# CHANGES IN THE AUSTRALIAN CARE ENVIRONMENT AND THEIR EFFECTS ON ELDER ABUSE


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BUT FIRST….

COGNITIVE DECLINE PARTNERSHIP CENTRE

# Clinical Practice Guidelines for Dementia in Australia

## Recommendations

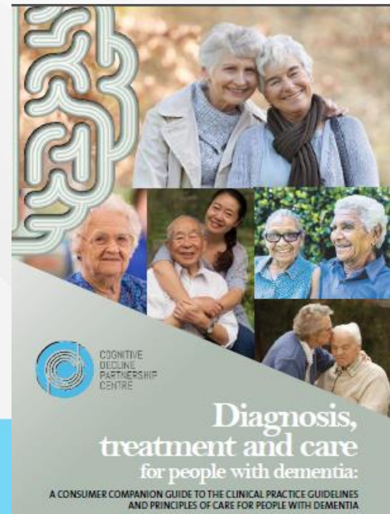
# CLINICAL PRACTICE GUIDELINES FOR DEMENTIA

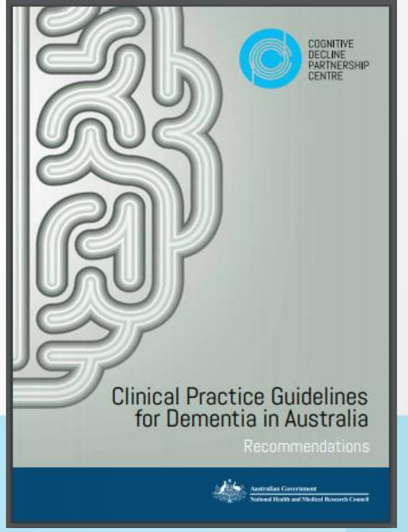
- **Adapted from the NICE (UK) Guidelines using the ADAPTE process in 2015 by the Cognitive Decline Partnership Centre**
- **Guidelines Adaptation Committee of 24 members with widespread representation across health professions and strong involvement of consumers**
- **Approved by NHMRC Council in Feb 2016 and released in March 2016**
- **109 recommendations with 29 evidence based**
- ***Consumer Companion Guide also developed and available***

http://sydney.edu.au/medicine/cdpc/resources/dementia-guidelines.php

# HOW TO GET YOUR COPY

- Google: Clinical Practice Guidelines for Dementia in Australia
- Go to: sydney.edu.au/medicine/cdpc/resources/dementia-guidelines.php
- Email me and we will send you a hard copy when they are reprinted



# CHANGES IN THE AUSTRALIAN CARE ENVIRONMENT AND THEIR EFFECTS ON ELDER ABUSE

# FINANCIAL ABUSE: NEED FOR NATIONAL ONLINE REGISTER OF POWERS OF ATTORNEY

## LAWS NEEDED TO CURB AGED FINANCIAL ABUSE

ELDER financial abuse affects thousands of vulnerable older Australians every year. Your local bank branch staff can play a vital role in detecting and preventing financial abuse. But they need help from the government to do it properly.

# MRS MARGARET SOLIS: VICTIM OF SEXUAL ASSAULT

The Australian, 9-10 June 2018

# CASE OF NEGLECT

## Death of elderly woman Marcia Clark highlights need for better carer support: coroner

By Meredith Griffiths

Updated 50 minutes ago

# POLICY CHANGES IN THE CARE ENVIRONMENT

- My Aged Care (2015)
- Changes in financing of residential aged care (July 2014)
- Australian Commission on Safety and Quality in Health Care

  2nd Edition National Safety and Quality Health Service Standards (Jan 2019)
- UN Convention on the Rights of Persons with Disabilities

  Supported decision making rather than substitute decision making
- Australian Law Reform Commission

  Elder abuse – a national legal response (2017)
- Review of National Aged Care Quality Regulatory Processes (Carnell – Paterson Review)

  New independent Aged Care Quality and Safety Commission (Jan 2019)
- New Aged Care Standards

  Focusing on consumer outcomes rather than provider processes (July 2019)
- Consumer directed care (Feb 2017)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# MY AGED CARE

- Single point of entry to aged care in Australia since July 2015
- Despite many changes and “improvements” it remains a major barrier to accessing services for older people and their carers
- It remains problematic for people with dementia, or people with hearing difficulties, or people who do not speak English
- Improvements allow for GPs to make initial referrals for assessment, and some ACATs will still take urgent referrals and “back refer”

# MY AGED CARE

- NSW Coroner has drawn attention to the fact that My Aged Care can be a barrier to older people accessing services
- Colleagues have reported numerous cases of inability of older people or their family members to access assessment and therefore appropriate services, resulting in significant failures in care provision with subsequent neglect
- Family carers have reported that people with dementia decline the assessment when phoned to ask for consent to a visit
- MAC staff vary considerably in communication skills and knowledge
- Many GPs decline to use MAC due to bad experiences and simply send patient to hospital for “sorting out”

# MR C

- 71 year old man with moderately severe Parkinsons disease
- Lives with wife who provides all care, minimal support from his family, self funded retirees, CALD background
- Late 2016: referral to MAC made by wife, MAC would only speak to husband, she did not understand what was being asked of her
- Early 2017: second referral made but when phone call to seek consent for visit was made, husband answered phone and declined
- Late 2017: third referral made, ACAT visited Nov 2017, approved for Level 3 4 Home Care Package, high level respite, and permanent residential care
- March 2018: waiting HCP, offered care at Level 2 but quite expensive, used some respite
- April 2018: referral made to MAC for prioritisation, ACAT visited immediately, found patient bedfast with pressure areas, dehydrated, admitted to hospital

# AGED CARE REFORMS

- Changes to financing arrangements for residential care
- Commenced July 2014
- Accommodation payment for all residents – RAD/DAP
- Families very unwilling for family home to be sold
  - older people being cared for at home rather than in residential care
  - significant cases of abuse and neglect being found
- Powers of attorney being misused to sell home to other family prior to assessment of assets

***Reforming the aged care system***

Financial changes to residential care


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# MRS P

- 81 year old lady with moderate Alzheimers disease, lived alone with community support, son nearby was POA and assisted with managing finances
- ACAT had approved her for residential care and HCP level 3 4
- Daughter  from interstate moved in with her to “provide care”, and ceased services
- Enduring POA and Guardianship was changed to daughter, and possibly will was changed, daughter on Carer pension
- Son reported concerns about care for mother as he had visited and found her on her own, undressed, unkempt, losing weight
- GP was denied access when she visited, strongly supported move to residential care
- Daughter declined residential care and refused son access
- Son called ambulance and Mrs C taken to hospital, expressed fear of daughter, found to be severely neglected and malnourished
- Guardianship application undertaken, son is now guardian and financial manager

# MRS D

- 79 year old lady with severe rheumatoid arthritis, daughter and son-in-law lived with her, had assistance with personal care
- Daughter had enduring POA
- Had multiple falls due to generalised weakness and poor balance, often not found for several hours
- Regularly admitted to hospital with bruising and fractures, always spent 2 to 3 months in hospital
- Assessed by ACAT as suitable for HCP level 3 4, and for high level respite and permanent residential care
- Over 3 years spent 29 out of 36 months in hospital
- Daughter always declined residential care despite mother expressing wish to go
- With Mrs D’s permission we began Guardianship proceedings citing neglect and financial exploitation, daughter then agreed to Mrs D’s move to care

# AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE: 2ND EDITION NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS (JAN 2019)

- Australian Commission on Safety and Quality in Health Care developed Standards in 2011 that all hospitals in Australia (public and private) are required to meet to ensure ongoing funding
- In late 2012 it was recognised that a greater emphasis on management of delirium and dementia in hospital was necessary, and this could be achieved through inclusion of delirium and dementia within the National Accreditation Standards
- Work began in early 2013 to rewrite the Standards to include cognitive impairment where appropriate, national consultation has occurred, and 2nd Edition Standards are available now, and will be assessed against from Jan 2019

# AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE NATIONAL STANDARDS

- 10 Standards were reduced to 8 with specific inclusion of cognitive impairment (delirium and dementia) in 5 of the Standards
- “How to” packages have been available since 2015 for hospitals to prepare for the changes, and many have programs already in place in preparation for the new Standards
- What effect are the new Standards already having, and are likely to have, on elder abuse?
  - Better recognition of delirium and dementia on presentation and during admission with reduction in use of chemical and physical restraints, less Aggression Response Team calls, and improved ability to care for these patients using non pharmacological interventions
  - Better recognition of cognitive impairment and awareness of possibility of financial abuse or exploitation whilst patient is in hospital

# MRS R 2009 (BEFORE HOSPITAL CHANGES)

- 78 year old lady, early Alzheimer’s disease but continued to manage daily activities with some prompting from her husband
- She had a fall in her garden resulting in a fractured pelvis and was admitted to hospital with pain and immobility. She was managed with regular analgesia, including opiates, and bed rest
- Over the following day she became more confused, calling out, refusing to eat or drink anything. Staff believed this was due to her dementia. Her underlying bladder infections was missed.
- She was physically restrained, and given antipsychotics. She developed pneumonia and became very deconditioned.
- She needed 8 weeks in the rehab ward to regain function, and when she finally returned home she required much more assistance.

# MRS D 2017 (AFTER CHANGES)

- Mrs D is an 81 year old lady with mild dementia, lives with her husband. Fell in shops, sustained fractured pelvis.
- Admitted to hospital, screened for delirium on admission, given adequate analgesia, nursed sitting out of bed during day, family visited regularly to orient and support her
- Staff well aware of how to manage delirium in dementia
- Onset of confusion noted, UTI diagnosed and immediately treated
- Moved to rehabilitation ward once pain improved, and mobilised well
- Discharged home within 4 weeks of fracture with minimal change in functional abilities

# UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES: SUPPORTED DECISION MAKING RATHER THAN SUBSTITUTE DECISION MAKING

- Australia is a signatory to the UN Convention on the Rights of Persons with Disabilities which includes reference to:
  - Equal recognition before the law
  - Equal right to "legal capacity"
  - Supported decision making

  Meaning a move away from substitute decision making to supported decision making for people with disabilities

- After reviewing Commonwealth and State laws, the Australian Law Reform Commission (ALRC) released a report in 2014 called "Equality, Capacity and Disability in Commonwealth Laws", which provides a framework for recommended reviews of state, territory and Commonwealth legislation and suggests 4 key principles

# SUPPORTED DECISION MAKING

- The National Decision-Making Principles are:
- **Principle 1**: All adults have an equal right to make decisions that affect their lives and to have those decisions respected;
- **Principle 2**: Persons who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives;
- **Principle 3**: The will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives;
- **Principle 4**: Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.

# SUPPORTED DECISION-MAKING

**“the process whereby a person with a disability is enabled to make and communicate decisions with respect to personal or legal matters”**

- A voluntary process
- About the person’s own decision
- Assisting person to understand
- Assisting person to weigh options
- Assisting person to communicate choice
- Create enabling contexts

Must acknowledge the will, preferences, and rights of the person

# SUPPORTED DECISION MAKING

- 91 year old lady with moderate dementia, living in dementia cottage
- Developed swollen R knee which restricted her daily walks
- GP wanted consent for her to have aspiration and injection of steroid
- She was assisted to make the decision herself

- 68 year old man with moderate dementia lived with wife
- Required amputation of toes due to diabetic gangrene
- Long discussion with wife and patient
- He understood that the gangrene was dangerous and his toes needed to be amputated
- His wife consented to the surgery knowing her husband was happy with this

# DRAFT AGED CARE QUALITY STANDARDS

- Replaces 44 Standards with 8 Standards
- Structured with consumer outcomes followed by organisation statement

FINAL DRAFT AGED CARE QUALITY STANDARDS



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# FINAL DRAFT AGED CARE QUALITY STANDARDS

## *Standard 1 – Consumer dignity and choice*

### Consumer outcome

I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement

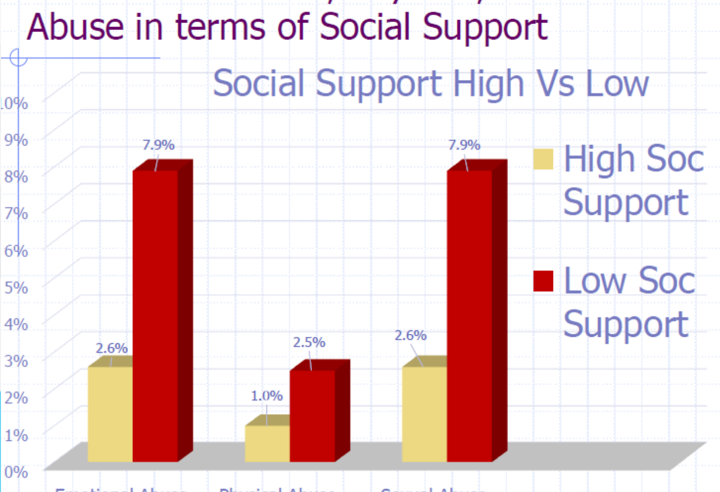
The organisation:

- Has a culture of inclusion and respect for consumers
- Supports consumers to exercise choice and independence
- Respects consumers' privacy.

DRAFT

# PROTECTION THROUGH CONNECTION
## (RON ACIERNO)

- Importance of social support in positively influencing physical and mental health
- National Elder Mistreatment Study (US) with 5700 plus older people (2008)
- 8 year follow up:





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### The National Elder Mistreatment Study: An 8-year longitudinal study of outcomes


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**ABSTRACT**

*Objectives:* To conduct an 8-year follow-up of the National Elder Mistreatment Study (NEMS) and specify risk ratios for negative outcomes of elder abuse, including DSM-5 defined depression, generalized anxiety disorder (GAD), post-traumatic stress disorder (PTSD), and poor self-reported health.
*Methods:* Attempts were made to re-contact, via Computer Assisted Telephone Interview, all 752 NEMS participants who reported mistreatment since age 60 at Wave I, as well as a randomly selected sample of non-mistreated NEMS participants
*Results:* 183 NEMS Wave I elder abuse victims and 591 non-victims provided data. In bivariate analyses, elder mistreatment 8 years earlier increased risk of negative outcomes by 200–700%. However, multivariate analyses revealed that Current (Wave II) social support was highly protective against most negative outcomes (excepting PTSD), and even appeared to nullify effects of mistreatment on GAD and poor self-reported health.
*Conclusions:* Outcomes of elder mistreatment have not been studied prospectively in a national sample. The NEMS 8-year follow-up findings indicate a strong relationship between elder mistreatment at Wave I and negative emotional and physical health 8 years later. Fortunately, current (Wave II) social support appears to be both consistently and powerfully protective against most negative outcomes.



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# PROTECTION THROUGH CONNECTION

- 2 Important findings from National Elder Mistreatment Study
  - 1. Social support is an important protective factor in preventing or reducing all forms of abuse
  - 2. Social support is protective after abuse has occurred in reducing problems in physical health, anxiety and depression

- What is the lesson from this?
- Stay connected, if you are not – become connected (in SA Creating better neighbourhoods)

FINAL MESSAGE from Ron Acierno:

"Bad stuff happens to older people – abuse, loss, illness, natural disasters – but with good social support and connection, the effect of this bad stuff is significantly reduced…."

Acierno 2017

Thank you