AN INTRODUCTION TO ABUSE PREVENTION STRATEGIES IN LTC

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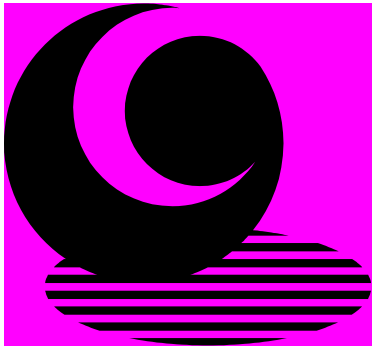

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AN INTRODUCTION TO ABUSE PREVENTION STRATEGIES IN LTC

"The most effective prevention programs, experts say, use a combination of strategies to protect vulnerable older adults." [1]

Abuse and neglect of persons in long term care settings is a complex and multi-faceted issue that may need multiple, integrated approaches in order to safeguard the physical, psychological and social integrity of the residents.

In 2002, the National Center on Elder Abuse in the United States commissioned a review of prevention research related to abuse in nursing homes and other long term care settings. [2] Strategies identified in the literature included:

- Support for 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.
- Improving 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.
- Assuring compliance with requirements in the jurisdiction concerning hiring of abusive nurse aides.
- Promoting environments conducive to good care.
- Assuring strict enforcement of mandatory reporting, as well as educating professionals and the public (non-mandatory reporters).
- Improving support for nurse aides (support groups).
- Supporting and strengthening resident councils.
- Assuring coordination between law enforcement, regulatory, adult protection, and nursing home advocacy groups.
- Assuring 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.

The following list includes commonly identified strategies in the abuse prevention and institutional care literature in Canada and the United States, as well as strategies that are currently in use in some parts of Canada. This document provides an overview and is not

intended to be a comprehensive listing or discussion. There are many other approaches, including resident empowerment that can and should be considered as important parts of abuse prevention strategies.

The alphabetical list introduces the focus, and some of the strengths and limitations of each approach. It is clear that no one strategy is likely to be sufficient to prevent and address abuse and neglect of older adults who reside in care facilities. Each approach is different in its underlying assumptions and the aspects of the problem that it seeks to remedy.

This overview is intended to help people develop a basic understanding of the purpose, strengths and limitations of some of the approaches commonly in use or proposed. This can help stakeholders identify how to strengthen existing approaches, where there may be gaps in prevention systems, and how existing approaches or approaches under consideration may be strengthened.

Type of Approach (Alphabetically)

- Abuse Prevention Policies
- Abuse Registry
- Accreditation
- Acknowledging/ Promoting Good Care and Practices
- Administrative Approach (Environmental Culture)
- Advocacy
- Bill of Residents Rights
- Coroner (Inquest & Death Reviews)
- Criminal Law
- Education and Information (Public and Staff)
- Education and Information (Residents)
- Family Councils (See also Resident Councils)
- Fines, Penalties
- Inspections
- Lawsuits
- Licensing and Regulation
- Long Term Care Ombudsman
- Pre-Employment Screening
- Professional Conduct Oversight/ Accountability
- Public Accountability
- Reporting Abuse
    - Mandatory reporting
    - Protections in reporting
- Public Accountability
- Residents Councils (User Committees)
- Special Protection Legislation
- Staffing Levels and Ratios
- Staff Qualification, Training, and Supervision
- Zero Tolerance

Abuse (Prevention) Policies

Purpose/ Underlying Assumption: According to the National Centre on Elder Abuse

> "Studies show abuse is more likely to occur and to go unreported in …[facilities]… that have no abuse prevention policy. Employees must be able to recognize the signs and symptoms of abuse and believe that they can report allegations to management without suffering negative consequences themselves."

- "An abuse prevention policy is also a public statement that a facility is committed to open communication and can be a step to a facility-wide culture that recognizes and supports the dignity of residents".[3]
- Effective abuse prevention policies require educating providers, staff, residents and the public, as well as ongoing monitoring of the policy's implementation and functioning.
- Abuse prevention policies are often developed as part of a package that will cover related policies (such as in what circumstances, if any, physical or chemical restraints can be used).

Focus (Staff/ Resident/ Facility/Other): Staff/ Facility

Examples of Canadian Jurisdiction Using It:

- British Columbia has established a specific legal duty of licensed care facility operators to protect residents. The BC adult care regulations require abuse prevention policies in all licensed care facilities.
- Under its personal care home regulations, Manitoba requires these abuse prevention policies for all
- personal care homes.[4]
- In 1995, the Provincial Strategy against Violence recommended that all Newfoundland health care facilities and the community health care boards to develop and implement appropriate abuse policies/protocols.[5]

Strength/Advantage: Policy (as well as procedures and protocols that go with it) can help staff and administration to recognize the signs and symptoms of abuse, and address the problem earlier and more effectively. Without a policy, the facility may be more likely to address the matter in an *ad hoc* manner, potentially resulting in increased risks for residents, as well as unfairness to resident and staff.

Limitation/Disadvantage:

- Abuse and neglect policies can vary significantly in their coverage; some may use narrow definitions of abuse or neglect- e.g., they may or may not cover the full range of harms by excluding use of restraints, violation of rights as types of abuse.
- Policy can vary with the facility. Facilities that are not regulated in some way may be much less like to have an abuse and neglect policy in place.
- It is important to distinguish between the *existence* of an abuse policy, the *content* of the policy, and the *adequacy* of the policy in abuse prevention.
- A policy is only effective to the extent that it is communicated with and understood by all, as well as supported by key stakeholders. Policies and procedures must be clearly communicated to residents, families and others and available so the information is accessible to all (e.g. posted in the facility)
- Abuse policies usually do not address systemic harms; definitions may tend to focus on interpersonal violence, overlooking other serious types of harms residents can experience, including neglect.

See Also: Reporting, mandatory reporting.

Abuser Registry

Purpose/ Underlying Assumption: The purpose is to protect the welfare of residents. It identifies individuals who have abused or neglected vulnerable persons in the past or are either involved in a current investigation. The registry is typically used to screen people who are applying to work with vulnerable adults, or provide services that involve contact with them.

Some abusers (staff, volunteers) may leave one position where they are providing care for another position. Unless the allegations were serious enough to warrant action by the police, it may be fairly easy for persons providing care to move from job to job. The focus of the registry is to identify persons have had substantiated allegations of abuse, neglect or exploitation to potential employers. It is part of a pre-employment screening process, and assists them screening for positions with access to vulnerable persons.

Focus (Staff/ Resident/ Facility): Staff or volunteers

Example of Canadian Jurisdiction Using It: No Canadian jurisdiction appears to currently use an abuse registry for care facilities.

It has been used in some American states, e.g. Tennessee. "The Tennessee Department of Health is required by state law and federal regulations to maintain a registry of persons who have abused, neglected, or misappropriated personal property. Allegations of abuse, neglect, or misappropriation of personal property against individuals are investigated thoroughly. Substantiated complaints are referred to the Office of General Counsel for review and processing".[6]

- Some Canadian jurisdictions have *child abuse* registries for persons suspected or convicted of abuse: e.g. Manitoba.[7] For a discussion of the seriousness of being identified as an abuser and having one's name wrongly placed on a registry, see the Supreme Court of Canada decision *Young v. Bella*, 2006 SCC 3 where a social work student's name was inappropriately placed on a child abuse registry after writing a compelling paper describing child abuse.[8]

Strength/Advantage: May reduce likelihood of employer inadvertently hiring persons with a history of abuse to vulnerable persons.

Limitation/Disadvantage:

- Placement on a registry is based on a lower standard of proof than that used in criminal cases or criminal background database. This lower standard may lead to unfairness for the identified person. [9]
- There are major questions about the abuse registry process:
  - What is the process for being considered for placement on the registry?
  - How were the rules for being placed on an abuse registry developed and adopted?
  - What is the level of proof?
  - Is there a hearing and is the hearing process fair?
  - How are reports of abuse, neglect and exploitation investigated?
  - What is the effect on being on the registry?
  - How is the registry maintained?
  - How is it accessed? and
  - How long does the person's name remain on the list?[10]

- There are also basic questions of:
  - Is all abuse the same….
  - Are all violations the same…?
  - What is the threshold for being placed on the registry…?
  - Is there a duty to check the registry?
- Cost of developing and maintaining the registry has been seen as another factor.
- Questions have been raised in the United States that the abuse registry can misused (e.g. an employer may make false accusations against staff as part of “union busting”)
- Registries tend to be staff focussed. They may not cover situations where the operator of the facility is the abuser, closes one facility, and moves to a different jurisdiction to open another.

Accreditation

Purpose/ Underlying Assumption: Facilities have to meet certain standards for environment, programming and developing home-like atmospheres. The focus of accreditation is on quality management, health and safety, and emergency preparedness.[11] 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.

The National Advisory Council on Aging recommended accreditation as one of the strategies for preventing abuse and neglect in long term care facilities. [12]

Focus (Staff/ Resident/ Facility): Facility

Example of Canadian Jurisdiction Using It - The Canadian Council on Heath Services Accreditation (CCHSA) provides a voluntary, external peer review to assess quality across a wide variety of health care sectors in Canada. CCHSA is involved in developing and testing standards, piloting accreditation programs, and establishing accreditation processes.

- Accreditation is currently voluntary, although in 2006 the Health Council of Canada recommended making accreditation mandatory for health facilities (including long term care facilities) that receive public funding, and recommended making the reports public.[13]
- Ontario Retirement Communities Association offers a form of "accreditation" for facilities, with identified standards.[14] Sixty percent (60%) of these types of facilities are accredited in the province.
- National Advisory Council on Aging emphasizes the benefits of accreditation.[15]
- By law (December 2002 - projet de loi 113-- LQ 2002, c. 71) all institutions in Quebec, including long term care facilities are required to be accredited.

Strength/Advantage:

- Responds to the demand for the increasing demand for accountability and transparency in health care. For example, CCHSA assesses the quality of services provided by a facility. The identified dimensions of quality are: responsiveness, system

competency, client/community focus and work life. Each quality dimension is defined and supported by several quality descriptors.
- Accredited facilities are monitored to maintain accreditation.

Limitation/Disadvantage:
- The focus on "quality" as conceptualized by CCHSA may be too narrow, and overlook key issues for residents in licensed care facilities and other settings proving care and support. The quality of their lives depends not only on access to care, but the day to day process of care. [16]
- Accreditation may give operators and the public an unwarranted sense of security that the facility has no problems and that will be abuse or neglect free, when that it is not its purpose or focus.
- Re-accreditation may not occur with sufficient regularity to avoid decline in quality.
- A general concern has been expressed about the proliferation of private bodies identifying themselves as capable and appropriate to "accredit" services.

Both American and Canadian experience with accreditation shows that only 30% to 60% of the facilities will seek accreditation.

- Cost and needed time/ resources for achieving and maintaining accreditation may be prohibitive, particularly for smaller facilities.

Additional Points to Consider:
- Can a strong focus on some quality areas inadvertently lead to rights violations e.g. can a strong focus in “patient safety” lead to intrusions on privacy, freedoms, choices/ risks?[17]
- Does the focus on the paper trail or the specific CCHSA indicators inhibit innovation in long term care facilities?
- What are the skills or focus of the accreditation surveyors? Are they likely to be able to identify any abuse and neglect issues? If they do identify it, does the accreditation process offer any real process for remedying it?
- How does abuse and neglect in particular differ from poor quality of care?
- Can a facility be accredited (meet paper criteria) and still be abusive or neglectful environment?

Acknowledging/Promoting Good Care and Practices

Purpose/ Underlying Assumption: Abuse prevention involves more than identifying what is harmful, or abusive, it also requires acknowledging and supporting positive practices in relating to residents, providing services and care, and fostering supportive environments that can enhance quality of life. [18]

Focus (Staff/ Resident/ Facility): Facility

Example of Canadian Jurisdiction Using It:

- Roses D'or Program- La FADOQ - *Mouvement des Aînés du Québec* - Operators of private residential facilities volunteer to have their facilities and programs evaluated on basis of the physical environment (the building), the quality of life and the satisfaction of the residents, with the purpose of being awarded recognition for good quality. [19]

- Each year the Quebec Network for the Prevention of Elder Abuse recognizes initiatives that reflect promising practices in preventing abuse or neglect. In 2003, they awarded "Honourable Mention" to Maimonides Geriatric Centre in Montreal for the most innovative project concerning the prevention and intervention of abuse in a long term care facility.

- The restraint-reduction program at Maimonides also won an Honourable Mention from the Prix d'excellence de l'administration publique Québécoise that same year.

- In 2004, Maimonides Geriatric Centre also received an Honourable Mention for its encouragement and support of nurses wanting to receive Gerontology Certification. The award is given by the Canadian Nurses Association.[20]

Strength/Advantage: The approaches rewards and encourages facility operators to aim for excellence. It places abuse prevention into the broader context of quality of care and quality of life provided in the facility. It is an effort to have an ongoing process of improving care and meeting older adults' needs in place.

Limitation/Disadvantage:

- The criteria for the evaluation may not capture the full scope of residents' needs, and may place more emphasis on things that are easier to measure.
- Facilities may have very good care practices in some areas but still have other practices that cause harms or violate rights. In some cases, “standard practices” (or the usual way of doing things) may be abusive, for example if they violate the person's rights.[21]

Administrative Approach & Environmental Culture

Purpose/ Underlying Assumption: It has been suggested that abuse prevention requires a multi-dimensional approach, which starts from the top, and filters into all parts of the delivery of care and services within a facility.

The administrative approach and the culture of the facility can significantly affect the way that people interact with each other, as well as the overall quality of care and quality of life in the facility. The environmental culture of the facility can foster and facilitate respect and wellbeing of residents, or undermine it.

Administrative approach and environmental culture in part reflect attitudes, personality and knowledge. Knowledge about positive practices for providing care is constantly changing. What was considered good practice in 1976, 1986 or 1996, may not be considered good practice in 2006. This will likely to continue to change in the future as knowledge on aging, quality of care, rights and personhood, and supportive environments continues to build.

Focus (Staff/ Resident/ Facility): Mixed

Example of Canadian Jurisdiction Using It: Administration of individual facilities may endeavour to modify the environmental culture. Some approaches such as the Eden model have been suggested.

Strength/Advantage:

The way the facility is run, and the extent to which residents, family and staff feel well supported and heard in the day to day and ongoing issues may be very important in helping recognize issues early on. Problem escalation and crisis approaches may be avoided.

Limitation/Disadvantage:

- Facility operators may integrate a few features of what is considered a "progressive" model, e.g. they may use plants, or may bring in animals, but still maintain the traditional approach in much of the care delivery.
- Some operators and their funders will give token recognition to concepts such as resident centred care.

Advocacy

"Advocate"
v. "To speak or write in favor of; defend"
n. "One who pleads the cause of another" *Webster's Collegiate Dictionary*

Purpose/ Underlying Assumption: The purpose of advocacy is to ensure that people receive the services, information, respect and recognition to which they are entitled. [22] Some people experience difficulty having their needs and wishes acknowledged in a care facility. Approaches in some institutional settings may tend to reflect what care providers consider as work -efficient or cost efficient, or prudent; in the administrative interest or the person's best interest, as opposed to what the person is entitled to expect.[23]

"Advocacy is usually sought when 'systems' that administer programs such as health care, are perceived to be all powerful in a given situation and the individual or group involved feels unheard, that their rights have been violated, or that they are powerless." [24]

There are many different types of advocacy, including self advocacy, advocacy on behalf of the resident by family, friends, or staff; as well as legal advocacy, social, political or systemic advocacy. Some types of advocacy will be formal, such as advocacy generated through residents (users) councils/ committees; family councils, ombudsman; or through legal advocacy.

Focus (Staff/ Resident/ Facility): Resident

Example of Canadian Jurisdiction Using It:
- *Legal advocacy:* Advocacy Centre for the Elderly.
- Also See ***Residents Councils*** and ***Family Councils***
- *Systemic Advocacy:* Concerned Friends (Ontario); volunteer ombudsman[25]

Strength/Advantage: Gives voice to those who may not be able to express their needs and enforce their rights. Helps to address power imbalances. Can respond proactively (avoid harms, rights violations) as well as reactively (after a harm has occurred).

Limitation/Disadvantage: The overall lack of available advocacy resources. Effective advocacy requires training and appropriate support for advocates, especially volunteers.
- Much advocacy functions on a case by case approach. Systemic advocacy is not very common.

Bill of Rights (Residents' Rights)

Purpose/ Underlying Assumption: The objective of these texts is to recognize the dignity of the residents and to preserve the persons' rights.[26] A bill of rights may be considered as a public statement that a facility is committed to a facility-wide culture that recognizes and supports the dignity of residents. A bill of rights may enumerate and consolidate person's rights that exist at common law as well as integrate rights from other sources (e.g., rights in health law, privacy of information rights, duties that are described in medical or professional codes of ethics, contractual rights).

It has been suggested that a bill of rights shifts the legislative focus in care facilities to the individual resident; empowers residents and their substitute decision-makers; and affirms the dignity of all the residents. [27]

A bill of residents' rights is substantively different from a provincial human rights code, a provincial charter of rights[28] or the Canadian *Charter of Rights and Freedoms*.

Focus (Staff/ Resident/ Facility, Other: Multiple.

Example of Canadian Jurisdiction Using It

- By law, Manitoba requires all personal care homes to have a bill of rights. The law provides a statement of what minimally should be in the bill of rights. [29] However, the care home operator identifies what other "rights" the resident is "permitted" to have in the care home's bill of rights.
- In Saskatchewan, a list of "rights and privileges" must be given to residents of personal care homes as part of the admission agreement. These must also be posted in every care home, and are part of the care home contract.[30]
- Quebec has a *Charter* of health care rights for "users" under the *Health and Social Services Act,* focussing on how they are to be treated in care.[31] Each institution is to create its own Code of Ethics.[32]
- The Ombudsman of New Brunswick 2003/4 Annual Report recommended the development of a Residents Bill of Rights for nursing home residents in the province.[33]

- In other jurisdictions (e.g. Nova Scotia) some special care home regulations could be framed as rights.
    - Ontario has enumerated a number of rights identified in nursing home and homes for the aged regulations which have been "translated" into a booklet for residents. These are also part of staff abuse prevention training and general training.[34]
    - Specific facilities may develop their own charter or bill of rights, e.g. Residence Yvon Brunet.[35]

Strength/Advantage: Bill of rights commonly identify that the person living in a care facility retains his or her privacy, has a right to expect to be treated with dignity and respect and to receive good care, retains rights to health care, personal decision and other rights and personal freedoms; and does not give these up. Also the bill of rights may include the right to safety and security; protection from abuse; and rights to self advocacy and advocacy by others.

Limitation/Disadvantage

- Bills of Rights tend to identify or focus only on select rights (a narrow part of all the person's rights).
- These documents are broad statements; it is often not clear on how they are to be interpreted or operationalized.
- There is often a distinction between rights *in care* and rights *to care* and the extent to which these different rights can be protected.[36]
    - Focus is largely on individual rights in care and not quality of life
    - Tends to overlook collective rights to good quality care and resource distribution.
- "Residents Rights" are sometimes placed in the context of "privileges" and "resident responsibilities", which can undermine their meaning as entitlements.
- Internally developed Bill of Rights may only reflect what the operator feels that the residents' rights are or should be.
- It has been noted in other related areas (such as patient's rights) that the trend has been to "system's shallow acceptance of consumer self-determination".
- Residents do not possess the kinds of social, economic, and political resources traditionally thought essential to wield power in policy of care settings. They frequently depend on a fragile network of care services in the facility to maintain their independence. As a result, the bill of rights without some enforcement or support mechanism may become lip service or any empty right.
- Without good staff training, rights may not be understood in context.

Coroner (Inquest & Death Reviews)

Purpose/ Underlying Assumption: In most Canadian jurisdictions, there is a legal responsibility to report accidental or "unexplained" deaths to coroners or medical examiners. This includes the deaths of persons residing in care facilities that may have occurred as a result of negligence or actions of volunteers, the staff or administration. The coroner or medical examiner, in turn, has a legal responsibility to determine the causes and circumstances of the death, and in some cases may request a public inquiry.

The review is intended to determine the causes and factors associated with the death and to prevent similar harm to residents of care facilities in the future.

Focus of the strategy (Staff/ Resident/ Facility/ Other): Mixed/ Multiple

Example of Canadian Jurisdiction Using It:

- The Geriatric and Long Term Care Review Committee of the Office of the Chief Coroner of Ontario assists coroners with their investigation into the deaths of the elderly in long term care facilities. [37] For several years, the Committees reviews have included recommendations on the use of restraints.[38]
- Alberta's fatality inquiry (e.g. into the scalding death of a resident) examined practices, such as the informal training the staff received [39]

Strength/Advantage: Determines the causes and factors associated with the death and to prevent similar harm.

Limitation/Disadvantage:

- Focus is *post mortem*. Focus is only on fatalities, leaving other serious harms unaddressed. Facility operators may inaccurately report resident deaths as anticipated, or of natural causes.
- In many instances, families have had to actively seek out inquest; a full inquiry is not automatic.
- Coroners and medical examiners in some jurisdictions have identified their own limitations in their capacity to separate out abuse or neglect as the cause of death from "normal aging".

(Enforcing) Criminal Law

Purpose/ Underlying Assumption: This is typically considered as another important part of any abuse prevention policy. Some forms of abuse and neglect of residents in care facilities will also be criminal matters and need to be treated as such to protect the individual residents, residents in general, and society.

Successful criminal prosecution for abuse in institutions will be dependent on the knowledge and skills of many parties, including police investigators, Crown Prosecutors and judges about care delivery and abuse and neglect issues in the institutional environment, the capacity of residents, and any potential legal justifications for contextual reactions, such as dealing with "aggressive behaviour".

Focus of the strategy (Staff/ Resident/ Facility/ Other): Mixed/ Multiple

Example of Canadian Jurisdiction Using It:

- The draft Ontario Ministry of Health and Long-Term Care consultation "Abuse Policy on the Prevention, Reporting and Elimination of Abuse of Residents of Long-Term Care Facilities" points out: [40]

> All abuse and neglect is wrong. Some forms of abuse may also be offences under the *Criminal Code.* When criminal activity is suspected, the police must be contacted.

Strength/Advantage: Accords criminal acts that occur in facilities the same level of seriousness they would receive in the community.

Limitation/Disadvantage:

- The use and enforcement of criminal law for harms in facilities will depend on the capacity of those working in a facility to recognize criminal acts as such.
- Concerns have been expressed that first pursuing abuse as an internal investigative process can mean delays and loss of evidence for the criminal investigation process**.**
- Private facility operators may be reluctant to call the police, for fear that it will reflect poorly on their public image.
- Concerns about the mental capacity of the residents, need to have good documentation and collateral information processes to help support the abuse or neglect criminal case.

Education and Information (Public and Staff)

Purpose/ Underlying Assumption: Awareness-building, education and prevention are often considered the keys to eliminating abuse or neglect. Education and information can help people recognize abuse or neglect; identify behaviours and actions that are harmful and unacceptable; as well as to recognize and appropriately respond to abuse or neglect situations they may encounter.

Part of awareness building includes having accurate information and knowing where to call. Public education, information and awareness building can occur at the local, regional or national level. Staff education can occur at a workplace level (in service or off site) or professional level.

In some instances the objective of this education is to empower staff to get involved to protect the residents, their colleagues and themselves.[41]

Focus of the strategy (Staff/ Resident/ Facility/ Other): Mixed/ Multiple

Example of Canadian Jurisdiction Using It: Most, if not all, Canadian provinces and territories have provided *some* education and information on these issues to some staff or the public at some point. However the need for education and information has consistently outstripped the resources to provide it.

Public Education:

- The Federal Provincial Territorial Ministers Responsible for Seniors supported a public awareness and education process in June 2006 for World Elder Abuse Awareness Day. Abuse in institutions was mentioned, but not specifically covered.

Staff Education:

- In the mid to late 1990s, the Abuse Prevention in Long Term Care Project developed education materials that were used primarily in publicly funded facilities.
- Re*ACT in Vancouver Coastal Health has been engaged in education work with facilities so that they will link to the designated agencies that are responsible for investigation of abuse and neglect of vulnerable adults.

- Alberta provided some staff education on their responsibilities under the law when the *Protection for Persons in Care Act* was first introduced in 1995.
- Recent changes to Alberta care standards specifically require operator to have policies and provide staff education on legislative (Protection of Persons in Care) provisions. This requirement is only for types of supportive living and long term care facilities that are covered by the legislation. *Private operators who do not receive public funding are not covered by this requirement.*[42]
- In Ontario, the Colleges of Nurses produced the "One is too many" prevention materials. First released in 1994 to respond to a government requirement that all Ontario health colleges provide member education about abuse, it was updated in 2005.[43] It was developed as part of a provincial **legislative requirement for all health regulatory colleges** to provide member education about client abuse.[44]
- Manitoba Protection for Persons in Care Office will give training to residents where operators make a request.

Strength/Advantage:

- It is important for people to understand what abuse means, what it looks like and what to do about it.

Limitation/Disadvantage:

- **Public education:** To date, most efforts to raise public awareness of abused and neglect of older adults has centred on abuses and neglect within the community, not institutional settings.

- **Staff education**: Few jurisdictions require education on patient/client/resident abuse in curriculum or in continuing education for health care providers.
- Operators and staff note that while some form of abuse prevention/ education standards exist, they need to have adequate resources to be able to live up to the standards, and **how to put what is learned into practice.**
- Training and education in care facilities has largely been piecemeal; and there is a low level of saturation. Any "one off" public education is unlikely to have significant impact. There is also a need for continuing education to add new skills, in order to address very high staff turnover in this area.
- Concern has been expressed that some for profit providers are less likely to provide training for staff in general, and rely on publicly funded efforts to provide the training to the private facilities.
- Abuse prevention education of this sort may be treated as a “frill”, or “luxury”, particularly where there is not sufficient staff to cover for those taking the education or training.
- High turnover of staff in some regions or jurisdiction means the training must be continuous. It is not at present.

Education and Information (Residents)

Purpose/ Underlying Assumption: The objective is to help raise residents' awareness about what they can reasonably expect in a facility as well as information about abuse and neglect. Some education and information is intended to help residents know their rights within the facility and to help them to be able to see those rights are respected.

Focus of the strategy (Staff/ Resident/ Facility/ Other): Resident

Example of Canadian Jurisdiction Using It:

- Since the early 1990s, Community Legal Education Ontario (CLEO) has published a Residents Rights booklet based on the nursing home and homes for the aged regulations in Ontario.
- In 2003, Simon Fraser University Gerontology Research Centre produced a plain language booklet identifying rights of residents in community care facilities.
- In Toronto, the Homes for the Aged have produced a booklet "Abuse: What residents need to know."[45]

Strength/Advantage: The education and information can help residents and other people know that harms by staff, volunteers, or others are not acceptable and where they can seek help. The education and information can be one means to reduce power imbalances and to dispel concerns, or correct misinformation.

Limitation/Disadvantage: Concerns have been expressed that simply providing residents with knowledge (information) without redressing the underlying power imbalances between residents and staff or administration, or residents and family may make knowing one's rights meaningless. Also, residents often need support to be able have their rights respected.

- Concerns have been expressed about the most appropriate presentation and timing of information for residents. For example, what are the strengths of providing the information immediately upon admission? What are the drawbacks?
- Who else needs the information? Families, friends, informal, advocates, others?
- Other considerations include:
  - What is the level of functional literacy among the residents and what are the suitable means of educating residents, some of whom may have cognitive impairments?

Family Councils (See also Resident Councils)

Purpose/ Underlying Assumption: 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.[46] 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.

Because of their unique relationships with residents and their life experiences, families often see problems and solutions that staff may overlook. [47] "The Family Council is a way for family to have meaningful involvement in the facility and the more involved family members are, the better the care is". Family and resident councils are considered as a means to achieving quality improvement.

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.[48]

Focus of the strategy (Staff/ Resident/ Facility/ Other): Mixed/ Multiple

Example of Canadian Jurisdiction Using It:

- British Columbia developed the first family council in 1992 at St. Vincent's. The current adult care regulations encourage the development of family/ resident councils.
- Ontario has begun providing government support to the non profit organization Concerned Friends and self help for training for the development of autonomous family councils. This will be mandated by law in the Fall 2006.

Strength/Advantage: A family council provides families and friends of residents with education and information related to the long-term care system. It can also be an important means to express concern and solve problems. It also provides

- mutual support, empowerment and advocacy to the family and friends of the residents of long term care facilities,
- "strength in numbers" by offering safe, confidential place for family members to bring their concerns to be processed,[49]
- input to aid staff in problem solving and finding solutions,
- support to facility staff and administration on mutual concerns and goals.

Limitation/Disadvantage: Like resident councils, family councils cannot exist in a vacuum. They need both support, and to be autonomous (See Resident Councils/ Users Committees)

- The family councils are often dependent on good will of the administration. The councils may or may not have any real means to change facility policy/ practice, which may reduce their effectiveness. Some become social bodies instead. Others may have difficulty offering concerns in a constructive manner.
- In many jurisdictions, there is no official recognition or support of family councils; there is lack of formal relationship with the ministry of health and long-term care, particularly with departments responsible for compliance and licensing, if the problems are not being addressed effectively internally. [50]
- Lack of core funding for the family councils or programs that help to establish them.
- Turnover or lack of continuity of knowledge, skills and experience on the family council. Because of age and frailty, many residents may live in the facility for only one or two years. They may move or more likely will die there. Family member involvement with the council may end at that point.

Fines, Penalties

Purpose/ Underlying Assumption: Fines and penalties are intended as an additional means to achieve compliance with laws and regulations, and are often intended to modify an operator's actions or lack of action in area of health and safety or in the delivery of care. They provide a monetary penalty for failure to change.

Focus of the strategy (Staff/ Resident/ Facility/ Other): Facility

Example of Canadian Jurisdiction Using It:

- Most jurisdictions provide some fine or general penalty for violating the provision of nursing homes law or regulations.
- Both Alberta and Manitoba's PPCA laws provide for fines.

Strength/Advantage:

- Provides an additional enforcement mechanism.

Limitation/Disadvantage:

- Fines and penalties are seldom used by authorities in most jurisdictions, even for the most egregious cases.
- This approach is tied to regulation and therefore is not available for unregulated facilities.

Inspections (Regular or Unannounced)

Purpose/ Underlying Assumption

Inspection of care facilities services is a review, conducted by external bodies that should be independent of the service providers. The purpose of inspections is to identify potential hazards and assess the risk to residents, staff and public arising from activities in the facilities; to assess effectiveness of management to achieve safe care; and to assess specific contraventions of regulations.

Major goals of long-term care regulation have been described as (1) consumer protection, specifically, ensuring safety, quality of the care received, and legal rights of consumers, and (2) accountability for public funds used for care. Where public funds are being used government has a responsibility to hold providers accountable for fiscal integrity and for the quality of care provided to beneficiaries.

Although it varies considerably among jurisdictions, a facility may be inspected because it is new or there has been a change of ownership, of management, of administrator; it has just applied for a contract, is being re-certified / licensed; it has recently failed certification, with serious deficiencies etc.

Inspection gives a public body the legal authority to enter the facility, examine the physical environment of the facility, and its books and records. It may also be authorized to speak with residents and others at the facility.

Inspection has been identified as having a key role in the reform and **improvement** of services. It provides assurances to the public, holds organisations to account for their performances and helps **drive up standards.**

In general, the guiding principles of inspection are:

- focus on improvement
- focus on outcomes
- proportionate to risk
- use of impartial evidence
- have criteria for making judgements
- be open
- have regard for value for money
- learn from outcomes of inspection

Inspections may reveal different kinds of harms – isolated events, patterns of harm or widespread harms.

Focus (Staff/ Resident/ Facility, Other): Mixed

Example of Canadian Jurisdiction Using It

- Since 2004, Ontario has made its inspection reports publicly available on the Internet.

Strength/Advantage:

- Regular inspections avoid a reactive or crisis management approach. They may help identify problems and poor practices early on so that they can address before the situation deteriorates or the practice or deficiency become more widespread.

Limitation/Disadvantage

- The inspection process may be deficient; and the resources to conduct proper and timely inspections and follow up may not be adequate**.** Recent American research suggests inspectors often overlook serious deficiencies, including life-threatening conditions.[51]
- Problems in the inspection process may arise in four broad areas: (1) attitudes of provincial and regional personnel about enforcement objectives and processes; (2) provincial rules and guidelines; (3) variation among jurisdictions in policies and procedures; and (4) resources to support enforcement activities**.**[52]
- Some systems may have significant legislative or policy deficiencies that undermine the capacity for inspections. For example, in one Canadian jurisdiction, outside of routine inspections, the facility review (inspection) process can only investigate complaints made by or on behalf of a specific patient or resident in a health care facility. Plus it can only be undertaken with signed

authorization from the resident or their legally authorized representative to disclose health information. Being the spouse or family member of a patient is not sufficient to provide authorization to disclose health information on a patient's behalf. As a result, only about one in five complaints about quality of care is investigated by that facility review body.[53]

- In the US, research also indicates state surveyors cite some facilities for deficiencies that appeared to be a function of their high prevalence of seriously impaired residents rather than poor quality care.
- Policy decisionmaking process may not consider there are significant risks to residents in some environments. In most jurisdictions facilities that provide lower levels of care, assistance, and support, e.g., assisted living or retirement communities tend to have a limited or non existent inspection process.
- Where there are inspections, the quality of the inspection is dependent on who is part of the inspection team; the training the inspectors receive; the threshold and level of tolerance that the inspectors have, and whether they use the inspection tools or go by "impressions".
- Inspections focus on health and safety; on paper trails ("Is there a written policy in a policy manual?"). The existence of the policy may erroneously be considered as evidence of its implementation and its adequacy.
- With the exception of Ontario, inspection reports for long term care facilities are not easily accessible to the public. A report may be accessed for a particular facility through a Freedom of Information request, which is lengthy cumbersome and costly process for consumers.
- Delays: It may take weeks or months to start investigating reports of harm to residents.
- Inspections tend to be infrequent (one a year, once every few years). The quality of care can change quickly, even for facilities that have had good records for extended periods of time.
- The facility is expected to meet the provincial/ territorial standards. Some people may question the adequacy of those standards in the first place.

Research suggests that inspections are more effective when:

- The inspections are unannounced, and include times where the staffing levels may vary, e.g. weekends and evenings.
- Inspections are conducted by official appropriately trained inspectors who are independent of the facilities and of the funding bodies.
- Inspection teams include health care professionals such as dieticians, RNs and licensed social workers
- A copy of each inspection report is sent to the facility after it is completed
- The facility must submit a plan of correction to the province or territory, if standards are not met.
- A follow-up survey is made to verify deficiencies have been corrected.

Lawsuits

Purpose/ Underlying Assumption: Canadians on the whole have not been considered overly litigious.

Lawsuits are an after the fact (reactive) response to abuse, neglect or other problems in a facility. The lawsuits initiated by family tend to be launched only after other efforts to address the problem and prevent recurrences have failed.

Some analysts feel that litigation against facilities may be the result of quality problems that are not adequately monitored during the inspection process. Others contend litigation merely causes quality problems by diverting financial resources away from care.[54]

Some American government reports indicate that regulations have been ineffective in improving quality of care in many nursing homes. [55] Quality of care problems, often attributable to inadequate staffing or negligent hiring and supervision practices, underlie most care facilities lawsuits.[56] [57]

Lawsuits may serve the function of providing both specific and general deterrence of certain kinds of institutional behaviours as part of risk management.

Operators may also use the legal system to respond harms or problems with family, e.g. banning family members from visiting the facility.

Focus of the strategy (Staff/ Resident/ Facility/Other): Facility

Example of Canadian Jurisdiction Using It:

- There have been some class action suits in the past few years for long term care in different parts of Canada, including Alberta, and New Brunswick. In the 1990s, the rights of Ontario seniors in retirement homes to tenancy protection were enforced by a class lawsuit through the Advocacy Centre for the Elderly.
- In 2005, a Nova Scotia resident filed a class action suit against the provincial government for its practice of charging for medical care services provided in long term care facilities.[58]

- In 2004 British Columbia, the Public Guardian and Trustee initiated a class action lawsuit on behalf of former residents who had experienced physical and other forms of abuse in Woodlands, an institution for people with cognitive disabilities. The decision for the lawsuit came after an independent report found individual and systemic abuses.[59]
- The largest and most far reaching lawsuits in Canada for institutional abuses are those on behalf of aboriginal persons who attended residential schools, who experience physical abuse, sexual abuse, and other harms.

Strength/Advantage:

- Legal claims may result from quality problems that go unmeasured during the inspection process. [60] Lawsuits are usually implemented in response to failure of other systems or approaches.
- While lawsuits will outlive the residents immediately involved in most cases, the long term effect may be to set up prevention of future problems as a pressing priority.
- The cost of defending a lawsuit may move apathetic, repeat offenders.
- Media attention with lawsuit may shift government priorities in a positive manner.

Limitation/Disadvantage:

- Lawsuits are extremely costly, and beyond the financial ability of most residents, family and other concerned bodies. There will be an inherent power imbalance between operators, health authorities, and residents, family and other concerned bodies in these situations**.** Many types of lawsuits are lengthy, and take considerable time, a scarce resource for residents and family.
- Some analysts argue that litigation duplicates the efforts of the inspection process.[61]
- Operators may use lawsuits (or threats of) as a defensive measure (to counter abuse reports).[62]
- Media attention given to lawsuit may shift government priorities, and focus more on crisis management than longer term planning.
- There are significant overall difficulties related to proof (fault, causal bond, damage) that cause uncertainty for the resident. being able to succeed with the action.
- The adversarial process may produce secondary harms, by scrutinizing a resident or family members' behaviours or actions as "faulty", or attacking the resident's or family's reputation.
- Proliferation of lawsuits or even belief in possible lawsuits can lead to the development of "defensive care" (and rights restrictions) to manage perceived financial risks.

Licensing and Regulation

Purpose/ Underlying Assumption: Provinces have primary responsibility for establishing, monitoring and enforcing standards and guidelines for the care of residents. The purpose of licensing is to assure that the operators adhere to certain standards in providing care and services to residents. The licensing process regulates basic areas of the health and safety, the environment and service delivery according to prescribed standards. Licensing may involve an inspection process, on a scheduled or unscheduled basis. Licensing may also involve fines or other penalties to help enforce standards.

Major goals of long-term care regulation have been described as (1) consumer protection, specifically, ensuring safety, quality of the care received, and legal rights of consumers, and (2) accountability for public funds used for care. [63]

The Licensing Body may also serve an important function as a place to which people can direct their complaints and concerns.

Regulation: The central elements of long-term care regulation are:[64]

- establishing quality and related *standards* for service providers;
- designing *survey processes* and procedures to measure and monitor actual conditions of residents or clients and *to assess compliance*; and
- specifying and imposing *remedies or sanctions* for noncompliance. [65]

Most policy makers acknowledge a particular need for regulation of long-term care for several reasons: [66]

- Regulatory protection is essential given the significant vulnerability of many of the people using long-term care, including the very old and frail, the very young, and those with dementia, mental illness, and developmental disabilities. Many people with severe chronic or disabling conditions are highly dependent on others and unable to protect themselves from abuses and neglect by caregivers. Moreover, many have no immediate family members, friends, or advocates who are able to oversee their care and protection.

- Individuals needing long-term care frequently have multiple diagnoses and chronic conditions that require a wide array of medical and nursing services, medications, and treatments. Although some individuals have the knowledge and skills to direct their own care, others do not.
- Those using long-term care rely heavily on nonprofessional and para-professional workers, which typically means they rely on workers who have little training or expertise in providing care.
- Much long-term care is relatively invisible, either because it is provided in facilities without much community observation.
- Users of long-term care often lack choice of providers or services, which limits the effectiveness of market forces in ensuring quality.

The Canadian Health Care Association states: "Licensing will help protect vulnerable citizens from receiving care in unregulated facilities and prevent cases of abuse/ neglect." [67]

Focus of the strategy (Staff/ Resident/ Facility/Other): Facility

Example of Canadian Jurisdiction Using It:
- All Canadian jurisdictions require licensing of some types of facilities that provide care and support to adults, but differ on which types of facilities and which residents in those facilities will be covered.
- Most licensing is geared to those providing some degree of "skilled nursing care".
- BC uses a registry process (as opposed to a licensing process) along with standards and guidelines for assisted living facilities.

Strength/Advantage: Licensing is an effort to establish and maintain minimum standards for the care and to protect persons who reside there in the care, support and assistance they receive. It is intended to be part of a larger effort to encourage and assist the facilities toward maximum standards. In the United States licensing and inspections were enacted in response to widespread problems that resulted from deregulation in the 1990s.

Limitation/Disadvantage: See Also Inspections.
- As the New Brunswick Auditor General notes, "*The license does not mean the nursing home is meeting the standards."* Licensing and inspection are different processes and serve different functions.[68]
- Inspection process is dependent on the quality of the inspector training.

- Advocates point out that in some jurisdictions, facility operators remove the facility from the “licensed" scheme to avoid the regulatory framework, and yet continue to provide to the same residents with the same care needs.
- Quebec appears to limit who can complain to licensing to users and a person with a contract. Someone who is not directly affected may not be able complain to licensing--e.g. an advocacy organization. [69]
- Critics of regulation, typically those within the industry, contend that regulation may encourage mediocrity and barriers to innovation. It has been argued that too many providers concentrate narrowly on minimum requirements instead of striving for providing quality care. They also express concern about the proliferation of “excessive regulations”.
- Others believe that regulations focus too single-mindedly on protection and safety as objectives. Other values such as the quality of life or autonomy of those receiving care may be underemphasized.

Other Considerations:

Over the years a growing body of empirical evidence on healthcare regulation has been developing, along with wider theoretical literature on regulation. This information suggests there are a number of characteristics of effective regulation:

- it should be explicitly directed at improving performance;
- it should be designed to be responsive to individual organization's performance and behaviour;
- it should be proportionate to the likely risks or opportunities for improvement;
- it should be rigorous and robust in its measurements and assessments;
- it should be capable of being applied in a flexible manner without creating inconsistency or unfairness;
- it should be open and transparent in its workings where that does not hamper improvement;
- it should be able to use a wide range of enforcement measures including both incentives and sanctions;
- it should be set up to be accountable for regulatory performance while preserving the regulator’s operational autonomy from stakeholders in regulation; and committed to evaluation and review.[70]

Long Term Care Ombudsman

Purpose/ Underlying Assumption: In the United States, the Long Term Care Ombudsman Program grew out of an effort by the federal government to correct widely reported problems of abuse, neglect and substandard care in American public and private nursing homes.[71]

The purpose of the ombudsman is to provide a coordinated advocacy approach to address older persons' understanding and exercise of their rights and access to assistance with problems they encounter. The ombudsman serves as an advocate on behalf of residents of long term care facilities. The Ombudsman also has a role in systems advocacy through the identification of significant problems and monitoring of federal, state and local laws and policies.

The original demonstration program in the United States focused on complaint resolution activities provided from one centralized point. Later, the program had adopted a model which relied on a network of local (trained) volunteers to act as advocates for residents.

The approach has been suggested in at least one Canadian jurisdiction (Ontario), with the view that the long term care ombudsman would act as a third party advocate or watchdog for seniors in long term care facilities.[72]

Focus (Staff/ Resident/ Facility): Multiple

Example of Canadian Jurisdiction Using It: None. Canadian jurisdictions may have ombudsman program to evaluate the fairness of public department and authorities. However only one Canadian jurisdiction (Nova Scotia) has staff in the Office of the Ombudsman whose work is focussed specifically on seniors or long term care facilities. [73]

In 2003/4 the New Brunswick Ombudsman recommended amending the *Ombudsman Act* to permit the Ombudsman to carry out investigations and exercise oversight with regard to residential facilities operating under the *Nursing Home Act* or as licensed by the Department of Family and Community Services.[74]

Typically the facilities are not treated as part of "government", although the health regions and health authorities will be. Quebec has an ombudsman (for "users") under the *Health and Social Services Act.*[75]

Strength/Advantage:

- Depending on the structure, an ombudsman may be a centralized complaints system with just one entry point. This means persons do not have to seek out multiple sources to have problems resolved (for example, the existence of twenty-three professional colleges in Ontario, which can cause confusion to the public regarding to which college a complaint should be made) .
- The ombudsman may deal with systemic complaints that are not attributable to a sole identifiable professional.
- The use of volunteer ombudsman may promote low-level resolution of complaints, provide remedies and facilitate ongoing dialogue as well as self evaluation.[76]

Limitation/Disadvantage:

- Traditionally the ombudsman process in Canada has been limited to examining whether the public agency followed its own procedures and examining the fairness of decisions made. It is not able to address the allocation and distribution of resources by government.

Other Considerations:

There are a multiple of structures needed to assure the Ombudsman can work effectively. A more effective process will be one where"

- The Ombudsman is independent and free of conflict of interest.
- The investigations are impartial.[77]
- The Ombudsman has access to residents, records and facilities,
- The Ombudsman can obtain the resident's consent to review medical and social records.
- There are prohibitions and sanctions for willful interference with Ombudsman representatives.
- People and organizations are prohibited from taking action against persons who file complaints or cooperate with the Ombudsman.
- There is a reporting system to collect, analyze and report data on complaints and conditions in long term care facilities.
- There are procedures for disclosure of information from the Ombudsman's files while ensuring the protection of confidential information, including the resident's and/or complainant's identity.
- There is training and ongoing support for volunteer ombudsman.

In the United States, the concern has been expressed that the long term ombudsman program has focused primarily on responding to complaints that relate to individual residents of nursing facilities, and has not been able to give sufficient attention to advocacy on the systemic issues. [78] The LTC ombudsman program has not been as available for assisted living residents, who are seen as an equally vulnerable population in the United States.

Pre-employment screening

Purpose/ Underlying Assumption: Pre-employment screening – including checking references and conducting criminal background checks – is essential to ensure that applicants who are not suited to care for vulnerable older adults are not hired. [79] Screening helps an organization create a safe environment by selecting the right people for each position. [80]

a. Criminal background check: Volunteer Canada notes "Any organization that provides programs to vulnerable people has a moral, legal and spiritual obligation to appropriately screen people who work for them, including volunteers. Screening is not only the right thing to do, it is legally required under the principle of "Duty of Care". Some statutes create a duty to conduct criminal background check.

There are commonly two different types of criminal checks- the RCMP's Canadian Police Information Centre (CPIC) database, as well as a search of the records held in the information database of a local police agency of every complaint they receive. Examples of local complaints include:

- local disturbances
- offences contrary to provincial statutes (such as traffic violations or liquor-related violations)
- abuse of children
- allegations of offences where charges were not laid.

b. Reference checks: Employment law: A previous employer may suspect abuse or harmful behaviour has occurred but it may or may not have been substantiated. Employers are often uncertain what can and cannot legitimately ask and answered when they follow up on or give a reference.

A screening inquiry may only be as good as the previous employer's own abuse policy, and their willingness to disclose a problem staff person. A previous employer who agrees to be a reference has a responsibility to give a fair and factual account. In a 2000 British case, an employer who providing a reference and identified serious complaints about the employee that she did not know about. The court found it was inappropriate for the employer to reveal these previously undisclosed complaints in a reference. [81]

Focus of the strategy (Staff/ Resident/ Facility/ Other): Prospective Staff

Examples of Canadian Jurisdiction Using It

- In 2004 Ontario developed a draft policy on abuse and neglect in long term care facilities, which among many other things included provisions for screening and criminal record checks. Also see: Ontario Law and Social Policy: Implications for Screening.[82]
- Under the *Protection for Persons of Care Act*, Alberta requires agencies to provide criminal reference checks for employees and volunteers for publicly funded facilities.[83]

Strength/Advantage: Pre-employment screening (criminal record checks and references) is among other things, a risk management tool.

Limitation/Disadvantage of Criminal Record Checks: Focus is on types of abuse or neglect that are crimes; may assume the cause of abuse in facilities is primarily criminality or psychopathology.

- May give a false sense of security if no criminal offences show up on the records or if person previously lived outside of jurisdiction (no Canadian record).
- Historically there has been a low level of criminal charges in this area in the first place, as many facilities have treated the matters internally, and have not treated the issues as criminal matters.
- Which criminal offenses are considered relevant? For example, for people working with children, BC considers 56 offenses as relevant, mostly sexual offenses, abduction, in addition to Canada's *Food and Drug Act Canada*-- trafficking (Trafficking in Controlled Drug), and the *Narcotics Act*.[84]
- Who do you check? The costs of having police records checks done, especially given high turnover, e.g. for volunteers. Records checks cost $15-25 per search, can be prohibitive when many volunteers are needed over the course of a year. Many non-profit organizations have limited funds, and the costs of doing appropriate screening become a problem.

Professional Conduct (Regulation, Oversight and Accountability)

Purpose/Assumption:

In Canada's report "Patient Safety Law: From Silos to Systems", the authors note that a very important aspect of healthcare delivery is the people who provide health services – healthcare professionals. They point out:

> "The chief objective of professional regulation is the protection of the public from harm. Provincial governments have adopted a model of self-regulation, in which the health professions are delegated authority via statute to administer a regulatory scheme. While schemes and delegated powers may vary from province to province and between health professions, self-regulating professions are usually given the authority to control entry into the profession and to monitor the conduct and competence of those they admit. In general, professional self-regulatory bodies set entry requirements as to who can be registered/ licensed as a professional, set standards of practice for the profession, investigate complaints and enforce standards through a disciplinary process. A number may also monitor ongoing professional competence through quality assurance mechanisms such as continuing education requirements or peer assessments."[85]

Professional oversight can 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.

Focus (Staff/ Resident/ Facility): Staff

Example of Canadian Jurisdiction Using It: Most Canadian jurisdictions have legislation regulating various health professions that may work in long term care. However, frontline staff members such as residential care aides or personal support workers in Canada typically do not have a professional body to which they are accountable.

Strengths:

- Self-regulatory bodies generally impose sanctions for behaviors that constitute professional misconduct, incompetence or incapacity, although the processes for dealing with them may vary. [86]

Limitations:

- The following are among some of challenges that have been noted for existing professional regulation: [87]
    - While some provinces have umbrella legislation, others province may have dozens of different health statutes that govern the wide range of health professions. The laws often developed at different times and are generally inconsistent.
    - The regulatory framework can be fragmented and inefficient to amend. This makes it difficult to ensure that the public are protected by the most effective regulatory provisions.

- The process excludes those directly affected by the staff person's actions. Traditionally, complainants do not have party status in disciplinary hearings, and the self-regulatory body's representative will bring its case against the member. [88]
- It has been pointed out that the current system may focus too much on establishing blame for individual incidents abstracted from their context. [89]
- As previously noted, frontline staff such as residential care aides typically do not have a professional body to whom they are accountable.
- The length of time for a matter to be addressed by a professional body can be significant. For example, Alberta's Protection of Persons in Care Office notes that it took just under a year (341 days) on average for the investigation of abuse cases referred to outside bodies.[90]

Reporting Abuse

A. Mandatory Reporting

Purpose/ Underlying Assumption: The purpose of mandatory reporting is to protect residents by encouraging and supporting residents, staff, and others to report; to overcome the common strong hesitancy by creating a legal responsibility on staff or members of the public to report suspected or confirmed abuse situation.

While there is a general trend to prefer voluntary reporting in most parts of Canada where there are concerns about abuse of older adults reside in the community, the institutional environment creates a special set of circumstances. Residents and staff are more isolated and residents in care facilities are believed to have multiple special vulnerabilities that make it more difficult for them to recognize and address the situations on their own. They are often highly dependent on others for care, and may fear loss of that care. There is a much higher percentage of persons with cognitive impairment living in care facilities than in the general community, and the degree of the impairment varies significantly among residents. The residents tend to be isolated from external resources.

There are often several different places where the report may need to go in order to be dealt with effectively. The report and the issues may need to be addressed internally. The report may need to be submitted to outside agencies responsible for investigation and follow-up, and it may need to be referred to police and treated as a criminal matter.

Focus (Staff/ Resident/ Facility): Multiple

Example of Canadian Jurisdiction Using It: Several provinces and territories in Canada require people to report suspected abuse or neglect of residents that occurs in a facility such as a nursing home, personal care home, or residential care facility.

- Reporting may be required under special protection legislation (see below). For example, Nova Scotia's new *Protection for Persons in Care Act* (not yet in force) requires the administrator of the facility to report and encourages others to report (voluntary reporting).[91]

- Some facilities may establish a duty to report internally. For example, Ontario includes this duty as a provincial policy/standard for nursing homes.
- Some provinces and territories may also include abuse or neglect as one of the special kinds of "major or unusual incidents" which the care facility operators are required to report. The duty may be to report immediately (British Columbia), as soon as possible (Saskatchewan)[92] or in quarterly reports.[93] In many instances, the incident reporting is only required where there has been an injury, hospitalization, or death. These incidents do not necessarily have to be caused by abuse or neglect of the resident.

Strength/Advantage:

- Mandatory reporting establishes a legal duty either on all persons or on select groups of persons to take the first step to help address a suspected abuse or neglect situation, so that it will stop and the situation will not further deteriorate.
- Mandatory reporting represents some intrusion into adults' lives. Some may question the appropriateness of focusing on protection of the individual rather than individual self-determination. However, others emphasize making institutions accountable for their treatment of their residents is in fact an affirmation of the dignity of the individual. An institution is the home of an adult in vulnerable circumstances; adults have the right to live in homes free of abuse. [94]

Limitation/Disadvantage:

- There are concerns about confidentiality, privacy, and risk of retaliation. Mandatory reporting needs to be considered within the broader context of professional responsibilities, protection for reporting and a supportive environment for reporting.
- Some people are concerned that mandatory reporting can become yet another means of taking control of residents' lives--particularly if the suspected harm comes from family and involves financial pressuring. The facility may have a responsibility to protect residents from harm from staff, volunteers, residents and others under their control. However, to what extent does that responsibility extend to the older adult's personal relationships?
- The existence of mandatory reporting does not necessarily mean there will be a mandatory response to the complaint or concern.

B. Protection in Reporting

Purpose/ Underlying Assumption:

A. General: Many staff and service providers may be wary about disclosing concerns, errors or problems in the facility. This can easily occur where there is a lack of support within the facility and where there is the fear of retaliation by the person or persons involved, which may include administration.

In some instances, staff members place their jobs at risk by reporting problems. Residents who report a concern risk being isolated, ostracized, or risk having the abuse or neglect escalate, if there is not a supportive environment for raising concerns and addressing problems.

In many instances, staff are discouraged from being candid about anything wrong that may have occurred – regardless of how the problem arose and whether or not the mishap was related to professional competence or whether the situation leading to the adverse outcome was within their control. Some providers may fear potential legal liability/insurance ramifications or poor public image if abuse or neglect leads to serious injury or death. They may be hesitant to publicly disclose problems or concerns.

However, without disclosure and examination of the event, no remedial action can be taken to ensure that in the future similar occurrences are avoided.

Three different types of persons are in need of protection from retaliation when reporting a concern– residents, staff and volunteers, and family/ public. Residents are the most vulnerable because their day-to-day care can be immediately negatively affected, and an already bad situation can grow worse.

B. Whistleblower protections: In some cases, the *facility operator (employer)* may not respond to the concerns raised by others and may have failed to address a problem within the facility. Or on occasion, the facility operator may be engaged in wrongdoing and causing the harm to residents. A staff person may want to report the problem or illegal activity to the authorities but may fear repercussions. In a few Canadian jurisdictions, there are some whistleblower protections for employees.[95]

Focus of the strategy (Staff/ Resident/ Facility/ Other): Staff/ Family/ Public

Example of Canadian Jurisdiction Using It:

- British Columbia provides some protection for the person who makes the report and for the resident in a residential care facility.[96] The licensee is not permitted to take action against its employee because that person made a report and is not allowed to alter, interrupt or discontinue, or threaten to alter, interrupt or discontinue, service to a person in care as a result of a report or a suggested or stated intention to make the report. There is no similar protection for staff or residents in facilities that provide assisted living services.
- In Nova Scotia, the *Protection for Persons in Care Act* (not yet in force) prohibits the facility administration from taking adverse employment action against a service provider of the facility because that person made a report of abuse in good faith under the Act. [97]

Strength/Advantage:

- The protections are public policy acknowledgement of the vulnerability of residents, family and staff. The policy underscores the importance of having problems and concerns effectively addressed. This only happens when the concerns are brought to light.
- The legal protection appreciates people's fear of retaliation (perception of the possibility) and the fact that retaliation does take place in some instances.

Limitation/Disadvantage

- The scope of the protection is often limited. It may be difficult to separate "abuse" or "neglect" from quality of care issues, potentially leaving reporters at risk.
- Operators may ignore the protection, and either threaten or initiate a lawsuit, which the person must then defend.
- Only some types of facilities are covered. This can be a problem particularly where the facility is a campus of care model. Staff and residents on one side of the door or wing may have safeguards when reporting, and in another wing of the facility, they may not.

Public Accountability

Purpose/ Underlying Assumption: Public accountability in this context refers to a constellation of approaches/ systems that demonstrate to the public protection of the welfare of residents -- existence of safeguards, effective enforcement of those standards, transparency of the process, fairness in the process, trust in the process, and avoidance of adversarial processes in dealing with concerns. Although public accountability may be considered as accountability for facilities receiving public funds, the public accountability actually refers to the accountability of the public authorities responsible for key areas of long term care delivery – including safeguards in facilities, registration, licensing, inspections, and accreditation.

According to the Canadian Healthcare Association: Accountability is different from other related concepts such as "role," "responsibility" and "answerability." While a role is one's function, responsibility refers to ". . . an obligation to act or make a decision", and answerability ". . . is the obligation to provide information and explanation to another party". [98]

Accountability is the relationship that exists when one accepts responsibility that has been conferred and the duty to report back to the persons or bodies that conferred it.

Public transparency and accountability involves those responsible for the health system explaining to, and involving the public in, what they plan to do, how well the system is performing, and the implications of both.[99]

Focus (Staff/ Resident/ Facility): Mixed/ government

Example of Canadian Jurisdiction Using It:
Jurisdictions vary considerably in the transparency of processes and information about long term care and about abuse or neglect, or quality of care issues, for example

- Nova Scotia provides its Long Term Care policy manual online.[100]
- Since 2004, Ontario has made its inspection reports for licensed care facilities available on line.
- Alberta provides quarterly reports for the Protection of Persons in Care Office online.

Resident Councils/ User Committees

Purpose/ Underlying Assumption: The purpose of the resident council is to provide a forum where issues that concern residents can be discussed, including the services provided to residents in the care facility. The discussion is to facilitate any needed changes in the facility.[101] Resident councils are considered as a means to achieving quality improvement.

Focus of the strategy (Staff/ Resident/ Facility/ Other): Mixed

Example of Canadian Jurisdiction Using It:

- Manitoba's *Personal Care Home* regulations require operators to help residents establish and maintain a residents' council, and investigate and respond to concerns raised by the council in a timely manner.[102]

- Ontario's *Nursing Home Act*, the *Homes for the Aged and Rest Home Act*, and the *Charitable Institutions Act*[103] formally recognize resident councils and require the facility administrator to annually let residents know of their right to establish a Council.[104] The function of the Residents' Councils is to [105]
    - advise residents of their rights in the home, as well as the rights and obligations of the facility operator[106]
    - review the operation of the home
    - mediate and resolve disputes between residents and the home
    - report concerns and make recommendations for improvements in the home.

Residents or their substitute decision maker can be members of the council. The operator is required to support the functioning of the Council, including providing an assistant and financial support. The operator is also required where practicable, act on the suggestions or complaints within a specified time. The Resident Council is legally protected for the advice it provides residents. Ontario also has an Association of Resident Councils.[107]

- Quebec has User Committees. The four (4) legal functions of the committee are specified in section 212 of the *Health and Social Services* Act.[108] They are:
    1. Inform users of their rights and obligations;
    2. Foster the improvement of the quality of the living conditions of users and assess the degree of satisfaction of users;

3. Defend the common rights and interests of users or, at the request of a user, his rights and interests as a user before the institution or an competent authority;
4. Accompany and assist a user, upon request, in any action he undertakes, including the filing of a complaint.[109]

Strength/Advantage: The Committee gives the residents a formal vehicle to collectively discuss issues and concerns, with the potential for providing input to the facility operator on needed modifications or changes in key areas, such as delivery of care. It provides the residents with a collective voice.

Limitation/Disadvantage:

- The councils are dependent on having residents with the physical and mental **c**apacity to participate.
- Resident Councils are intended to represent all residents in a particular setting, which may not effectively support minority needs or concerns. Individual and collective interests and rights may be different.
- In some cases, the resident council members may not be able to identify and adequately represent interests of those lacking capacity.
- On one hand the councils need the support of the operator/ administration, but also need to be autonomous.[110]
- There are concerns about the role of management/ staff in the councils, and that in some facilities, the councils are structured in ways that inhibits frank discussion of issues, for fear of retribution. In some jurisdictions, it has been noted that structural changes in the health authorities (amalgamation of services) has affected the ability and functioning of the user committee.

Special Protection Legislation

Purpose/ Underlying Assumption: Residents in a range of facilities of that provide care, assistance and support may be more vulnerable to abuse or neglect than other persons residing in the community by virtue of

- their special circumstances (mental, physical and social condition, less ability to "stand up for self" and address problem on own)
- situation (dependency on others for care, lack of options- no place to go) and
- characteristics of the environment (e.g. isolated from the community, lack of options)

Special protection laws for care facilities are typically designed to protect vulnerable persons in care from specified kinds of abuse and neglect and to see that harmful situations that arise are addressed in an appropriate and timely manner.

Focus (Staff/ Resident/ Facility): Multiple

Example of Canadian Jurisdiction Using It

- **Alberta-** The law only applies to specific types of *publicly funded* facilities.[111]
- **Manitoba -** The law applies to private and publicly funded facilities.[112]
- **Nova Scotia -** The province has enacted the *Protection of Persons in Care Act*, but the Act is not yet in force. When the Act comes into force, it will cover a residential care facility, nursing home or any licensed home under the Homes for Special Care Act. [113]

Strength/Advantage

- The laws provide opportunities to educate operators and staff on more appropriate approaches to care. The offices responsible for applying the protection laws have been engaged in some prevention and education work, particularly when the laws first were enacted.
- The offices also use the laws and the incidents as springboards to prevent further occurrences of the kind reported in a particular facility.

- The laws may significantly raise awareness, by specifically acknowledging the existence of abuse and neglect. It is no longer a completely hidden problem and taboo subject.

Limitation/Disadvantage

- Depending on its structure, protection legislation can largely be reactive, particularly if it is only *responding to* problems that have occurred, rather than actively engaged in helping facility operators and staff prevent the abuse or neglect situations from occurring.
- In some jurisdictions, the protection legislation may be a minimalist government approach. It may not go far enough to deal with the issue of abuse and neglect of vulnerable adult.[114]
- In Alberta and Manitoba, the investigations and protections are only initiated in after a complaint has been made by someone. The protection laws and their implementation have been criticized in the community for failing to be sufficiently proactive
- If people do not trust the system and the fairness of its outcomes, they will not report.

A special protection for persons in care law is more likely to be considered as more effective where it:

- Is designed to assure that all facilities develop abuse protocols, procedures and guiding principles.
- Enables the facilities to routinely assess for, and address risk factors that contribute to the occurrence of abuse.
- Provides a mechanism to assure operators follow through on the protection officer's recommendations.
- Establishes an explicit obligation upon the government ministry to advocate for, protect, or assist the abused person
- Has an effective "response- back" mechanism so that the person reporting the concern has a clear idea of the investigation and what the operator has done or is doing to address the concern. It avoids vague and general statements in responses to complaints or concerns.
- In addition to requiring investigation, it has a mechanism for the provision of services where there are deficiencies. [115]

The laws are also considered to be more effective where investigations are conducted by well trained personnel, who

- can operate at arm's length from the facility and the funding bodies
- understand the care environment
- understand people's rights
- understand the dynamics of people's interactions in the care environment, and
- have a good understanding of abuse and neglect dynamics.

Staffing Levels

Purpose/ Underlying Assumption: Most provinces require facilities to have "adequate staffing" but the actual level and mix of staffing is often left to the discretion of the operator. There is a level of staffing below which it will no longer be possible for staff to provide adequate care to residents. Inadequate levels of staff will increase the likelihood of resident neglect or abuse occurring.

There is considerable variability in staff levels. It can vary among different types of facilities (e.g. personal care homes, assisted living, and licensed care facilities) and among facilities of the same type. Staffing levels also often depend on whether the facility operates on a for-profit or not- for-profit basis.

In Canada and the United States, family organizations, health unions, and nursing home coalitions have expressed strong concern about low staffing levels. For example, a major American government study identified 2.9 hours of care per resident day by nursing aides as the minimum level needed to provide optimal care to patients. They also found that over 90% of nursing homes in the United States fell below that level, and about half of the facilities would have to double nurse aide staff to reach this threshold.[116]

According to American research, fewer registered nurse hours and nursing assistant hours are associated with total deficiencies in the facility and quality of care deficiencies, when other variables are controlled. Fewer nursing assistant staff and other care staff hours are associated with quality of life deficiencies.[117]

A literature review carried by the Task Force on Resident/ Staff Ratios in Nova Scotia[118] notes there are several factors that contribute to the determination of appropriate direct care staffing levels to support the delivery of quality client care.[119] These include but not limited to:

- the variety of direct care staff available
- the existence of non-direct care staff available
- the experience and education of staff
- the roles and responsibilities of direct care staff
- the intensity and complexity of resident care needs
- the physical layout of the nursing home
- the availability of time saving equipment and supplies
- the quality of care expected

The report concluded that minimum staffing ratios can help impose a standard on facilities that have inadequate staffing, but staffing ratios are not the only factor affecting the quality of care residents receive.

Focus of the strategy (Staff/ Resident/ Facility/ Other): Facility

Strength/Advantage: Identifying and establishing some specific staffing levels may help reduce the likelihood of neglect.

- Some Canadian research has found that the number of hours per resident-day provided by direct-care staff and support staff was significantly higher in the not-for-profit facilities than in the for-profit facilities after adjusting for facility size and level of care. [120] The researchers note**:** Although staffing differences do not necessarily imply differences in quality of care, an extensive body of research in the United States links higher direct-care staffing levels in long-term care facilities to better care outcomes.
- Research indicates that "minimum" staffing levels may reduce the likelihood of quality problems in several areas. However, research also identifies that there are higher "preferred minimum" levels exist. When staffing is above this level, quality of care was improved across the board.
- A recent study commissioned by the US Congress examined over 5000 long-term care facilities in 10 states and determined that higher staffing continued to predict improved care outcomes (e. g., maintenance of skin integrity, good nutritional status) up to certain thresholds. Beyond these thresholds no further improvements could be demonstrated. [121]

Limitation/Disadvantage:

- Critics of establishing levels of staffing point out that at best, available research is sufficient to conclude only that there appears to be a negative *association* between nurse staffing levels and adverse patient outcomes, but is not able to show *causation*.
- The focus of the research on outcomes tends to be largely on physical care.

- Some American states have moved away from minimum ratios because good facilities might not meet the staffing ratio and some poor facilities successfully defend neglect reports by showing they were meet the minimum standards of the ratios.

Canadian Healthcare Association offers as a recommendation:

- Improve collection of information on staffing ratios, level of care being delivered, admission waiting lists, discharges, deaths, health of residents and quality of care. Better information makes it easier to compare facilities and pinpoint problems.[122]

Staff Qualifications/Staff Training/ Staff Supervision

Purpose/Underlying Assumption. Over the past ten to fifteen years, the level of complexity of needs and conditions, as well as the needed care of the residents across the housing and care continuum has increased significantly. Older adults are living longer, but with multiple chronic conditions. Staff may be providing physical, mental and social care and support to residents with heavy and complex needs.

During the same period, there have been major changes in who delivers the hands on care to residents, and who supervises the delivery of that care. It has been noted that at the same time that efforts have been made to make residences "homelike", the staffing for the care homes has been de-professionalized. In many communities, there has been an overall reduction of the role and availability of registered nurses, especially those with geriatrics skills to supervise and help staff problem solve.

Because they have not had the training opportunities, some staff members who provide direct care and some administrators or providers may not be able to distinguish between "normal aging" and pathology. Some may not understand the causes and diseases underlying residents' behaviours, or may not understand residents' needs. They may not know effective ways to defuse and address behavioural problems they encounter at work. Or, they may know, but may not have the appropriate resources in the facility to follow through.

In any or all of these circumstances, staff may not respond to the residents appropriately. These factors may heighten the likelihood of abuse and neglect occurring in that unit or facility.

Focus (Staff/ Resident/ Facility): multiple- staff, but for residents' benefit

Example of Canadian Jurisdiction Using It: Most Canadian jurisdictions have a general requirement that the operators will have staff appropriate for the position.

A. General Training

The kind of training the person may need depends on the position. Not all providers require staff, including direct care staff to have training, or the training may be limited to basic health and safety such as food safety. There is considerable variation across the country in who delivers the "hands on" care to residents, as well as what formal or in-house training, if any, they will receive. There may or may not be a standard curricula used for care aides and personal support workers. There may be important differences between the types of courses and quality of the courses offered by various private and publicly funded colleges.

B. In Service Training

- In-service training may focus on any of a wide range of topics related to the care and work in the facility, include abuse and neglect prevention. In service offers opportunities for staff to develop and enhance their skills.

C. Specialty Training

- P.I.E.C.E.S. and U-First training options were part of the Government of Ontario's Alzheimer's Strategy, aimed at enabling long-term care staff to assess residents for behavioral and psychiatric issues, and to problem solve regarding these issues within the home. [123]

Strength/Advantages

Training appropriate to the work needs of the staff can build skills and self confidence. Training often needs hands-on approaches to help staff see how what is learned "plays out in practice".

Limitation/Disadvantage

- Education and training costs. The question is, "Who bears that cost of general training and in service training?" Prospective caregivers may not have the social and economic circumstances to afford the necessary education to undertake more comprehensive training, particularly considering the average wage paid, and part-time or casual work status commonly experienced. Some colleges may cover basic physical care techniques ("body work"), but not the social and psychological care.
- At present in most communities, in service training in most facilities is piecemeal and very limited time (e.g. 15 minutes may be devoted to the training). Often it may be scheduled after shift on the staff's unpaid time.
- Some staff may experience challenges to learning and applying skills, including cultural differences in recognizing acts as abusive or neglectful, and poor language skills that affect working with residents.

Zero Tolerance Policy

Purpose/ Underlying Assumption: All forms of abuse in a care facility are serious, and need to be addressed in an effective manner by the administration. There is a need for strong, effective policies to protect residents and to help them feel safe.

The term "zero tolerance" is used in different ways in Canada as well as other jurisdictions. As a result it often creates confusion. Zero tolerance can mean that there will be a response to all suspected or confirmed situations of abuse and neglect. However, in some jurisdictions it may mean that there will be a specific predetermined response (strictest sense). The policies are frequently termed "zero tolerance" may require that administrators consistently enforce certain infractions, such as abuse, with strong punitive measures, such as firing the person.

Focus (Staff/ Resident/ Facility): Multiple

Example of Canadian Jurisdiction Using It:

- In 2004 Ontario developed a draft zero tolerance policy. See below for definition and recommended policy in Ontario.
- Nova Scotia sets a specific penalty for infractions.

Strength/Advantage: Zero tolerance approach recognizes the seriousness of abuse and neglect in care facilities, and recognizes it as a social problem.

Limitation/Disadvantage:

- Zero tolerance is theoretically directed at people who harm intentionally, yet it also applies to those who may harm as a result of lack of knowledge, training or resources. Zero tolerance in its strict sense can mean that administration will automatically and severely punish staff for a variety of infractions.

- Zero tolerance can take away any discretion and common sense in the situation. An alternative might be to establish consequences that take into account a wide range of circumstances. Responses should be appropriate to the position and circumstances as well as to the nature of the offence.

- There is also a concern about the inverse correlation between response and breadth of definition. For example, the stronger (more disproportionate) the potential responses, the more likely the definition of abuse or the interpretation of it will become narrow. As a result only very narrow sets of situations receive the zero tolerance punitive response. That may leave other serious situations which will not described as "abuse" under the policy and consequently may nor receive appropriate or any remedy.

- Alternatively, zero tolerance is sometimes placed within a broader policy of "zero tolerance of abuse of anyone" in the facility, including staff. When coupled with a wide definition of "emotional abuse", a zero tolerance policy can be used against family members who are trying to advocate for residents.

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Definition: "Zero Tolerance Policy"

A **"zero-tolerance policy"** means a policy that:

• Builds awareness of and educates to achieve the goal of elimination of abuse
• Allows no exceptions
• Tolerates no abusive behaviour, and
• Requires strict compliance and enforcement.

"**Zero tolerance**" means within this policy, that the LTC Facility Operator shall:

• Uphold the right of the residents of LTC facilities to be treated with dignity and respect within those facilities, and to live free from abuse and neglect.

Recommended Policy

• Neither abuse, nor allow the abuse of any resident in the Operator's LTC Facility by Staff or volunteers, nor condone the abuse of any resident by any other person(s) at the facility.
• Provide information and education regarding abuse and the prevention of abuse
• Treat every allegation of abuse as a serious matter
• Investigate every allegation of abuse
• Take corrective action, including sanctions or penalties against those who have committed abuse against a resident
• Report to police any suspected criminal activity
• Report to the Ministry of Health and Long-Term Care every suspected or confirmed incident of abuse.

- Make every effort to eliminate abuse through the quality and risk management programs.

[1] Abuse in Nursing Homes, Special Research Review Section National Center on Elder Abuse Newsletter, May 2002, by Lisa Nerenberg, Online at: www.ncea.org.

[2] L. Nerenberg (May, 2002) "Abuse in Nursing Homes", Special Research Review Section. *National Center on Elder Abuse Newsletter.* Online at: www.ncea.org. See: www.elderabusecenter.org/default.cfm?p=abuseinnursinghomes.cfm

[3] National Center On Elder Abuse, Nursing Home Abuse Risk Prevention Profile and Checklist, www.elderabusecenter.org/pdf/publication/NursingHomeRisk.pdf, page 7

[4] Personal Care Homes Standards Regulation, (The Health Services Insurance Act (C.C.S.M. c. H35)) http://web2.gov.mb.ca/laws/regs/2005/pdf/030-h035.05.pdf

Manitoba - Freedom from abuse

15(1) The operator shall establish safeguards to prevent residents from being abused.

15(2) The operator shall establish a written policy that sets out

(a) the safeguards established to prevent residents from being abused; and

(b) the appropriate action to be taken when abuse is alleged.

[5] Newfoundland. *Towards the Year 2000. The Provincial Strategy Against Violence-- An Action Plan (Strategy #10)* June 1995, Women's Policy Office. www.exec.gov.nl.ca/exec/wpo/eng/strategy**.**htm

It says :

- Revise the current Abuse of Persons Policy of the Department of Health to require all health care facilities and the community health care boards to develop and implement appropriate policies/protocols.

  Process for Implementation:

  - The Abuse of Persons Committee of the Department of Health will draft a policy statement which requires all Board-operated health facilities, which are funded by the Department of Health, to develop and implement policies/protocols related to preventing and responding to abuse. The statement will also reference the need for accountability mechanisms.

    The draft policy will be submitted to the Departmental executives for revisions and approval.

The approved policy statement will be communicated to all health facilities through a method which is selected by the Department of Health.

The Department's role in monitoring compliance with the policy will be determined by the executive in consultation with the Abuse of Persons Committee and other appropriate staff within the Department.

Responsibility :

- The Department of Health is the only government department which has responsibility, but the Newfoundland Hospital and Nursing Home Association may be invited as a partner in the process.

Timeframe:

- The strategy can be completed during the 1995-96 fiscal year.

Budget:

- This initiative would require a monitoring process and thus would mean additional duties for people in the health system. The tasks involved in implementing and monitoring the policy could be built in to existing roles of administrative personnel and committees. The exact amount of funding needed is difficult to determine but it can be built into existing budgets.

[6]Tennessee Commission on Aging and Disability. "Elder Abuse". Online : www.state.tn.us/comaging/elderabuse.html

[7] In Manitoba, there are 3 ways that a name may be listed on the child abuse registry:

1. A person was found guilty or pleaded guilty to an offence involving the abuse of a child in a court either inside or outside of Manitoba;

2. A family court has found a child to be "in need of protection" due to abuse; or

3. A child and family service agency's Child Abuse Committee has reviewed the case and formed an opinion that a person has abused a child.

[8] Young *v.* Bella, [2006] 1 S.C.R. 108, 2006 SCC 3. Online : http://scc.lexum.umontreal.ca/en/2006/2006scc3/2006scc3.html

[9] National Center on Elder Abuse. *(*June 2002*) Preventing Elder Abuse by In-home Helpers.* Washington, D.C. Online: www.elderabusecenter.org/pdf/publication/preventing.pdf

[10] New Mexico, *Fiscal Impact Report (Employee Abuse Registry Act).* Online : http://legis.state.nm.us/Sessions/05%20regular/firs/HB0626.pdf

[11] Wilson, C. "The facility's safety net." Canadian Council on Health Facilities Accreditation. Leadership Health Services. 1992 Jan-Feb;1(1):18-20.

[12] National Advisory Council on Aging (NACA) The Changing face of long term care, Expressions, 18 (4) Online: www.naca.ca/expression/18-4/pdf/exp18-4_e.pdf

[13] Health Council of Canada (2006) Health Care Renewal In Canada - Clearing the Road to Quality, Executive Summary http://www.healthcouncilcanada.ca/en/index.php?option=com_content&task=view&id=97&Itemid=72

[14] "About ORCA's Standards Evaluation Program". Online: www.orca-homes.com/documents/AboutORCA2.pdf

[15] NACA, supra, n. 12

[16] For example, under Resident Care, the quality indicators are: safety and security; food quality; access to clinical services; medication regime; access to spiritual guidance; socialization-recreation; activation and ambulation; personal care; sanitation, and; access to specialized services.

[17] One CCHSA category in particular may actually lead to systemic violations of residents' rights. Respect the need to ***guide*** clients' future health care decisions (emphasis added)• Ensure that advanced directives are part of a broader consent policy" It by appearing to require (mandate) residents having advanced directives instead offering a choice. "A Look inside Canada's Health Care System 2004 Accreditation Report" Page 23 Online: www.cchsa-ccass.ca/pdf/2004report.pdf

[18] Administration and staff in some facilities may work to achieve this through processes such as continuous quality improvement.

[19] NACA, supra, n. 12

[20] Canadian Network for the Prevention of Elder Abuse. "Abuse in Institutions" Online : www.cnpea.ca/abuse_in_institutions.htm#What%20%20are%20Some%20of%20the%20Other%20Ways%20of%20Encouraging%20Abuse%20%20Prevention

[21] Saskatchewan Steering Committee on Vulnerable Persons.

[22] http://www.bcifv.org/resources/newsletter/1997/summer/speak.shtml

[23] http://www.bcifv.org/resources/newsletter/1997/summer/empowerment.shtml

[24] http://www.bcifv.org/resources/newsletter/1997/summer/empowerment.shtml

[25] See also, Voices Against Elder Abuse http://www.voicesagainstelderabuse.com/

[26] FRANCE: FAMIDAC http://www.famidac.net/article94.html

[27] *Office of the Ombudsman of New Brunswick Annual Report 2003/4*, at page 27. Online www.gnb.ca/0073/2003-2004_Report-e.pdf#search=%22New%20Brunswick%20Ombudsman%20nursing%20homes%22

[28] For example, the Quebec Charter of Rights identifies freedom from exploitation for vulnerable adults.

[29] Personal Care Homes Standards Regulation, http://web2.gov.mb.ca/laws/regs/2005/pdf/030-h035.05.pdf

Manitoba: The bill of rights must be consistent with the Act and this regulation and must, at a minimum, reflect the following principles:

1. Residents are to be treated with courtesy and respect and in a way that promotes their dignity and individuality.

2. Residents are to be sheltered, fed, dressed, groomed and cared for in a manner consistent with their needs.

3. Residents or their legal representatives have the right to give or refuse consent to treatment, including medication, in accordance with the law.

4. Subject to safety requirements and the privacy rights of other residents, residents are to be encouraged to exercise their freedom of choice whenever possible, including the freedom to do the following:

(a) exercise their choice of religion, culture and language;

(b) communicate with, and have contact with and visits to and from friends, family and others in private if desired;

(c) choose their recreational activities;

(d) choose the personal items to be kept in their rooms, when space permits;

(e) select the clothing to be worn each day.

5. Residents are to be afforded reasonable privacy while being treated and cared for.

6. Residents are to be provided with a safe and clean environment.

7. Residents may communicate and meet with their legal representative as often as necessary and in private if desired.

[30] *Saskatchewan Personal Care Home Handbook.* Online: www.health.gov.sk.ca/ps_personal_care_homes_licenseeshdbk.pdf

[31] R.S.Q., chapter S-4.2, An Act Respecting Health Services and Social Services

[32] M. Beaulieu and M.J. Tremblay, (1995) *Abuse and Neglect of Older Adults in Institutional Settings: A Discussion Paper Building from French Language Resources.* Health Canada, Mental Health Division. Online: http://dsp-psd.pwgsc.gc.ca/Collection/H72-21-133-3-1995E.pdf

[33] Office of the Ombudsman of New Brunswick Annual Report 2003/4. at page 22. Online :www.gnb.ca/0073/2003-2004_Report-e.pdf#search=%22New%20Brunswick%20Ombudsman%20nursing%20homes%22 .

[34] *Long-Term Care Act, 1994* (which governs the provision of services to patients in the community) sets out a "bill of rights" for people receiving community services.36 The rights include: the right to be dealt with in a courteous and respectful manner and to be free from mental, physical, and financial abuse by the service provider; to be dealt with by the service provider in a manner that respects an individual's dignity and privacy and that promotes an individual's autonomy; to give or refuse consent to the provision of any community service; and to raise concerns or recommend changes in connection with the community service provided to him or her and in connection with policies and decisions that affect his or her interests, to the service provider, government officials, or any other person, without fear of interference, coercion, discrimination, or reprisal. The common law also recognizes certain rights *in*

[35] Charter of Rights, Online : www.residence-ybrunet.qc.ca/pages/charte.htm

[36] Flood, C. & Epps, T. (2004) Waiting Times and Waiting Lists: What Role for a Patients' Bill of Rights, *Mcgill Law Journal / Revue de Droit de Mcgill* [Vol. 49, no. 3] 515 at 538. Flood and Epps point out in an endnote that in New Zealand, a *Code of Health and Disability Consumers' Rights* was enacted as a regulation under the act in 1996.

The *Code* provides for ten general rights: the right to be treated with respect; the right to freedom from discrimination, coercion, harassment, and exploitation; the right to dignity and independence; the right to services of an appropriate standard; the right to effective communication; the right to be fully informed; the right to make an informed choice and give informed consent; the right to support; rights in respect of teaching or research; and the right to complain. A number of these rights were already recognized to some extent at common law and in professional codes of ethics. Under the *Code*, the rights are applicable to *all* health and disability service providers, including alternative providers such as naturopaths and homeopaths, whether working in the public or private sector. A Health and Disability Commissioner is charged with promoting the rights of consumers and investigating alleged breaches of the *Code*.130

[37] On an annual basis the committee puts together a report summarizing the deaths that have occurred in the past year and provides recommendations that are intended to prevent similar deaths in the future. The recommendations are not intended to be policy directives from the office of the coroner but are intended to be educational discussion and aid discussion about geriatric care in Ontario. See online: www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/page/Annual+Reports+from+the+Coroners+Office+2005!OpenDocument

[38] Ibid, page, 14-15

[39] Ontario Hospital Association, Annual Reports from the Coroner's Office, Online: www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/page/Annual+Reports+from+the+Coroners+Office+2005!OpenDocument

[40] Ontario, *Abuse Policy on the Prevention, Reporting and Elimination of Abuse of Residents of Long-Term Care Facilities - Consultation Draft,* August 2004. Ministry of Health and Long-Term Care. Document 0808-01.

[41] Ontario College of Nurses. *One is too Many Fact Sheet. Online:* www.cno.org/docs/ih/47008_fsPreventAbuse.pdf

[42] (Alberta) *Supportive Living Accommodation Standards Checklist*, May 2006, Standard 19, page 25. Also (Alberta) Long Term Care Accommodation Standards, May 2006, Standard 19, page 14.

[43]Ontario College of Nurses. "One Is One Too Many" Video, Online : www.cno.org/pubs/oiotm/video/winmedia.htm
[44]Ontario College of Nurses (February 2003) *A Report on the Evaluation of One is One Too Many: A Program for Learning About Prevention of Abuse of Clients.* Online. www.cno.org/policy/initiatives/oneisonerep.pdf

[45] Toronto Homes for the Aged. (2004). "Abuse: What residents need to know." Online: www.toronto.ca/homesfortheaged/pdf/jfr_abuse_book.pdf

[46] A Family Council is an organized, self-led, self-determining, democratic group composed of family and friends of the residents of long term care homes

[47] Spencer, C. "Who Will Speak For Me?" BC Institute Against Family Violence Newsletter, Spring/Summer 1997, Vol. 2/3.

Online : www.bcifv.org/resources/newsletter/1997/summer/speak.shtml

[48] Online : www.familycouncils.net/def.html Literature Review - (Boyle and Kauffman (1981)

[49] Ontario Family Council Program. Online : www.familycouncils.net/def.html

[50] Ibid.

[51] "Nursing Home Inspections Miss Violations, Report Says" Robert Pear, *New York Times,* January 16, 2006, reporting on the GAO Audit.

http://www.globalaging.org/health/us/2006/Homeviolations.htm

[52] Ibid.

[53] Alberta Health Facilities Review Committee**.** Online: www.health.gov.ab.ca/about/hfrc.html#role

Some of procedural/ policy challenges that can be found in some jurisdictions in being able to carry out effective monitoring are exemplified in Alberta's Health Facilities Review Committee reports. In 2003/4, the Committee received 34 public complaints, most concerning

long term care facilities. Of these, two investigations were conducted and concluded that year, and six were carried over to the next fiscal year. For 24 of the complaints, the signed health information authorization forms were not received, and so none of these were investigated. See: *Alberta Health Facilities Review Committee Annual Report, 2003-2004.* Online: www.health.gov.ab.ca/about/HFRC_Annual03_04.pdf

In 2004/5 the Committee received 28 complaints. Of these one investigation was conducted and concluded that year, and four were carried over to the next year. For 20 of the complaints, the signed health information authorization forms were not received, and so none of these were investigated. See: *Alberta Health Facilities Review Committee, Annual Report, 2004-2005.* Online: www.health.gov.ab.ca/about/HFRC_Annual04_05.pdf

[54] J. L. Troyer & H. G. Thompson (February 1, 2004) "The Impact of Litigation on Nursing Home Quality" *Journal of Health Politics Policy and Law,* 29(1), 11 - 42.

[55] Ibid.

[56] Peterson, Ann M., Overview of the *nursing home litigation* process, Geriatric Nursing. Jan-Feb 2002, 23 (1). 37-42.

[57] D. M. Studdert, & D. G. Stevenson**,** (2004) "Nursing Home Litigation and Tort Reform: A Case for Exceptionalism" *The Gerontologist* 44:588-595.

[58] The suit alleges that the practice of charging nursing home residents for their medical care and the forcible division of a married couple's assets to pay for it, violate provincial and federal laws and the Canadian Charter of Rights and Freedoms,

"N.S. woman who paid husband's medical care in nursing home sues province." CP Wire, Thursday 08 September 2005, Section: Atlantic regional general news.

[59] Public Guardian and Trustee, *The Woodlands Project Report, August, 2004.* Online: www.trustee.bc.ca/news_information/woodlands/Woodlands%20Project%20Report.pdf

[60] J. L. Troyer & H. G. Thompson (February 1, 2004). "The Impact of Litigation on Nursing Home Quality" *Journal of Health Politics Policy and Law,* 29(1), 11- 42.

[61] Ibid.

[62] Some will use the legal system to challenge publicly made concerns claims, framing these public statements as libel and defamation. It has been suggested that some of these lawsuits by operators are intended to "chill".

[63] Adapted from: Gooloo S. Wunderlich & Peter O. Kohler, *(eds.)* (2001). Improving the Quality of Long-Term Care (2001) Institute of Medicine, Committee on Improving Quality in Long-Term Care, Division of Health Care Services. Online: www.nap.edu/catalog/9611.html

[64] Ibid, page. 137.

[65] Ibid.

[66] Ibid.

[67] http://www.cha.ca/documents/naca-ccnta.pdf

[68] Office of the Auditor General, *Annual Report, 2004, Vol. 2 Chapter 4, "Department of Family and Community Services- Nursing Home Services"*, page 64. Online: www.gnb.ca/oag-bvg/2004v2/chap4e.pdf

For example, licensing is usually a limited process. In Downie, W. Lahey D. Ford et al. *Patient Safety Law: From Silos to Systems Appendix 2: Country Reports (Canada)*, at page 12 the authors note : "In British Columbia for example, applicants must provide their name address and occupation, a statement of their interest in the facility, the maximum number of patients the facility will accommodate, a legal description of the land, description of the premises, photo of the facility, floor plan, dimensions of rooms, statement of sanitary arrangements, description of fire escapes and statement about the classes of patients to be admitted. A license can be granted if the chief inspector approves the building and the character and fitness of the applicant is established (s. 7). Licenses are usually granted for one year and can be revoked for cause." Online : www.patientsafetylaw.ca/documents/Patient_Safety_Main_Report_final.pdf

[69] See, *Health and Social Services Act*, Division III Examination of Complaints by Agency Complaints, 60**.** A complaint may be addressed directly to the agency. Online: www.canlii.org/qc/laws/sta/s-4.2/20060525/whole.html

[70] Walshe K. Healthcare Regulation in the United States and the United Kingdom: Lessons for Quality Improvement**, 2003 I**nternational Society for Quality in Health Care Conference. Abstract online: www.isqua.org/isquaPages/Conferences/dallas/DallasAbstractsSlides/WebMaterial2003/Abstractsforweb/MONDAY/A12B/209-Walshe.pdf

Full presentation online at : www.isqua.org/isquaPages/Conferences/dallas/DallasAbstractsSlides/WebMaterial2003/Abstractsforweb/MONDAY/A12B/209-Walshe.pdf#search=%22The%20rise%20of%20regulation%20in%20the%20NHS%2C%22%20British%20Medical%20Journal%202002%3B%20324%3A%20967%E2%80%93970%22

[71] National Long Term Care Ombudsman Resource Center (1996). *What's It All About? Ombudsman Program Primer for State Aging Directors and Executive Staff.* Online: www.nasua.org/pdf/LTC%20Ombudsman%20Primer%20for%20State%20Government%20Officials.pdf

[72] Monique Smith (Spring 2004) *Commitment to Care: A Plan for Long-Term Care in Ontario*. Online:

www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohltc_report04.pdf

In addition, a Private Member's bill (Bill 92) was put forward to expand the powers of the Ombudsman to hospitals and long term care facilities

An Act to amend the Ombudsman Act with respect to hospitals and long-term care facilities, April 5, 2006 (1st Reading) Online: www.ontla.on.ca/documents/Bills/38_Parliament/session2/b092.pdf

[73] Office of the Ombudsman, Nova Scotia, "Senior Services". Online: www.gov.ns.ca/ombu/Child_Ombud/senior.asp

[74] Office of the Ombudsman, New Brunswick, *2003-4 Annual Report*, at page 28. Online: www.gnb.ca/0073/2003-2004_Report-e.pdf#search=%22New%20Brunswick%20Ombudsman%20nursing%20homes%22

[75] R.S.Q., chapter P-31.1 An Act Respecting the Health and Social Services Ombudsman.

[76] *What's It All About? Ombudsman Program Primer for State Aging Directors and Executive Staff*, National Long Term Care Ombudsman Resource Center, 1996. Online: www.nasua.org/pdf/LTC%20Ombudsman%20Primer%20for%20State%20Government%20Officials.pdf

[77] Newfoundland notes the need for impartiality in investigations - *Strategic Plan to Address Elder Abuse in Newfoundland and Labrador*, page 19. Online: www.seniorsresource.ca/docs/StrategicPlan.pdf

[78] The barriers to systems advocacy included insufficient ombudsman education and training, lack of monitoring and enforcement on the state and national level, and inadequate partnering with other appropriate organizations. See: National Association of State Long-Term Care Ombudsman Programs. "Long-Term Care Ombudsman Programs, Rethinking and Retooling for the future, (NASOP Retreat) Proceedings and Recommendations April 2003". Online: http://longtermcare.state.wi.us/home/whitepaper03_FINAL.pdf

[79] People who would be inappropriate are people who lack empathy, who have no real interest in the welfare of the residents for whom they care, who are disrespectful or controlling, who have known substance abuse, domestic violence or criminal histories.

An important strategy for preventing abuse is asking questions to learn the job applicant's:

- feelings about caring for (frail) older adults;
- how they might react to an abusive situation;
- their work ethic;
- how they handle anger and stress; and

- history of alcohol or substance abuse.

Page 9 - http://www.elderabusecenter.org/pdf/publication/NursingHomeRisk.pdf

[80]Volunteer Canada. “Understanding police record checks”, Online: www.volunteer.ca/volunteer/pdf/PRCBrochureEng.pdf

[81] "Employment references" Referring to the case of **TSB Bank** plc v Harris [2000] IRLR 157, EAT, Summary online at : www.schools.bedfordshire.gov.uk/circulars/00/h-00-14.htm

[82] Ontario Law and Social Policy: Implications for Screening. Online: http://www.volunteer.ca/volunteer/pdf/Ontario_law_sSpolicy_nolo.pdf

[83] Alberta Protection For Persons In Care Act, Chapter P-29, Online: http://www.qp.gov.ab.ca/documents/Acts/P29.cfm?frm_isbn=0779728998

[84] Criminal Records Review Act, [RSBC 1996] Chapter 86. Online: www.qp.gov.bc.ca/statreg/stat/C/96086_01.htm#section28

[85] Downie, W. Lahey D. Ford et al. *Patient Safety Law: From Silos to Systems Appendix 2: Country Reports (Canada).* Online : www.energyk.com/healthlaw/documents/Appendix_2_Canada.pdf

[86] Ibid.

[87] Ibid.

[88] Ibid.

[89] Ibid.

[90] Alberta *Protection for Persons in Care, Monthly Reports, 2005-6.* Chart 8, Investigation Duration (Time In Days)

Online: www.seniors.gov.ab.ca/CSS/persons_in_care/reports/2005_06/PPC_MonthlyRpt2005_06.pdf

[91] Protection of Persons in Care Act (Nova Scotia Health Presentation). Online: www.gov.ns.ca/scs/pubs/ProtectionofPersonsinCareDMBandJM.pdf

[92] Online: www.qp.gov.sk.ca/documents/English/Regulations/Regulations/P6-01R2.pdf, sec. 13 (2)

[93] Homes for Special Care Regulations, N.S. Reg. 127/77. Online: www.canlii.org/ns/laws/regu/1977r.127/20060718/whole.html

Nova Scotia's Homes for Special Care regulations requires reporting any resident's deaths (by natural cause, or otherwise) that may have occurred in the previous quarter.

[94] Steering Committee on the Abuse of Adults in Vulnerable Circumstances in its Report and Recommendations -December, 1997

[95] In Saskatchewan, employees who report wrongdoing have even stronger protection following amendments to the *Labour Standards Act* introduced by the Saskatchewan government on November 19, 2004. Bill 86, the *Labour Standards Amendment Act, 2004* (No. 2) passed third reading on May 25, 2005. The amendments were introduced to improve the pre-existing protection of whistleblowers through the *Labour Standards Act*, which offered more protection for employees than in most other parts of Canada. The amendment allows the Director of Labour Standards to investigate and issue a decision respecting an employee's complaint of wrongful dismissal or discrimination as a result of reporting an illegal activity. Under the amendments, the Director of Labour Standards can order the employer to:

- Cease any discriminatory activity toward the employee
- Restore the employee to his or her previous position
- Pay any wages that the employee lost as a result of the employer's violation of section 74 of the Act and s. 62.4 (2.1) (a).

Saskatchewan , *The Labour Standards Act*, Chapter L-1 of *The Revised Statutes of Saskatchewan, 1978*, as amended, see s. 74 (1).

Online: www.qp.gov.sk.ca/documents/English/Statutes/Statutes/L1.pdf

[96] Online: www.qp.gov.bc.ca/statreg/stat/C/02075_01.htm#section22

Protection for persons who report

> s. 22 (1) No action or other proceeding may be brought against a person for reporting abuse under this Part if the report is made in good faith.
>
> (2) A licensee must not take action against its employee or agent because that person made a report under subsection (1).
>
> (3) A licensee or other person must not alter, interrupt or discontinue, or threaten to alter, interrupt or discontinue, service to a person in care as a result of a report or a suggested or stated intention to make the report under subsection (1).

[97] Community Care and Assisted Living Act, SBC 2002, Chap. 75. Online: www.canlii.org/ns/laws/sta/2004c.33/20060614/whole.html, s. 13 &14.

[98] Canadian Healthcare Association, *Towards Improved Accountability in the Health System: Getting from Here to There, Policy Brief*

Online: www.cha.ca/documents/accountability.pdf

[99] Canadian Healthcare Association “Health System Effectiveness Principles” Online: www.cha.ca/documents/HealthSystemEffectivnessPrinciples_E.pdf

[100] Nova Scotia Health, *Long Term Care Policy Manual* (Revised May 10, 2006). Online: www.gov.ns.ca/health/ccs/ltc/Policy%20Manual_May_10_06.pdf

[101] *Health Services Insurance Act* (C.C.S.M. c. H35), Personal Care Homes Standards Regulation. Online: http://web2.gov.mb.ca/laws/regs/2005/pdf/030-h035.05.pdf

[102] Personal Care Homes Standards Regulation, ibid, s. 5(1)

[103] See *Charitable Institutions Ac*t, R.S.O. 1990, Chapter C.9, s. 9. 22 Online: www.e-laws.gov.on.ca/DBLaws/Statutes/English/90c09_e.htm

[104] See *Homes for the Aged and Rest Homes Act*, RSO 1990, cH13 s. 36.1. Online : http://www.e-laws.gov.on.ca/DBLaws/Statutes/English/90h13_e.htm

[105] Ontario Ministry of Health and Long Term Care. (2004) *Future Directions for Legislation Governing Long-Term Care Homes.*

Online: www.health.gov.on.ca/english/public/updates/archives/hu_04/ltc_leg/ltc_leg.pdf

[106] Nursing Homes Act R.S.O. 1990, Chapter N.7, Online: www.e-laws.gov.on.ca/DBLaws/Statutes/English/90n07_e.htm#BK48

[107] Ontario Association of Resident Councils. Online: www.residentscouncils.ca/links.asp

[108] Conseil pour la protection des malades (CPM) " Object : Legal Opinion on the Autonomy of Users’ Committees" Online: www.cpm.qc.ca/Publications/Avis/Legal%20Opinion%20Autonomy.pdf

[109] Ibid.

[110] Ibid.

[111] Protection for Persons in Care Act, R.S.A. 2000, c. P-29 Online: www.canlii.org/ab/laws/sta/p-29/20060614/whole.html

[112] Protection for Persons in Care Act, C.C.S.M. c. P144 Online: www.canlii.org/mb/laws/sta/p-144/20060614/whole.html

[113] Nova Scotia Protection of Persons In Care Act (Nova Scotia Health Presentation) Online: www.gov.ns.ca/scs/pubs/ProtectionofPersonsinCareDMBandJM.pdf

[114] M Pauls & L MacRae, (May 2006). *The Response to Elder Abuse in Alberta: Legislation and Victim Focused Services Final Report* Canadian Research Institute for Law and the Family, page 92. Online: www.child.gov.ab.ca/whatwedo/familyviolence/pdf/CRILF%20Elder%20Abuse%20Final%20Report%20-%20June%202006.pdf#search=%22The%20Response%20to%20Elder%20Abuse%20in%20Alberta%3A%20Legislation%20and%20Victim%20Focused%20Services%20Final%20Report%22

[115] Ibid at page. 97

[116] Office of Legislative Research (OLR) Research Report, October 23, 2000 (200-R-1006) Nursing Home Staffing. Online at: www.cga.state.ct.us/2000/rpt/olr/htm/2000-r-1006.htm. Accessed July, 27, 2006.

[117] Harrington C, Zimmerman D, Karon SL, Robinson J, Beutel P. Nursing home staffing and its relationship to deficiencies. *Journal of Gerontology B Psychological Sciences & Social Sciences* 2000; 55(5):S278-87.

[118] *Task Force on Resident/ Staff Ratios in Nova Scotia*, (February 2002). Online: www.gov.ns.ca/heal/downloads/taskforce_report.pdf

[119] *Research and Recommendations of the Task Force on Resident/Staff Ratio in Nursing Homes*

(February 2002). Online: www.gov.ns.ca/health/downloads/taskforce_report.pdf

[120] M J. McGregor, M. Cohen, K. McGrail, et al. (March 1, 2005) "Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter**?"** Canadian Medical Association Journal, 172 (5). Online: www.cmaj.ca/cgi/content/full/172/5/645

[121] Ibid.

[122] Canadian Healthcare Association 2004 Policy Brief, *Stitching the Patchwork Quilt Together: Facility Based Long Term Care within Continuing Care – Realities and Recommendation.*

[123] See: Online: www.piecescanada.com/

For a brief description of PIECES, Enabler, and U first see S. Bailey, Psychogeriatric Resource Consultation Program of Toronto *Bulletin* (October 2005). Online: www.rgps.on.ca/PDFfiles/ProgrambulletinOctober2005.pdf#search=%22CAMH%20%22PIECES%22%20training%22 Bailey notes:

> "The PIECES training focused on developing the psychogeriatric assessment skills of registered staff and enhancing dialogue among peers within their organizations. The Enabler program assisted long-term care managers to best support their PIECES-trained staff. U-FIRST concepts were woven into the PIECES and Enabler training and were also provided to leaders in community health organizations."

The role of PIECES in aiding staff understanding of dementia and aggression is mentioned in the article by Jane Meadus "Homicide in long term care: search for answers", *Advocacy Centre for the Elderly Newsletter*, Spring 2005, Vol. 3 (no. 10) Online: www.advocacycentreelderly.org/pubs/newsletter/newsletterspring2005.pdf