Elder abuse in aged care

By Kim Forrester and Karen Williams

Elder abuse has increased to the point where it is acknowledged to be a significant medical, social and legal problem.

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However, there is a paucity of accurate data about elder abuse, thought to be the result of an inability or unwillingness of the elderly to report episodes of abuse. Although the reporting of concerns about elder abuse first occurred in Australia in the mid- to late-1970s,[1] very little information is known about the actual numbers of elderly people who are the victims of abuse, or the context in which the abuse takes place.

The Commonwealth government recently released a report from the Office of Aged Care Quality and Compliance indicating an increase in the numbers of cases of elder abuse and mistreatment in Australian nursing homes.[2] The cases investigated between July and December 2007 included allegations of serious physical assault, failed personal care and medical mismanagement. There were 418 sexual and physical assaults on elderly people in the aged-care sector, 138 of which occurred in NSW nursing homes; >>

and 332 reports of medication mismanagement. In NSW, there were 929 nursing home accreditation breaches reported within aged-care homes. In the last half of 2007, the police investigated 23 incidents in aged-care homes that were ultimately referred to the coroner, professional regulatory bodies and the Aged Care Standards and Accreditation Agency (ACSAA). International data indicates that approximately 3 per cent of those over the age of 65 are physically abused.[3]

Problems arise in an aged-care sector staffed primarily by unregulated health workers, whose conduct is not reviewed by regulatory authorities.

Elder abuse has been defined as the 'wilful or intentional harm caused to older adults by other persons with whom they have a relationship implying trust'.[4] Most often, the abuser will be a spouse and/or adult children. However, the abuse may also be perpetrated by other family members, or by a paid or unpaid carer. While there are many types of abuse, those most commonly reported include physical abuse (sexual abuse, shaking, striking, restraining); psychological abuse (threatening, intimidating, creating dependence, isolation and ignoring), neglect (failing to provide the necessaries of life); or financial abuse.

Abuse of the elderly is frequently difficult to detect. This may be due to a reluctance on the part of the elderly person to disclose the abuse, a lack of capacity to seek assistance, or an inability to access assistance due to social isolation. Abuse may take many different forms, which also hinders identification and detection. For example, the abuse may not be physically evident, or not identifiable through financial irregularities.

This article will address abuse of the elderly in the aged-care sector, with a focus on those forms of abuse perpetrated by health professionals, and the problems posed by an aged-care sector that is staffed primarily by unregulated workers.

ISSUES RELEVANT TO ELDER ABUSE

The challenges posed by elder abuse are multi-faceted and are significantly different to those relating to abuse in the general population. As an example, the recent Commonwealth report, *Older Persons and the Law*, identified the difficulties that an elderly person has in accessing appropriate legal assistance in response to abuse. Apart from the considerable hurdle posed by financial limitations, the report indicated that the problems experienced by elderly people were extensive, diverse and required multi-disciplinary responses. One fundamental problem was the fact that elderly people may not report abuse due to their inability to recognise it as a legal problem requiring a legal response. Consequently, they fail to seek appropriate legal and other assistance or services.[5]

Even when an allegation of abuse is made, there may be major barriers to carrying out an investigation of the allegation in the aged-care sector, where a significant proportion of the residents are extremely frail and vulnerable. In addition, many aged-care residents have multiple and complex health problems, including conditions such as severe dementia, stroke and arthritis, and are frequently being maintained on poly-pharmacy regimes involving medications that potentially interfere with their cognitive capacity, memory and communication ability.[6] Taken together, these factors can create enormous difficulties in investigating complaints of elder abuse. While it is not a complete solution, some international jurisdictions have attempted to address these problems by expediting criminal matters where the witnesses are older,[7] creating statutory exceptions to the rule against hearsay, and by permitting elderly people to give evidence in their ordinary surroundings.[8]

Recent amendments to the *Aged Care Act* 1997 (Cth) address a number of the issues surrounding identification and notification of elder abuse in the aged-care sector. The requirement for the mandatory reporting of 'reportable assaults'[9] of residents in aged-care facilities by 'approved providers' came into effect in July 2007. This section imposes an obligation on approved providers to report all allegations or incidents of assault to the police and the Commonwealth Department of Health and Ageing. Operators of aged-care services in receipt of Australian government subsidies are also required to ensure that staff, volunteers and contractors who have, or are likely to have, unsupervised contact with residents, undergo a national criminal history check. The establishment of the Office of Aged Care Quality and Compliance, the appointment of an Aged Care Commissioner, and the development of the Aged Care Complaints Investigation Scheme provide a reform agenda aimed at protecting the elderly residents of aged-care services in Australia.

The impact of the amendments will be far-reaching, with the Department of Health and Ageing overseeing more than 2,870 accredited nursing homes; that is, 167,070 aged-care beds across Australia. Where the aged-care sector is staffed by both regulated health professionals and unregulated health workers, it is important to consider the potential outcome when the carer is the perpetrator of the abuse.

REGULATED AND UNREGULATED WORKERS IN THE AGED-CARE SECTOR

The aged-care sector is notable for its high level of staffing skill-mix. Large numbers of unregulated health workers, such as assistants in nursing and personal care attendants, in addition to enrolled nurses, work under the direct and indirect supervision of registered nurses. Generally, medical practitioners do not review residents in the aged-care sector

on a daily basis but, rather, are more likely to attend for the purpose of regular treatment review and monitoring. Given the hands-on nature of their work, the large numbers of unregulated health workers are also more likely to have a higher level of participation in the day-to-day care of aged-care residents. The potential for abuse of the elderly by this sector of the workforce is therefore greater, and any alleged abuse must be reported to the police, rather than to regulatory authorities, which have no authority over this sector of the workforce. Currently, the professional regulatory authorities cannot review the conduct of general, unregulated aged-care workers, and may address allegations only of professional misconduct or unsatisfactory professional conduct by professionals licensed by the authority to practise.

Because the majority of elderly aged-care residents are cared for by unregulated health workers, few cases of elder abuse involving health professionals have been reported. Two such cases were *Gabrielsen v Nurses Board of South Australia*,[10] and *HCCC v Gabrielsen*.[11] These cases involved the conduct of a registered nurse towards two patients being cared for within a health facility. In the first incident, the nurse was found to have physically and sexually assaulted an elderly patient who suffered from dementia. The court heard how the registered nurse had entered a bathroom where the woman was being bathed by an enrolled nurse, and attempted to pick her up by the nipples. In addition, the registered nurse had, while drying the patient in a passageway, slapped her bottom with a towel wrapped around his hand. The second incident also involved an elderly patient suffering from dementia. After the registered nurse had finished drying the patient he threw her roughly on to a chair. The enrolled nurse, who had witnessed the incidents, lodged a complaint with the hospital Director of Nursing, who notified the South Australian Nurses Board. Both the SA Nurses Board and the NSW Health Care Complaints Commission, in reviewing the allegations, found the registered nurse guilty of unprofessional conduct and professional misconduct. The substantive elements of the charges against the nurse were that he had demonstrated a level of knowledge and judgement in his practice of nursing that was significantly below that reasonably expected of a nurse of an equivalent level of training or experience; and/or he had engaged in improper or unethical conduct related to the practice of nursing. The court found that his treatment of the first patient amounted to an assault of a sexual and violent nature, and his handling of the second patient, while not as violent, was not only very serious but also unethical and seriously inappropriate.

Another relevant aspect of this case was that the enrolled nurse (who reported the abuse) and Director of Nursing (who received the notification of abuse) were themselves subject to a series of 'abusive, disrespectful, discourteous and disparaging letters, faxes and emails from the registered nurse'.[12] The regulatory authority held that the registered nurse's unsatisfactory professional conduct was sufficiently serious to justify the removal of his name from the roll.

The legislation in each of the states and territories provides the grounds for initiating disciplinary proceedings. While the language of the legislation varies between the jurisdictions, activities that amount to professional misconduct, unsatisfactory professional conduct or unprofessional conduct will result in disciplinary action by the regulatory authority in the relevant jurisdiction.

For example, the definition of 'unsatisfactory professional conduct' in the *Health Practitioners (Professional Standards)* Act 1999 (Qld) for all regulated health professionals other than nurses (who are covered by the *Nursing Act* 1992 (Qld)) includes:

(a) professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant's professional peers;
(b) professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgement or care, in the practice of the registrant's profession;
(c) infamous conduct in a professional respect;
(d) misconduct in a professional respect;
(e) conduct discreditable to the registrant's profession;
(f) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for the person's well-being;
(g) influencing, or attempting to influence, the conduct of another registrant in a way that may compromise patient care;

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(h) fraudulent or dishonest behaviour in the practice of the registrant's profession; and
(i) other improper or unethical conduct.

The reporting of conduct amounting to elder abuse by a regulated health professional to a professional regulatory body would no doubt trigger disciplinary proceedings. But, as identified above, the issue is that a high proportion of the aged-care sector workforce is not regulated and, therefore, while subject to criminal charges, is not reportable to any professional authority. The Australian Nursing Federation federal secretary, Jill Iliffe, has stated that all care staff in nursing homes should be licensed as well as being subject to police checks. This suggests that a regulatory body should be established to develop a set of standards for workers who are currently unregulated, to ensure that appropriate standards of conduct are maintained, and that breaches are punished.

> The most commonly reported forms of elder abuse include physical assault, neglect and medical mismanagement, psychological and financial abuse.

LIMITATIONS ON DISCLOSURE UNDER THE *AGED CARE ACT*

While the *Aged Care Act* 1997 (Cth) imposes an obligation on the 'approved provider' to report abuse, this obligation does not apply to medical practitioners, nursing staff or allied health professionals. If an approved provider is not made aware of elder abuse, there are no provisions compelling disclosure by any member of the healthcare team. However, protection for disclosing a reportable assault is predominantly limited to staff members and approved contractors of the aged-care provider.[13]

THE INTERNATIONAL RESPONSE TO ELDER ABUSE

The term 'elder abuse' has its origins in America.[14] The US National Centre on Elder Abuse provides information on how to report abuse in all US states, along with reports on the effectiveness of the regulatory frameworks in identifying and prosecuting elder abuse.[15]

One such study examined the effectiveness of legislation equivalent to the *Aged Care Act* 1997 (Cth), in relation to the physical and sexual abuse of the elderly. A number of deficiencies were identified, including delays in notifying police, which resulted in the subsequent deterioration or lack of evidence, and insufficient background criminal checks. Although the US safeguard provisions allowed for financial penalties to be imposed on service-providers, their responsibility to protect nursing home residents from abuse means that, in reality, very few monetary penalties had in fact been imposed. The US has now established a 'nurse aide' registry that provides for a professional disciplinary response similar to other professional regulatory bodies. This does not extend to all staff working in nursing homes, however, such as maintenance and housekeeping personnel.[16]

CONCLUSION

In Australia, there is little data on the physical and sexual abuse of nursing home residents, or complaints to professional regulatory bodies. The recent amendments to the *Aged Care Act* 1997 (Cth) appear to introduce safeguards in order to protect this vulnerable population. However, as elder abuse is a complex and multi-layered problem, an effective response will also need to include a sophisticated and comprehensive range of measures. This should specifically include a registration scheme for all workers in aged-care facilities and services, along with changes to rules of evidence that accommodate the frailties of this population. The recent changes to the Act appear to be an encouraging development in an area of law that will no doubt evolve and develop further over time. ■

Notes: **1** A A Baker (1975), 'Granny Bashing', *Modern Geriatrics*, 5 at 20; G Burston (1977), 'Do your elderly patients live in fear of being battered?', *Modern Geriatrics*, at 54. **2** 'Abuse in Nursing Homes Soars', *Australian*, 23 March 2008. **3** B Coulson (2003), 'Dealing with elder abuse', *Medicine Today* 4(9) at 69. **4** *Ibid.* **5** House of Representatives Standing Committee on Legal and Constitutional Affairs, *Older Persons and the Law Report*, 2007, pp159, 163 and 165. Although this report considered a broader range of abuse than is considered in this article, the insights of the committee on the reticence of elderly people to identify their problems in legal terms, combined with the multi-layered and complex nature of their particular problems, militates against simple processes and responses being effective in this area. **6** J M Chalmers, K D Carter and A J Spencer, 'Oral Health of Adelaide Nursing Home Resident: Longitudinal Study'(2004) 23, *Australian Journal on Ageing*, 63, p66. **7** California Penal Code s1048, California District Attorneys Association, *Prosecutor's Brief, vol XXI, No. 2, pp13 and 45 at http://ag.ca.gov/bmfea/laws/private_elder.php*. **8** American Prosecutors Research Institute, *Prosecution of Elder Abuse, Neglect and Exploitation*, 2003, p36, pp40-42 *at* www.ndaa.org/pdf/elder_abuse_web.pdf. **9** 'Reportable assault' is defined as unlawful sexual contact, unreasonable use of force or an assault. **10** [2006] SA SC 199. **11** [2008] NSW NMT 2. **12** In light of the conduct of the registered nurse, it is relevant to note that the provisions contained in s96.8 of the Act aim to provide protection for reporting reportable assaults. **13** Section 63.1AA the Act. **14** House of Commons Health Committee, *Elder Abuse*, 2003-04, p7. http://www.publications.parliament.uk/pa/cm200304/cmselect/cmhealth/111/111.pdf. **15** See http://www.ncea.aoa.gov/ncearoot/Main_Site/index.aspx. **16** United States General Accounting Office, *Nursing Home Resident Abuse*, 2002, pp4-6.

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