Clinical Management of Elder Abuse

Procedure code: OP-CM2	Current version: March 2021
Previous version: October 2019	Next review date: March 2023
Section: Communicating Clearly	Sub-Section: Health Equity

1. Overview

This procedure outlines staff response to suspicion of, witnessed or disclosed Elder Abuse.

2. Applicability

All Western Health staff and managers need to be aware of Elder Abuse if they work with older people and/ or work with people at a higher risk of abusing older people (perpetrators). Staff members should know how to detect Elder Abuse and what to do when they suspect, witness or there is a disclosure of Elder Abuse.

3. Responsibility

In areas where Western Health provides care for older people; and people at a higher risk of perpetrating against older people, department managers are responsible for introducing and implementing this procedure, & clinicians are required to follow it.

The designated Elder Abuse Liaison Officer (EALO) will provide workforce clinical support, advice and consultancy related to Elder Abuse for the duration of the Integrated Model of Care for responding to suspected Elder Abuse project (IMoC) . Senior clinicians at Western Aged Care Assessment Service (ACAS) or a Health Equity project team member will provide workforce clinical support in the absence of the EALO.

The Western Health 'Clinical Practice Group Champions for Elder Abuse' (CPG-EA), multidisciplinary team Social Worker/s (SW), emergency department Advise, Co-ordination & Expertise (ACE-ED) care co-ordinators or team specific family violence (FV) advisors remain the first point of contact when staff suspect, witness or there is a disclosure of Elder Abuse.

The Elder Abuse Steering Committee (EASC) is responsible for the safe, effective and Department (DFFH) aligned delivery of the IMoC project in Western Metropolitan Melbourne. The EASC & CPG-EA will provide review of complex Elder Abuse cases and consideration of related trends and possible improvement activities.

4. Authority

Exceptions to the clinical practices described in this procedure can only be authorised by an Executive, Divisional or Clinical Services Director.

5. Associated Documentation

In support of this procedure, the following Manuals, Policies, Instructions, Guidelines, and/or Forms apply:

Code	Name
P-CM2	Health Equity
P-CM3	Information Privacy
OP-CM2	Clinical Management of Family Violence under Multi-Agency Risk Assessment and Management Framework (MARAM)
OP-CM2	Family Violence and Child Information Sharing procedure.
OP-CM3	Freedom of Information
OP-CM3	Release of Personal and Health Information
OP-EP2	Professional Misconduct and Reportable Conduct Scheme
OP-EP2	Workplace Support for Employees and Volunteers Experiencing Family Violence
DP-GC7	Serious Incident Response Scheme (SIRS)

6. Credentialing Requirements

A designated Western CPG-EA clinician must undertake advanced (DFFH approved) training in Elder Abuse within four months of inclusion within CPG-EA.

7. Definitions and Abbreviations

For purposes of this procedure, unless otherwise stated, the following definitions/ abbreviations shall apply:
(All links sourced from respective service websites on 13th December 2021)

Aged Care Act (1997): "Under the *Aged Care Act 1997 (the Act),* approved providers of residential aged care must: 1. Report to the police and 'the department' (Australian Government: Aged Care Quality & Safety Commission) incidents of alleged or suspected reportable assaults within 24 hours of the allegation, or when the approved provider starts to suspect a reportable assault has occurred. 2. Take reasonable measures to ensure staff members report any suspicions or allegations of reportable assaults to the approved provider (or other authorised person), to the police and 'the department'. 3. Take reasonable measures to protect the identity of any staff member who makes a report and protect them from victimisation". *(Australian Government: Federal Register of Legislation)*

Clinical Practice Group – Elder Abuse (CPG-EA): Is a multi-disciplinary clinical work group, who work across the continuum of care within Western Health (or within services who routinely collaborate with Western Health). They have additional expertise in recognising and responding to Elder Abuse in their specialised work areas.

Elder Abuse: "… is a form of family or domestic violence that is experienced by older people. Like family violence, elder abuse is about one person having power and control over another person" (DVRCV). "Elder abuse 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. This type of violence constitutes a violation of human rights and includes physical, sexual, psychological, emotional, financial and material abuse, abandonment, neglect and serious loss of dignity and respect" (WHO). Elder Abuse may be intentional (deliberate mistreatment) or unintentional (resulting from lack of information, support or ability). One in six older Australians (15%) reported experiencing abuse within 12 months (AIFS, Apr. 2021) .

Elder Abuse Helplines:

Seniors Rights Victoria (SRV) (phone: 1300 368 821)
1800ElderHelp - Australian Human Rights Commission (phone: 1800 353 374)
Men's Referral Service (phone: 1300 766 491)
24/7 Family Violence Response Helplines:
Safe Steps (phone: 1800 015 188)
1800RESPECT (phone: 1800 737 732)

Serious Unlawful Elder Abuse *(escalation to external agency should be undertaken in consultation with your Department Manager or Executive on call).*
Victoria Police - 000 or local police station
Western Region Centre Against Sexual Assault (WestCASA, phone: 03 9216 0444) *(where there is suspicion of unlawful sexual contact/ refer to WestCASA for Forensic Medical Officer (FMO) attendance and forensic examination in their dedicated forensic suite within the Emergency Department or similar).*

Elder Abuse Liaison Officer (EALO): Is an appointed Western Health staff member who has specialised training and skills in the assessment and management of Elder Abuse. EALO chiefly provides secondary consultation support (during business hours) to all professionals working in western metropolitan Melbourne (and where no similar service exists outside of region, mobile: 0423 842 103, elderabuseenquiries@wh.org.au). EALO collaborates with other IMoC project partners to support the broad delivery of IMoC, inclusive of promoting free, DFFH approved elder abuse workforce training via the Elder Abuse Learning Hub, participation in Western Elder Abuse Prevention Network activities, triaging referrals for Elder Abuse informed therapeutic and financial counselling; and providing expert Elder Abuse support to the Health Equity Steering Committee at Western Health.

Elder Abuse Steering Committee (EASC): Is a multi-agency and multi-disciplinary group of expert clinical and managerial staff who are responsible for the safe, effective and 'Department' (DFFH) aligned continuous delivery of the IMoC project in Western Metropolitan Melbourne.

Family Violence Protection Act (2008): "The purpose of this Act is to- maximise safety for children and adults who have experienced family violence; and prevent and reduce family violence to the greatest extent possible; and promote the accountability of perpetrators of family violence for their actions. This Act aims to achieve its purpose by- providing an effective and accessible system of family violence intervention orders and family violence safety notices; and providing for the sharing of information that is relevant to assessing and managing a risk of family violence; and creating offences for contraventions of family violence intervention orders and family violence safety notices; and providing a framework for achieving consistency in family violence risk assessment and family violence management". (Australasian Legal Information Institute)

Older Person: Is a person aged 65 years or older or an Aboriginal and/or Torres Strait Islander person aged 50 years or older. Additionally, the psychological and psychosocial toll of traumatic experiences, combined with poor nutrition and exposure to disease, can cause refugees and other cohorts to prematurely age. As a consequence, many challenges associated with older age (inclusive of heightened risk of abuse) will be apparent in people under 65 years (UNHCR) (AIHW) (ALRC).

Patient Alerts: Are alerts that are not visible to the patient or others that highlight important information about the older person to health care professionals and other members of staff.

Perpetrator: Is 'a person who uses violence toward' or 'controls' an older person (The Bouverie Centre, 2021).

Self-neglect: Is the "inability or refusal *to attend adequately to one's own health, hygiene, nutrition, or social needs" (Abrams et al., 2002, p.1724). Older people who self-neglect lack the social engagement that gives life purpose, have fewer social resources, and often live in isolation from others (Burnett et al, 2006; McCarthy, 2003).*

Serious Incident Response Scheme (SIRS): "…is an initiative to help prevent and reduce incidents of abuse and neglect in residential aged care services subsidised by the Australian Government. The SIRS sets out arrangements for approved providers of residential aged care and flexible care delivered in a residential setting to manage and take reasonable action to prevent incidents with a focus on the safety, health, well-being, and quality of life of consumers. Approved providers must have an effective incident management system (IMS) in place and use this to continuously improve the management and prevention of incidents. In addition to the IMS, providers must notify the Commission when 8 types of reportable incidents occur. Reportable incidents must always be reported within set timeframes depending on the level of impact to the consumer". **Aged Care Quality & Safety Commission (ACQSC):** 'How does the SIRS work?' SIRS Provider Support Tool SIRS Work flow Chart

Will and preference: Could be thought of as what is important to the person. "A person's *'will'*…. is what drives them and gives their life meaning. Sometimes this can only be seen through their actions. A person's *'preferences'* are the things they like. A person's particular *'will and preference'* may arise from experience, knowledge or intuition. Our will and preferences can change over time" (OPA, 2019).

8. Procedure Detail

8.1 Management of Elder Abuse – Work Flow Chart

At all stages consider if there is an immediate risk to health and safety?

Consider:
-Hospital admission or delaying discharge or admission to emergency respite care
-Discussing with Department Manager or Exec. on-call, in particularly serious cases
-Escalation to external agency, inclusive of Victoria Police

Detection/ Notification

Staff member suspect's abuse:
Consider using screening tool: WHAD151: FV Adult Victim Survivor Screening & Identification Tool (including Elder Abuse) found at WH Forms Database.

As required advice from EALO:
Ph: 0423 842 103 (business hrs) or elderabuseenquiries@wh.org.au

Consultation with own team/ on-shift:
-CPG-EA, SW, ACE-ED Co-ordinator or FV Advisor (External EA helplines also available - refer to section 7).
-Advise your supervisor &/or Exec on call

Assessment/ Management

Actions:

-Ensure the Older Person feels supported and heard.
-Undertake information gathering in keeping with consent and information sharing obligations (Family Violence Protection Act 2008).
-Arrange decision-making capacity assessment (if indicated)
-Undertake actions as agreed with EALO, CPG-EA, SW, ACE-ED care co-ordinator or FV Advisor.
-Document in WH EMR
-Liaise with treating team
-Brief Operational/ Lead Manager
-Record alert on EMR

If older person declines consent & appears to have decision-making capacity

Abuse likely or confirmed

Abuse unlikely or No Abuse

In collaboration with the Older Person complete agreed actions & ensure investigation outcomes and action plan are documented.

Document & Monitor

8.2 Suspected Abuse

8.2.1 Detection

Older people most at risk of experiencing abuse may have cognitive impairment, dementia diagnosis or mental health concerns. They may be living in poverty, need assistance with daily activities, identify with a minority group/s or have experienced family violence or other trauma through their lives. Furthermore, people most at risk of perpetrating against older people, may have concerns inclusive of gambling, alcohol or other drug misuse, mental health concerns and dependence on the older person for housing, money, transport or similar. They may be experiencing carer stress or have a history of family violence themselves. The historic quality of relationships between caregivers and older care recipients may be a contributing factor. (The Bouverie Centre, 2021).

When Elder Abuse is suspected, all staff are required to respond (in alignment with responsibilities stipulated in the Family Violence Protection Act, 2008). Perpetrators of Elder Abuse are most often someone the older person knows and trusts, usually a relative or carer. Your client may be the older victim/ survivor, the perpetrator or another involved person who discloses their concerns. Elder Abuse in Aboriginal Communities may look different and may require a different response and referral pathway. In conjunction with your team Elder Abuse clinical expert/s, please contact the **WH Aboriginal Health Unit to discuss ph. 8345 0952.**

Suspicions of Elder Abuse will require additional sensitive inquiry, inclusive of careful questioning and observation. To screen for family violence, use the *WHAD151: Family Violence Adult Victim Survivor Screening and Identification Tool* (including Elder Abuse), found at WH Forms Database. Additional advice on how to progress will be provided by the EALO, CPG-EA, Social Worker, ACE-ED care co-ordinator or team Family Violence Advisor. For out of business hours, external secondary consultation: contact Elder Abuse Helplines (Refer to section 7).

If the situation poses an **immediate risk** to the health and safety of the Older Person, consider:

a) Admitting the Older Person to hospital, urgent respite or delaying discharge from hospital.
b) Contacting Victoria Police for advice or attendance (non-urgent matters phone: 13 14 44).
c) Seek advice from the Office of the Public Advocate (OPA) enquiry line, particularly when there are concerns related to an Older Person's decision–making capacity (phone: 1300 309 337).
d) More serious presentations (inclusive of suspected unlawful behaviour) should be discussed in a timely manner with your department manager or the Executive On-Call (after hours).

Upon review if you find **abuse is unlikely** to have occurred, complete documentation and continue to **monitor** the situation. Post discharge older people believed to be at ongoing risk of Elder Abuse may be monitored via programs inclusive of: Hospital Admission Risk Program (HARP), Rapid Allied health (RAH), Community Based Transitional Care Program (CB-TCP), GEM@Home or other similar service, where suitably skilled clinicians can follow up in community. A MyAgedCare (MAC) referral may be indicated to elicit Regional Assessment Service (RAS) involvement or a comprehensive Aged Care Assessment with Western Aged Care Assessment Service (ACAS).

Situations of self-neglect are likely to raise similar practice issues for health care staff, and although not considered a form of Elder Abuse, people who self-neglect are at a greater risk of experiencing other forms of Elder Abuse and the same guidelines should be followed.

8.2.2 Notification

If your initial inquiries support your suspicion that Elder Abuse has occurred, notify your team leader, Manager or appointed out of hours representative and consult with your CPG-EA, Social Worker, ACE-ED care co-ordinator or team specific Family Violence Adviser. Should additional expertise be required, please contact EALO phone: 0423 842 103 elderabuseenquiries@wh.org.au during business hours. For urgent out of business hours family violence secondary consultation, contact 24-hour hotlines: 1800RESPECT (1800 737 732) & Safe Steps: 1800 015 188.

Where there is *suspicion of serious unlawful Elder Abuse escalation to an external agency may be required and should only be undertaken with the guidance of your Department Manager or Executive on call. For example, where there is suspicion of sexual assault of an older person in conjunction with your manager or 'exec on call' contact* Western Region Centre Against Sexual Assault (WestCASA, phone: 03 9216 0444) *WestCASA Forensic Medical Officer (FMO) will attend and undertake a forensic examination in their dedicated forensic suite within the Emergency Department or similar.* Additionally, Victoria Police involvement may be indicated Victoria Police - 000 or local police station.

8.2.3 Assessment

Assessment will include:

a) Obtaining **consent** from the older person. Ask the older person whether they would like assistance from a support person i.e., nominated family member, social worker, psychologist, or advocate from another organisation.
b) If the older person **declines consent:**
    - Consider relative *'risk of serious harm'* to the older person & others and explore any concerns around cognitive changes inclusive of the older person's decision making-capacity.
    - High-risk situations, where the older person has been diagnosed with or is suspected of having significant cognitive impairment or psychiatric illness, may indicate the need for capacity-assessment

with a Geriatrician, Psychiatrist or Neuropsychologist.

c) Undertaking a risk assessment **with consent:**
   - *WHAD152 Adult Victim Survivor Family Violence Brief Risk Assessment Tool* (WH Forms Database).

d) **Information gathering** with consent:
   - Older person/s.
   - Alleged perpetrator/s (to be undertaken with caution & ideally expert support)
   - Others: inclusive of current treating team, home based care provider/s, General Practitioner (GP) & other trusted formal and informal support people involved with the older person/s (ensuring compliance with consent & information sharing obligations)

e) **Monitoring** the situation.

f) Completing an **alert** in the older person's medical record where appropriate. This is essential to avoid future 'missed opportunities' to support the older person.

g) Undertaking mandatory reporting to the ACQSC and possibly Victoria Police, if the older person is in one of Western Health's aged care programs governed by the *Aged Care Act 1997* and amendments related to the Serious Incident Reporting Scheme (SIRS, new guidelines rolled out 2021 in response to findings of the Aged Care Royal Commission 2021).

Should the case review require additional expertise (or assurance of meeting Western Health expectations), staff will seek advice or consultation from the EALO (or their proxy).

8.2.4 Management

The outcome of assessment should be discussed with the older person and treating team to formulate and enact a management plan that is reflective of the older *person's 'will and preference'*. If the older person needs to remain in hospital for longer than is typical due to perceived risk of harm, then early planning is essential and should be highly prioritised. Consider using *WHAD147 Making a Safety Plan for Adults (*WH Forms Database). Elder Abuse specific interventions for consideration are inclusive of therapeutic counselling &/ or family consultation, financial counselling, advocacy and specialised aged care services, family violence, health, social & legal services. Other support pathways may be suitable dependent on an older person's unique needs and preferences. The EALO or your team CPG-EA, SW, ACE-ED Care Co-ordinator or FV Advisor will be able to recommend best practice intervention options available.

8.2.5 Documentation and Alerts

Document Elder Abuse allegations in the older person's electronic medical record (EMR) using the older person's and/or 'other informant's' own words. Carefully document all physical injuries inclusive of signs and symptoms of sexual assault. Record observations of older person and other involved people's behaviour and communication; inclusive of response to toileting, showering, interactions with other people and impacts of environmental change/s. Documentation should be inclusive of written reports, investigations, photographs, and other accepted methods of recording in EMR.

Where abuse or neglect of an older person is suspected but not disclosed, the reasons for the suspicion must also be documented. Staff should document what they have observed in an objective and non-judgemental manner, using language used by the people involved to accurately represent their issues or concerns. Where appropriate an alert should be added to the older person's medical record. Consider if the risk should be included in the discharge summary to the GP and/ or included in any referrals for community services post discharge.

9. Document History

Number of previous revisions: one
Previous issue dates: October 2019
Documents superseded or combined:

Code	Name
OP-AP1.1.2	Clinical Management of Elder Abuse

10. References (all accessed 20th December 2021)

Aboriginal and Torres Strait Islander people (AIHW)
Aged Care Quality and Safety Commission SIRS Guidelines (last updated October 2021)
Australian Government: Federal Register of Legislation
Australian Institute of Family Studies (April 2021) - National Elder Abuse Prevalence Study
Australian Law Reform Commission
Australasian Legal Information Institute
Decision tree sharing information under FVISS
Domestic Violence Resource Centre Victoria (DVRCV) - Elder Abuse & Family Violence
Ministerial Guidelines Family Violence Information Sharing Scheme (FVISS)
Multi-Agency Risk Assessment and Management Framework (MARAM)
National Ageing Research Institute (NARI) research on Elder Abuse (2016 - 2020)
Office of the Public Advocate (2019)
Royal Commission into Aged Care (March 2021)
Royal Commission into Family Violence (March 2016)
Seniors Rights Victoria - Elder Abuse Toolkit
The Benevolent Society: The Drivers of Ageism (September 2017)

The United Nations Refugee Agency (UNHCR)
University of Melbourne: Reframing Aging in Australia (June 2020)
WHO Elder Abuse Fact Sheet

11. Sponsor

Health Equity Committee

12. Authorisation Authority

Executive Director of Community Integration, Allied Health and Service Planning