28].

> Short staffing is a serious form of financial and personal abuse and is particularly apparent in private facilities. It is no wonder most people hope they die before they have to go into care.
>
> **Assistant in Nursing RACF**

Chemical restraint is widely considered counter-productive and, at worst, life threatening[29,30] and is not approved for use in the behavioural manifestations of dementia in some countries[31]. As a protective document the *Results and Processes Guide* appears lacking an evidence base or safe practice guidance and as such does not afford sufficient protection against abuse.

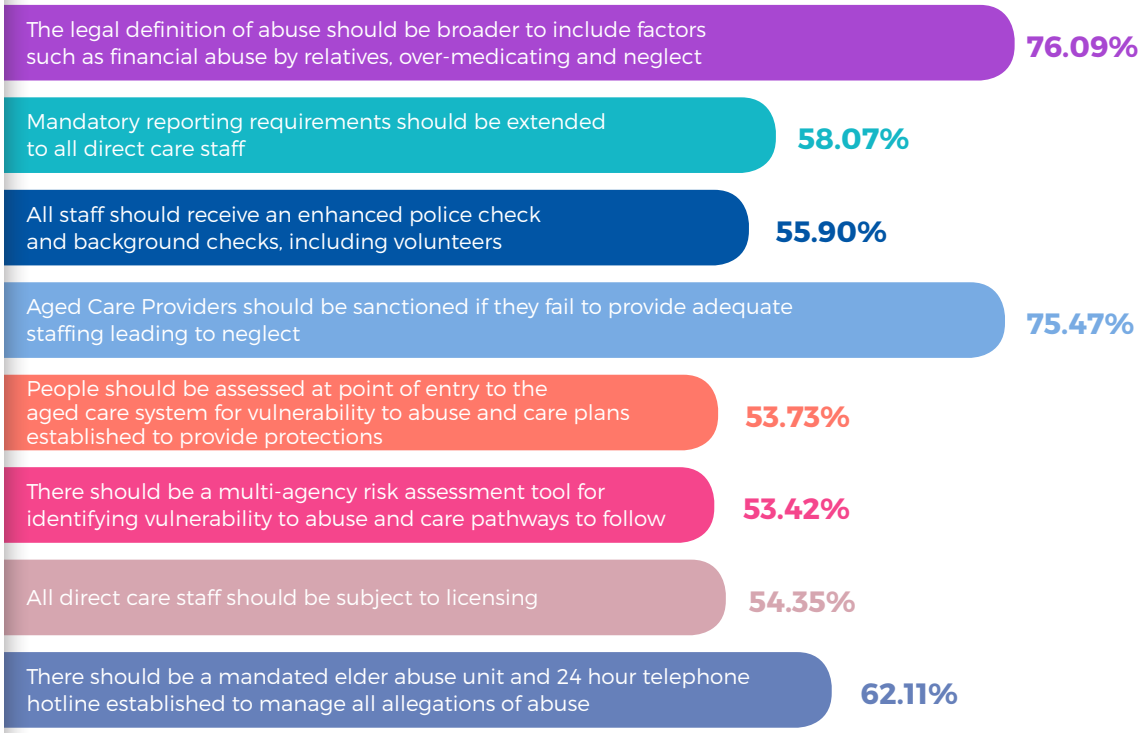
The guide recommends that: *"Homes should be able to demonstrate all other options and alternatives for managing a resident's behaviour have been exhausted before any form of restraint is employed." (p57)* It would naturally follow that exploration of staffing ratios should occur. However, despite high levels of challenging behaviours in residential aged care facilities[3], the nursing workforce regularly cite staffing ratios of around one registered nurse to 100 residents. It is of little surprise that workers are unable to provide the necessary oversight to safeguard residents in some facilities. Whilst the provision of safe staffing remains unchallenged by the AACQA, the use of physical and chemical restraints to control challenging behaviour is likely to continue.

Despite high levels of challenging behaviours in residential aged care facilities[3] the nursing workforce regularly cite staffing ratios of around

The extent of abuse

Nurses called for a range of strategies to assist them to keep people safe, as demonstrated by the table below. Nurses not only require enhanced mandatory guidelines to inform their practice but also see value in mandatory minimum safe staffing ratios and skill mix. Clinical guidance to identify and respond to abuse also featured highly in their responses. The need to extend the current definition of abuse to determine a reportable assault and greater sanctions for aged care providers who fail to protect residents were of primary importance. In addition, qualitative responses identified the widespread personal and professional ethical dilemmas nurses face when encountering abuse. The lack of clear direction and personal guilt and anxiety caused by the perceived lack of power to take appropriate action is evident. Some reported having their concerns dismissed by their employers. Difficult though it is to read some of these testimonials, they provide real evidence of the nature of elder abuse in aged care.

How can aged care laws and legal frameworks be improved to make it easier to prevent, detect and respond to elder abuse?



(NSWNMA survey)

"Equipment, whether faulty or not is used because of the time factor. When a full complement of staff is on this is still not sufficient to give residents the care they need. Trying to deal with dementia residents when they are mixed in with those that do not have dementia is very difficult. Alarms are not efficient because there is not enough staff to act. This to me is abuse. All nursing homes should have dementia units where they are safe. Staff are at times doing back to back shifts because of staff shortfalls and expected to train new staff while on their shift, which makes our work twice as difficult. Extra staff should be put on during training not just 'buddying'. Staff cannot care for residents as they should because the current staffing levels are not adequate. No one complains for fear of losing their job, so the residents are the ones that suffer."

Assistant in Nursing RACF

"I have seen staff treat residents roughly and bully them. I have also witnessed residents being pushed, hit and force fed."

Assistant in Nursing RACF

"There is a lack of time to feed residents their meals completely, due to deliberate under staffing. More staff shortages happen when a decision is made not to replace staff. This results in these fragile residents becoming undernourished, losing weight and developing pressure sores. People are left restrained with lap belts in water chairs that are not comfortable for many hours. Charts are forged to show they are released, but they are not. Abuse and or neglect are not based on gender or race, but lack of time, empathy and skill."

Enrolled Nurse RACF

"I have witnessed clients being dragged across the floor, AiNs eating their [clients'] food, then told when they are hungry 'there is no more'. A man in palliative care sucking tomato sauce out of a container and when I went to the kitchen to get some soup, I got yelled at to go away. Swearing at residents is common, as is leaving them in soiled underwear... I still have trouble sleeping of a night."

Designation unspecified

"When I was working as an AiN in a nursing home the elderly would sit in their beds most of the day not showered and sometimes wet for hours due to lack of staffing."

Enrolled Nurse, Public Health

"I have witnessed unintentional neglect due to a lack of adequate staffing to resident ratios within the aged care system. Staff become burnt out due to the heavy workload and take shortcuts in care. I believe that staff shortages are due to facilities not having appropriate funding and/or the facility trying to save money to ensure a profit is made for shareholders. I believe registering cert 3 and 4 aged care workers would help reduce neglect as they would have more accountability for their actions."

Enrolled Nurse, Public Health

"As an AiN I witnessed some other AiNs yelling at patients and leaving them on toilet for long periods as punishment for 'bad behaviour'. Also, being threatened to force feed elderly clients rather than giving appropriate time for meals due to staff shortages. Terrible. Staff shortages and resources meant some patients were left wandering at night. Once I found an elderly man sitting naked on the face of another elderly lady who was unable to move and was told not to report this to anyone. This was not a one off. This man could not be supervised at nighttime. I still feel sick about this after many years. Finally, as an RN visiting my elderly grandfather in the nursing home - he was placed in a dementia ward despite being of sound mind due to limited beds in the regional town. He was terrorised by other patients who could not manage their anger. They charged at him and climbed into bed with him. Worse still, the AiNs repeatedly put the air-con directly on him constantly, despite our pleas, and he got pneumonia."

Registered Nurse, Public Health

"I previously worked at an aged care facility and reported elder abuse to my boss but nothing was done. I was called a liar and was not popular because this certain staff member was a favourite. She had left decent sized bruises on a resident's wrists and ankles by pulling her up out of bed forcefully. The resident was afraid of the staff member."

Assistant in Nursing RACF

"One of my colleagues grabbed a resident so hard that it tore his skin off and her handmark print was on his arm and thigh. I reported it but the management told me to shut up or I'd lose my job."

Assistant in Nursing RACF

"A few years ago, I did a short stint at a remote aged care facility and witnessed numerous forms of elder abuse, by more than one staff member. At the time, I was a very young, new AiN, shy and naive. On reflection, things that would have helped me in this situation include having further education in elder abuse, knowing who to speak to outside of the facility about this matter and having support for this incident. Thinking about my tertiary degree, I think elder abuse needs to be focused on more, especially with our ageing population. In my current small community, I know of two staff members who have been reprimanded for financial abuse and I believe that all aged care providers need to be under a licensing agency for this reason."

Registered Nurse, RACF

Conclusion

There must be urgent legislative action taken to ensure:

- there are sufficient numbers of registered nurses, enrolled nurses and assistants in nursing to reduce the risk of abuse in aged and disability services;
- licensing of assistants in nursing (however titled) to increase protections, particularly in the community;
- workers are able to seek support and advice from an impartial agency;
- better training of workers to provide them with the necessary skills to identify and act on actual or potential abuse;
- better safeguards to ensure workers concerns are taken seriously and acted upon;
- systems to prevent reporters being at risk of reprisal from employers and a framework for assessing risk of abuse,
- guidelines for workers on how to respond.

There are already 3.5 million Australians aged over 65, with more than a third receiving care services in some form. Failure to recognise the importance of adequate staffing ratios and skill mix both in community and residential care services has the potential to create an epidemic of abuse. The financial burden associated with a properly staffed aged care and disability workforce would be insignificant compared to the potential life limiting cost to our older generation and those living with disabilities if we fail to meet their care needs adequately. These people are equal members of our society, yet their needs are consistently overlooked within government policy and workforce planning. Valuing the rights of care recipients means we have to value the contribution of their care givers. Only once we have the right number of staff with the right skills can we depend on them to keep people safe from abuse.

References

1. NSW Parliament (2016) General Purpose Standing Committee No.2 Elder Abuse in New South Wales. Available at: https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6063/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf
2. https://www.alrc.gov.au/inquiries/elder-abuse
3. NSWNMA (2015) *Who will keep me safe: Elder Abuse in Residential Aged Care*. Waterloo, NSW: NSWNMA.
4. https://myplace.ndis.gov.au/ndisstorefront/about-us/what-ndis.html
5. Commonwealth of Australia (2015) *Report on the Inquiry by the Senate Community Affairs References Committee into the adequacy of existing residential care arrangements available for young people with severe physical, mental or intellectual disabilities in Australia – June 2015*. Canberra: Commonwealth of Australia.
6. Australian Institute of Health and Welfare (2016) *First admissions into permanent residential aged care, by age group and sex, 2014–15.* Available at: http://www.aihw.gov.au/aged-care/residential-and-home-care-2014-15/data/.
7. World health Organisation (2016) Health statistics and information systems: definition of an older or elderly person. Available at: http://www.who.int/healthinfo/survey/ageingdefnolder/en/. Accessed online 03.08.16 13:23.
8. Advanced Care Planning Australia (2016) Substitute Decision Maker (Definition). Available at: http://advancecareplanning.org.au/advance-care-planning/for-professionals/substitute-decision-maker/.
9. AIHW (2016) Health status and risk factors of Australians with disability 2007-2008 and 2011-2112. Available at: http://www.aihw.gov.au/publication-detail/?id=60129554512&tab=3.
10. AIHW (2016) Care needs in residential aged care. Available at: http://www.aihw.gov.au/aged-care/residential-and-home-care-2014-15/care-needs/.
11. Australian Aged Care Quality Agency (2014) Results and processes guide. Parramatta, NSW: AACQA.
12. NSW Parliament (2016) General Purpose Standing Committee No.2 Elder Abuse in New South Wales. Available at: https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6063/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf
13. https://agedcare.health.gov.au/aged-care-reform/home-care/home-care-packages-reform
14. https://agedcare.health.gov.au/ageing-and-aged-care-aged-care-reform/why-is-aged-care-changing.
15. Willis, D.S. (2015) Inconsistencies in the roles of family and paid carers in monitoring health issues in people with learning disabilities: some implications for the integration of health and social care. British Journal of Learning Disabilities, 43(1), pp. 24-31.

16. Donnelly, S. et al (2016) "I'd prefer to stay at home but I don't have a choice": Meeting Older People's Preference for Care: Policy, but what about practice? Dublin: University College Dublin.

17. DeVleigher, et al (2015) Exploring the activity profile of health care assistants and nurses in home nursing. British Journal Of Community Nursing, 20(12), pp. 608-614.

18. Commonwealth of Australia (2016) Budget 2016/17: Overview 3 May 2016. Available at: http://www.budget.gov.au/2016-17/content/glossies/overview/downloads/Budget2016-17-Overview.pdf.

19. Ansell Strategic (2016) "In a Nutshell" The Impact of Budget Cuts to Aged Care #2: Budget cuts understated and misdirected. Available at: http://www.ansellstrategic.com.au/wp-content/uploads/2016/05/AS_NUTSHELL_Budget2016_v2.pdf.

20. Ansell Strategic (2016) Budget 2016: ACFI Modeling – Summary Findings June 2016. Available at: http://www.unitingcare.org.au/images/stories/publications/2016/160628_report_acfi_review_report_ansell.pdf

21. Commonwealth of Australia (2013) 2012 National Aged Care Workforce Census and Survey Report. Available at: http://apo.org.au/files/Resource/DepHealthAgeing_AgedCareWorkforce1012_2103.pdf.

22. Australian Institute of Health and Welfare (2016) Admissions into aged care services. Available at: http://www.aihw.gov.au/aged-care/residential-and-home-care-2014-15/admissions.

23. Australian Government Department of Social Services (2016) Stocktake of Australian Government Subsidised Aged Care Places and Ratios as at 30 June 2015. Available at: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2015/op_places_ratios_by_state_territory.pdf.

24. Australian Aged Care Quality Agency (2016) National Data Set 1.4.13 to 31.3.16. Parramatta, NSW: AACQA.

25. Department of Health (2016) Notices of Non-Compliance and Sanctions by State. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/NNC+and+Sanction+by+State?OpenDocument&State=ACT.

26. Commonwealth of Australia (2015) 2014-15 Report on the Operation of the Aged Care Act 1997. Canberra: Commonwealth of Australia Department of Health.

27. http://www.aacqa.gov.au/assessors/copy_of_RPguideJan2015.pdf

28. Agens, J.E. (2010) Chemical and physical restraint use in the older person, British Journal of Medical Practitioners 3(1). Available at: http://www.bjmp.org/content/chemical-and-physical-restraint-use-older-person.

29. Wang PS, Schneeweiss S, Avorn J, et al. (2005) Risk of death in elderly users of conventional vs. atypical antipsychotic medications. New England Journal of Medicine. 353(22) pp. 2335-2341.

30. Jusic N, Lader M. (1994) Post-mortem antipsychotic drug concentrations and unexplained deaths. British Journal of Psychiatry, 165(6) pp.787-791.

31. Friedman JH. (2006) Atypical antipsychotics in the elderly with Parkinson disease and the "black box" warning. Neurology.67(4) pp.564-566.

Solutions from the frontline

Practical approaches to reduce the risk of abuse in aged and disability services

NSW Nurses and Midwives' Association
Australian Nursing and Midwifery Federation NSW Branch

50 O'Dea Avenue
Waterloo NSW 2017

PHONE
8595 1234 (metro)
1300 367 962 (non-metro)

www.nswnma.asn.au

Publised by the NSWNMA/ ANMF NSW Branch, 50 O'Dea Avenue, Waterloo NSW 2017, Australia.

ISBN 978-1-921326-09-7 (Australia)

Issued September 2016.
Authorised by Brett Holmes, General Secretary, NSWNMA and Branch Secretary, ANMF NSW Branch, September 2016

NSW Nurses and Midwives' Association
PROFESSIONAL ISSUES | 2

NSW Nurses and Midwives' Association

PROFESSIONAL ISSUES | 2

Solutions from the frontline

Practical approaches to reduce the risk of abuse in aged and disability services

ISBN 978-1-921326-09-7 I Issued September 2016