National Snapshot:
Preventing Abuse and Neglect
of Older Adults in Institutions

2008
ACKNOWLEDGEMENT

We would like to sincerely thank the 65 key stakeholders from across Canada who took the time to share their expertise, experience, and insights into the complex area of abuse and neglect prevention relating to regulated and unregulated care facilities in Canada. There is often a noticeable difference between “what sits on paper” and how matters actually function in practice.

Your insights from the diverse perspectives of government, industry, labour, advocacy and education have helped immeasurably.

We also appreciate the time and many insights given by our project advisory team.
**Project Coordinator:** Dana Howse, University of Toronto

**Authors & Project Team:** Charmaine Spencer, Gerontology Research Centre, Simon Fraser University; Michèle Charpentier, École de travail social Université du Québec à Montréal; Lynn McDonald, Institute for Life Course and Aging, University of Toronto; Marie Beaulieu, Département de services sociale, Centre de recherche sur le vieillissement, Université du Sherbrooke; Joan Harbison, School of Social Work, Dalhousie University; Sandi Hirst, Faculty of Nursing, University of Calgary; Elizabeth Podnieks, Ryerson University.

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# Table of Contents

## PART ONE

A. Introduction & Background .......................................................... 5  
B. Objectives of the "A Way Forward" Project ................................... 8

## PART TWO

Basic Terminology ............................................................................. 10

A. What is an "institution"?  
1. What is the difference? ................................................................. 10  
2. The changing nature of institutions ............................................. 13  
3. Who lives in institutions? .............................................................. 17  
4. Who works here? ......................................................................... 23

## PART THREE

Exploring Abuse and Neglect in Institutions ...................................... 24

A. What is abuse and neglect ............................................................. 24  
B. Which harms? .............................................................................. 25  
C. Who might cause the harm? ......................................................... 29  
D. How common is the problem? ...................................................... 30  
E. Who is at risk and why? ............................................................... 32

## PART FOUR

The National Snapshot .................................................................... 33

A. Purpose and Scope ....................................................................... 33  
B. Methodology ................................................................................ 33  
C. Emerging Themes  
   Theme # 1 A Shared Concern ....................................................... 34  
   Theme # 2 A Safe Place to Address the Issue .................................. 35  
   Theme # 3 Vulnerability ................................................................. 39  
   (1) Resident vulnerability ............................................................... 39  
   (2) Vulnerability and isolation ....................................................... 41  
   (3) Staff vulnerability .................................................................... 42  
   (4) The care gap factor ................................................................. 43  
   (5) Facility vulnerability ................................................................. 45  
   (6) Environmental factors ............................................................. 47  
   Theme # 4 Abuse, Neglect and the Many Roles of Ageism ................. 48  
   Theme # 5 Right Person, Right Place, Right Time ......................... 51  
   Theme #6 Education, Training and Beyond .................................. 52  
   Theme #7 Bringing the Pieces Together ....................................... 54

## PART FIVE

Working towards Solutions ............................................................... 56

Appendix A  Scope and Methodology .............................................. 70  
Appendix B National Center on Elder Abuse Recommendations .......... 71
PART ONE

A. Introduction & Background

Canada prides itself for being a caring society, in which all people have a reasonable expectation of not being harmed by others and of having certain basic needs met, irrespective of their age, gender, race, culture, or social and economic background. At the same time, we recognize that as a society we do not always meet our professed social capacity for caring for people and about people as well as we could, and we search for ways to improve that situation.

In the 1980s and through to the late 1990s, Canadians faced a series of revelations about abuse and neglect of people who lived in a range of institutional settings. The reports about the harms and victimization occurring in these facilities highlighted a number of commonalities — often these occurred in facilities very isolated from the community and with little, if any, oversight. The focus at that time was on the actions of specific individuals who appeared to act maliciously or with total disregard to the significant harms they were causing to the people under their charge. To the general public, that may still be a common view of how abuse and neglect in institutions is manifested.

In subsequent decades we have come to understand that while malicious harms and exploitation certainly can occur, the reality of institutional abuse and neglect is more complex. It is a multi-dimensional, and multi-factorial issue. The collective nature of institutions means that the potential for abuse and neglect may be significant, and the nature of institutions can create strong power differences between administrative personnel, staff, residents and their families. The risk harms to residents in the institutions is very fluid. Many factors can increase or decrease the risk.

The concern about institutions may reflect several different considerations

- That individuals residing in the institutions will tend to have certain characteristics that leave them dependent on others or otherwise vulnerable to certain risks or harms from others, and
- That there may be certain characteristics about the environment, including how it functions which may create a degree of vulnerability for residents.
**National Snapshot:**
**Preventing Abuse and Neglect of Older Adults in Institutions**

**A convergence of concern in Canada**

In recent years a wide array of individuals and private and public organizations in Canada have given considerable attention to the quality of care and assistance that residents receive in care facilities. It has been considered in the context of the work environment, the inspection and oversight process, as well as systemic problems that may be occurring in long term care. Licensed facilities and the myriad of unregulated options developing in the country have been receiving attention in recent years. These concerns have surfaced in

- media accounts
- reports from national and provincial seniors groups (Newfoundland and Labrador) as well as advocacy groups (Ontario, Alberta)
- Auditor General reports in Ontario, Alberta, Newfoundland and Labrador and New Brunswick
- reports from Ontario, Quebec, and Alberta Human Rights Commissions
- government reviews in Ontario, Quebec, and Alberta
- Ombudsman reports (Quebec, New Brunswick)
- independent audits funded by service providers, professional or union organizations
- academic research on abuse and related areas such as conditions in unregulated private residences
- coroner inquiries
- union reports and industry surveys, as well as criminal cases, hunger strikes and lawsuits.

Long term care policy research along with labour and labour market research have added further evidence of strains within the long term care system that negatively affect care and may lead to abuse or neglect of the residents.

**A world wide phenomenon**

The World Health Organization in its 2002 *World Report on Violence and Health* noted that mistreatment of older people has been identified in facilities for continuing care (such as nursing homes, residential care, hospitals and day care facilities) in almost every country where these institutions exist. The spectrum of abuse and neglect within the institutions spanned the provision of care, staffing problems, resident-staff interactions, environment and organizational policies.
In that report, the WHO drew an important distinction between individual acts of abuse or neglect in institutional settings and institutionalized abuse – where the prevailing regime of the facility itself is abusive or negligent. In Canada, the term “systemic abuse” or “systemic neglect” is sometimes used to describe this phenomenon of institutionalized abuse. The WHO authors point out:

“In practice, though, it is often difficult to say whether the reasons for abuse or neglect found in an institutional setting have been caused by individual acts or through institutional failings, since the two are frequently found together.”

It is clear that both harm by individuals and institutionalized abuse need to be addressed.

International research indicates that abuse and neglect can occur in many types of institutions, including those that seem to provide high-quality care to residents. An acceptable or good regime of care can be transformed into an abusive one relatively easily and quickly, with little detectable change in the outward situation.

It has been suggested that resident maltreatment may be related to three key factors: (i) the care facility environment; (ii) staff characteristics; and (iii) resident characteristics. As well, exogenous factors such as the supply and demand of hospital beds and the unemployment rate may need to be taken into account.

A look back

While Canada has been aware that abuse and neglect can arise in institutional settings since at least the 1960s, academics and others did not pay much attention to the issue in the context of older adults until the late 1980s and early 1990s. In the mid-1990s, the federal government as part of its broader violence prevention endeavours started highlighting institutional mistreatment issues by means of discussion papers prepared as part of a broad family violence prevention initiative. These placed abuse and neglect in the context of behaviours from individual staff or others, such as volunteers, as well as systemic harm that might result from institutional practices. The types of harms being identified included physical, psychological, sexual, and financial abuse, active and passive neglect, as well as violation of rights, medical abuse, and systemic harms.
In the mid to late 1990s, a special national project titled “Abuse Prevention in Long Term Care” (or APL) highlighted abuse and neglect issues from the perspective of residents and staff in licensed public funded facilities. It underscored that the foundation of much of the abuse (and particularly neglect of residents) that occurred in care settings was systemic in nature. This work led to recommendations for a comprehensive approach to the prevention of abuse of residents in long-term care facilities with four key components:

(a) monitoring and learning from existing legislative and regulatory strategies to address abuse in long-term care facilities;
(b) evaluating and learning from organizational-level practices and policies to prevent abuse and develop supportive, caring environments;
(c) continuing to implement awareness, education and training initiatives; and
(d) enhancing knowledge development to guide prevention and intervention strategies.

B. OBJECTIVES OF THE "A WAY FORWARD" PROJECT

"A Way Forward" explores abuse and neglect prevention issues within a variety of regulated and unregulated care settings that provide assistance and care to older adults (discussed in Part Two). Private and public unregulated residential care facilities have become an increasingly important component of the continuum of housing and care for frail older adults in Canada. In some parts of country, they often represent up to two thirds of the spaces available to older adults needing care, support and assistance in their lives.

Background documents and descriptions of these various facilities and the laws and regulations that relate to prevention of abuse and neglect in institutions can be found in a separate series of documents from the A Way Forward project (see: http://www.elderabuse.utoronto.ca/ or www.cnpea.ca )

The project's focus includes both publicly funded and private pay facilities. The objectives are to:

1. Increase awareness and understanding of approaches being used to promote and support seniors’ well-being in the range of facilities providing care and support
2. Enhance the capacity of community, institutional and government stakeholders across Canada to understand and respond to the complex issues and problems of abuse and neglect in these facilities.
For the purpose of this Project, "abuse and neglect" mean

"actions or inactions by a person in a position of trust or power (either formal or informal) that jeopardizes the health, wellbeing and/or dignity of the resident."

The project focuses on harms from staff, volunteers, administration, or family, and only briefly touches on harms by residents to other residents, although we recognize that this is a very important related issue.

*We hope that this National Snapshot can be an important step in engaging stakeholders in the process of building a common understanding of abuse and neglect in institutions, its "causes" and appropriate responses to this social and health issue.*

*Care facilities are an integral part of communities, and they need to be engaged as such. There is a need to share and integrate knowledge between the people working or living in congregate settings and people in rest of the community on abuse and neglects issue and a need to develop awareness of institutions as special communities of residents and staff striving for the wellbeing of all.*
PART TWO

Basic Terminology

A. What is an institution?

Many researchers and public agencies have noted the difficulty of distinguishing what is or is not an "institution", as well as the difficulty of drawing comparisons among the many types of facilities that provide assistance and care to older adults in Canada. "Institutions" can connote to people medical care, or regimentation, or ideas of relative degree of choice or control over one or more parts of the person’s life. Some businesses that provide services to older adults work very hard to emphasize that their facility is “not an institution”, instead they are “home like”.

In a general sense, a long-term care institution is any facility that provides support and care on a sustained and prolonged basis to meet the physical, psychological, social, and personal needs of individuals whose functional capacities are chronically impaired or at risk.

The facilities can vary significantly in size, as well as in the model or approach used to provide the care, support and assistance. They may be able to provide only a specific level of services or may draw on a “campus of care” model, where buildings, or wings of units in a common setting offer different levels of care and assistance, and where people can move from one level of assistance to another. The facilities can be funded in part or whole through public funds or private (person pay) funds; they can also be operated on a for-profit or not-for-profit basis.

1. What’s the Difference?

Probably one of the better explanations of traditional differences between high need/ high care nursing homes and somewhat lower need/ care retirement homes come from Ribbe, Ljunggren, Steel, et al over a decade ago. The authors explain :35

“A nursing home is an institution providing nursing care 24 hours a day, assistance with activities of daily living and mobility, psychosocial and personal care, paramedical care, such as physiotherapy and occupational therapy, as well as room and board. Availability of these different types of care .... may vary from facility to facility ... “36
Nursing homes mainly serve frail older adults with chronic diseases, disabilities, either physical or mental (mainly dementia) or both. These facilities usually provided care which can be characterized as the ‘highest level of care’ with residential homes offering lower levels of care. However some facilities also serve younger persons with physical, mental or developmental disabilities.

By way of comparison:

“[a] residential home for elderly people (home for the aged) is an institution providing living conditions adjusted to the needs of residents usually requiring no more nursing care than can be given by a visiting nurse.” ..."In general, the person moves to this type of facility because they are assessed or they or someone else decides they are unable to manage at home, usually because they are having difficulty with activities of daily living and instrumental activities of daily living.”

“In some homes, assistance can be provided for some basic activities of daily living, including assistance with dressing, assistance with mobility from a private room to a communal room for meals and limited assistance with appliances such as urinary catheters. Usually, most care in residential homes is provided by nursing aides and personnel with little or no training. In many countries, residential homes are building complexes (apartment buildings) where elders reside in private apartments or single rooms.”

Since the late 1980s, the special functions, conditions and ways of operating for these alternatives to licensed care facilities have caught the long term care industry and academic attention for their potential positive aspects, and possible drawbacks:

"Residential care, in its development as a form of housing and/or service provision for elderly persons, has been caught in a peculiar bind. On the one hand, the framers of policy have tried to retain the non institutional character of such residential alternatives. On the other, evidence of abuse (for example, lack of necessary medical care, exploitation, physical abuse) in these facilities and the level of frailty of many residents require that regulations be implemented to assure the quality of care provided. Trying to accomplish these often contradictory goals has
left a confusing state, within which the potential for inadequate care is great.”

Figure 1 illustrates different levels of support across the continuum of facilities in Canada, and the scope of discussion for this National Snapshot.

**Figure 1**

<table>
<thead>
<tr>
<th>Care Continuum in Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Living Independent</strong></td>
</tr>
<tr>
<td>Living in own home</td>
</tr>
<tr>
<td>May have access to home</td>
</tr>
<tr>
<td>care or home care</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

* May or may not be licensed or regulated.

**A myriad of terms with little continuity (commonality)**

The language used to refer to the various institutional settings varies extraordinarily across the country. Official terms used in one jurisdiction tend to not mean the same in another jurisdiction. The area is further complicated by what the owners of the facilities decide to call the residence, as well as the preferred terms of the residents and general public.

See Figure 2 for Canadian terms.

While the official term “residential care facility” as used in British Columbia refers to a licensed facility and staff model that provide care and support to people with the most extensive needs, the same term is reserved in Manitoba for the lowest level of care and support.
“Personal care homes” in Manitoba are licensed and regulated skilled care facilities; whereas next door in Saskatchewan, “personal care homes” refer to regulated but privately operated small group homes. In Saskatchewan “special care homes” are considered as the ones that provide care for people with the higher care needs, but in New Brunswick the same term signifies facilities that offer a lower level of care.

Assisted living facilities in British Columbia are registered public and private pay facilities that provide care, support and assistance, whereas in Nova Scotia, "assisted living" refers to private pay residences that provide minimal care, and residential care facilities provide an intermediate level of assistance.42

2. The changing nature of institutions

Many people who ten years ago would have likely moved into a nursing home for care and support, now may live in one of the many types of alternatives that provide support and care. Depending on jurisdiction, the alternatives may include personal care homes, special care homes, retirement communities, group homes or assisted living, including designated assisted living. The residents are essentially the same people, with the same needs, just living in a different type of place to receive needed care and support.

Internationally, there has been a similar growing trend to provide care to older adults in facilities other than licensed skilled nursing facilities. For example in the United States, the Administration on Aging data from 2001 showed that in the previous five years, the number of “board-and-care” facilities rose by 17.5% while the number of nursing facilities declined by 3%.43

While some jurisdictions such as the United States license and regulate all facilities that provide "assisted living", until recently most Canadian provincial or territorial governments have drawn a conceptual and political distinction between licensed and regulated “skilled care facilities”, and other types of facilities that also provide care, support and assistance to frail older adults. While they may be required to have a business license, follow ordinary fire regulations or building codes, zoning regulations, and food handling safety44 in many Canadian jurisdictions these “lower care” facilities have not been regulated in terms of the care and assistance they are providing and the staff they engage to provide it. Moreover, in some jurisdictions, they are even excluded from basic landlord and tenant laws as well.
**Figure 2**  
**Terminology across Canada for Various Institutions**

<table>
<thead>
<tr>
<th>Province</th>
<th><strong>Living with Assistance</strong></th>
<th><strong>Licensed Care Facilities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Facilities in this category may or may not be regulated)</td>
<td>(May be public, private for profit or private not for profit).</td>
</tr>
<tr>
<td><strong>Newfoundland and Labrador</strong></td>
<td>Personal Care Homes and Community Care Homes.</td>
<td>Nursing Homes and dedicated units within Health Centres.</td>
</tr>
<tr>
<td><strong>New Brunswick</strong></td>
<td>Adult Residential Facilities include Special Care Homes and Community Residences.</td>
<td>Nursing homes.</td>
</tr>
<tr>
<td></td>
<td>Adult Residential Facilities in NB are, for the most part, private and not-for-profit organizations.</td>
<td>These are private, not-for-profit organizations, except for one facility that is owned by the Province.</td>
</tr>
<tr>
<td><strong>Prince Edward Island</strong></td>
<td>A community care facility is a privately operated, licensed establishment with five or more residents.</td>
<td>Long term care facilities in PEI are referred to as nursing manors (public) or licensed private nursing homes.</td>
</tr>
<tr>
<td><strong>Nova Scotia</strong></td>
<td>Residential care facilities</td>
<td>Nursing homes.</td>
</tr>
<tr>
<td><strong>Quebec</strong></td>
<td>Private residences for the elderly (residence privée)</td>
<td>Residential facilities and long-term care units in acute-care hospitals</td>
</tr>
<tr>
<td><strong>Ontario</strong></td>
<td>Retirement homes</td>
<td>Nursing home, home for the aged, municipal home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The three types have been brought together under the new <em>Long Term Care Act</em>, which is not yet in force.</td>
</tr>
<tr>
<td><strong>Manitoba</strong></td>
<td>Residential care facility</td>
<td>Personal care home</td>
</tr>
<tr>
<td><strong>Saskatchewan</strong></td>
<td>Personal care home</td>
<td>Special care home</td>
</tr>
<tr>
<td><strong>Alberta</strong></td>
<td>Supportive living, assisted living</td>
<td>Nursing home</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Operator may refer to as a “care centre” or “health centre”.</td>
</tr>
</tbody>
</table>
### Living with Assistance
(Facilities in this category may or may not be regulated)

| British Columbia | Assisted living
(3 or more residents and facility meets other service criteria) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest Territories</td>
<td>Supported living[^53]</td>
</tr>
<tr>
<td>Yukon</td>
<td>Supported living; adult group homes[^55]</td>
</tr>
<tr>
<td>Nunavut</td>
<td>Homes or elders homes or residential care facility</td>
</tr>
</tbody>
</table>

### Licensed Care Facilities
(May be public, private for profit or private not for profit)

| British Columbia | Residential care facility (legislative language for licensed facilities)
- 3 or more residents |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwest Territories</td>
<td>Group homes, long-term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24-hour basis[^54]</td>
</tr>
<tr>
<td>Yukon</td>
<td>Extended care facilities, complex care, special care[^56]</td>
</tr>
</tbody>
</table>

In 2005–2006, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services: personal care; extended care services; intermediate care; special care; respite care; day program; and meals on wheels. ^[57]

[^53]: Group homes, long-term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24-hour basis.
[^54]: In 2005–2006, there were three facilities providing services in the Yukon. These facilities provide one or more of the following services: personal care; extended care services; intermediate care; special care; respite care; day program; and meals on wheels.
[^55]: Extended care facilities, complex care, special care.
[^56]: "Adult Residential Care Facilities" are located in a total of seven communities with a total of 64 beds. Each facility offers Level III or Level IV type care on an indeterminate basis.
Working towards guidelines

In Canada, supportive and assistive living environments are sometimes actively marketed by industry promoters as business opportunities with considerable flexibility and little, if any, oversight. That “freedom to roam” situation is beginning to change, as more provinces and territories start developing standards and guidelines for these care environments.

Public decisions of when and how to regulate or not regulate a sector often reflects a combination of

a) perception of the degrees and types of risk involved and
b) public interest in that risk (interest in the sense of pressure from the public or various stakeholders, and in the sense that it is in the public’s interest).

There are various means of “regulating” private and public bodies, each with a different pace of change and degree of enforceability. See Figure 3.

Laws, regulations, standards: what's the difference

Regulations refer to rules of behavior backed up by the sanction of the state. However the rules are expressed variously through laws, delegated legislation (the regs), guidelines, codes and standards. ...[T]here are many types of rule making even in the core definition of regulations. Guidelines and codes are often seen in the realm of ‘soft law’ or rule making in the shadow of the law. 59

The distinction between nursing homes and the other facilities that provide care can be fairly permeable at an operational and policy level in some jurisdictions. For example, advocates note that Alberta has been working to increasing staff hours for residents in their licensed care facilities. They have expressed concern that some licensed care facilities with residents with high care needs seek re-designation as assisted living to circumvent the staffing requirements. The residents are not changing, just the designation. When a facility does not have adequate staffing or the right mix of staff, the likelihood of systemic neglect occurring may increase substantially.
3. Who lives in "institutions"?

According to Statistics Canada, at any given point about 7% of adults aged 65 and over reside in a care facility that provides support, care and assistance so that the persons may be able to live their lives with some degree of independence or interdependence. About 9% of all older women reside there, compared to 5% of all older men. However, approximately one quarter of all older adults will live in a facility that provides care, support and assistance at some point in their later years. 60

Mainly women

Women often comprise the large majority of the residents in institutional settings. For example, New Brunswick noted that in 2007, seventy percent of its nursing home residents were women. 61 Similar figures are offered throughout the country. Women in general tend to outlive their spouse or partner by several years, and women are more likely to develop chronic disabling physical conditions that affect their ability to live independently as they age.
**Often considerably older, but some are much younger**

Across Canada, over twenty-two per cent (22%) of men aged 85 and over, and over thirty-five per cent (35%) of women aged eighty-five and over resided in an institution, but with considerable variation across jurisdictions. See Chart 1.

Chart 1

Percentage of seniors aged 85 and over in health care institutions in 2001.

![Chart showing percentage of seniors aged 85 and over in health care institutions across different provinces.](chart)

*Due to small numbers, data for the territories are not presented.*

Source: Statistics Canada, 2001 Census.

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**Points to Consider**

*What is the degree of risk and vulnerability in the facilities that are providing less than skilled nursing care?*

*What kinds of special risks, if any, do these residents face compared to residents in independent living settings or licensed settings?*
There are several variables that historically distinguish the person living in a facility that provides assistance from persons living independently in community.  

See Figure 4

**Figure 4 Summary Differences in Resident Profiles**

<table>
<thead>
<tr>
<th></th>
<th>Independent in Community</th>
<th>Living with Assistance</th>
<th>Living in Skilled Nursing Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Diverse in age, but greater proportion of younger seniors</td>
<td>Significant proportion aged 85+</td>
<td>Greater proportion 85+: but also young disabled</td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td>Heterogeneous in marital status</td>
<td>Some couples, but most single (widowed), living alone</td>
<td>Mostly widowed, or ever single</td>
</tr>
<tr>
<td><strong>Family Status</strong></td>
<td>Heterogeneous in family status</td>
<td>Aging or deceased children</td>
<td>Aging or deceased children</td>
</tr>
<tr>
<td><strong>Mental Status</strong></td>
<td>Most with unimpaired or marginally impaired mental status</td>
<td>1/5 with diagnosis of dementia, and showing significantly more impairment in mental status</td>
<td>Moderate to severe dementia commonplace</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Represent at least ½ of all persons with dementia</td>
</tr>
<tr>
<td><strong>Functional Impairment</strong></td>
<td>Little if any functional impairments, or degree of impairment can be met with family support, private pay or public home care services</td>
<td>May start off with few functional limitations, but this status often changes over time</td>
<td>Most common reasons for admission are stroke, incontinence, and dementia.</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td>Fewer medications, can take on own</td>
<td>More on more medications and inability to take without assistance</td>
<td>More medications and inability to take without assistance</td>
</tr>
<tr>
<td><strong>Continence</strong></td>
<td>Little if any trouble with incontinence</td>
<td>Increasing difficulty with continence over time</td>
<td>Increasing difficulty with continence over time: continence common reason for admission</td>
</tr>
</tbody>
</table>
An Alberta Long Term Care survey conducted in 2000 found that 75% of the long term care residents were aged 75 and over, and one in three (32%) were aged 90 and over. According to family respondents in a 2006 Alberta survey, 86% of the long term care residents were aged 75 and over, and 31% were aged 90 and over.

Yet not all residents living in care facilities are old. For example, one in six people living in Ontario’s “complex continuing care” facilities is under 65. In recent years in some jurisdictions mental health institutions have closed and the residents have been moved to long term care facilities along with older residents, leading to concerns about the safety of the residents and the appropriateness of this as a care setting for people with serious mental illness.

Overall, younger persons tend to be somewhat more clinically stable than older persons, but are more likely to be totally dependent on staff or their activities of daily living (such as eating and personal hygiene). Some younger patients had extremely long nursing home stays (up to 32 years). In marked contrast, an Alberta study found that just over 5% of the nursing home residents were under the age of 65.

The average age of people living in either unregulated or licensed (skilled) care facilities throughout Canada is approximately 85 years. An Ontario study of unregulated care facilities showed that more than half were in the old-old category of age 85 and over. Over three quarters (77.5%) were women, and 77.6% were widowed. A sizeable proportion of the people living in care facilities are in their 90s or 100s.

Age itself does not necessarily create vulnerability. However, there can be physical, mental and social circumstances that can accompany advanced aging. This, along with socio-economic position and generational experiences of these adults who live in the diverse range of care facilities, may heighten their vulnerability.

These basic resident profiles are important to keep in mind, not only in terms of factors that might increase vulnerability to abuse and neglect, but also person’s ability to seek out help and resources, if some harm does occur.

**Multiple health conditions**

One half of all people with dementia live in some type of institutional setting. The other half live on their own or with others in the community.
Quebec research indicates the unlicensed facilities house people who are, on average, less cognitively and physically impaired than their counterparts in the licensed facilities. Nonetheless 29.8% of residents in the unlicensed Quebec facilities had a diagnosis of dementia, and additional 10.1% had active cognitive impairment. British Columbia research suggests that assisted living settings have high proportions of tenants with cognitive and functional limitations. The average assisted living resident was a widow in her mid-to-late 80s, and more than 80% of the people lived alone.

Unlicensed facilities may accept people with few functional limitations at the outset. However, as the residents grow older some may gradually lose their autonomy, and their need for health care services and support may increase. However, because of limited nursing home spaces, operators may keep the resident even when the person’s care needs exceeds the resources they can offer.

Ontario research looking at private, unregulated residential care facilities also indicates considerable diversity in resident profiles in these settings. However the “special care units” in the residential care sector have become increasingly close to being “unlicensed pseudo-nursing homes”.

In work by Aminzadeh, et al (2001), many senior managers felt their facility was not adequately equipped to the meet the care needs of an increasingly frail older population nor to address the educational needs of staff, especially with regard to adequately assessing and managing residents with dementia and behavioural disorders.

Growing diversity

Canadian and American research notes the changing profile of nursing home residents. Recently released data from the United States indicates that multiple conditions were more common among elderly nursing home residents in 2004 compared to 1999 indicating an increasingly sicker population in nursing homes. According to a June 2007 report, 53% of the nursing home population was aged 85 and older; 36% did not walk or 50% could walk only with assistance of others; 79% needed help with four or more activities of daily living.

Compared to nursing home residents in previous decades, today's residents are becoming older on average, more racially, linguistically, religiously and culturally diverse. Also previously "invisible" groups of older gays, lesbians, bisexual and transsexuals are becoming "visible" in care settings.
Education and income can be a challenge

Residents' education and income level are important considerations. Education level can significantly affect knowledge (e.g. ability to understand contracts, access to information about rights and resources). Income affects "purchase power" in the facility, and probably equally important, the options and choices on where to live. Quebec research found that 80.0% of the residents in licensed and 52.2% of the residents in the unlicensed Quebec facilities had low income, that is they were receiving the Guaranteed Income Supplement. In Alberta, 70% of the long term care residents in 2006 had an income of less than $25,000 a year.

Many residents of licensed and unlicensed facilities may have low education. This may be reflective in part of the general level of education among older adults aged 85 and over. In the 1998 Quebec study, 65.0% of residents in unlicensed and 71.7% of those residents in licensed facilities in the province had grade 7 or less education. Another 20.9% of persons in licensed and 23.9% in unlicensed had only grade 8-12. However there may be regional differences.

Ontario research shows that one in nine (11.8%) residents of unregulated facilities had reached elementary school; 33.1% had achieved secondary school; and 55.8% had post secondary. The level of education is important when considering how to best provide information to the group.

Other important trends

The average length of resident stay is decreasing in many long term care facilities, especially those that provide the highest levels of care. For example, since 2004-05 the average length of stay, overall, in New Brunswick nursing homes had become shorter and in 2007 the average length of stay in a nursing home was 2.6 years. This likely reflects the high acuity of those being admitted to the licensed care facilities these days. Research on Manitoba nursing homes from 1995 noted that a quarter of the spaces in nursing homes each year would be new residents. Among other things this can affect the staff's ability to get to know, understand and relate to the residents' needs.
4. **Who works here?**

Given the increasingly complex profile of residents, who runs the homes? Some Canadian research indicates there is often a lack of training and experience among some of the managers of the unlicensed care homes. According to a 1998 Quebec study, while many managers have college or university training, about one in six had considerably lower education: 15.9% of licensed managers, and 12.7% of unlicensed had grade 7 or less. 87 In the same study 31.9% of the managers acknowledged having no training and 58.8% said they had no previous experience in caring for dependent elderly people at the time they were hired. 88

Is there a belief in some quarters that almost anyone can provide this care and support to frail adults, and that one simply needs to be a caring soul with good intentions? What is the best mix of skills needed?
A. What is abuse and neglect?

There is no one common definition of abuse and neglect being used in the community or in the wide range of care facilities across the country. Canada is not alone in this regard. A recent review of definitions used in American nursing home statutes found that less than one third of the states had any definition for abuse in these institutions, and there were 27 different types of harms identified among the 15 states that did. The common types of mistreatment described in those statutes were physical and emotional abuse, neglect, financial and property exploitation, and sexual abuse.\(^89\)

Researcher and writer Clough asks "What do we mean by abuse?" and points out

"... the general usage in social care we recognise that the term is used to describe practice that is improper and unacceptable from one person to another person who is a recipient of ... care services. The word 'abuse' on its own tells us nothing about the nature of the event, nor its severity. Some acts are unacceptable in any circumstances, and any form of hitting is one such. Others nearly always are unacceptable, such as speaking harshly.

...Thus, what has to be determined is the acceptability or unacceptability of practice. Whether the term ‘abuse’ is helpful or not in such discussions is debatable. Typically, ‘abuse’ is used to refer to one person with power over another abusing that power to the detriment of the other."\(^90\)

Some writers have suggested that that the construction of abuse simply involves developing lists of unacceptable behaviour from one person to another: "[R]esidents may not be...slapped, punched and so on."\(^91\) In reality, defining abuse in institutions, along with the resulting efforts in abuse prevention, involve much more. It requires critical thinking about social norms, good care practice, legal rights and the ability to know what a caring and supportive environment looks like.

Canadian researcher Hirst has offered a taxonomy for institutional abuse drawn from the views of nursing staff and administrative nurses. In this taxonomy, abuse involves hurt, plus commission or omission. Abuse may be context bound or context free. It is also important to differentiate intentional
from unintentional harm. Both types of harm need to be addressed, but usually in somewhat different ways.

*The nature and effect of abuse*

It is also important for us to understand these various harms have consequences for residents. The actions or inactions may:

- Undermine the person's physical integrity or psychological integrity,
- Undermine their sense of security
- Treat them as if they have less entitlement to the basic rights that society accords to other adults - violate their rights
- Fail to meet care obligations to the person.

Abuse and neglect have both subjective and objective dimensions. Residents or families sometime express concerns about behaviours that may or may not seem particularly harmful or disrespectful to persons in licensing or administration, or to the care aide who is providing care. However, the actions or pattern of behaviour can still feel abusive to the individual resident. “Small harms or indignities” can have a cumulative effect. There are also important gender, cultural, and generational differences which need to be acknowledged when looking at what is or is not considered "resident abuse" or "resident neglect", and it is important who gets to define the problem.

At the same time, as a society, we deem certain actions as unacceptable, as harmful and disrespectful, whether or not the person receiving the care and support necessarily understands or accepts what is happening. So, for example, a right to respect privacy in personal care is not contingent on the person's cognitive ability to appreciate that right to privacy or the ability to communicate his or her concern. Or because a resident does not challenge someone's action, that does not make it less abusive.

**B. Which harms?**

To a large extent, abuse and neglect in institutions encompass the same types of harms as are considered wrong in the community - physical abuse, emotional abuse, sexual, financial abuse, active and passive neglect, and violation of rights. But in institutional settings, some harms such as violation of rights may take on more diverse forms. Abuses in this setting can include medical abuses in care, inappropriate use of restraints and broader system neglect.
Achieving consensus on “a definition” for abuse and neglect is challenging. In part this reflects the fact that definitions are used for very different purposes and functions. For example, definitions can be used:

- as a societal statement of disapproval about certain actions
- to set standards or expectations,
- to educate about those expectations,
- for regulatory purposes,
- to penalize (fine an operator, to demote or fire a staff member) or to lay criminal charges.

Different functions of the definition may lead to a different scope and thresholds.

"Neglect" is particularly difficult to characterize. In care facilities, operators have a contractual responsibility to provide care and assistance. There is no obvious line that demarcates the point at which "good care" transitions to "unacceptable care" or where "poor care" becomes "neglect". The spectrum of care occurs along a continuum; there is often a social and professional judgment call involved in labeling a situation as “neglect.” There are also different types of neglect. Failure to provide needed assistance is one of the many types. However, that failure may occur willfully (active neglect) or unintentionally as a result of lack of knowledge or adequate time and resources (passive neglect).93 Both forms may be equally harmful to the resident, but may require different approaches to remedy the problem.

The underlying issue for neglect in institutions, is where will the responsibility for a failure to provide the care, support and assistance lie? With the individual staff member, the administration or operator, government or society?

**Points to Consider**

At what point of the continuum is something "just" poor quality care, and at what point do the actions or inactions become "abusive" and "neglectful". Conceptually where do they overlap? In what ways are they distinctive?
• **Who defines?**

Not surprisingly, because abuse and neglect exist on a continuum and vary in type, it has been recognized that people may have different perspectives on what is or is not "abuse". The multi-site Canadian Abuse Prevention in Long Term Care (APL) prevention initiative highlighted that residents' and staff members' views can differ from administrative views of what is “abuse”. Residents and staff often stress the psychological aspects, and the loss of rights. Residents may see certain actions as hurtful, but not necessarily use the language of “abuse” to describe what they are experiencing. "Resident abuse" as term of art has only recently entered the professional repertoire of some administrators.

• **Is intention a prerequisite?**

A person's intention may be appropriate to consider when looking at the remedy or the solution, but not in determining whether abuse or neglect has occurred. People may act with good intentions, and yet their actions can still be abusive, neglectful or violate rights. Or people may respond in a way that is abusive or neglectful out of indifference or lack of knowledge, to simply to get the job done, or because they do not know any better.

• **Thresholds of abuse**

American definitions of institutional abuse and neglect in some jurisdictions use higher thresholds for deeming harms as abusive or neglectful in institutional settings than they do for similar harms to older adults in the community (e.g., requiring the behaviour show “gross negligence” or “wanton disregard” before it is considered abusive). It is not clear whether this is considered the "real threshold" for abuse or simply the policy threshold at which the operator must report to an outside authority, and the threshold at which legal or monetary penalties might accrue to the operator if the abuse or neglect situation was substantiated in their facility.

• **Systemic abuse and neglect**

The term "systemic" underscores that institutional harm is much less likely to involve an "evil minded" staff person who hates older people and intentionally sets out to harm them. In many cases, abusive or neglectful staff members usually are not intending to harm in a malicious sense. Some may
simply be ignorant of the impact of their conduct, or management may have failed to make it clear that the behaviour was unacceptable.

The Ontario Human Rights Commission states

“Systemic or institutional discrimination consists of patterns of behaviour, policies or practices that are part of the social or administrative structures of an organization, and which create or perpetuate a position of relative disadvantage for persons identified by [a particular] status. These may appear neutral on the surface, but nevertheless have an exclusionary impact.”

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**Systemic Abuse**

*What is it? What does it mean? What does it do?*

The term “systemic abuse” has multiple meanings.

- It may mean rules in the facility or at government level that have the iatrogenic effect of causing physical, psychological harms or rights violations to residents.
- It can refer to repeated patterns of substandard care (patterns of abuse), not isolated incidents.
- It can also refer to situations where there is little indication that a group who work in a particular setting view what they are doing as wrong, and as a result there is no remorse.
- It can also refer to a failure of the administration to address incidents of abusive conduct in an open and forthright manner.
- It may denote system wide problems, such as resource allocation or an institutional culture where staff are afraid to report as they make risk their jobs or relationship with other staff.

The environment, the culture of the institution, the way it is staffed and administered can be very important parts of whether or not abuse or neglect occurs, particularly neglect.
C. Who might cause the harm?

The harms in this setting may come from anyone who has access to or circulates in the environment. That can include fulltime, part-time, casual or temporary staff, volunteers, external service providers, operators or administration or the resident’s friends or family members. The broad range of potential harms and the broad range of people who might cause harm are important considerations when considering how to prevent and address the harms.

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**Points to Consider**

*Promising approaches to abuse prevention will need to reflect the range of persons who may cause harm to a resident, and the diverse types of harm that can occur. Approaches will need to address both individual and systemic aspects of the harms to residents.*

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**Points to Consider**

*Is there an implicit or explicit assumption that individuals who live in unregulated care facility settings are sufficiently independent that they can seek help on their own if a problem arises?*

*Is there an assumption that existing resources such as complaint based systems will work for them?*

*Is there an assumption that existing community services are able to access the person and help the abused or neglected older individual who lives in an unregulated care setting?*

*What if the harm is from family or friends? What if the harm instead comes from others such as staff, volunteers, or administrators?*

*What resources might they need to better fulfill this role?*
According to Alberta Protection for Person in Care Office statistics, 76% of the cases reported to PPIC the alleged abusers are staff, 16% are clients/residents, 5% are family and 3% are classified as “other”.98 In contrast, the Manitoba's Protection for Person in Care Office has found the alleged abuser is most commonly another resident in 45% of the cases reported, followed by staff 23%, family 14%, facility personnel 10% or other 8%.99 This is because the Manitoba protection law covers resident to resident harms, and staff is required to report suspected abuse by residents or to residents.

D. How common is the problem?

What (if anything) do we know about prevalence or incidence of the problem?

Very little is known about the prevalence or incidence of abuse and neglect of residents in licensed care facilities or other types of institutional settings.100 There are beginning efforts to build better data.101

Existing information from staff and residents in Canada, the United States and other jurisdictions suggest that it certainly is not a rare phenomenon, and that some types may be fairly widespread. 102 Much of the research work in this area arose in the 1980s and early 1990s. Recent reports to Canadian oversight bodies by service providers and advocates also suggest that some types of abusive or neglectful practices may be commonplace.

In a 1992 Ontario College of Nurses study of registered nurses and registered nursing assistants, between one quarter and one third of the staff said they had witnessed roughness, yelling and swearing, offensive comments by nursing staff to patients or residents. One in ten stated they had witnessed residents or patient being physically harmed by hitting or shoving. 103 This study did not ask staff to identify a specific timeframe in which they had witnessed this. However research by Pillemer and Moore in the United States has found similar if not higher rates reported by staff in nursing homes, both in terms of abuse they have witnessed and what they had done themselves.
Limited and unreliable data

It is well-recognized that formal complaints provide a significant underestimation of the actual instances of abuse or neglect, since residents and families are often unwilling to file a formal complaint. According to Manitoba Protection for Persons in Care Office, of 3339 complaints to their Office between 2001 and 2005, only 2.4% of these calls came from persons in care (that is, the residents).

While staff has a legal duty to report, residents and family may not know about the appropriate avenues to report concerns, or in the case of residents, may not have mental or physical capacity to voice their concerns. Two other common reasons for residents and families not reporting incidents are that they fear retaliation or they believe that complaining would be futile.

Government data is often lacking for many reasons. In New Brunswick, adult protection services cover abuse in community and care home settings, unlike some other adult protection provinces. They note, however, there is no means

Learning from Other Countries

A pilot study in Germany (Goergen, 2001) found that 79% of staff indicated having abused or neglected residents in the previous two months, and 66% witnessed physical or verbal aggression of residents by colleagues.

In another study
- 70% of nurses reported at least one incident where they themselves behaved abusively or neglectfully.
- These were mainly acts of low to moderate severity.
- Paternalism and infantilisation, psychosocial neglect and psychological abuse, and verbal aggression were reported much more frequently than physical abuse, neglectful care or inappropriate use of restraints.
- Nights shifts/periods of low low staffing/dealing with fecal incontinence raised special risks.
- Under conditions of time pressure and inadequate staffing, nursing is reduced to basic and indispensable activities at the expense of holistic and psychosocial care.

Source: (Goergen, 2004)
to distinguish abuse case files where residents live in care homes from cases where they live independently.

There is also significant underreporting at the facility level. For example, administration may not be aware of abuse or may or may not recognize problems as abuse, while the front line staff and others may be keenly aware of it. Some administrators may fear the consequences of identifying abuse within their facilities if it potentially affects community or family perceptions of their facility.

Because provincial and territorial systems are highly variable, it is impossible to generate useful estimates of abuse and neglect in residential care. It may also be difficult to separate estimates of neglect from reports about quality of care problems. These problems include high rates of psychotropic drug use, poor management of behavioral symptoms among residents with Alzheimer’s disease or other dementias, inappropriate use of physical restraints, and poorer functional outcomes (which may or may not suggest care needs being neglected).

**E. Who is at risk and why?**

*Risk of harms to residents in facilities that provide housing and care*

The fact that residents of traditional institutions such as nursing homes may become vulnerable to abuse or neglect is relatively well recognized. However, according to the National Center for Senior Law in the United States, the potential for exploitation and neglect in "lower care" settings is significant because there can also be a fair amount of control over the activities and lifestyles of the individuals who live in residential care or assisted living facilities. Operators often have wide discretion (and therefore power) in terms of who stays and who goes.

National Center for Senior Law points out this is an important power and the threat of being forced to leave can be used as a means of controlling the lives of people who live there. Among other things, people in these facilities may also be subjected to violation of human rights such as privacy, discrimination, or they may experience neglect as a result of being "inappropriately housed" in facilities that accept them but are unable to meet their needs.
A. Purpose and Scope

The purpose of the National Snapshot of Abuse Prevention in Long-term Care Settings was to capture a "point in time picture" of where things currently stand in Canada. It had two components: the first was to identify key issues and themes underlying abuse and neglect in the range of care facilities as identified by key stakeholders. The second was to examine relevant policies, laws, regulations, standards and practices that are currently used to:

i) prevent and address abuse and neglect of residents

ii) promote safe, supportive, respectful environments in long-term care facilities.

The intention is to introduce ideas and generate discussion across the country. Many of the topics mentioned here merit further more detailed consideration on their own in order to gain an understanding of how they may help reduce abuse and neglect from occurring and help create a caring, supportive environment for the residents.

B. Methodology

Between August and October, 2006, sixty-five key stakeholders from across Canada were canvassed. The stakeholders included representatives from:

- advocates and educators;
- government representatives;
- the retirement community and long term care industry, as well as
- staff representatives’ associations, and unions.

The interviews were conducted by telephone. See Appendix for a general description. Stakeholders were approached based on their familiarity with various aspects of policies and operational aspects of a wide range of facilities that provide care and assistance to older adults. These key informants helped immeasurably to give context for understanding the issues of abuse prevention in Canada, looking at what is in place, what is showing promising and where there are gaps.

As previously mentioned in the Introduction, excellent work directly with residents and staff to give their perspectives on abuse and neglect has been done in the past by Jean Kozak and colleagues to gain insight into their perspectives on the issues. By way of contrast, the focus of this National Snapshot relates to the issues at the meso and macro level.
C. Emerging Themes from A Way Forward

Theme #1 A Shared Concern

In the National Snapshot, stakeholders identified in a fairly consistent manner across the country that most staff, volunteers, and operators in care facilities today are caring individuals, doing the best they can in often strained circumstances. However, they also identified that the current societal approach to long term care has been failing to meet the needs of many of the residents who live there and need support and assistance. In some cases, these system failures may lead to significant harm, including abuse or neglect of residents.

In 2004 the Alberta's Auditor General found that one third of the licensed facilities in the province failed to meet the province's own minimum standards. Although categorized by some as "technical" breaches, in reality the Auditor General expressed most concern that facilities did not meet the care standards for:
- providing medication to residents,
- maintaining medical records, particularly the application and recording of physical and chemical restraints, and
- developing, implementing and monitoring resident care plans.

The same year, an Ontario government report highlighted important areas needing improvement in the province's long term care facilities as well as the system that monitored and funded them. The report identified many areas needing change in the province, including the need:
- to ensure public accountability through openness and transparency in the complaint process;
- for new standards, inspection and compliance;
- to improve staffing and continuity of care; and
- for new legislation and a review of funding models.

At any given point in time, about 4% of the over 600 licensed care facilities in Ontario were in serious breach of the regulations set out, and were constantly being monitored to try to improve the situation.

What is the nature of the concern?

Stakeholders observed that older adults in some care facilities (particularly those adults with the highest needs) may only receive what may be character-
ized as "custodial care". This means only basic physical needs are being met. Emotional, social, spiritual and cultural needs are largely overlooked or unaddressed. They expressed concern about harms from residents to residents, and staff's ability to care properly for people who have cognitive impairments. They also identified the financial vulnerability of some operators (especially small facilities) in terms of being able to meet the needs of residents within the resources available.

While there was a high degree of consensus among the operators who provide the care, the staff who work there, along with family and advocates, and government advisors that there was a problem, there is less consensus on the solutions. Which group said what?

People articulated the issues in long term care in different ways (e.g. framing it as challenges in workforce retention, staff training needs, resource allocation, de-professionalization, business viability). They might or might not necessarily be considering the issue specifically in terms of the impact on residents. However, a group of stakeholders identified significant systemic problems that negatively affect the lives of a sizeable proportion of residents who are dependent on the care of others, and identified the growing evidence to back those concerns.

Theme #2 A Safe Place to Address the Issues

*The Quebec Human Rights Commission (1999) notes that “cases of exploitation in institutions create double victimization because such closed environments make other residents insecure to the point they remain silent. Instead of stopping, such cases often go on and on and intensify.”*

Most stakeholders felt that we do not currently have an institutional, social or political culture throughout much of the country in which it is safe for people to talk about the fact that abuse and neglect of residents may and does occur in a wide variety of care facilities. Staff members and advocates note that some staff have faced backlash from staff and administration when reporting a legitimate concern to outside bodies, usually after internal mechanisms have failed.

As a result, the issues of mistreatment, violation of rights, medical abuse and neglect remained hidden or treated as taboo topics. Open discussion at the political, facility, and unit level about how and why these harms and rights violations might occur, and how best to prevent them is far less likely to occur in a “there is no problem here” environment.
Today, residents, family and staff often find it is not safe to raise general concerns about care in this environment, let alone mention the possibility that abuse or neglect might be happening. Operators may fear the effects of acknowledging those problems, or they may feel powerless to change systems.

One of the promising approaches to abuse and neglect prevention is to foster an environment in which it is safe to talk about the issues; as well as understand the resident, staff and family needs.

This has been a longstanding challenge in Canada. Throughout the 1990s when the need for discussions on abuse and neglect of residents were being raised, one of the more common initial responses among operators and administration, unions, staff, oversight bodies and government was to become defensive about the possibility of resident abuse. Common responses included

- denial and minimization ("we don’t harm residents"); “abuse or neglect are rare, isolated problems”);
- transference: “it is the residents who harm us”.

Researcher Les Bright talks of the ‘tired phrase’: ‘It couldn’t happen here.’ He notes:

“After all, most of the time most older residents are not being physically assaulted by care staff, are not having their money or possessions stolen, and are not suffering sexual assaults. However, it seems that far too many of them are subjected to psychological abuse in the form of name-calling, being ignored or being spoken to unpleasantly, and a significant number of residents will experience neglect in one or more of the ways in which it can surface: being made to wait too long for the toilet, not receiving attention for a physical or mental health need soon enough, or being fed a poor diet with little food that they enjoy…” 116

In the National Snapshot, many stakeholders underscored the tendency to deny the problem exists, particularly at the administrative, health authority or ministry, and political level. Where evidence of abuse or neglect does surface, the problem may be treated as a rare event or a matter of "a few bad
apples” or focus on narrow parts of the problem, leaving the bigger systemic problem unaddressed.

Minimization and denial can often be supported at a policy level because, as noted earlier, the available data in this area is limited and poorly developed. For example, while Ontario has developed a fairly comprehensive abuse prevention strategy for licensed care facilities, the official rate of abuse reported by the operators of licensed care facilities in the province is reported to be 0.0000%.

Underreporting consistently occurs throughout Canada, even when the law or regulations require people to report. As well, the limited available data on reportable abuse incidents may subsequently be intentionally misinterpreted at a policy level. For example, in Alberta, two thirds of the abuse reports coming to the attention of the Protection of Persons in Care Office are categorized as "unfounded" because the case did not meet the legal threshold of “intent to harm” or because investigators were unable to find sufficient evidence. However this has subsequently been used in consultation documents as "evidence" that abuse is “rare” in the facilities or simply the actions of “a few bad apples”.

In the National Snapshot, respondents' comments highlighted two other trends:

- **Re-direction.** This is where the attention is placed on the residents as the "cause" of the abuse to them, or where people suggested that families or others are mistaken about their concerns, "they feel guilty about placement", or they have "unrealistic expectations" about the care that elderly people should be receiving in the facilities.

- **Waiting for a crisis.** In at least three provinces, legislative or policy action on abuse and neglect in long term care only developed after there had been a crisis-- usually involving highly publicized death or deaths of residents, and sometimes the crisis-based solutions or policies only address part of the problem.

Fortunately some jurisdictions are beginning to move beyond this type.

A caring and supportive environment (both within facilities and more broadly within health care delivery) is one that has recognized the need to create a place where concerns about abuse and neglect and about quality of care can be raised without resorting to the defensive responses, where issues and respective responsibilities can be identified and where the appropriate resources are available to carry out the responsibilities.
Moving from Secrecy to Openness

In Manitoba, the Protection for Persons in Care Office notes how their legislation with its focus on education and abuse prevention has helped increase trust and create more open environments. In abuse prevention training, staff view reporting concerns as part of their professionalism and the general well-being of residents and staff. They are usually able to see fairness and positive change happen in the facility.

Secrets

Clough draws a distinction between secrecy and an open environment. In an environment of secrecy:

- Residents keep secrets out of vulnerability and dependence, despair and feelings that nobody listens; not knowing their rights; fear derived from threats; shame; ambivalence towards the abuser; or thinking that they will be blamed.
- Relatives keep quiet out of fear for the well-being of the resident; they assume the resident will not be believed; or have no other place for the resident to go.
- Staff may keep secrets because of misplaced loyalty; not knowing when or how to tell others (‘to blow the whistle’); their own involvement (implicit or explicit) in the event; fear of job loss or other adverse employment consequence, or fear of other staff.
- Managers do not say anything because matters are kept from them. They may not bother or know how to find out what is going on. Some keep secrets out of fear of an individual; fear of tackling people on bad practice; or not knowing how the organization will cope if the place closes.
- People keep secrets because as insiders, the norm is keep matters secret from outsiders.117

In the National Snapshot, advocates and staff described other elements of an environment of secrecy: when staff members risk being changed to another shift, or worse still losing their job. Family and visitors may keep problems in the facility secret when they see other family members or visitors being “evicted “by the operator under trespass law when they try to raise legitimate concerns.
Theme #3 Vulnerability

Although internationally there has been some efforts to examine factors associated with reported abuse in long term care, there are currently few theoretical models that describe, analyze and explain the nature of resident abuse and neglect in long-term care, and none in Canada. Those that do exist have focused largely on physical abuse cases and criminal matters that come to the attention of authorities, and not neglect.

In the National Snapshot stakeholders identified of several factors that they felt likely affected the situation in their part of Canada. Many of these parallel contributory factors identified elsewhere (e.g. Payne and Cikovic, 1996).

(1). Resident Vulnerability

*Nursing home residents are an extremely vulnerable population group. They are people often unable to voice their own concerns or to defend their own interests.*

New Brunswick Ombudsman

We found considerable agreement among key stakeholders in identifying factors that may leave some residents at risk of abuse and neglect. These included:

Cognitive impairment. By far, this was seen as the most significant resident-related factor associated with resident abuse and neglect, as well as resident to resident harms. Stakeholders pointed out as Alzheimer's disease and other dementias progress, they can lead to residents behaving in ways that frontline staff may not understand. Without understanding the brain disorder, staff members often feel the resident is doing the behaviour "on purpose" or maliciously, and sometimes the staff member "retaliates".

Also, it was generally felt that a cognitively impaired person was considered an "easy victim"; if harmed by someone, their statements would not be given much credence.

Physical conditions and dependency on others for care. In most licensed facilities, residents have difficulty with many activities of daily living including bathing, dressing and toileting, and depend on others for assistance. In "lower care" facilities, residents may begin with relative independence but progress to needing more help.
**Ability to express wishes.** This may be reflected in the person's cognitive status or communication difficulties (aphasia and other speaking difficulties, hearing problems, language differences). The ability to express wishes also depends on whether there is encouragement as well as mechanisms for expressing wishes at the individual level and facility level. Power imbalances between residents and others may affect residents' ability to express their wishes.

**Isolation.** This includes social isolation (few if any contacts with people inside or outside the facility "alone in a crowd"), or geographic isolation (where the facility or community is located, or as a result of a resident being transferred "uprooted" or required to take the first available space irrespective of where it was located).¹²¹

**Lack of choice** - People who need care and support may be forced by government policies to go where there is a space available, not a place that is best suited for them. This in turn increases isolation.

**Economic vulnerability** - A resident with few financial resources may have far fewer choices. He or she may be unable to move elsewhere if the care and assistance being provided is not adequate.

Some government policies may increase economic vulnerability and isolation of both residents and families. For example, until October, 2006, New Brunswick's long term care policy required division of a couple's assets when one of them moved into a nursing home, and based the nursing home costs paid on those assets. This left high fees, created poverty and increased the vulnerability for the resident and the spouse who was left behind in the community.

**Summary:**

Some of these factors such as cognitive impairment may affect residents' ability to recognize abuse or neglect. Other factors such as isolation, or impairment will affect the ability to advocate for themselves, or their ability to seek help.

Other factors reflect the degree to which there is any real "choice" in the long term care system e.g., in where to live; the general culture of care; and whether the level of care in the facility can be supplemented by more staff, with appropriate training and supervision.
Vulnerability & Isolation

Isolation was another commonly identified factor. Stakeholders felt that isolated residents, usually those who did not have someone (whether that be family, friends, a staff member, or an outside body) actively supporting and advocating for them were much more likely to experience neglect. Isolated residents could also experience other harms such as emotional abuse with relative impunity because, there was no one to speak up for them if they could not speak for themselves. Individual staff members often tried to advocate for residents they knew were alone.

Canadian research indicates that family see themselves as having an essential role in seeing that the needs of the older adult in care are met and protecting the person. Research also suggests that families have several important abuse prevention roles, acting as sentinels, providing practical help and in helping to communicate the resident's needs to staff.

Stakeholders pointed out that isolation in a care facility can result from many things:
- Being widowed, and death of friends, personality, the "risk" of befriending people late in life
- Distance from family or friends. This situation can be created or facilitated by government policies such as "first bed available" which may remove the person needing care from his or her community.
- Geographical location of the facility in relation to the broader community.
- Communication. Strokes can cause aphasia. The residents' physical condition (e.g. mobility impairments or stroke) may leave them isolated and at risk. Communication difficulties can affect the staff's ability to recognize and respond to resident's needs, such as pain control. The language of staff and the language of the residents affects whether they understand
what is being said by the other. Some staff members may talk to each other in their most familiar language, and "talk over" the resident.

- **Physical environment.** Unsupportive environments where there is also high privacy (private rooms, closed doors) may lead to higher risk for some individuals, because there are no eyes to watch what happens behind those doors. Residents in rooms with two or more beds will have more difficulty having their privacy respected.

- The physical environment of the facility may also lead people from the community (friends, neighbours) to disengage. In a poorly run or inadequately resourced facility, people may avoid visiting because of the smells, hearing residents yell or constantly calling for assistance, or seeing residents “parked” in the hallways. Conversely, quiet facilities may have their own risks if residents are kept quiet through sedation.

**(3) Staff Vulnerability**

In many cases stakeholders pointed out that the vulnerability of staff is an important part of the broader context of how abuse and neglect can occur. The staff members (particularly those responsible for direct care) are often disempowered. (See section on Ageism. Labour and work environment)

Direct care staff members may work in an environment with a lack of supervision and role modeling of good care and good practices. Their overall work environment can become very task oriented, almost like piece work, rather than resident centred. Their work environment may also become a desensitized environment-- one that is accepting of violence, aggressiveness, or ignorance.

Stakeholders pointed out that systemic neglect such as rationed continence garments, obviously has important negative consequences on the lives of residents. However it also negatively affects staff. It can be very degrading for a resident to wear a continence pad or garment, but it can also be degrading for staff to be placed in a position of constantly dealing with inadequate resources, and where they have to check and recheck that the pads are "full enough", and negotiate before the resident is "allowed" to be changed.

As noted by the stakeholders, direct care staff is heavily represented by immigrant groups in many parts of the country. In several provinces, key informants questioned whether cultural differences might be another factor in abuse and neglect. We have given very little consideration to what people consider as "good care" or "doing a good job" within different cultures. Is it simply doing the task efficiently, and following orders?
How do different cultures look at caring for older people, especially when the elderly residents are not family, not from their own background, or do not speak their language, and may not treat the staff well? Does a person's culture or experience in country of origin influence the way a person might look at care of people with disabling mental or physical conditions?

**Very precarious workplace**

In some Canadian jurisdictions, the staff members are vulnerable to contracting out, and lay offs. Workers may be "hired and fired and rehired, often losing wages and benefits."124 In at least one province, existing unionized direct care workers have been laid off and had their positions replaced with temporary foreign workers.125 These workers are very unlikely to know about the rights of residents and even more unlikely to advocate for those rights, when their own legal status in Canada is so precarious.

Some stakeholders note that many frontline care aides are at a disadvantage in that they have no professional association to provide oversight and to whom they are accountable. For many direct care aides, there is no organization to promote proficiency, continuing professional education and career development among members so as to ensure a high standard of practice and safeguard the welfare of the public receiving the care.

(4) **The Care Gap Factor**

Many stakeholders pointed out many people coming into care facilities now have much more complex needs – some are moved directly from hospital and need medical care at the acute care level.

Some stakeholders note the “care mix” is no longer the same in either licensed or the unregulated facilities. Licensed care facilities in many parts of Canada are far less likely to have mixed care, with some residents who have lower care needs, and others with higher needs to ease the workload. Instead, today, most if not all may all have high needs.

Stakeholders commonly stated that many staff who provide direct care suffer from a lack of training especially compared to the residents' needs. There is in effect a "Care Gap" as illustrated in Figure 6.
As residents care needs have been increasing, and staff resources have been decreasing, or at best, not kept pace. Abuse and neglect risk increases with the gap.

According to the stakeholders, the average care needs of residents across the range of care facilities have become heavier and significantly complex over the past 15 years.\textsuperscript{126} Health care research bears this out. For example, in Ontario, the proportion of residents receiving extended care increased from 53 per cent in 1996 to over 61 per cent in 2002.\textsuperscript{127}

Care needs versus staff resources

Levels of staffing, along with qualifications, training, and supervision of persons who provide the care have not kept pace, and in many cases have decreased. In a 2007 interest arbitration, an arbitrator took the unprecedented step of committing to alert the Ontario health ministry of unacceptable staffing levels in nursing homes.\textsuperscript{128}

Some stakeholders expressed concern about the adequacy of staffing levels, especially in for profit facilities. Canadian research shows that there are sig-
significant differences in staffing levels across levels of ownership. Nursing staff intensity (i.e. the ratio of registered nurses to residents) and direct care staff levels are significantly higher in government owned facilities compared to all other facility types. Proprietary for profit ownership have significantly lower intensity staffing and lower staffing levels.

Intersections --- Quality of Care and Abuse and Neglect

How are quality of care and abuse and neglect related? There are many possibilities. A range of unaddressed care deficiencies may seriously compromise the health, safety and well being of residents. A consistent critical shortage of qualified professional and non-professional care staff on site may impact the quality of care and quality of life of residents. There may be a departure from identified appropriate or responsible care practices. Family monitoring and intervention can be critical to residents receiving necessary medical, nursing, or acute care services. When families report their observations of health decline in resident, these may not be taken seriously or acted on by staff or administration in a timely manner. Care may deteriorate without advocacy efforts to protect or improve the quality of care of resident or other residents, and sometimes advocacy simply proves futile.

(5) Facility Vulnerability

Different Facilities, Different Types of Risks

Stakeholders pointed out that facility size and abuse or neglect risk are often related, in complex and somewhat contradictory ways. See Figure 7 below. Larger nursing homes may have a higher risk of harm occurring due to the larger number of residents who live there, as well as the numbers of staff and volunteers involved in their care and support. However, larger facilities may have less risk of some forms of abuse or neglect because they may have access to more specialized resources and personnel than a small facility would.

Small facilities may provide individualized care or try out new approaches. On the other hand, very small facilities may become easily isolated. In this environment, abuse and neglect could be more easily hidden. Small facilities may not have the staffing; the available staff may or may not have the training to be able to recognize and respond to residents needs; and the staff may be working in isolation. They may not have enough staff to relieve others for in-service or external training.

Some small operators begin their business with good intentions, but may have little knowledge about the realities of the work they will need to do in
order to provide good well rounded care to residents. The small facility operator is also much less likely to belong to a formal association where he or she can obtain information and support to maintain and improve services. Quebec research in the late 1990s on unregulated facilities also highlighted the financial vulnerability of many of the operations. In Saskatchewan, regulatory amendments were made in 2003 to address the problem of "large" (40+ residents) personal care home operators suddenly going out of business, leaving residents at risk of having no care. Because staff costs are the largest part of the business cost for care facilities, this is where the cuts tend to occur and where the direct effects are felt, increasing the risk for the residents.

**Figure 7 Strengths and Weaknesses of Facilities**

<table>
<thead>
<tr>
<th></th>
<th>Perceived Strengths</th>
<th>Perceived Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Small Size Facility</strong></td>
<td>Individualized approach to care</td>
<td>May be too small to have specialized staff; so small, may be no oversight required by law; may not have enough staff to cover shifts during training</td>
</tr>
<tr>
<td><strong>Larger size</strong></td>
<td>May be able to hire and support specialized staff, e.g. geriatric mental health, education resources</td>
<td>Potential for regimentation, de-individualization of care, group processes, bureaucracy</td>
</tr>
<tr>
<td><strong>Rural</strong></td>
<td>People who know each other may be less likely to harm, if know the information may circulate in the community.</td>
<td>People may be less likely to report staff or other who is a close friend or neighbour. Fewer choices, fewer options in the community, this may be the only facility available.</td>
</tr>
<tr>
<td><strong>Social Care</strong></td>
<td>Tries to meet social needs</td>
<td>Staff may not have the skills to recognize and address medical needs in time</td>
</tr>
<tr>
<td><strong>Medical Care</strong></td>
<td>Able to recognize physical care issues</td>
<td>May use an acute care approach, or only focus on the physical care needs</td>
</tr>
</tbody>
</table>
(6). Environmental Factors

What Does the Research Say?

Government reports in the United Kingdom on abuse in institutions for people with mental health problems identified a number of “known risk factors for abuse”. These include a poor and institutionalized environment, low staffing levels, high use of part-time and casual staff, poor supervision, a closed inward-looking culture and poor management. A series of Canadian reports flowing from substantiated institutional abuse of children and youth or persons with disabilities have highlighted other potential risk factors. System wide abuse and neglect in a facility (affecting multiple people living there) tends to occur in an isolated environment - one that is psychologically and functionally cut off from the broader community. It also tends to occur where there is a lack of oversight or external scrutiny, or where there is a breakdown of the mechanisms that have been established to provide that oversight.

Other research emphasizes the working, structural, knowledge and emotional factors and suggests abuse in institutions is more likely to occur when:

- a staff member works alone, and there is little oversight and supervision;
- work is in private—away from other residents;
- staff are under pressure;
- people don’t know their rights;
- residents are at a low ebb—frightened, tired, depressed or at night time;
- there is discouragement of showing, and talking about, feelings;
- there is no clarity that the overriding loyalty is to the task and the residents, not to one’s colleagues.
- there are no acceptable or easy ways for staff to talk about their concerns in their own work or those of others.

Others point out the risk of abuse is greatest in institutions with poor management, too few staff, little direction from the outside, and poor communication with the outside world.
Theme #4 Abuse, Neglect and the Many Roles of Ageism

There is a difference between the state’s inability to fund and its unwillingness to fund good quality long term care.

In the National Snapshot, one of the strongest and most consistent themes expressed among stakeholders was that societal ageism has a fundamental role in fostering and perpetuating abuse and neglect of residents in care facilities. Ageism in this context refers to the whole set of negative attitudes towards aging and towards loss of autonomy. Ageism intersects with gender, disability, sexual orientation, and citizenship status, language, ethnicity and race.136

Ageism is an integral part of the fabric of society, and it can strongly influence a government’s way of thinking and decisionmaking. It is often reflected in the low priority given by government to the needs of seniors or others who may need care and assistance on an ongoing basis. As a group, as people age, they become invisible or treated as a heavy social cost, a social burden, and their needs are given much lower consideration in society.

Societal ageism filters throughout the long term care system - first in way that the people are treated, and second through the lack of educational and financial resources being allocated to it.

Ageism in the health and care sector

Ageism can be reflected in the way that people who work within long term care are treated. For example, long term care nurses report that their work has been disparaged by their acute care peers, as “not real nursing”. International research supports the fact that this type of ageism exists—registered nurses tend to see working with older people as the least desirable career choice as it attracts a lower status and is viewed as not technically oriented.137 In reality, working with older and younger adults in long term care often requires considerable skill to understand and respond appropriately to people’s often complex and changing needs, as well as the ability to integrate multiple types of specialized skills.

Ageism, labour and work environment

Frontline staff members also report experiencing the brunt of this type of ageism, pointing out their jobs are typically devalued. Many work on a part-time or casual basis, trying to piece together jobs to make a living.138 In provinces with strong economies, a rural care facility operator may be concerned if a new business such as new grocery store opens, because it means fewer
available candidates for the care facility. The grocery clerk position may pay better and have less job stress.

Across Canada, communities are increasingly finding it hard to find and retain staff willing to take these long term care positions. Alberta notes recruitment, retention, and training of health and housing staff across the continuing care system remains a challenge. The work environment in care facilities may have low level pay, lack training relative to the skills needed to do the job, lack supervision and mentoring, and lack good leadership and mentorship. Alberta, for example, reports a turnover of 23% among care aides every year. Atlantic Canada respondents noted the effect of out-migration of their skilled health care workers to other parts of Canada.

Many long term care facilities try to function in an environment where nothing stays the same—not the residents, not the staff, not administration, and not even any external body to whom the operator may be accountable. Research from other jurisdictions supports the proposition that direct care staff turnover and administrative turnover are both important concerns in the institutional setting. Turnover may compromise service continuity and quality. Research indicates that administrative turnover is associated with increased likelihood of having high nursing aide turnover. High turnover has important implications for care continuity, resident and staff morale, and staff education and other costs. Staff turnover has also an effect on the quality of care that residents receive.

In recent efforts to develop and retain staff, particularly in rural areas, some provinces (e.g. Alberta and British Columbia) have begun supporting access for care aide training, focusing on affordability and accessibility issues.

A Point to Consider

Given the many challenges in this area, what makes those workers who stay, stay? Is it something about their personality, life circumstance or job or work environment?

What are the positive aspects of working with older residents? Can those aspects be built into abuse prevention?
**Ageism and policy**

The respondents in most parts of the country were also very clear about the largely negative impact of government policies in long term care in their jurisdictions, especially during the last 10 years, which they saw as indicative of active systemic neglect. For example, a ten year moratorium was placed on building care homes in New Brunswick, a political decision which had a significant effect on older adults, families and the health system. In other provinces, facilities were closed, or converted to social care.

Stakeholders pointed out how ageism in long term care is also reflected in the commoditization of older adults. Older adults or others needing care simply become bodies that can be moved to the first available space, or shuffled or from one care facility to another. They are no longer referred to as people, but as “beds”, “spaces”, and “units”.

Ageism carries the underlying expectation that people should simply accept whatever is made available, because they are old, and they “are going to die anyhow”. Some key informants pointed out how this, in turn, becomes a self fulfilling prophecy. Residents die because they are old and have multiple problems. But some may die earlier than necessary in care facilities because there is little quality of life. Or their care can easily be neglected when there is a lack of staff able to recognize and address health problems before these reach crisis proportions and they need to be hospitalized.

Systemic issues such as the existing physician payment structures can lead physicians to avoid caring for long term care residents. This may also increase the risk that the residents' medical needs will be neglected. Because of ageism, residents in care facilities can easily become cast offs, and in this context it becomes easy to treat both the people who live there and those who work with them as “lesser” persons.

### A Point to Consider

How do we address this underlying ageism that may operate within a facility and within our society? Can abuse and neglect prevention within the facility be effectively addressed without addressing it in the broader social structure?
Theme #5 Staffing: Right Person, Right Place, Right Time

“Staff are providing compassionate care and doing the best they can with their current resources, but there aren’t enough trained people to meet the basic needs of dependent long-term care residents. There is an immediate need across the province for more trained staff.”143

“There is an increasing need in supportive living, including lodges, to provide health care services that were not traditionally part of the mandate for supportive living operators. Long-term care and supportive living staff are struggling to care for residents with higher and more complex health care needs. Funding formulas, policies and legislation do not always reflect the changing needs of continuing care clients.”144


Although speaking from the Alberta experience, the observations of respondents to the MLA Task Force paralleled the issues raised in many parts of the country. Quite consistently, the key stakeholders across the country pointed out that the strong trend to de-professionalizing care in many care settings and the significant negative impact this has on the caring for residents and caring about them. This wasn’t a debate about whether a social care or medical care model was better. It was a recognition that all models were struggling.

On the other hand, stakeholders observed that abuse and neglect of residents may be much less likely to occur where there are

- adequate numbers of staff in the facility,
- an appropriate staff mix, and
- where staff members have the personality and aptitude, along with the formal education and training to understand and appropriately respond to the physical, emotional and social needs of the residents, and to understand the residents' behaviours, actions and responses.
This was particularly the case for residents who have dementia. Leadership, mentorship and good supervision of the staff were identified as very important aspects of abuse prevention. The importance of dementia training for nursing aides and units with specialized care has gained increasing recognition in the literature for the wellbeing of residents and sanity of staff. 145

Key informants identified this training and care planning is often not currently happening in their jurisdiction. Some expressed concern that nursing staff work focussed too heavily on administration and paperwork, not supervision or encouraging and modelling good practice among care aides who are responsible for most of the direct care and contact with residents. In other cases, licensed practical nurses expressed concern about being given responsibilities to supervise care aides but without having the requisite skills. These observations have also been borne out in 2005 national survey of 19,000 registered nurses and licensed practical nurses across Canada.146

Respondents offered illustrations:

  For example, a Director of Care might be in charge of three facilities, and the staff stated they seldom if ever saw the Director. In this environment, it may be easy for neglect or abuse to inadvertently develop, as the internal supervision and mentorship may be absent.

Theme #6 Education, Training and Beyond

Looking beyond training and guidelines

At least two provinces have begun to recognize and respond to the various care training issues being identified in their provinces. However, multiple initiatives (for dementia care, aggressive behaviours, continence care) may occur at the same time, and lead to competing demands on facilities' staff, time and resources. The operators are often at a loss -- "Which of this training is useful, which makes sense for our staff?" and "How do we find the needed time and resources to spare staff to get the training?"

Even with training available, facility operators remain in the same position where they cannot spare the staff to cover those going for training. So while there may be provincial requirements for training and education to build basic and enhanced competencies, as well as a desire by staff or administration for this training, it still may not get to the people who need it the most.
Promising work has also been initiated in recent years in some jurisdictions to develop best practice guidelines focussing on care issues such as incontinence, dementia care or "aggressive behaviours". However, explicit recognition of the pathways between training, quality of care or practice issues, and resident abuse or neglect prevention are noticeably absent.

While some stakeholders felt education and training in areas such as incontinence or dementia care is valuable, they also pointed out that this training does not address the underlying problem of staffing. So in some facilities, while some staff may be aware of good practice in toileting (what they should be doing) the daily reality and pressures of the workplace mean they may still end up relying on "fallback" practices, which might include using continence garments on continent residents for convenience and to get the job done. In this environment, there are tensions between knowledge and practice.

For example, without adequate staff resources and a resident centred attitude, a harried staff person may respond to a resident's request to be taken to the toilet, by disrespectfully telling the resident "Go in your pants, you are wearing your toilet",

A Point to Consider

Promising approaches to abuse and neglect prevention may require a combination of:

- developing appropriate education and training for staff to meet the care and other real needs of residents (including using good practices),
- having sufficient staff and other resources to deliver the care and support, and
- fostering respectful and compassionate attitudes among the staff towards the residents, and their co-workers.

The dilemma of language

Some stakeholder expressed concerns about whether or not the use of the language of "abuse" and "neglect" is beneficial in terms of raising awareness and remedying the problems. Because the abuse discourse is often character-
ized in the public mind as involving physical abuse, or "good persons" and "evil persons", calling certain actions "abusive" or "neglectful" evokes a strong emotional reaction. In some quarters, the focus has shifted to addressing staff-resident behaviours, and the perceived underlying causes for "negative interactions" (often framed as "aggressive behaviours") without using the terminology of abuse and neglect.

On one hand, these approaches build people's knowledge and may reduce the harms to residents, without necessarily naming the staff or volunteers' actions as "abusive" or "neglectful". At the same time, use of the terms "abuse" and "neglect" specifically frame the issues in terms of basic rights to physical and emotional security etc., place these problems in the context of harms to the resident and meeting residents' needs, and clearly name the problem as unacceptable at a societal level. A discourse that functions absent of language that explicitly acknowledges the potential or actual abuse or neglect may overlook key aspects of the situation, including the power dynamics and the resources. Not talking about abuse or neglect as such treats the symptoms, not the causes and inadvertently may reinforce secrecy.

**Theme #7 Bringing the Pieces Together**

Many parts of Canada have made important strides in recognizing the potential vulnerability of residents in care facilities. Over the years provinces and territories have developed a number of structures and mechanisms to address parts of the issue. There is however, significant concern about the ways those mechanisms function and how they are resourced. For example, it has been noted in Quebec that some oversight bodies such as commissions only work on a part time or contract basis.

Inspections are one of the basic oversight mechanisms in many jurisdictions. However, bodies responsible for inspection and review have come under significant scrutiny in recent years. According to third party reviews in at least three jurisdictions, licensing and inspection bodies have failed to carry out their responsibilities and simply rubberstamp renewals. Other review bodies have structures so burdensome, no one could put it to use.

Some stakeholders also raise the general question of coordination. How do these pieces fit together? How do they work together? Even at the basic complaint level, how do people know what to do, where to call? If abuse or neglect happens, how is the resident, family, staff, administration treated? Is there feedback and follow up?
Abuse and neglect issues do not belong to one ministry of government, or one industry or group of people. They can involve departments or ministries responsible for health, housing, labour/employment, administrative and criminal law, human rights, consumer protection, to name just a few. How does government assure that there is coordination between public agencies and between ministries? What are the appropriate links between non-governmental bodies and government in this area? How can government monitor the effectiveness of the oversight structures it has in place? If government is relying on private industry to provide some of the oversight, how does industry avoid conflicts of interest in such a critical area? Development of standards and guidelines are appreciated, but do these get to the source of the problem, and who bears the burden?

There is also the process and knowledge issues of where to find information, and how and where to voice concerns—e.g. in British Columbia, there are five health authorities, each with a separate process for complaints, a barrier which affects residents, local and out of province family members, and others concerned about the welfare of residents.
PART FIVE

WORKING TOWARDS SOLUTIONS

The following list includes strategies in the abuse prevention and institutional care literature and currently in use in some parts of Canada.

The approaches fall into five main categories: general mechanisms to assure general quality of care; mechanisms focusing on staff before and during employment; oversight; mechanisms to identify and respond to problems or concerns; and mechanisms to empower residents. See Figure 8.

Figure 8

Type of Approach (listed alphabetically)

- Abuse Prevention Policies
- Acknowledging/Promoting Good Care/Practices
- Accreditation
- Advocacy
- Bill of Residents Rights
- Care Standards, regulations
- Changing Environmental Culture
- Coroner (Death Reviews)
- Criminal Law
- Education and Information (Public, Residents, Staff)
- Family Councils
- Human Rights
- Inspections
- Lawsuits
- Licensing
- Long Term Care Ombudsman
- Mandatory Reporting
- One Stop Shop
- Public Awareness Campaigns
- Pre-Employment Screening
- Regulations, Laws and Standards
- Reporting & Protections for Reporting
- Residents Councils (User Committees)
- Special Protection Legislation for People in Care Facilities or Other Vulnerable Persons
- Staffing Levels and Ratios
- Staff Training
- Zero Tolerance

The purpose and underlying assumptions for each of these are outlined in a separate project document (www.cnpea.ca), along with strengths and limitations of each. See Appendix B, for approaches identified in the American field.

The following section provides a sample of some of these.
**RESIDENT CENTRED CARE**

Ontario's new *Long Term Care Act*, 2006 which received royal assent but is not yet in force, has taken the largest political step to develop a comprehensive long term care approach to focus and place the resident in the centre of considerations in licensed care facilities. The Act sets out the expectation of a resident centred system. The fundamental principle is:

“A Long-Term Care Home is the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort.”

Among many other things in this Act, the Residents’ Bill of Rights was expanded and strengthened to enhance enforceability. The Act requires a mission statement for each home that is consistent with the fundamental...
principle and Residents’ Bill of Rights and developed in collaboration with Residents'/Family Councils. The Act allows for the establishment of an Office of the Long-Term Care Homes Resident and Family Adviser to assist and provide information to residents, their families and others and also advise the Minister on issues concerning the interests of residents.\textsuperscript{147}

These have been recognized as important achievements. However there are concerns the lack of staffing standards will impede resident centred care.\textsuperscript{148} Academic research has emphasized that "authenticity" is at the core of being resident centred. At the minimum, it means having the time, opportunity and resources to be able to get to know, understand and appreciate the resident as unique individuals.\textsuperscript{149}

**RESIDENTS RIGHTS**

Yves Brillon notes that respect of rights entails first and foremost “recognition of these rights – through explicit definition -- and through the recognition of their existence both on the part of the institution and the staff it employs”.\textsuperscript{150}

The New Brunswick Ombudsman notes the importance of a bill of rights. \textsuperscript{151} Bill of Rights have the potential to:

- make explicit guarantees that are already implicit in the various provisions of care facility regulations regarding minimum standards of care;
- provide government a new opportunity to rethink and reaffirm their commitment to seniors’ well-being;
- shift the focus to the individual resident;
- empower residents and their substitute decision-makers;
- affirm the dignity of all nursing home residents.

Ontario has incorporated a statement of residents' rights in the law for various types of nursing homes for over seventeen years. The rights statements were develop into a residents' rights handbook which is published by Continuing Legal Education of Ontario and is received by all nursing home residents. The booklet is also used for staff training. The Gerontology Research Centre at Simon Fraser University published a similar plain language residents' rights booklet for British Columbia in 2003.

In Saskatchewan certain rights are set out in law and are required to be displayed prominently in the personal care home. Operators are required to give residents a copy of the rights at the time of admission to the facility.\textsuperscript{152}
The law in Manitoba places a duty on operators to create a bill of rights for residents. The law sets certain standard rights, but operators may set out other “rights”. Deer Lodge Centre took this one step further. Each March, the Centre’s Bill of Rights and the Problem Solving Process are displayed prominently in the "main street" as part of Residents Rights Month at the Centre. Yet some groups of residents such as people with aphasia will have greater difficulty exercising their rights—they are usually mentally competent but cannot speak.

A Point to Consider

_Exercising rights is as important as having them._

Participating in a residents' council can feel threatening for some residents who have moderate cognitive impairment. Recreation therapists at a Manitoba facility developed a program specifically tailored to empower residents who have moderate cognitive impairment so they would be able to express their interests, needs and wants in a less formal and less threatening way. The program has been successful in providing the residents with a unique venue to voice their preferences for activities, meals and entertainment.

Rights, by their nature, are not contingent on the individual doing anything, including claiming them. However in some jurisdictions, residents rights have been placed within the context of “rights & privileges” or “responsibilities” (e.g. Saskatchewan personal care homes, or the Alberta’s standards and guidelines).
Rights, Privileges and Responsibilities

What's the difference?

An inherent right is something an individual is with, and will die with. These exist by virtue of being a human being.

A privilege is a special advantage or benefit not enjoyed by all. A privilege is granted to the person by someone in authority and may be revoked at any time, if the person loses favor or fails to do something.

A responsibility refers to an obligation that a person has to do something. It is often identified by another, not necessarily the individual. Sometimes residents in care facilities may not have the cognitive capacity to carry out certain responsibilities. Residents also may not have the ability to speak or know the language.

Rights should not be contingent on whether or not the person has fulfilled that responsibility.

Residents “rights” are interpreted and applied by staff: often by those with the least knowledge and training. Where there is ambiguity or lack of operational experience, it is often easiest for staff to say “no” or narrowly apply rights.

A SUPPORTIVE CULTURE

A positive approach from the provider or operator is central not only to preventing abuse or neglect, but also to appropriately addressing it, if it arises. When the operator creates a positive work environment and culture, and sets the tone from upper to lower level management, most problems can be addressed effectively within the facility at the earliest point possible. Government, ministries, regional and local authorities also play important roles in achieving a supportive culture within regulated and unregulated facilities.
An important part of overall abuse and neglect prevention involves putting the residents' needs first in all aspects of care and support. In a supportive environment, creating an abuse-free environment becomes an integral component of all the training, policies, and practices of the facility. The focus is to move away from adversarial systems, and tensions that can arise from blaming, shaming and “fingerpointing”.

**Model of care:** Stakeholders offered a few models of care which they felt illustrated good practices or elements that might help reduce the likelihood of abuse and neglect occurring in long term care facilities. They also noted that any given model of care, (whether it was a broadly framed “resident centred care” model or a specific model such as the “Eden Model”) often ran the risk of being accepted in name only, or with few of the practices being used.

**Developing internal processes:** All facilities should have a specific process (a “protocol”) for dealing with abuse or neglect situations. If abuse or neglect occurs, a positive approach means the provider or operator provides the abused resident with emotional and physical safety immediately, and addresses any longer standing trauma that may occur. It also involves openness with family or other key contact person about the incident and the steps being taken, as well as providing fairness to the staff member under investigation. In a positive environment, a provider or operator will ensure that the administration does not directly or indirectly prevent employees from speaking to authorities about a legitimate concern.

**AWARENESS BUILDING AND ADVOCACY**

In Ontario, Concerned Friends has been advocating on behalf of residents of long term care facilities in Ontario for over 25 years. In recent years they have developed several mechanisms to identify and track problems and to raise the awareness of families and other advocates. These include:

- Checklist to help families choose a care facility that fits their needs, with questions to ask and things to look for when touring a facility.
- An annual Report Card distributed at no cost to Ministry of Health officials, MPPs, service providers, community agencies, seniors organizations, and members. This is based on their review of the Compliance Review reports issued by the Ministry of Health and Long-Term Care.
RESIDENT COUNCILS & FAMILY COUNCILS

The purpose of the resident council is to provide a forum where issues that concern residents can be discussed, including the services provided to them in the care facility. The discussion is to facilitate any needed changes in the facility.\(^{158}\) Resident councils are considered as one means to achieving quality improvement.

A family council is an organized group of family members of residents in care who meet regularly to discuss problems that may arise in the care facility and to explore potential ways of formally dealing with their problems with the administration.\(^{159}\) The main purposes for having a Family Council are to:

(a) protect and improve the quality of life in the care facility and within the long-term care system as a whole,
(b) give families a voice in decisions that affect the residents and
(c) to establish 2-way communication between family members and staff in order to contribute to the facility decision making process by providing family members with the opportunity to become informed about the long-term care system and by providing a means of mutual support for members and for families of new residents.\(^{160}\)

The emphasis is on care and quality of life of the residents. One of the objectives is to identify and address problems early on.

Family councils are seen as having a special role in speaking on behalf of residents who can no longer speak for themselves (e. g., those with moderate to severe dementia). A Council is also a support for residents who do not have concerned families or friends available.

TRAINING

“Work with an aging or severely impaired clientele cannot be improvised. A lack of training affects both workers and the elderly people with whom they work.”

Ordre des infirmières et des infirmiers du Québec, translation as cited in Quebec Human Rights Commission.\(^{161}\)
There is a growing awareness that working with and helping older adults in regulated and unregulated care facilities requires a number of special skills. In the past, the training received by care aides and personal service workers has varied considerably with the school, private or public college providing it. Alberta has recently developed a standardized curriculum which includes a module on communication for health care aides that will be used by private and public colleges. British Columbia is engaged in a similar process.¹⁶²

**ABUSE PREVENTION TRAINING**

Some collective agreements now specifically include in-service for resident abuse as a term of the collective agreement.¹⁶³

**DEMENTIA TRAINING**

The need for staff education on dementia and ways to support person-centred care has been noted in the past by the National Advisory Council on Aging,¹⁶⁴ in several provincial reports, in advocacy reports from the Alzheimer society,¹⁶⁵ and in recent Special Senate Committee on Aging hearings.¹⁶⁶ The Alzheimer Society of Canada identifies long term care staff training "to preserve function and maintain a good quality of life for people with dementia, including high quality end-of-life care" as one of the six critical areas that currently needs to be addressed through a Canadian national dementia management strategy.¹⁶⁷ Dementia training needs to be based not only on understanding the nature of the disease, and its effects on behaviour, but also with practical strategies in how to communicate better with (talking with and listening to) people who have dementia, and the time to carry these into practice on a day to day basis.

**ONE (EASY TO FIND) PLACE TO CALL**

Health care systems and long term care in particular are notoriously difficult to navigate. Residents, family and others need clear simple, easily accessible information on where to call or contact if a problem arises within a facility and has not been adequately addressed internally. They also need to know there is a process in place that will respond to those concerns fairly and in a timely manner.
IMPROVING TRANSPARENCY OF OVERSIGHT

Although licensing, inspections and compliance reports are considered fundamental aspects of oversight and accountability, the public typically has no ideas what problems were uncovered. People often had to request the inspection reports from specific facilities through a Freedom of Information request to government.

Ontario has put its licensed care facility inspection/compliance reports online, a process that has been in place for public health reports for restaurants in some jurisdictions for many years. While at face value this is a positive measure, the actual site is cumbersome to use if people are trying to determine the nature and seriousness of problems. British Columbia will also begin posting inspection reports online in 2008.

By way of comparison, the United Kingdom’ Commission for Social Care Inspection lists the results from the inspections of the social care facilities in a very accessible manner, identifying both what the facility is doing well and where it is experiencing problems.168

ACCREDITATION/ CERTIFICATION

While accreditation is commonly espoused to help improve quality of care, it is not intended to prevent or address problems like abuse or neglect.169 The purpose of accreditation is for a facility to meet certain standards for environment, programming and developing home-like atmospheres. It is often a self assessment process. The focus of accreditation is on quality management, health and safety, and emergency preparedness.170 An additional purpose is to help consumers and others distinguish the quality provider from those providing lower quality care and services. Voluntary standards are often intended to “raise the bar” by promoting and recognizing performance beyond a basic, legally established level.

On February 1, 2007, the provisions of the Act respecting health services and social services171 regarding certification of residences for the elderly in Quebec went into effect. The Act provides that all operators of residences for the elderly must hold a certificate of compliance issued by the health and social services agency. This certificate attests to the fact that the operator has satisfied conditions related to the social and health criteria and satisfies the requirements set out in the Regulation.172
Screening/ Criminal Record Checks

Criminal records checks are one part of pre-screening process to find the best employee for the position. For example, Saskatchewan requires the operator of a personal care home to have a criminal record search for staff at the time of hiring, and every three years. In some jurisdictions, before students enroll in care aide programs at colleges or institutes, they are required to have a criminal record check, as they will be working with vulnerable persons as part of their practicum.

Use of Criminal Law

Some abuse and neglect situations are criminal matters. However, they are often not treated as such. Stakeholders acknowledged that there are serious deficiencies in the use of criminal justice system for addressing criminal matters in care facilities. These relate to lack of recognition of the matter as a crime, the timing of the internal investigation (loss of evidence), and (mis)perceptions by police and administration or staff about the relative reliability of the resident as witness.

Professional Associations

Professional organizations were identified by some stakeholders as an important mechanism to assure qualified persons are providing good quality care, for addressing concerns about individuals who do not appear to adhere to those standards, and to advocate for systemic change where needed. It was pointed out however, that while registered nurses and licensed practical nurses have this representation, the staff members who provide the bulk of the direct care to residents (residential care aides, personal support workers) do not have this support or accountability.

Special Protection Legislation

Throughout Canada most jurisdictions address prevention and intervention in potential abuse and neglect situations through the general legislation for care facilities. However, two provinces (Alberta, in 1995 and Manitoba in 2001) have enacted special laws and dedicated offices for the protection of persons in care. Nova Scotia has initiated similar legislation; however, it is not currently in force. The Alberta legislation covers only publicly funded facilities for older adults. The focus of the legislation and the role of these offices is educative not punitive.
DUTIES TO REPORT SUSPECTED ABUSE

Provincial law (e.g. nursing home or residential care law) may place a special duty on the operator to protect residents from abuse and may require people to report suspected abuse situations to an outside authority. Alternatively, abuse may be treated as one of the special kinds of "incidents" which the care facility operators are required to report. A responsibility to report suspected abuse or neglect may be part of the funding contract. This is often the case for licensed facilities.

Alberta, Manitoba, Nova Scotia (not yet in force) each have established a duty to report. That duty to report may lie on all persons (as is the case in Alberta) or only on specific groups of service providers (in Manitoba). The usual corollary for an adult who has a responsibility to report is to impose some consequence (penalties) for not reporting. The mandatory reporting requirements are based on several overlapping public interest grounds. These include

(a) public interest in protecting the vulnerable resident who as an individual is experiencing harm
(b) public interest in protecting vulnerable people who as a group have a right to a safe and respectful care environment (they witness and are affected by how others are being treated),
(c) professional responsibility, and
(d) in the case of facilities that receive public funds, public accountability.

The overarching issue often raised in long term care settings is who should be required to report (e.g. all staff, certain staff, volunteers, other parties), for what types of harms and for which persons causing harm (other residents, family, staff, administration)? For example, does a resident being financially exploited by a family member have a “right” to say “I will put up with this?”

However equally important is the need for an effective response upon reporting. Reporting is not an end in itself.

THE NEED FOR REPORTING PROTECTION

There are often important power imbalances in care facilities (between staff and the resident or family: between the administration and the staff or resident). Stakeholders point out that there are real risks when it comes to raising concerns and reporting suspected abuse or neglect in some care facili-
ties. In unsupportive care environments, residents, family, staff, volunteers and others who report problems and concerns may risk retaliation or other repercussions. Without safeguards, family risk or believe they risk being denied access to the resident, or loss of "visiting privileges". Family members are often extremely concerned about “what happens to the resident after they leave”.

Staff who report problems may risk job loss, or other employment consequences such as being moved to another less desirable shift or demotion. Advocates (including family) may risk legal action, or be denied continued access to the facility/ residents. Some long term care operators have inappropriately used trespass law to “evict” family members including using the police to enforce this “eviction”.  

Who requires reporting?

In Figure 9 below, sets out the reporting requirements by jurisdictions, highlighting those currently with a law or regulation that requires reporting of suspected abuse or neglect of residents to some authority. Over one half of the provinces have mandatory reporting for some or all of their facilities that provide care and assistance. Four others require the operator to report or record injury, “unusual” or serious incidents.

Please note: In some jurisdictions, there may be other mechanisms such as funding contracts that require the administrator or staff to report resident abuse or neglect.

At the national level: In 2004, Bill C-13 amended the Criminal Code of Canada to make it a criminal act for any employer to threaten or take disciplinary or retaliatory action against an employee who believes that a provincial law is being violated and who then reports that potential violation to an authority responsible for enforcing the law. The section of the law has not been used to protect care facility staff or others. However, for example, it would be a criminal offence if an employer threatened staff of a long term care facility when they made a report to a licensing body or other designated authorities about violations that affected the health and safety of the residents.
### Figure 9 Reporting requirements

<table>
<thead>
<tr>
<th>BC</th>
<th>Alberta</th>
<th>Saskatchewan</th>
<th>Manitoba</th>
<th>Ontario</th>
<th>New Brunswick</th>
<th>Nova Scotia</th>
<th>Prince Edward Island</th>
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<tr>
<td>Mandatory reporting of abuse for licensed care facilities. Assisted living: reporting resident abuse to police or designated agency is encouraged but not required by law or regulations. Voluntary reporting under adult guardianship law.</td>
<td>Mandatory reporting for all persons, but only for publicly funded facilities covered by PPCA. Most supportive living is not publicly funded, so not covered. There are also new standards, guidelines for abuse reporting for nursing homes and supportive living (May/June 2006).</td>
<td>Mandatory reporting for personal care homes. Report “serious incidents”. Abuse is considered a serious incident. Special care homes (provide higher care) are required to report only “critical incidents”.</td>
<td>Mandatory reporting for service providers in facilities that are covered by PPCA. Voluntary reporting for other person.</td>
<td>Mandatory reporting for nursing homes, homes for the aged and similar facilities. No provision for retirement communities.</td>
<td>Reporting is required only for “unusual occurrences” in nursing homes. Also, voluntary reporting under adult protection law.</td>
<td>Reporting is required only for “unusual occurrences” in nursing homes. Operator just required to record injury in nursing home.</td>
<td></td>
</tr>
<tr>
<td>Quebec</td>
<td>Newfoundland and Labrador</td>
<td>Yukon</td>
<td>Nunavut</td>
<td></td>
<td>Has no legislation governing facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not required to report abuse in nursing homes (Voluntary reporting to local quality and complaint commissioner)</td>
<td>Nothing mentioned in homes for special care act or private homes for special care act. Voluntary reporting to Seniors Services/Adult Protection under adult guardianship law.</td>
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</table>
RAISING PROFESSIONAL AND PUBLIC AWARENESS

In the mid 1990s, following the results from the nurses’ survey, the Ontario Nurses Association engaged in a concerted effort to raise professional awareness that harming clients was unacceptable behaviour for nurses.175

Most of the public awareness and prevention work done in Canada around abuse or neglect of older adults has been focused on the community. June 15, 2006, was the debut of World Elder Abuse Awareness Day. For this event in 2007 a small number of care facility staff in rural British Columbia and Alberta used World Elder Abuse Awareness Day posters to raise the awareness among residents and families. More are planning similar events for 2008.

The Protection of Persons in Care Office (Manitoba) has strived to raise awareness among service providers by using abuse prevention posters and brochures in multiple languages. Posters are available in multiple languages including English, French, Cree, Cree syllabic, Ojibway and Ojibway syllabic.

CONCLUSION / SUMMARY

In summary, Canada has taken a patchwork approach to abuse prevention in the continuum of facilities that provide care and support, frequently in response to a crisis and sometimes without the benefit of guiding principles or a framework for considering who is abused or neglected, who the abusers are, and why the abuse may occur. There are significant gaps in key areas, such as protections in reporting and in creating an environment that is supportive of reporting and culture change. Abuse of older adults in care by staff cannot be considered in isolation from broader systemic issues of staffing, training, ageism and resource allocation.
APPENDIX A

SCOPE AND METHODOLOGY

The purpose of the “A Way Forward” project is to provide a “point in time” glimpse of issues and approaches that are in use to prevent abuse and neglect of older adults living in a range of facilities that provide support and assistance to frail adults. This is the first time an initiative of this nature has been undertaken in Canada. Previous initiatives on abuse and neglect in institutions have been limited to licensed care facilities such as nursing homes. The project and the accompanying reports are exploratory and not intended to be a comprehensive statement of the issues or approaches in place.

This project started with a literature review. In addition, we drew on the considerable knowledge of our advisory team and sixty five persons from government, industry, advocacy, education and labour organizations. In advance of the stakeholder interviews, project team members sought and received ethics approval of their respective universities. The interviews were carried out between August and October 2006.

Each stakeholder had been recommended by one or more of their peers as “people in the know” about the issues, systems, and processes in that province or territory. They were asked to reflect on the extent of abuse and neglect of residents in care facilities in their province or territory; factors that might leave persons vulnerable to abuse or neglect in that environment; approaches in their jurisdiction (or others they knew) that were being used to help prevent abuse and neglect (including those in place or under development); and emerging issues that might affect the support and assistance that older adults were receiving.

Most of these interviews were conducted by phone, but two respondents faxed written responses. Many of the stakeholders sent us valuable additional materials to help inform us about their province or territory. We sincerely thank them for their generosity and their many insights that have helped expand the project in many unanticipated ways.

Five regional focus groups were held in late 2006 and early 2007 to “validate” the findings. The results of those focus groups are available in separate reports to this project. See: http://elderabuse.aging.utoronto.ca

Fortunately this is becoming a dynamic area, and many changes have occurred in provincial or territorial law, regulation and practice over the course of this two and a half year project. We have endeavoured to keep current on those changes throughout the course of the project.
APPENDIX B

In 2002, the National Center on Elder Abuse (Administration on Aging) in the United States commissioned a review of prevention research related to abuse in nursing homes and other long term care settings. Strategies identified in the literature at that time included:

- Support education and training in interpersonal caregiver skills, managing difficult resident care situations, problem-solving, cultural issues that affect staff-resident relationships, conflict resolution, stress reduction techniques, information about dementia, and witnessing and reporting abuse.

- Improve work conditions, through adequate staffing, enhanced communication between direct care and administrative staff, more time to nurture relationships between staff and residents, humane salaries, opportunities for upward mobility, and greater recognition, respect and understanding for the difficult lives many workers lead.

- Assure compliance with requirements in the jurisdiction concerning hiring of abusive nurse aides.

- Promote environments conducive to good care.

- Assure strict enforcement of mandatory reporting, as well as educate professionals and the public (non-mandatory reporters).

- Improve support for nurse aides (support groups).

- Support and strengthen resident councils.

- Assure coordination between law enforcement, regulatory, adult protection, and nursing home advocacy groups.

- Assure that hiring practices include screening of prospective employees for criminal backgrounds, history of substance abuse and domestic violence, their feelings about caring for frail older adults, reactions to abusive residents, work ethics, and their ability to manage anger and stress.

A variety of other options have been proposed to reduce the risk of abuse and neglect in care facilities:

1. Improve coordination between the various law enforcement, regulatory, protective services, and advocacy organizations that are involved in nursing home care.
2. Improved conditions for workers, through adequate staffing, enhanced communication between direct care and administrative staff, more time to nurture relationships between staff and residents, humane salaries, opportunities for upward mobility, and greater recognition, respect and understanding for the difficult lives many workers lead.

3. Training that focuses on interpersonal caregiving skills, managing difficult resident care situations, problem-solving, cultural issues that affect staff/resident relationships, conflict resolution, stress reduction techniques, information on dementias, and witnessing and reporting abuse.

4. Improve compliance with federal requirements affecting hiring of abusive nurse aides.

5. Improve reporting through consumer education and stricter enforcement of mandatory reporting.

6. Create support groups for nurse aides.

7. Strengthen resident councils.

8. Improve the screening of prospective staff to focus on applicants' criminal backgrounds, history of substance abuse and domestic violence; their feelings about caring for the elderly; reactions to abusive residents; work ethics; and their ability to manage anger and stress.

9. Create an environment that is conducive to good care.

10. Establish consistent definitions of abuse to improve tracking and research.

At present, there is little if any evidence of which approach (or more likely what mixture of approaches) helps to prevent abuse and neglect of residents in care facilities.
Typically these involved physical or sexual abuse of children and youth in “training schools” or orphanages, people with physical or mental disabilities, or people with mental health problems living in institutions. For example,

- Jericho School for the Deaf (1980s) in Vancouver (physical and sexual abuse).

See: Office of the Ombudsman of British Columbia. (November 1993). Abuse of deaf students at Jericho Hill. Public Report No. 32. Online: www.ombudsman.bc.ca/reports/Public_Reports/Public%20Report%20No%20-%2032.pdf (Retrieved May 15, 2008) Describes staff and peer abuse. Talks about attitudes to the students, staff who were unable to communicate in sign language, and how as a result of being short staffed, they kept on abusers.


- Mount Cashel Orphanage in Newfoundland (physical and sexual abuse). Report talks about the isolation of the orphanage from the broader services.

- Grandview Training School for Girls in Galt, Ontario (physical, sexual, psychological abuse)


For further information on institutional abuse in the context of children and youth see, see:


6 For example, Families Allied for Responsible Eldercare


"Ministry of Health and Long-Term Care, 4.04–Long-Term Care Facilities Activity". Online:
See the follow up report on the progress made. Report of the Auditor General of Alberta—April 2008. “Seniors Care and Programs”, pp. 95-147. Online:
9 Auditor General of Newfoundland and Labrador, Annual Report 2005, “Personal care homes” at p. 285. Online:
15 See for example June 7, 2007 Press release of Protecteur du citoyen (Quebec Ombudsman) giving highlights of the 2007 Annual Report, p. 6. Online:
17 See for example:
National Snapshot:
Preventing Abuse and Neglect of Older Adults in Institutions


National Union of Public and General Employees (NUPGE). (February 2007). Dignity denied: long-term care and Canada’s elderly. Online:


While the majority of families report satisfaction, 13% rated the quality of the health care received by residents as poor or very poor.


For example, abuse, neglect, serious care deficiencies and lack of standards have been raised by professionals, advocates, and even occasionally industry and government representatives in Canada, Australia, England, France, United States, Hong Kong, Jamaica, Taiwan and Columbia.

World Report on Violence and Health, supra, n. 23, at 133.

Ibid.


For example:

- Spencer, supra, n. 29.
- For example, Newfoundland and Labrador notes:
  "In 2004-05, there was a monthly average of approximately 2,500 seniors residing in publicly-funded long-term care facilities. These include Nursing Homes and dedicated units within Health Centres. Additionally, there was an average of 1,900 seniors residing in Personal Care Homes and Community Care Homes. Together, people living in these settings represent 6.6 per cent of the seniors' population." (March 2006) Healthy Aging for All in the 21st Century -Seniors Profile. Department of Health and Community Services Newfoundland and Labrador, pg. 18. Online: www.health.gov.nl.ca/health/publications/2006/seniorsprofile.pdf (Retrieved May 15, 2008)
- In Quebec there are approximately 46,000 nursing homes spaces and about 88,000 spaces in residences for the elderly (Résidences privées pour personnes âgées) within the provincial registry. See: Santé et Services sociaux Québec. « Capacités: Lits ou Places autorisés au permis. Sommaire provincial selon les mission-classe-type>>.
Preventing Abuse and Neglect of Older Adults in Institutions


**Assisted Living** - Assisted living is defined by the Department of Health as including the following elements:

a. A living arrangement where individuals, able to direct their own care, reside in separate, self-contained units. (Individuals able to self direct their own care are cognitively capable and have the ability to make informed, voluntary decisions regarding care requirements and living arrangements or alternatively, are living with a spouse/partner able to do so.) The resident controls access to the unit.

b. An arrangement where some or all of the individual's needs, related to activities of daily living, are met through services which are provided as a formal part of the person's daily living, residential arrangement. (That is, the services are provided by the operator of the residence and are a mandatory part of the individual's monthly accommodation costs. This requirement may be incorporated in a lease/rental agreement or in some form of a documented service plan negotiated between the resident and the operator.) This includes Enriched Housing units under the jurisdiction of the Department of Community Services, Housing Services branch


44 Secrétariat aux aînés Québec, avril 2005 « Fonctionnement des résidences privées pour personnes âgées : Approches mises de l'avant par les administrations canadiennes »


The number of available beds fluctuates constantly as private entrepreneurs open and close residential facilities. Clients are admitted after going through the same evaluation process used for nursing home admissions.


47 These facilities provide semi-dependent seniors and semi-dependent physically and mentally challenged adults with accommodation, housekeeping, supervision of daily living activities, meals and personal care assistance for grooming and hygiene. Care needs are assessed using the Seniors Assessment Screening Tool and are at Level 1, 2 or 3. In addition, there were 38 licensed community care facilities in the province. As of March 31, 2007, the total number of licensed community care facility beds was 938.


48 CHA Report, 2006, PEI” There are currently 18 long-term care facilities in the province, nine public manors and nine licensed private nursing homes, with a total of 968 beds, including respite and temporary beds. Nursing home admission is for individuals who require 24-hour registered nurse (nursing care) supervision and care management.

National Snapshot:
Preventing Abuse and Neglect of Older Adults in Institutions

50 CHA Report, 2006, NS, ibid.

In 2005, the Personal Care Homes Standards Regulation and Personal Care Homes Licensing Regulation were enacted under the same Act, linking licensing to compliance with a range of standards designed to ensure safe, quality care. Both proprietary and non-proprietary homes are licensed by Manitoba Health.


In January 2005, the Department of Health in the Northwest Territories introduced Services Standards and Guidelines for People in Supported Living Homes. The Guidelines assist potential supported living service providers to prepare for the pre-certification process. The Standards create a framework for quality of care and life, and for the review of organizational evaluation process. Supported living services provide a home-like environment with increased assistance and a degree of supervision unavailable through home care services. Current services in this area include supported living arrangements in family homes, apartments and group-living homes, where clients live as independently as possible. Group homes, long-term care facilities and extended care facilities provide more complex medical, physical and/or mental supports on a 24-hour basis.


54 CHA Report, 2006, NWT, ibid.
55 These programs and services in the Yukon operate where applicable according to the Department of Health and Social Services Establishment Policy, the HIHSSA and the Hospital Standards Regulations.
57 CHA Report, 2006, YK


The report notes these are a mix of predominately privately owned service providers and one publicly-owned and operated facility. Licensing agreements are in place to provide for the leasing of the publicly-owned facilities. There is no legislated requirement for long-term residential care services for adults in Nunavut.

The language used in Nunavut for the facilities can vary somewhat from year to year. "Nunavut" Canada Health Act Annual Report 2004-5, p. 225 states "Nursing home services are available at the Elders Homes in Iqaluit and Arviat. These facilities pro-
vide the highest level of long-term care in Nunavut; that is, extensive chronic care services up to the point of acute care services.


60 Murtaugh, C.M., Kemper, P.M., & Spillman, B. (October, 1990). "The risk of nursing home use in later life". *Medical Care*, 28 (10), 952-962


The report also notes that more than half of the younger residents in complex care have a neurological disease or condition; nearly a quarter of all younger persons who were in CCC in 2005–2006 had cancer.

67 ALTCA, supra, n. 64.

68 Aminzadeh, supra, n. 33


71 Aminzadeh, supra, n. 33


74 Bravo, et al. *supra*. n. 70

75 Bravo, et al. *supra*. n. 70
National Snapshot:
Preventing Abuse and Neglect of Older Adults in Institutions

76 Aminzadeh, supra, n. 33
77 Aminzadeh, supra, n. 33.
81 Bravo, et al. supra. n. 70
83 Bravo, et al. supra. n. 70
84 Aminzadeh, et al. supra, n. 33.
85 Statistically speaking”, supra, n. 61
87 Bravo, et al. supra. n. 70
88 Bravo, et al. supra. n. 70.
91 Clough, ibid.
96 Hirst, supra, n. 92.
98 (n.d.) Alberta Protection for Persons in Care Act PowerPoint presentation.
99 (n.d.) Manitoba Protection for Persons in Care PowerPOint Presentation.
100 Hawes, C. (June 18, 2002). Elder abuse in residential long-term care facilities: what is known about prevalence, causes, and prevention. Testimony given before the U.S. Senate Committee on Finance. [Hereafter “Hawes”]

102 See for example,


- **Overall Quality & Care Issues (Canada)**


106 Hawes, *supra*, n. 100, Testimony, pg. 3-4

107 Hawes, *supra*, n. 100, Testimony pg. 3-4

108 See for example, Hirst, *supra*, n. 92.

Hirst notes while registered nurses in administrative positions stated that resident abuse was not common in their facilities: “I’ve never seen resident abuse here”, nurses directly involved in providing care felt “it happens all the time,” “we just don’t recognize it as abuse,” and “you’ll often see a bruise and know that it’s not the result of fragile skin.”

109 Hirst, *supra*, n. 92 at pg. 279.


111 AB -OAG, 2005. *supra*, n. 102


113 Monique Smith report, *supra*, n. 13

114 Monique Smith report, *supra*, n. 13

114 Online: www.pch.gc.ca/progs/multi/assets/pdfs/sen-pub1_e.pdf
National Snapshot:
Preventing Abuse and Neglect of Older Adults in Institutions


117 Clough, *supra*, n. 90 at 220.
119 Payne, et al. *ibid*.
128 Service Employees International Union Local 1. Press release. “Arbitrator issuing warning that staffing levels in nursing homes too low.”
129 Berta, supra, n. 1275.
130 Adapted from The Citizens’ Watch Network, Continuing Care in Alberta. (August, 2006). *An inside look at the continuing care experience in Alberta*.
131 Bravo, et al. *supra*, n. 70.
133 Botting, supra, n. 126
Preventing Abuse and Neglect of Older Adults in Institutions


137 Stevens, J. & Herbert, J. (1997). *Ageism and Nursing Practice in Australia (Discussion Paper No. 3)*, Royal College of Nursing, Australia.


Notes that casual nurses are the ones likely to exit the force.

Findings from the 2005 National Survey of the Work and Health of Nurses—LPNs were less likely than RNs and RPNs to have full-time jobs. LPNs working part time were also far more likely to be unhappy with their job arrangement. Of LPNs who worked part time, 42% would have preferred full-time employment, compared with 18% of RNs and 11% of RPNs.


140 Prins Report, *ibid*.


This American study found the mean annual turnover of administrators in nursing homes was 43%. Facilities where there was high administrative turnover were likely have higher percentage of residents who were catheterized, had pressure ulcers, were given psychoactive drugs. These facilities also had higher than average quality of care deficiencies, and higher than average portion of residents restrained.

143 Prins Report, *supra*, n. 139

144 Prins Report, *supra*, n. 139


NACA recommended that:

- Provincial governments conduct research, collaborate with providers and offer sufficient funding to ensure there is an adequate supply of long-term care for people with ADRD who are no longer able to live in the community.
- Provincial governments develop appropriate legislation and create the necessary monitoring and compliance activities to ensure that all long term-care institutions, including hospitals, meet quality standards consistent with maintaining a good quality of life for residents with dementia.
- Provincial/territorial governments provide increased staffing ratios and provide specialized staff education and training in dementia care for long-term care facilities, including hospitals. Provincial/territorial governments should also ensure that these
institutions be designed creatively to provide safe and homelike environments for people with ADRD.

165 See:
- Online: www.health.gov.ab.ca/resources/publications/AlzheimerReprt.pdf


Mr. Dudgeon notes:
"With regard to improved care, we need to look at approaches to be adopted by home care, community services and long-term care facilities to preserve function and maintain a good quality of life for people with dementia, including high quality end-of-life care. We need to improve care delivery by assisting health care workers with appropriate training and support interventions."


169 A scandal took place in 1999 at the Rivière-des-prairies mental hospital in Quebec, which had just received its accreditation from the Canadian Council on Health Services Accreditation. (La Presse, 1999) Québec's Public Trustee revealed that this hospital had practiced gross abuse and neglect of its patients over an extended period of time.

In explaining how accreditation could have been given to such a hospital, a spokesman for the Canadian Council on Health Services Accreditation remarked that "We are an organization with a formative approach based on the principle of self-evaluation. We try to help the hospitals improve their performance. Our role is not that of an inspector who can remove an agency's permit."


171 R.S.Q., c. S-4.2

These social and health criteria pertain to the training of staff, entrance protocols, confidentiality, transparency, consumer protection, the exchange of information, assistance, accommodation, access to first aid, the health and safety of residents, food and medication, and the use of restraint. The Regulation also provides that the operator must hold and maintain general civil and professional liability insurance.


175 College of Nurses of Ontario (1995). *One is one too many: a program for learning about prevention of abuse of clients.*


Summary at: [http://www.ncea.aoa.gov/NCEAroot/Main_Site/FAQ/Nursing_Home_Abuse/Prevent_Abuse.aspx](http://www.ncea.aoa.gov/NCEAroot/Main_Site/FAQ/Nursing_Home_Abuse/Prevent_Abuse.aspx) (Retrieved May 15, 2008)