

Elder Abuse Policy

Purpose

The purpose of this policy/procedure is to:

- Ensure that tools are in place to identify cases of elder abuse and that appropriate action is taken in cases of elder abuse or suspected elder abuse
- Maintain the dignity and protect the safety and security of older people utilising the organisation's service
- Achieve an integrated and standardised approach to the management of elder abuse

This policy should be read in conjunction with the following document:

- *'With respect to age 2009: Victorian Government practice guidelines for health services and community agencies for the prevention of elder abuse.'*

The following Organisational Policies should also be taken into consideration:

- Occupational Health & Safety Policy
- Home Visiting Policy
- Client Confidentiality and Privacy Policy
- Storage of Client Records Policy
- Client Referral Policy
- Assessment of Client Capacity Policy
- Client Intake Policy
- Independent (Third) Person Policy
- Emergency procedure
- Public health risk policy
- Working with people from CALD backgrounds policy
- Using interpreters policy

*With respect to age 2009 can be viewed or downloaded online at:

<http://www.health.vic.gov.au/agedcare/publications/respect/index.htm#download>

Policy Statement

This organisation will address suspected cases of elder abuse in accordance with 'With respect to age – 2009: Victorian Government guidelines for Health Services' and 'Community agencies for the prevention of elder abuse'.

Elder Abuse Definition (See page 4 – *With respect to age 2009*).

Elder abuse is any act occurring within a relationship where there is an implication of trust, which results in harm to an older person.

This policy is not concerned with situations of abuse in consumer-based circumstances, professional misconduct, harassment and criminal acts by strangers, self-neglect or mistreatment, or Residential Aged Care Services (RACS) (See pages 5 & 6 – *With respect to age 2009*).

Abuse of older people is a complex problem and each situation will be unique.

Personal beliefs and professional values, social, cultural and family experiences all influence perception of what constitutes abuse and neglect of older people.

Key principles underpinning the implementation of the Victorian Government Elder Abuse Prevention Strategy (See page 3 – *With respect to age 2009*)

- **Competence** - All adults are considered competent to make informed decisions unless demonstrated otherwise.
- **Self Determination** – With appropriate information and support, individuals should be encouraged to make their own decisions.
- **Appropriate protection** – where a person is not competent to make their own decisions, it may be necessary to appoint a guardian or administrator. If a person is represented, their wishes should still be taken into account as far as possible.
- **Best Interests** – The interests of an older person's safety and wellbeing are paramount. Even when they are unable to make all decisions themselves, their views should be taken into account as far as possible.
- **Importance of relationships** – All responses to allegations of abuse should be respectful of the existing relationships that are considered important to the older person.
- **Collaborative responses** – Effective prevention and response requires a collaborative approach which recognises the complexity of the issue, and the skills and experience of appropriate services.
- **Community responsibility** - The most effective response is achieved when agencies work collaboratively and in partnership with the community.

Duty of care (See page 99 – *With respect to age 2009*).

A duty of care encompasses a duty not to be careless or negligent and arises from a relationship between parties that are regarded as sufficiently close as to infer that an obligation exists in some form. This relationship involves the notion of 'proximity' or a degree of closeness. Proximity is usually described in terms of time and (physical) 'circumstantial casual' relationship, such as the relationship between employer and employee, health worker and client.

Duty of care involves a legal obligation to avoid causing harm or to prevent harm occurring to another person. This only arises where it is reasonably foreseeable in a particular situation that the other person would be harmed by an action or omission without the exercise of reasonable care. Health and aged care workers have a duty of care to older people they are assisting. Under the Wrongs Act 1958 (VIC) a worker is not negligent in failing to take precautions against a risk of harm unless:

- a) The risk was foreseeable (that is it is a risk of which the person knew or ought to have known);
- b) The risk was not insignificant (not far fetched or fanciful); and
- c) In the circumstances, a reasonable person in the workers position would have taken those precautions.

The duty of care obligation of an employee to foresee and prevent or avoid harm is limited by the employee's professional expertise and competence.

If a worker breaches their duty of care, they have failed to meet the expected standards of care. Duty of care not only refers to the actions of a worker but also to the advice the worker gives or fails to give.

Procedure if you suspect potential abuse

Action taken will depend on the individual situation and will often involve a primary assessment team such as a Geriatrician, Doctor and Social Worker in conjunction with the person already involved with the situation of suspected abuse.

1. Staff should report any **suspicion of abuse** to their supervisor. (See attachments 1 & 2 for information of types and signs of abuse and risk factors and attachment 3 for questions to assist with identifying abuse).
2. If there is a concern that the older person does not have competence to make decisions, an appropriate referral to **assess their capacity** must be made. Assessment of an older person's capacity to make decisions and informed choices is important. Their right to refuse support should be respected. An older person with mental capacity may be capable of managing their own affairs with minimal support from a health / community care worker. Mental capacity is the ability to understand an act, a decision or transaction and its consequence. A person has capacity to make an informed decision if they understand the general nature and effect of a particular decision or action and can weigh up the consequences of different options and communicate their decision. A person's capacity to make a particular decision should only be doubted if there is a factual basis to doubt it (See pages 23 & 24 – *With respect to age 2009*).
3. Most situations of elder abuse are not emergencies. If it is an emergency situation, staff should **activate the organisation's emergency procedure**. An emergency is defined as a situation that poses an immediate threat to human life or a serious risk of physical harm or serious damage to property. Depending on the type and context of abuse, it may be useful to talk through the idea of planning an emergency response with the older person, should it ever need to be activated. In an emergency response, an older person should be involved in making decisions about their life as much as possible. However, if a worker assesses that an older person is in imminent danger of harm or death, it may be necessary to arrange the following:
 - Support (for example, ambulance services)
 - Medical treatment for an older person or carer (for example, referral to local doctor or hospital emergency department)
 - Emergency accommodation for an older person or carer (for example, referral to supported housing services in the region, a women's refuge or other temporary housing)
 - Police involvement, which may be required for the safety of the worker as well as an older person
 - An emergency application to VCAT (if the appointment of a temporary guardian is necessary, for instance, the Public Advocate) or a temporary administrator (for instance, State Trustees Limited) to protect an incompetent older person or their property and assets
 - Other matters sensitive to cultural considerations, including religious beliefs, which ideally should be known prior to any emergency (See page 27 of *With respect to age 2009*)
4. Gather and document clear and relevant **evidence of abuse** (See page 36 – *With respect to age 2009* for more detail about documentation).
5. Arrange for an **assessment of needs** of the older person, either in-house or refer to an appropriate funded assessment service (See page 23 – *With respect to age 2009*).
6. **Develop a care plan** to support an older person to prevent further abuse. The care plan should include interventions to stop reoccurrence and may include a safety plan, developed in consultation with the older person. Provide information about the older person's rights and services available to assist, such as emergency services, local services, and state-wide services i.e. Seniors Rights Victoria (See page 31 – *With respect to age 2009*), local agency networks (LANs), and referral and interagency strategies.

Reluctance to accept intervention

If an incompetent older person is at risk and refusing help (despite efforts made to persuade) it may be necessary to contact the older person's substituted decision maker. For example, Medical Attorney under power or Guardian under power or apply to the Victorian Civil and Administrative Tribunal to appoint a temporary guardian to consent to support services or some other intervention.

If an older person is competent but refuses help, a direct care worker can support and advise about options such as how to deal with emergencies. Strategies can then be developed to help the older person understand their rights, and feel confident and comfortable to take action. In a case of self-neglect in which a competent older person chooses to live in squalor, the situation could be considered as a public health risk under the Health Act.

People with dementia and their carers

People with dementia (Alzheimer's or related disorders) may be at risk of financial neglect and self-neglect/abuse that includes actions of self-injury by the individual upon themselves which are passive or active.

Carers of persons with dementia may require special attention where abuse or neglect is occurring, as they can be the recipients of verbal and physical abuse.

People from Culturally and Linguistically Diverse (CALD) backgrounds

Cultural factors influence how all forms of abuse are viewed, and specific strategies and responses to elder abuse should address such differences. Being culturally informed and providing sensitive support is an integral component of service provision. It is important that support is provided with an understanding of the cultural background.

People from different cultural backgrounds may require interpreter services. Family and friends should not be used as an interpreter (See pages 9 & 10 – *With respect to age 2009*).

Aboriginal and Torres Strait Islander People

Advice should be sought from people experienced with the particular cultural background of the family concerned, acknowledging that cultural difference may require special sensitivity in relation to neglect and abuse (See pages 7 to 9 – *With respect to age 2009* for more detail about Aboriginal and Torres Strait Islander People)

Confidentiality and Privacy

Where possible, discuss with the person the concerns and gain permission to refer to other agencies. It is permissible to breach confidentiality in some very limited circumstances including where the older person has consented to the disclosure of information; where the law allows or requires the disclosure of confidential information; and, in extreme circumstances, where there is a clear and imminent threat to an identifiable person of serious bodily injury or death. (See pages 36 to 38 – *With respect to age 2009* for more information about privacy and confidentiality)

Types and Signs of Abuse (See pages 12 to 16 – *With respect to age 2009*)

Physical Abuse:

Behaviours that are physically abusive include:

- Pushing and shoving
- Kicking, punching, slapping, biting and burning
- Rough handling
- Restraining with rope, belts and ties
- Locking the person in a room, building or yard
- Using substance restraints including alcohol, prescribed and un-prescribed drugs, household chemicals, poisons
- Holding a pillow over a persons head
- Intentional injury with a weapon or object

Signs of physical abuse may include:

- Internal injuries, unexplained bruises, pain on touching
- Bruises, lacerations, choke marks, abrasions or welts (ie evidence of hitting, punching, shaking, slapping or use of a weapon)
- Burns (ie.: ropes, cigarettes, matches, iron, hot water)
- Broken or healing bones
- Observed unexplained injuries or conditions such as paralysis, scalp injuries, scratches, sprains, punctures, unattended injuries, hypothermia, dehydration, pressure sores due to physical restraint
- Over sedation / under sedation
- Unexplained pain or restricted movements
- Cringing or acting fearfully
- Unexplained hair loss (perhaps from pulling), eye injuries, missing teeth
- Unexplained accidents
- Stories about injuries that conflict between the older person and others

Financial Abuse:

Behaviours that are financially abusive include:

- Threatening, coercing, putting undue pressure or forcing an older person into selling or handing over an asset or property, or signing a document, wills or POA
- Abusing or neglecting POA to manage an older persons finances
- Stealing goods from an older person, i.e. jewellery, credit cards, cash, electronic equipment, blankets or food
- Using an older persons banking and financial documents without authorization
- Managing the finances of a competent older person without permission)
- Misuse of an older person's possessions or money or possessions (e.g. vehicle, phone, internet connection)
- Taking an older person to a general practitioner other than their own, for an assessment of decision-making capacity, in order to access an EPOA, particularly if the doctor speaks a language different from the older person
- Appropriating the proceeds of the sale of an older person's home with the promise of providing future accommodation or care and then not providing it.
- Pressuring an older person to relinquish (hand over) an anticipated inheritance or for a gift or a loan
- Incurring bills for which an older person is responsible

Signs of financial abuse may include:

- Missing belongings
- The inability of an older person to access adequate food, shelter or utilities
- Unfamiliar or new signatures on cheques and documents
- The inability of an older person to access bank accounts or statements
- The inability to pay normal accounts and the presence of unpaid bills
- Significant withdrawals
- A decline in the older persons spending habits
- Fear, stress and anxiety expressed by an older person
- Transfer of assets in circumstances where the person may no longer be sufficiently competent to manage
- Pressuring an older person to provide a deposit, or large investment into a property in return for accommodation and care, without sufficient protection and legal advice for the older person
- Threatening loss of an asset, e.g. family home if the older person does not contribute to mortgage, repairs or debts

Psychological or emotional abuse:

Behaviours that are psychologically or emotionally abusive include:

- Pressuring, intimidating or bullying
- Name calling, degrading, humiliating or treating the person like a child, in private or public
- Threatening to harm the person, other people, or pets
- Verbally or physically abusing an older person
- Preventing an older person from speaking
- Talking about not being able to cope as a carer
- Repeatedly telling an older person that they have dementia
- Threatening to withdraw affection or access to grandchildren or other loved ones
- Threatening to put an older person into a nursing home
- Emotionally harming (blackmail) via threatening remarks, insults or harsh commands
- Preventing access to services

Signs of psychological / emotional abuse may include:

- Resignation, shame
- Depression, tearfulness
- Confusion and social isolation
- Feelings of helplessness
- Unexplained paranoia
- Excessive fear
- Insomnia
- Marked passivity or anger

Neglect:

Behaviours that are actively or passively neglectful include:

- Failure to provide the necessities of life, such as food, warmth and shelter or blocking others from providing basic needs
- Receiving the carers allowance and not providing care to an older person for whom one has a responsibility
- Active neglect is the intentional withholding of clothing, food, personal or health care and leaving the older adult in an unsafe place or in isolation, this includes misuse of medications and prescriptions including withholding and over medicating
- Passive neglect occurs when the caregiver unintentionally does not provide necessities because of lack of information, skill or interest
- Self neglect which is not a life long pattern and reflects a change in cognition

Signs of neglect may include:

- Inadequate nutrition, accommodation, clothing, medical or dental care
- Poor personal hygiene
- Poor skin integrity
- Exposure to unsafe, unhealthy, unsanitary conditions
- Malnourishment and unexplained weight loss
- Hypothermia or overheating
- Inappropriate clothing for the season
- The person left alone, abandoned or unattended for long periods
- Lack of social, cultural, intellectual or physical stimulation
- Injuries that have not been properly cared for
- Carer displaying overly attentive behaviour in the company of others
- Under medication or over medication

Social abuse:

Behaviours that are socially abusive include:

- Preventing contact with family and friends
- Withholding mail
- Not allowing the older person to use the phone or monitoring their phone calls or disconnecting the phone without consent
- Living in and taking control over an older person's home without their consent
- Preventing an older person from engaging in religious or cultural practices including preventing those from CALD backgrounds from meeting their cultural needs
- Moving an older person far away from the immediate family or friends
- Preventing an older person from engaging in Aboriginal cultural practices if they identify as Indigenous

Signs of social abuse may include:

- Sadness or grief at the loss of interactions with others
- Withdrawal or listlessness due to people not visiting
- Changes in levels of self-esteem
- Worry or anxiety after a particular visit by specific person
- Appearing ashamed

Sexual abuse:

Behaviours that are sexually abusive are:

- Non-consensual sexual contact, language or exploitative behaviour
- Touching an older person inappropriately or molestation
- Sexual assault
- Cleaning or treating the older person's genital area roughly or inappropriately
- Viewing obscene video's or making obscene phone calls in the presence of an older person without their consent

Signs of sexual abuse may include:

- Unexplained sexually transmitted disease (STD)
- Recent incontinence (bladder or bowel)
- Internal injuries
- Human bite marks
- Scratches, bruises, pain on touching, choke marks on throat, burn marks
- Injury to face, neck, chest, abdomen, thighs or buttocks
- Trauma including bleeding around the genitals, chest, rectum or mouth
- Torn or bloody underclothing or bedding
- Anxiety when near or contact suggested with the alleged perpetrator
- Changes in sleep patterns, sleep disturbance or nightmares

Attachment 2

Risk factors (See pages 16 to 18 – *With respect to age 2009*)

Risk identification in Elder Abuse is complex. The following risk factors may help to identify older people who are at a higher risk of abuse and may indicate a need for extra support and services to reduce their risk of abuse.

- **Family violence** – Family violence can occur in a number of circumstances and in a range of family settings. It can take the form of abuse of the elderly, sibling abuse, violence between same-sex couples, adolescent children being violent towards parents, carers being violent towards a person with a disability, or female-to-male partner violence.
- **Isolation** – If an older person and the carer are socially isolated, lacking supportive contacts and social networks, there may be an increased risk of abuse and neglect.
- **Dependency** – Dependence of a frail older person on a family carer is not necessarily a cause of abuse. An abusing relative is more likely to be materially dependent on an older person than non-abusing relatives (refer to Pillemer and Finkelhor, 1989).
- **Psychopathology in an abuser** – The abuser may be dependent on an older person for material support, and have a mental health condition as well as dependencies, such as alcoholism or drug abuse. An abuser may also have carer responsibilities.
- **Stress in the care relationship** – Caring for a frail and dependent older person can be extremely stressful. The carer may have adopted the role through a sense of duty or pressure from other relatives. Sometimes carers experience resentment, frustration or anger. These feelings — however they are expressed — may be reciprocated by the dependent person. Few people enjoy being dependent on others for basic daily living needs.
- **Difficulties accepting care due to health status** – In some situations, an older, dependent person may abuse a carer. This may occur due to difficulty in accepting reliance on another person. Psychiatric illness or dementia may result in aggression or a loss of insight and perspective.
- **Older parents caring for a mature-aged child with a disability** – Sometimes, situations of abuse occur where older parents are caring for a relative with a disability. Many parents of children with disabilities remain primary carers into late middle age and beyond. They are usually co-resident, primary carers of their children who predominantly have an intellectual disability or, less frequently, an acquired brain injury (ABI) or physical disability, for example, multiple sclerosis, cerebral palsy or multiple chronic illnesses. Primary carers may be up to, or even beyond, eighty years of age. These living/caring arrangements are usually based on a strong commitment by the carer to continuing care, and are most likely to be of mutual satisfaction to both parties. The living arrangement often involves the co-resident person with a disability taking an active role in running the household.
For the carer, these arrangements may also result in social isolation, depression and poor health. The factors that lead to abuse of the carer are complex, and can involve isolation, the challenging behaviour of the person with the disability, increasing frailty of the carer, and belief by both parties that there no alternatives to their present situation.

Other risk factors may include:

- Lack of information about their rights
- Insufficient planning for a purposeful and secure old-age
- Existing frailty or physical dependency or the expectation or fear of approaching frailty
- Psychological dependency
- Inadequate social networks and poor housing conditions
- Cultural factors

Attachment 3

Questions to assist with identifying elder abuse

- Do you have enough privacy at home?
- Do you trust most of the people in your family?
- Can you take your own medication and get around by yourself?
- Are you sad or lonely often?
- Do you feel that nobody wants you around?
- Do you feel uncomfortable with anyone in your family?
- Has anyone close to you tried to hurt you or harm you recently?
- Are you afraid of anyone in your family?
- Has anyone close to you called you names or put you down or made you feel bad recently?
- Does someone in your family make you stay in bed or tell you that you are sick when you know you are not?
- Has anyone forced you to do things you did not want to do?
- Has anyone taken things that belong to you without your okay?

(Vulnerability to Abuse Screening Scale (VASS) items - page 34 Victorian Community Council Against Violence – Preventing Elder Abuse through the Health Sector Nov 2005)

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things that you didn't want to do?
- Has anyone taken anything that was yours without asking?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when you needed help?

(Routine Screening Questions for Elder Abuse – American Medical Association, 'Diagnostic & Treatment Guidelines on Elder Abuse and Neglect page 35 Victorian Community Council Against Violence – Preventing Elder Abuse through the Health Sector Nov 2005)