

Inquiry into Elder Abuse in NSW

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**Submission from:
Dr Maree Bernoth
Senior Lecturer Charles Sturt University
Wagga Wagga**

My credence in writing this report is based on the years I have worked as a Registered Nurse in aged care (20 years), my time as an educator in aged care facilities and the research I have conducted with colleagues and students since 2001.

Elder abuse unexpectedly came to my attention while I was undertaking my PhD research. That research was focused on education programs to support aged care workers to work safely but in the interviews to gather the data for the research project, the aged care workers were not concerned for their personal safety but they wanted to disclose the instances of abuse and neglect they were encountering in their workplaces. When those reports were shared by me with managers, I became the target for abuse.

I heard about abuse, I witnessed abuse and neglect and I have experienced the consequences of reporting abuse.

A confounding factor of preventing, detecting and addressing abuse in residential aged care facilities is that it -

- Does not occur in all facilities. I have witnessed the highest quality, person-centred care to treatment that is totally unacceptable, negligent and abusive. The Accreditation and Standards Monitoring System cannot be relied on to detect disparity in care, detecting abuse or ensure standardised, quality care.
- Abuse ranges in severity from grossly unacceptable acts to acts of unkindness, absence of care, carelessness, negligence and ignorance of appropriate clinical care.

This report covers instances of institutional abuse and neglect predominantly in residential aged care but also includes the acute care system. Some of the material has been presented in my submission to the Productivity Commission in 2011 and my submission to the Upper House Inquiry in the role of the Registered Nurse in aged care in 2015. Attached to this submission are relevant journal articles that have been peer reviewed and published in business and nursing journals.

The definition of abuse for this document is espoused by the International Network for the Prevention of Elder Abuse, (2002) –

Abuse of older people is a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. The abuse may be physical, sexual, psychological or financial or may involve neglect.

The following are instances of abuse and neglect that I have witnessed or have been reported to me by relatives whose loved ones were/are in residential aged care in NSW so that the committee has an insight into the types of abuse, neglect, ignorance and dehumanising behaviours that exists in some of our facilities.

Malnutrition and dehydration:

I was working with a group of carers and we went into a room of four very emaciated older women to feed them their lunch. These women were very slow chewing and swallowing their food. On the tray there was a main meal and dessert as well a drink. We had just started to feed them when my mobile telephone rang so I left the room to answer it. I was away for only a few minutes but when I returned to the room, all of the dishes had been cleared away and the carers told me they had finished feeding the women. It was impossible that those women had eaten two courses and a drink in the time that I was away. How often did that happen?

A family member told me:

Everybody's so busy, they didn't even feed her. Near the end when she couldn't feed herself anymore, she couldn't see. She was being handed these tubs of fruit, you have got to peel off the top, piece of plastic. She couldn't see it, and she didn't have the dexterity with her fingers. She should have been fed probably for a long time before we said: can we, and we used to feed her ourselves when we were there. Another thing is that the food was shit, shit. One night a week they used to get two little half sausage rolls and a little container of tomato sauce and maybe a container of orange juice or something like that that you had to pull the lid off and that was dinner. I can't believe that was dinner for anyone – possibly a snack on a special day or something maybe, but not dinner and it was like, the most horrible quality. The soups, like, when Mum was here I used to cook Indian, but she loved food. It was her only joy left in life, the taste of food. She was still tasting food but at the nursing home, she tried to eat something but there was never, never, anything. She didn't complain. (2010)

Another food issue:

And then I noticed that the plates were dirty, always dirty. The tea cups had stains in them that were obviously there for a long time. And I watched them put out the dinners; the dinners were being put out on plates that were dirty with dried food from soup that they had. Sometimes they used the cups for soup and then sometimes they'd be cups of tea. They had a trolley coming around mornings and evenings with soup, dried soup on the cups. (2010)

This was an incident between a family member and care staff in another facility:

... one afternoon, we were having trouble. One of the kitchen staff came around with afternoon tea and I forget why I looked at the cups ... um I picked it up and said "You can't use this, you can't use this" and started taking all the cups off the tray because they were foul. And, shoot the messenger, she turned on me and sort of said what was I doing. I said "Would you drink out of this?" She said "No". "But you expect these people to?" She said "But I haven't got time to ...". And I said "Well, I want you to check them. It is fair enough that someone else has loaded them on your tray but you have got to check them before you put tea in them". [She said] "I haven't got time!" I very nearly picked up the cups and

smashed them, but I didn't, I restrained myself. But I could not believe the response: "I haven't got time". When coupled with "No, I would not drink out of this cup" it was just totally incomprehensible! So I went and I found clean cups and I put them on her tray. (2010)

One family member was concerned about the lack of fluids:

Because the workload was increasing, the workers decided, without telling anyone, to stop having the tea cart come around in the mornings and afternoons. So people were not getting hydrated. They had their cup of tea at breakfast and nothing 'til lunch and then nothing 'til dinner, which is disgusting (2010).

This family member went on to say that the residents were given a bottle of water which was placed beside their beds. However, some of the residents could not open the bottle and others could not reach it so, even though the bottle was there, it was of no use to the majority of residents. This family member took it on themselves to go around the residents' rooms to open the bottles and give them some fluids.

One resident's daughter told me:

Quality of food ... that's revolting but as for what is being presented, often it looks alright but I think a lot of it is inappropriate for the age of the people we're dealing with. But things have improved because one of the other resident's wives is there all the time and she has got them so that they are allowed to have sandwiches. She buys bread and jam.

I needed to have this clarified so I asked, "She brings it in from home, bread and jam?"

Yes, yes ... But she does it. As far as I am aware, she'll get a loaf of bread every now and then and a jar of strawberry jam or something, and she goes around at most meals and offers them bread and jam and they all love it! (2010)

With staffing levels inadequate, it is going to be the most dependent residents who are neglected, especially with nutrition and hydration. They can take a long time to assist with their food and to get them to drink so the carers choose who will be fed and who will be inadequately fed or even decide who does not get not fed at all. Carers make decisions about the amount of food a resident will receive so that, even though the diet has been determined by a dietician, the nutritional requirements of the residents are at the mercy of unskilled carers or the beneficence of other resident's relatives.

In the article by Bernoth, Dietsch, and Davies, (2014) the issue of malnutrition and dehydration is further elaborated and includes the case of an older man admitted to an acute facility from a residential aged care facility who was diagnosed with malnutrition dehydration and died a few days after admission.

Skills/Knowledge of care workers

In June, 2012 in a large aged care facility, students noticed that a patient diagnosed with alcohol-related dementia had suddenly developed Bell's palsy and also had trouble moving his left leg and arm. This was reported but they were told that *it was just a part of his dementia and they should not be concerned*. The clinical picture however, is that he had suffered a stroke but this could not be verified as he received no medical attention. In the same facility an elderly lady sustained head trauma. The students wanted to perform neurological observations but were told *not to bother*. A few days later, the students convinced senior staff that there was a soft area on her head where she had sustained the trauma. She was taken to hospital and a fractured skull was diagnosed.

Pain management

Research published this year indicates that abuse and neglect happens in acute hospitals. Green, Bernoth and Nielsen (2015) explored the experiences of people with a diagnosis of dementia admitted to an acute care hospital after sustaining a fractured femur and the management of pain.

In the study, all patients had an acute reason for pain (bone fracture) and yet 60% did not receive a PRN analgesic medication in the first 24 hours of admission. It cannot be presumed that all the patients in the study were experiencing pain that was not treated; however, it is likely that patients admitted to hospital with an acute bone fracture would experience pain.

It was found that instead of analgesia, patients with dementia were more likely to receive haloperidol (a psychotropic medication).

Further instances of inadequate pain relief are documented in my submission to the Upper House Inquiry in the role of Registered Nurses in aged care (2015).

Responding to calls for assistance

Because of the lack of staff in aged care facilities, the ability to respond to call bells or buzzers is problematic. Visitors can hear bells ringing and call systems being activated and continuing for long periods of time without response. What has become common practice is for the aged care workers to remove the buzzer or bell so that it appears that everyone is comfortable.

This is done by placing the mechanism in a position so that it cannot be reached. Another practice is removing the mechanism from the wall or removing batteries so the resident actually pushes the button but there is no call registered and visitors do not hear the incessant ringing.

I had to call the staff up because Mum had been sitting on the loo waiting for them for at least 20 minutes, beyond the time she had finished being put on the loo. She said I had rung the bell 20 minutes ago for them to come and get me and so I arrived that afternoon and I was ringing the bell and this nurse came along and she was moving Mum from the bathroom to the bed. I complained then that there weren't two people looking after her.

Then the nurse dropped her. Mum had bruising. I know she was injured because it was one woman lifting her and when it was supposed to be two. The instructions from day one on Mum's chart were two people to lift all the time. I was actually sitting there watching this woman with Mum and watched her drop her and then have to lean down and Mum got pushed against the bed and I ran over and helped and immediately said "aren't there supposed to be two of you doing this?"

Another family told me:

The only frigging time they would come when a button was pressed was, they have 2 buttons, one that the resident presses and one that a nurse presses if a nurse needs assistance. You press that one (the nurse assist) and they are there, can't get there any other time! Jesus that annoyed me! That was terrible, terrible. Some of them leave the buzzer so that they can't reach them. We got a chain for Mum to help lift herself up and we tied the buzzer to that and people that were inexperienced or just too busy or didn't remember, I had to write a note saying "please remember to put the chain and the buzzer down for Mum, please" and I put it at the door as they came in and tied to the chain, a big A4 because they wouldn't do it. And I'd come in, I left in the morning to go to work and get back there at 3.30, 4 o'clock and Mum hasn't had a drink because she couldn't reach it and she couldn't reach the buzzer to tell anybody.

Yet another incident:

On weekends you could shoot a gun down these long halls. There was one RN for four areas. Although they say we put staff on in the high demand times, in the morning when you're getting people up, showering them and dressing them and the evenings, when you're feeding them. But in the middle of the day anything could be happening and there would be no-body there. And you'd press a button and ask somebody to come and help and the button would be beeping, and you know that it's been activated and then after awhile, you'd wander down trying to find somebody and then you'd see somebody, one of the carers on their mobile phone, outside on the landing talking and having a cigarette. People could be dying, people could have fallen over, press their buttons for assistance and they're having a smoke. It just didn't work. Then when they only had a few staff on, in the end, I got so angry one day because they have their break together. They'd have two carers for each wing and they'd decide to have their break together, to go off to the kitchen, there was nobody on at all! What a joke.

One day when I found Mum trying to get out of bed and she had pressed the button, nobody there, I just went off and went down and found them, I said "how dare you do that, why are you doing this?" They were having their break. They said "we are having our break." I said "why are you having it together? There are people who need help." They are not treating them as humans, they are objects that they are being paid to look after and it's a bit of a pain.

Infantilisation is endemic in residential aged care. When there is pressure of time and staff with no or little skills, those staff will relate to the residents as if they are children. Treating them like children means ignoring all of the resident's rights especially to self-determination because the staff member knows what is best and will chastise the resident if they transgress what the staff member deems to be the right thing to do.

An elderly gentleman living in an aged care facility in a large city in NSW and when a group of his friends visited the facility, they noticed he was withdrawn and lonely so they invited him on one of their social outings. Even though he needed assistance with various tasks, the group felt that they could manage to assist him. He was delighted to be invited and had a wonderful evening out with the group. They returned him to the nursing home about 10pm. One of the carers came to the door to let him in. The group heard the carer admonish him saying, *"What do you think you are doing staying out this late! If you can stay out this late, you can get yourself to bed!"* That night he slept in his clothes.

The gentleman rang the group the next day to say that he could no longer go out with them because he was fearful of the treatment he would receive when he returned to the facility.

Another incident that was reported to me by a colleague was at change over between the morning and afternoon staff in a residential aged care facility. The staff was gathered around the nurses' station ready for report. A male resident, who was in a wheel chair, approached one of the nurses. He was trying to apologise to her for something that had happened the previous day; it was difficult to understand what it was he was apologising for but he seemed genuine. The female nurse turned and leant over his wheel chair, she yelled obscenities at him and told him loudly what a dirty old man he was and she would have nothing more to do with him. Everyone in the area heard this, other residents, other staff and visitors but no-one reacted, it was as if this was common practice for staff to yell at residents and the general consensus seemed to be that he deserved what he got. The man in the wheelchair turned around and wheeled himself back to his room. These were his carers, those he depended on for assistance with living or rather existing.

Depersonalised care

An incident I witnessed as a consultant in a residential aged care facility, I witnessed two of care workers were getting an older woman out of bed. She was a thin, frail woman who was curled up in a foetal position facing the wall. The two care workers approached the woman, grabbed her knees and rolled her onto her back. They removed her wet pad and then left the room to get another. They swung her around, took off her nightie, put on her top and bent down to put on her pants. At this stage, she woke up and started to kick her feet. My suggestion to the care workers was that if they spoke to her and gained her co-operation, she would not kick them. They ignored me and continued to put on her footwear. The care workers had not said a word to this woman.

A walker was produced and the older woman was stood up into it. The care workers moved a chair in behind her and sat her on it. Then they started to push her out of the bed room door. I asked if they were going to wash her. With this, one of the care workers pushed her over to the basin at which the staff wash their hands and wet some paper towel with water that was cold. Then they roughly rubbed the paper towel over her hair and then her face. She was then pushed into the lounge area where a tray was attached to the chair and a drink placed on the tray. These picked up the liquid and threw it at the care workers. The care workers made some comment about her being cantankerous. I immediately sought the manager whose response was “they all have green bowls in their lockers”. I had a meeting with the Director of Nursing to report this incident and my contract was terminated.

From our research into the experiences of families when a loved one was in residential aged care, we were told that care workers were fixated on their particular role and failed to respond to an emergency situation, willing to leave a resident on the floor so they could continue the bingo session. It is evidence of the inability of care workers to prioritise and demonstrates the need for skilled aged care nurses to support and mentor care staff.

Part of my frustration was people got to the point, the workers, were refusing to do the work that wasn't their job. There were people who were ENs or carers on some shifts, and the on other shifts they were allocated as Activity Officer (AO). So they'd be out there with people doing an activity and there'd be people fallen over in bedrooms who have been calling out for help and I've gone in and say "do you need a hand?" and they'd say, "yes, I've fallen over." Then I'd go out and say to the AO, "there's a person who's fallen over in their room, can you go and help?" They would say to me "I am the Activity Officer today. I can't do that!"

How ridiculous is that!! And I'd say "just go and do it, please. I think the bingo can wait." A person is hurt on the floor. She (the AO) was furious with me. Red flushed, threw down the bingo calling numbers and stormed off to look after the lady who was on the floor. It was disgusting!

Oral hygiene

In 2015 and in a NSW regional town, an older woman from a residential aged care facility was admitted to the local acute hospital. The reason for her admission was that her dentures were cemented onto her gums because of the filth that had accumulated there over weeks of no oral care. She had stopped eating, had become withdrawn and had halitosis. Once her oral health was restored, she was able to eat and was more alert.

During my consultancy work, I noticed that oral hygiene was not mentioned in the care plans. Staff reported incidents where residents purchased their own toothbrushes and toothpaste but these go missing. Afternoon staff reported that water is not changed in the denture containers and they have had incidences where mould has grown in the containers.

An oral hygiene program that was successfully conducted in the Riverina under Murrumbidgee Medicare Local was ceased because of the restructure of the Medicare Local system. There is no standard related to oral hygiene and so no incentive for facilities to address oral hygiene despite the impact on nutrition, enjoyment of food, halitosis, xeristoma, stomatitis, cardiac function, prevention of ulcers and oral cancers.

Cost of reporting abuse

There are regulations requiring mandatory reporting of abuse in residential aged care however reporting abuse or making a complaint has repercussions for the resident, their family and the staff. These issues are articulated in our article which was published in the Journal of Business Ethics and attached to this submission. –

Bernoeth, M., Dietsch, E., Burmeister, O., & Schwartz, M. (2013). Information management in aged care: Cases of confidentiality and elder abuse.

The most disturbing reports are from relatives about the abuse dealt to their vulnerable relatives when they make a complaint. The following is one instance.

She (the aged care worker) came and abused me after you left – you got no idea what she said to me. They get me in the shower and they hurt me ... they were that rough (Bernoeth, Dietsch, Burmeister, & Schwartz, 2013).

As stated previously, I have experienced the abuse and know how frightening it can be and the potential for the abuse to silence vulnerable people. I am fortunate to be able to work in a university where I am able to write papers and conduct research to provide evidence and have a voice. Relatives, aged care staff and vulnerable older adults are not as fortunate.

Eliminating institutional abuse

Eliminating institutional abuse can be achieved by:

- Management that celebrates education and enquiry and mirrors to staff what care means thus building a culture where abuse and neglect is not tolerated. Examples I have witnessed where such cultures exist are Holy Spirit, Dubbo, Bushland Health facilities, Taree and the Masonic Villages in Newcastle, the Central Coast, Bellingen and Coffs Harbour.
- Instigation of adequate support for all facilities by professionals such as Nurse Practitioners, dieticians, physiotherapists. The support of the Nurse Practitioner at Bushland Health in Taree is invaluable in supporting the care staff to deliver quality care.
- Change in the approach to accreditation and standards monitoring such as that used at Calvary Retirement Community at Cessnock in 2006..
- Clinical supervision, mentoring and support for staff
- Adequate staffing
- Appropriate skill mix that includes sufficient Registered Nurses to direct and prioritise care
- the focus on evidence based, person centered care with a culture of inquiry within the facility
- Close ties between universities, aged care facilities and services to develop and foster a culture of enquiry and learning
- Use of a clinical governance approach to address any adverse events or complaints
- Transparency in the followup to complaints and open communication with the complainant even including the complainant in the development of solutions.
- Appropriate on-going education of staff based on the assessed needs of the staff and addressing the clinical issues that are relevant to the residents within the facility.
- Care plans that are living documents, reflecting the person they are focused on; that include the person and their family in the development phase and are used on a daily basis to direct care.

Conclusion

There is a broad disparity in the quality of care delivered to frail, older people in residential aged care facilities with no surety of quality care offered by the accreditation and standards monitoring system.

The causes of neglect and abuse in residential aged care facilities are many and varied as demonstrated in the cases that have been cited in this document.

Older people in institutional aged care constitute a vulnerable group. The person is in residential aged care because they require the services that such a business offers. If an alternative existed they would most probably have availed themselves of it. Their inability to do so depicts their status as consumers of that service in that they require it and no alternative exists for them. In such a relationship, where the one party is dependent upon the other, the dependant party is in a position of vulnerability. This is compounded by the associated increasing frailty of the older person which heightens their dependency. Realistically their options are limited. Ignoring the dynamics of the aged care market itself, and the alternative options—or, more realistically perhaps—the lack of readily available alternatives within that market, the elderly in aged care have no option: they require aged care; they may become increasingly dependent upon such services and, simultaneously, more vulnerable. Vulnerability is closely tied to identity; vulnerability limits control and people unable to exert control can be perceived as less than human and targets for abuse. Our population is ageing; subsequently the business of aged care provision is increasingly the reality for the older person. Businesses and care workers are charged with creating environments where older people, their family members, professionals and researchers feel safe to disclose and report suspected or actual elder abuse without fear of repercussion. In doing so however, ethical dilemmas must be acknowledged and addressed and the safety, employment security and wellbeing of the person reporting abuse, protected (Bernoth, Dietsch, Burmeister, & Schwartz, 2013).

We look to this inquiry to recognise and address these by enacting legislation and facilitating services and structures to ensure safe environments for vulnerable older people, their families and those who work in residential aged care.

References

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