Long-Term Care Homes Third Party Independent Review

Submitted to Janice Burelle, GM, Community and Social Services, City of Ottawa

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Acknowledgements

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Residents, families, staff and volunteers were extensively consulted. The Presidents of the Resident and Family Councils and Council representatives from each home were interviewed. Every person approached was keen to respond. Their trust in openly sharing their perspectives is greatly appreciated. Confidentiality was promised, and results are provided in aggregate.

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Neil Fuller, Business Application Support Specialist, provided Telestaff statistics in a timely and understandable manner.

Seven comparators, 4 municipal and 3 charitable LTC homes, provided nursing staffing patterns and related information. Confidentiality was guaranteed for comparator homes.

Several external interviews were held. Experts freely gave of their time and knowledge. The information they provided was invaluable.

Executive Summary

Introduction

The City of Ottawa requested an independent review in October 2017 following a staff to resident physical assault at Garry J. Armstrong long-term care home and a verbal assault at Peter D. Clark. This abuse negatively affected these two residents and their families, and raised concerns and worries with many others.

City staff worked extensively to comply with a subsequent Compliance Order and Director Referral under the Ontario Long-Term Care Homes Act and its regulations. This resulted in a successful return to compliance in January 2018.

Mandate

Influencing factors for staff-to-resident and resident-to-resident physical, verbal, emotional and sexual abuse between 2015-2017; failure to report; and fact-based actionable recommendations were the focus of the Review.

Methodology

240 interviews and discussions were held with residents, families, staff and volunteers during Discovery Phase 1. Observations were made while assisting residents with their meal and shadowing Personal Support Workers at various times over 6 days at each home.

Phase 2 involved a literature review; a nursing staffing comparator survey; detailed analysis of City statistics and documents; a detailed analysis of 2015-2017 compliance findings; and external interviews.

Phase 3 synthesized Phase 1 and 2 findings in a report, with actionable recommendations.

Background

The City of Ottawa operates 4 long-term care homes ranging from 160 to 216 beds. There are 1,000 staff and 570 volunteers providing care and services to residents. The homes cost $66 million to operate annually. The capital budget is $350,000 annually.

The average age of the 717 residents is 85, with an average length of stay of 2 years and 3 months. 61-87 percent of residents have dementia. Peter D. Clark has highest number of male residents. 2 % to 93% of residents are francophone, depending on the home.

Findings

The Reviewer found:

- no additional physical or verbal assaults on residents; and
- neglect and emotional abuse towards some residents in all homes.

There are multiple systemic and individual factors that likely contributed to the incidents of staff-to-resident and resident-to-resident abuse and neglect. Strategies to minimize risks are provided throughout the report and its appendices.

Observations and discussions during site visits confirmed that the vast majority of staff are caring and strive to do their best. Many positive comments about care were made.

Capable residents interviewed were in control of their care and felt safe. Residents and families expressed concerns about some staffs' suitability, especially related to attitude and poor English. Families and substitute decision-makers expressed more concern about the risk of resident-to-resident abuse than staff-to-resident abuse, although both risks caused anxiety about the care of loved ones.

This Review focussed on areas requiring the greatest attention to minimize risk. The findings should be considered in their entirety. If not, they are subject to misinterpretation.

Top Ten Influencing Factors

The following influencing factors should be improvement priorities.

Quality and Risk Oversight
Human Resources Leadership
Nursing Staffing
Resident mix
Specialized dementia care
Communication
Volunteer Base
Failure to Report
Design and Essential Equipment
Information Technology and Care Planning

Risk was not well managed for the major influencing factors from 2015-2017. The risk levels between and within the four homes ranges from low to high.

Given the complexity of influencing factors that may have contributed to an environment conducive to abuse and neglect, and the overall size and unique aspects of

the four homes, each finding should not be generalized to all homes or to all resident home areas within each home.

Nursing and Personal Care Staffing

Insufficient numbers of nursing and personal care staff is a critical risk.

The average 2016 nursing and personal care hours per resident per day was 2.70 for City homes versus 3.00 hours in Ontario non-profit homes. On average City homes provide 18 minutes less Personal Support Worker and registered nurse care for each resident each day compared to other Ontario non-profit homes.

An increase in Personal Support Workers was unanimously identified as the top staffing priority by all interviewed. 35 additional PSWs and 5.5 additional registered staff would be required to reach the Ontario 2016 average.

A nursing practice manager position on the senior management team is recommended.

Nursing staff at all homes, especially Personal Support Workers (PSWs), are working under a microscope and stressed. Many are fearful. A large number of staff has lost pride in their work, an unintended consequence of extensive media coverage. PSWs worry about losing their jobs.

An increase in nursing staff is not the panacea to manage the risk of abuse and neglect at City homes, however implementing other recommendations and strategies will be difficult to achieve without it.

Failure to Report

Failure to report was a concern related to the two incidents of publicly reported abuse in 2017. Nursing staff rotation on all residential home areas would help mitigate this concern.

Resident Mix

There is a need to balance the complexity of residents with special needs on each resident home area. The level of dependence for partial or full assistance must be considered.

Specialized Dementia Care

The City should increase nursing and personal care staff to reflect the Ontario trend or reduce the number of secure resident home areas for people affected by dementia. This level of care normally has higher nursing staffing levels than resident home areas focussed on physical functional decline.

The need for education about dementia for staff and families was a dominant theme.

Communication

Residents and families expressed concern with some staff working in the homes just "for the money." Attitude and English language communication were identified as applicant attributes that needed to be screened. Excellent care is about relationship building, which is impossible without good communication and compassion.

The City's long-term care homes' website needs refreshed to include a broader range of information to enhance public accountability.

Quality and Risk Oversight: Management

Instability in management leadership was a major influencing factor. There were 52 changes in 21 senior management positions between 2015-2017. This instability was mainly due to 43 transfers between positions and between home. This practice should cease except for emergencies. Management qualifications and long-term care experience are a concern. Search and recruitment methods need to be broadened for management positions.

Quality and Risk Oversight: Governance

Quality and risk management for long-term care homes is needed at the governance level. The Community and Protective Services Committee should consider the creation of a Long-Term Care Board, with a quality and risk management function. This is in addition to current CPSC financial and regulatory oversight functions.

A quality improvement and risk management staff position should be considered.

Human Resources Leadership

Corporate human resources are not integrated to the level needed to support long-term care home managers. A dedicated senior Human Resources manager is recommended.

Volunteer base

Volunteer hours declined from 2015-2017. Additional volunteer help would be beneficial. Assisting residents at mealtime and monitoring residents at shift change are two practical needs. Review of the volunteer program was out of scope.

Design

The home designs are reflective of the residents and "thinking" 13-30 years ago when they were built or renovated. The design of some resident home areas is out-dated for secure and safe dementia care, and difficult to retrofit.

Equipment

The $350,000 annual capital budget for the 4 homes is not adequate to purchase lifts, new beds, and other equipment and furniture identified in the 10-year capital plan. The gap between the $350,000 annual capital budget and the 10-year capital plan should be identified for the 2019 budget process.

Information Technology and Care Planning

New resident care technology will be implemented in 2018. This is supported, and will improve care planning. It will also provide improved quality and risk data for analysis and reporting to a new Long-term Care Board of Directors or the Community and Protective Services Committee.

Conclusion

Abuse and neglect are symptoms of a multitude of factors that require governance and transformational change management to minimize risk and fulfill the City's duty of care.

The cost of additional Personal Support Worker staff to reach the 2016 provincial average is $2.3 million annually.

Six additional positions are also recommended, at a cost of $600,000 annually.

If the staffing recommendations from this review are approved, the City contribution to long-term care home operations would increase from $14.5 to $17.3 million annually. Costs related to increasing registered staff to the Ontario average need further study and would be additional.

1. Introduction

The City committed to an independent review in September 2017, and engaged Greg Fougere (Appendix H) to begin the Review on November 1, 2017.

This report focuses on the influencing risk factors of abuse and neglect in the four City of Ottawa homes. Abuse and neglect are defined through the Ontario Long-Term Care Homes Act and City policy. (Appendix B).

People interviewed and observations during site visits confirmed that the vast majority of staff are caring and do their best within the staffing levels and resources at City homes. Many positive comments about care and services were received during the site visits. Recent 2017 in-house survey results provide additional insight regarding areas of satisfaction.

Mandate

This report fulfills the deliverables for the *Long-Term Care Homes Third Party Independent Review*. The requirements included:

a. a comprehensive analysis from 2015-2017 of contributing/influencing factors to physical, verbal, emotional and sexual abuse as defined by Ontario legislation and regulation and City policy;
b. staff-to-resident and resident-to-resident abuse; and
c. a truthful and fulsome review based on accurate and fact-based information, free from bias or prejudice, with actionable recommendations, including failure to report.

Scope

Although priority areas for possible abuse and neglect influencing factors were identified and analyzed, the mandate was not a full operational or financial review.

The Review began broadly and evolved to focus on nursing and personal care, as the vast majority of critical incident and complaint investigations regarding alleged abuse and neglect involved nursing and personal care staff.

For the most part, clinical aspects of resident care were out of scope, such as the matters related to medication. However, issues related to the care plan are relevant as influencing factors.

2. Methodology

The Review was completed in three phases.

Phase 1, Discovery (November 1 to December 18, 2017)

Site visits were completed over four weeks. The four homes were visited at different times on the day, evening and night shifts during the week and weekends. Formal unscheduled unstructured interviews of 15 minutes to 2.5 hours were held with 140 residents, families, staff and volunteers; as well as about 100 informal "corridor/main entrance" discussions under 15 minutes. PSW staff was shadowed on at least two resident home areas (RHAs) in each of the four homes. The Reviewer observed and assisted residents with their meals during at least two mealtimes on different RHAs in each home.

Phase 2 (January-February 2018)

Analysis, findings and preliminary recommendation development was the focus of Phase 2. The major report themes were developed and priorities were assigned.

A detailed review of all 2015-2017 Resident Quality Inspections, Critical Incident and Complaint investigations was completed to identify any additional influencing factors.

External interviews were completed. As well, seven comparator homes provided information and responded to a nursing hours survey. City documents were analyzed.

The Reviewer's findings were compared to City stakeholder engagement findings and a comprehensive literature review.

Phase 3, Reporting back (March-April 2018)

Information from Phases 1 and 2 was synthesized for the final report, and recommendations were finalized. A management level report was prepared. An Executive Summary and PowerPoint Presentation with key recommendations were created for reporting back to the Community and Protective Services Committee and Council. Detailed analyses and exhibits were consolidated for management.

3. Background

City of Ottawa Long-term Care Homes

The City of Ottawa operates Garry J Armstrong (Porter's Island in Ottawa Centre), Centre d'accueil Champlain (Vanier), Peter D Clark (Centrepointe in Nepean), and Carleton Lodge (Nepean).

The homes serve 717 residents and their families. They operate on a $66 million operating budget, employ close to 1000 staff, and engage about 570 volunteers.

The majority of residents and families interviewed were positive about care and services. At the same time, many had concerns and several had complaints. Some are more fearful since the two abuse incidents have been extensively and repetitively covered in the media since mid 2017. Trust has been damaged.

Ontario Long-term Care Home Compliance

A major transformation started in 2010 and was phased-in across Ontario over several years. The extent of change affected many aspects of long-term care operations.

Non-compliance findings increased significantly due to the sophistication of a new annual Resident Quality Inspection (RQI) software and methodology, also used for critical incident and complaint follow-up site visits. Non-compliance findings became more evidence-based through inspection protocols. Non-compliance sanctions are incremental and elevate for repeat non-compliance and high risk. Compliance findings are posted on a provincial public reporting website.

Following 2016 RQI annual inspections, 22 % (N=136) of Ontario LTC homes were issued written notifications for s. 19 Duty to Protect and 13% (N=79) were issued non-compliance orders related to s. 19 (1) Duty to Protect.

In January 2018, then Minister of Health and Long-Term Care Dr. Eric Hoskins wrote to LTC home Licensees stating that non-compliance with the Act, especially when it impacts resident safety, is unacceptable and will not be tolerated. Enforcement powers were strengthened.

In mid-2017, three of the four City homes received a Director's Referral related to abuse and neglect. As of November 2017, 92 Director's Referrals were issued in 2017 in Ontario.

City staff worked diligently on safety issues identified by Compliance Inspectors and were returned to compliance with the Act in January 2018.

4. Literature Review

A literature review is provided in Appendix C. An annotated bibliography is provided in Appendix F. These documents will help build on abuse and neglect prevention strategies, including continuing education and professional development.

Table 1 below summarizes staff-to-resident abuse factors, and Table 2 provides trends for resident-to-resident abuse.

Table 1: Staff-to-Resident Abuse and Neglect Risk Factors

Systemic/Organizational Risk Factors	Staff Factors	Resident Factors
-Staffing shortages -Skill set of staff not aligned with needs of residents -Lack of education or training -Staffing mix -Overcrowding of residents -Heavy workload -Time pressures to complete care -Long hours -Low wages -Lack of job stability -Lack of sick leave benefits -Equipment shortages -Insufficient equipment to meet needs of residents -Overload of administrative duties taking away from direct care time -Workplace bullying -Poor teamwork -Lack of integration of personal support workers with care planning -Lack of resident-centred culture -Organizational desensitization to violence -Lack of support and follow-up for reporting abuse -Lack of administrative and supervisory oversight -Lack of management appreciation for staff -Lack of management support for staff dealing with aggressive behaviours from residents	-Burnout -Low job satisfaction -Fatigue -Emotional exhaustion -Lack of satisfaction with management -Lack of stability with personal life -History of experience with domestic abuse -Stress related to immigration -Mental illness -Drug or alcohol dependence -Working multiple jobs -Attitude conveying low level of respect for residents	-Behavioural issues -Cognitive impairments -Physical impairments -Mental illness -Communication difficulties -Limitations in activities of daily living -Heavy incontinence care required -Abuse to staff -Previous victimization from non-staff perpetrators -Social isolation

Table 2: Resident-to-Resident Abuse and Neglect Risk Factors

Systemic/Organizational Risk Factors	Perpetrator Factors	Victim Factors
-Overcrowding -Higher proportion of shared rooms -Environmental factors aggravating/exacerbating wandering or way-finding confusion -Ambient features increasing confusion or agitation (e.g., noise disruption, poor lighting, poor temperature control) -Staffing quantity and skill set do not meet needs of residents -Lack of activities for residents -Lack of documentation for incidents of resident-to-resident aggression	-Strong personality -Short temper -Pre-morbid racial and stereotypical opinions -More cognitively intact -Little empathy and patience for other residents -Severe mental illness -Prior abuse by staff -Cognitive impairments (related to sexual aggression) - Frontal or temporal lobe dementia (related to sexual aggression) -Being a registered sex offender (related to sexual aggression)	-Physically mobile -Prone to wandering -Cognitive impairments -Dementia -Disruptive and socially inappropriate behaviours -Communication barriers -Functional limitations -Prior abuse by staff

5. Review Findings

Caring Staff

The vast majority of staff are caring and strive to do their best. Many positive comments about care were received during site visits. The 2017 in-house survey results provide additional insight regarding areas of satisfaction. Capable residents interviewed were in control of their care and felt safe, although several had concerns about some staffs' suitability related to attitudes and inability to clearly speak English or French while providing care.

Abuse and neglect of residents affected by dementia is a high risk, albeit by a minority of staff.

Expectations and Safety Perceptions

Residents

The majority of capable residents had reasonable expectations within the resources available. Many are functionally dependent on caregivers and able to manage their care. Capable residents are a minority of the total resident population.

Garry J Armstrong had the lowest number of residents affected by dementia (61%). The results for the other three homes were more in line with provincial trends with CAC (75%), PDC (86 %) and CL (87%). PDC and CL are in the top range. These numbers will continue to grow.

At the end of interviews residents were asked, "Do you feel safe here?" Generally, the majority of capable residents interviewed stated they felt safe. Question 48 "I feel safe living in the home." was added to the 2017 satisfaction survey. A low resident response rate compared to the total 717 residents (PDC = 2 %; CAC = 7%; GJA 15 % and CL 16 %) makes this result difficult to interpret. However, the trend was consistent with the Reviewer's finding that residents have a greater perception of safety than family members and Substitute Decision Makers (SDM), especially family members of residents affected by dementia.

Families

Within available resources, family expectations ranged from reasonable to unreasonable.

Generally, family members had more concerns about safety than capable residents. A higher family and SDM response rate of 26% makes this result somewhat more meaningful. The trend was consistent with the Reviewer's finding that families had a lower perception of safety than capable residents. CL and GJA had the highest proportion of families responding "Excellent" or "Good" (88% combined average) compared to CAC and PDC (72% combined average)

Tables 3 and 4 summarize the Reviewer's findings following phase 1 site visits.

Table 3: Staff-to-Resident Findings

Abuse/Neglect*	***Finding***
Emotional (including verbal altercations)	Evidence
Physical Assault	No Evidence
Sexual Assault	No Evidence
Verbal Assault	No Evidence

*** Verified publicly reported physical and verbal assaults of Mr. x at GJA and Mrs. y at PDC are exceptions.**

Systemic and individual neglect were the most prevalent concerns.

Low nursing staff levels were reported as the greatest systemic reason for neglect. Staffing levels resulted in rushed care and abrupt behaviour and comments to residents; poor continence care; issues with meal assistance; poor response to call bells and/or promising to return but not returning; not turning residents as frequently as required; poor nail and mouth care; waking residents before 7 a.m. to give morning care and putting residents to bed early; leaving residents in bed for breakfast; care plans not being read before providing care; rushing residents who can't move fast; attempting one-person lifts instead of two-person according to care plans; using shower chairs for transport to the bath versus a one person Sarah lift for bed to chair and chair to bath; insufficient resident supervision especially during shift change at 3 PM; and poor cleaning of resident equipment such as wheelchairs.

Some individual staff traits and poor suitability resulted in the same neglect as many of the above systemic driven examples. Some staffs' inability to speak English with residents caused increased physical and verbal aggression during care, increasing the risk.

There were several reports of emotional abuse at each home. The prevalence of this type of abuse was lower than neglect, however the emotional impact on the residents involved was high. Examples provided by residents and families included insulting and humiliating comments to residents such as "You're fat"; abrupt PSW orders such as "Come for your bath"; upsetting comments to a married resident; undignified care to a resident at night by pulling down the covers, feeling the resident's incontinence brief, and announcing "You're dry"; chastising a resident with "Don't yell at me"; shunning, ignoring, cold, and non-smiling to residents; accusing comments about continence care such as "I just did you" and "You go to the bathroom too often"; teasing comments to a resident; dehumanizing comments such as "heavy wetter" and "feeder"; and comments such as "sweetie" and "dearie".

Table 4: Resident-to-Resident Findings

Abuse/Neglect	***Finding***
Emotional	Evidence
Physical	Evidence
Sexual	Evidence
Verbal	Evidence

6. Top Ten Influencing Factors

All homes were at risk for resident abuse and neglect to varying degrees, mainly the result of 10 key influencing factors. Risk was low to high between homes and within each home.

Quality and Risk Oversight

Governance

One of the seven 2015-2018 Strategic Plan's Term of Council Priorities relates to Governance, Planning and Decision-Making. City Council's priority is to achieve measurable improvement in how the City is governed, apply a sustainability lens to decision-making, and create a governance model that compares to best in class cities around the world.

One important and achievable improvement is to enhance the accountability of the Community and Protective Services Committee (CPSC) and Council for strategic planning, partnerships and quality and risk oversight for the four City-operated homes. Financial and regulatory oversight should include an annual resident impact assessment.

Table 5 provides a high-level assessment of the extent to which the CPSC and Council are achieving five universally accepted governance responsibilities.

The breadth of the Community and Protective Services Committee's mandate includes housing, parks, recreation, cultural programming, long-term care, social services and protective services. Given the Committee's broad mandate, governance oversight of the four City long-term care homes cannot be effectively carried out at CPSC committee meetings. A Long Term Care Board of Directors reporting to Council through the CPSC is critical to fulfill City Council's Duty of Care.

Table 5: Governance

Accountability	Council	CPSC	Recommendation
Strategic Planning and policy development			Preliminary discussion about strategic planning and short-term direction by the CPSC: 2018 A policy to increase and maintain nursing staffing levels based on the average Ontario nursing staffing hours should be considered. LTC Department Strategic Planning: 2019 • Long-range vision from both service and sustainability lenses. • Strategic Plan implementation: 2020-25
Partnerships and stakeholder engagement			Consider during 2019 strategic planning.
Effective quality and risk oversight			Add reporting to CPSC in 2018-19 based on the Health Quality Ontario Quality Improvement Narrative for Health Care Organizations in Ontario and Goldcare quality and risk indicators. Define expected outcomes to be measured, reported, and transparently communicated.
Financial oversight			Add an annual resident care impact assessment. Nursing staffing levels did not increase from 2015-2017, despite an annual 1 percent increase in resident care needs in Ontario.
Regulatory oversight			Long-term Care Service Accountability Agreement and numerous other legislation and regulations

CEO Evaluation and Succession Planning (City Manager) accountability was out of scope

Governance recommendations:

- Create a Long-term Care Board of Directors:

    - Co-chaired by two Councillors from the CPSC, at least 1 francophone/bilingual Co-Chair.
    - Create a skill-set matrix for up to 6 appointments from the community-at-large.
    - Adopt terms of reference with a quality and risk management focus initially for 2018-2019, in addition to financial and regulatory oversight.
    - Meet every two months with a minimum of 6 times annually.
    - Add an annual budget resident impact assessment.
    - Add reporting to the CPSC in 2018-19 based on the Health Quality Ontario Quality Improvement Narrative for Health Care Organizations in Ontario and Goldcare quality and risk indicators.
    - Report to the CPSC at least twice per year, with a quality and risk report by June 30, 2019.
    - Add long-term care strategic planning in 2019, including strategic partnerships.

- Approve a policy to increase and maintain nursing staffing levels based on the average Ontario nursing staffing hours.

- Approve at least 50% of Ministry of Health and Long-Term Care annual funding increases for staffing, with the remaining 50% to offset cost of living expenses.

Management Leadership

There is one Director for the four homes who reports to the General Manager, Community and Social Services. There are 5 senior management positions at each home: an Administrator and four Program Managers.

<u>Instability</u>

Management leadership was extraordinarily unstable between 2015-2017. Table 6 summarizes the instability for each management position. In the 3 years reviewed, 52 changes in 21 management positions. Forty-three were movements within or between homes; 4 were retirements; 2 leave of absences; 2 dismissals and 1 resignation.

Table 6: Management Instability 2015-2017

Date Range	Jan. 2015 - Oct 2016 Total # Occupying Management Position Over 22 months (2015-16)	Oct 2016 - Dec. 31 2017 Total # Occupying Management Position Over 14 Months (2016-17)	Total # Occupying Management Position Over 3 Years (2015-17)
Director LTC	1	1	2
Garry J Armstrong Administrator	2	2	4
Program Manager Resident Care (RC) (RN; RPN)	1	NC*	1
Program Manager Personal Care (PC) (PSW)	2	NC	2
Program Manager Hospitality	2	1	3
PM Recreation and Volunteers	1	1	2
Total GJA	8	4	12
Carleton Lodge Administrator	2	1	3
Program Manager RC	2	1	3
Program Manager PC	2	1	3
PM Hospitality	2	1	3
PM Recreation and Volunteers	1	NC	1
Total CL	9	4	13
Centre d'Accueil Champlain Administrator	1	1	2
Program Manager RC	1	1	2
Program Manager PC	1	1	2
PM Hospitality	1	NC	1
PM Recreation and Volunteers	1	NC	1
Total CAC	5	3	8
Peter D Clark Administrator	3	NC	3
Program Manager RC	2	1	3
Program Manager PC	2	2	4
PM Hospitality	3	1	4
PM Recreation and Volunteers	2	1	3
Total PDC	12	5	17
Total # Occupying Position 2015-2017	35	17	52

*NC = No change

Qualifications

Long-term care and management qualifications have been lacking for some senior positions between 2015-2017. Some senior leaders were hired without the long-term care and management education and experience outlined in the position descriptions. Several people were put into senior leadership positions without the necessary qualifications and experience.

Inadequate search methods have been an influencing factor. Two methods have predominated: within-City staff competition and advertising through AdvantAge. On their own, these two recruitment methods limited the number of qualified candidates considered for vacant management positions.

Structure

Management is organized in a traditional functional management structure. Given the size of the organization, the levels of care and programs and the instability noted above, the structure is appropriate.

The nursing management structure needs to be reviewed to better support both nursing operational and clinical responsibilities. Clinical leadership should be represented on the senior management team.

Approach

The management approach since the public reporting of the abuse incidents and Director's referral was to a large extent disciplinary. This was a preliminary response to managing the risk. The unusual increase in discipline of nursing staff since mid 2017 is largely the outcome of years of both management shortfalls and unacceptable staff actions, due in many cases to unsuitability for LTC.

Although a disciplinary approach may have been required given the level of risk the City homes found itself in during 2017, it will likely not be successful over the long-term. Dealing with the "bad apples" is a limiting approach. Transformational change management is required.

Management deficiencies and the lack of adequate governance oversight related to risk and quality of care are the most significant factors resulting in below average results. The 8 remaining abuse and neglect influencing factors are mainly the symptoms and outcomes of these shortcomings.

Three of the four Administrators have been in their roles for 1 year or less. Their commitment over the long-term is vital to getting City homes back on track. They need autonomy and support for the homes they are accountable for, within approved parameters. This review should not be viewed as a commentary about their leadership, as the issues precede their appointments.

Management Recommendations:

- Create a quality improvement management position.

- Review position description qualifications for the Director of Long-Term Care. This position is the CEO of the Long-Term Care department and should require a Master-level management qualification combined with 10-years' long-term care experience. Experience should also be elevated with more emphasis on CEO level experience such as strategic planning, stakeholder development and collaborative partnerships, public and government relations, funding negotiations, and effective succession planning.

- Ensure that the Director and Administrator positions are recruited at least Canada-wide. Internal applicants should be given the opportunity to compete.

- Establish at least an undergraduate degree, regulated health profession background and/or five years' multidisciplinary healthcare experience in a long-term care setting, and management education for the Administrator position. Experience in seniors care is too general. Administrators who do not have long-term care experience should be supported by managers that do. Similarly, Administrators with strong long-term care experience could work with managers who have worked in other multidisciplinary work environments. Both models are appropriate.

- Limit temporary movement within and between management positions and between homes to short-term support in emergencies. The Director and Administrator positions should not be used as training positions for succession planning.

- Increase the senior management team by a nursing practice manager dedicated to the homes.

- Shift the Director of Long-term Care focus to CEO-level accountability for strategic planning, government relations, support to the CPSC, financial advocacy, change management, etc.

- Provide more autonomy for Administrators to operate within the City and long-term care mission, vision, policies, procedures, budgets, and other approved parameters. This is supported by the City's "Let managers manage" objective.

- Reduce functional meetings between homes to provide more time for on-site responsibilities.

Human Resources Leadership

Human Resources and Labour Relations are divided corporate services within the City. This model is not well integrated and creates challenges to support homes.

There is one HR Strategist supporting the entire Community and Social Services Department. The human resources "Developing Our People" vision for implementing the tenets of the Servant Leadership framework is positive for the future. However, the corporate human resources model does not support Administrators and Managers at the four City LTC Homes in a comprehensive or timely manner.

The success of the "Let managers manage" and coaching culture objective is directly related to managers' qualifications.

Discipline spiked in the fall of 2017. This followed media coverage about abuse and neglect at GJA and PDC. The Labour Relations model is appropriate, however timeliness related to rights grievances was reported as an issue throughout 2017. The Reviewer was informed that changes were made to reduce the departments that the City labour relations consultant was responsible for, mainly removing Paramedic Services from the workload. Other recent changes to administrative processes, such as the LTC department authority to sign-off discipline letters, should improve timeliness. Some comments were that Labour Relations take a more assertive approach.

Regular monthly meetings between corporate Human Resources, Labour Relations and Administrators have recently been established. This should provide better support to Administrators and Program Managers, but will be insufficient.

Dedicated corporate human resources leadership is inadequate to move forward on the multitude of HR issues affecting the homes and ultimately resident care.

Residents, families and staff at CAC reported concerns about staff relations that were affecting care.

A dedicated Human Resources manager would reduce the demand on corporate Labour Relations services.

Human Resource Leadership Recommendations:

- Establish a dedicated senior human resources manager for City homes responsible for leading HR planning, implementation and operational support. Labour relations support should decrease as a result.

- Set standard response times for Labour Relations, audit performance, and take corrective action to improve support to managers.

- Assign an experienced staff development position to improve staff relationships. A minimum 2-year assignment should be considered.

Nursing and Personal Care Staffing

Background

Nursing is the largest group of caregivers in long-term care homes working within a multi-disciplinary team made up of a multitude of other professions and care staff, albeit in smaller numbers.

Registered Nurses (RNs) and Registered Practical Nurses (RPNs) make up the regulated health professionals on the nursing team, under the Ontario College of Nurses and the Ontario Regulated Health Professions Act. Personal Support Workers (PSWs) are the largest number on the nursing and personal care team providing direct "hands on" care 24/7. The PSW certificate course is 6-8 months of in-class and practicum components adhering to provincial standards. PSWs receive a certificate attesting to their completion of the PSW course, however PSWs are not certified nor regulated. PSWs need to be supervised by registered staff.

The average age of all classifications of City nursing staff is 50. This is consistent with trends of an older workforce in long-term care and needs to be considered in a renewed recruitment strategy. Residents and families commented on the need to recruit younger staff.

City of Ottawa compensation rates are higher than most Ontario long-term care homes. Partial high wage funds are received from the province towards this unique cost, however far less than required. The City of Ottawa needs to provide additional funds to provide equitable staffing levels compared to the majority of Ontario long-term care homes.

Sick leave and modified work increased during the 2015-2017 Review timeframe. This is an area that was identified for action prior to the Review, with reductions in sick leave reported by the Director of Long-Term Care. Action in this area needs to continue, however is not dealt with further in this review.

Many PSWs enter long-term care careers with little experience caring for seniors. Continuing in-service education and support in early years is critical to good care. Lifelong learning is important. Due to the special nature of caring for people with dementia, who are less capable of expressing their needs, education should be an ongoing priority. PSWs should not be assigned to secure special care RHAs for people affected by dementia unless they have a minimum of 6-months of related dementia care experience. An in-house designation should identify PSWs who are qualified to work with people with dementia. This should be a normal requirement of the job. Seniority should not be the only criteria.

Many RPN and PSW staff expressed frustration with how performance issues are dealt with. "Why bother" was often used to express frustration. Labour relations, management and Unions were often perceived as not providing enough support.

Both management and CUPE have publicly promoted quality resident care. However, they have been failing to correct inappropriate behaviour that puts residents at risk. It will take both parties collaborating much more closely to move the yardstick forward.

The summary LTC Department 2017 financial statements were reviewed. The combination of higher compensation, sick leave and modified work costs require the City to fund an additional $14.5 million for operating the four homes. $13 million relates to nursing and personal care staff.

Surpluses in the "Other Accommodation" funding envelope are often available in Ontario long-term care homes and redirected to staffing, capital or profit. As well, preferred accommodation revenues from semi-private and private room rates are usually invested in care, capital, or profit.

About 10-15 years ago, the City of Ottawa had higher nursing staffing levels than most charitable and for-profit homes in the region. There has been a gradual decline in staffing levels over the past 5-10 years. City homes now fall 10% or 18 minutes below the average for Ontario non-profit homes.

Resident care needs in Ontario long-term care homes have been increasing 1 percent per year. (Source: MOHLTC) There was no increase to the budgeted City nursing staffing levels for the years 2015-2017 to respond to increased care needs. This is a major influencing factor that increases risk and negatively impacts many aspects of care, including potential abuse and neglect. Additional nursing staffing, especially PSWs, was the #1 priority for virtually everyone interviewed.

The Homes report that recruitment of nursing staff is a challenge, especially PSWs. During the Review, no evidence of a RN, RPN and PSW recruitment strategy was provided. This is another example of the need for a dedicated senior HR manager.

Staff at all four homes expressed fatigue since being under the microscope throughout 2017. Many expressed loss of pride and fear of losing their job. Many PSWs worry that what is filmed on camera may be misinterpreted, especially when providing care to people with aggressive symptoms due to some forms of dementia. Some RNs expressed concern about their accountability given the perceived low level of staffing.

The rush, task orientation and stress related to care contributes to abruptness by many staff. Incivility was reported and observed. Many families, at all 4 homes, spoke positively about most nursing staff but stated there were PSWs who were working in long-term care "just for the money".

Resident to Staff Abuse

Resident to staff abuse may trigger abusive staff reactions.

Incident reporting indicates that staff assault represents about 30 % of all types of staff heath and safety incidents. Of the 335 incidents in 2017, 14 % (N=48) resulted in lost time and 9 % (N=31) required health care. 76 % (N=254) were classified as incident only, the majority being assaults by residents who have dementia and not capable of understanding their actions. Resident to staff abuse was higher on secure dementia RHAs at CAC (1), GJA (2), and PDC (2). Resident to staff abuse was higher on the physical functional decline RHA at CL (1).

Suitability – attitude and language

Poor attitude was noted by several interviewees, possibly the result of a lack of interest in long-term care for some staff.

Many residents and families stated that they do not understand many staff. As relationship building is key to compassionate and respectful care, inability to clearly communicate negatively affects resident care. As should be expected, care issues will arise when residents cannot understand nursing staff or sense a lack of compassion.

Poor staff attitude and the inability to communicate clearly in the language of the majority of residents are two risk factors for some staff that must be addressed. Initial applicant screening must be improved.

The Reviewer was informed that improvements in the applicant screening process have begun.

Education

Education throughout 2015-2017 was mainly through the online SURGE modules. There have been programming issues that have allowed staff to bypass abuse and neglect education while signing as if it had been completed. The limitations of the non-interactive program were one of the reasons the Director ordered face-to-face training on abuse and neglect.

As noted above, the PSW Certificate education is 6-8 months. Some PSWs have little to no experience caring for older adults, especially those affected by dementia, when starting in LTC homes. Ongoing in-service education is critical, beyond the use of the SURGE on-line training. In January 2018 the MOHLTC Director put the City homes back in compliance. This supported the increased effectiveness of the face-to-face training provided in 2017.

All Ontario LTC homes provide abuse and neglect training, yet problems related to abuse and neglect exist for many homes. It is clear that education alone is not effective for abuse and neglect prevention.

Education of staff and family on dementia was a top priority mentioned by many.

A trend in long-term care homes is to engage PSWs in training for tasks related to direct resident care, such as lifts and transfers training. This peer-to-peer training can be effective, and provides opportunities for PSW development and recognition.

Nursing staff should have access to tools to audit care, such as Ministry of Health and Long-Term Care Inspection Protocols. There are many well-developed inspection protocols, such as the Abuse and Neglect inspection protocol. Managers have used these audit tools, however they were not part of education provided to frontline nursing staff. These tools are used by Ontario LTC Compliance Inspectors during annual Resident Quality Inspections, and for critical incident and complaint investigations. Education on their availability and use for audits and corrective action is required.

Nursing Classification Mix and Hours of Care

The mix of nursing classifications to provide the best care possible within approved funds is a continual balancing exercise.

Detailed analyses were completed for nursing hours scheduled on weekdays and weekends. The four City homes' nursing staffing patterns, the Service Delivery Model, were compared to 2016 Ministry of Health and Long-Term Care staffing report summaries for non-profit and for-profit homes. A nursing staffing survey was also completed. Four municipal and three charitable homes responded. These homes were promised confidentiality and therefore are referred to by number in all analyses. The

gap between RN, RPN and PSW scheduled hours compared to Ontario and survey comparators, and the nursing classification mix, were analyzed. City homes are staffed below every average in multiple analyses. The number of RN compared to RPN staff is greater at City homes and therefore the exception.

Ontario long-term care homes submit regular detailed staffing worked hour reports to the Ministry of Health and Long-Term Care. The averages for Ontario's 627 homes are provided to provincial associations about one year after the end of the fiscal year. The data is submitted to the Ministry electronically. It should be made available in a timely manner to provide budgeting information for nursing and personal care hours per resident day. 2016 nursing and personal care statistics were provided in February 2018. Six months earlier, mid-year, should be reasonable and possible and should be requested for budgeting.

Recommendations in this report are in part based on the most recent 2016 Ministry information, which reports 2015 actual hours. Therefore, projections of increased Personal Support Workers and registered nurse hours are based on dated information. The comparator survey is based on 2017 information.

Nurses document for care planning and increased Case Mix Index (CMI) for staffing. Managers communicate both reasons to staff regarding the importance of accurate documentation.

Good documentation is essential to communicate for 3 shifts per day, seven days per week. Although the focus is care planning, nurses are encouraged to improve documentation to increase the annual Case Mix Index for increased nursing and personal care staff funding. Nurses have not seen increases between 2015-2017 except in crisis situations.

RN leadership varies greatly. New RNs need support to be successful. Supervisory training is being offered. It will take time for less experienced RNs to reach their full potential.

Many families and staff raised concerns about PSW short-shifts. They are the least desirable shifts. Staff accepting these shifts will often change to full shifts when they become available. PSW short-shifts are problematic and should be eliminated.

PSW involvement in care planning and critical incident reporting was included in the 2017 Director's order. This is part of the transformational change required and is supported.

Many families and staff expressed concern about nursing staff shifts left vacant. A review of Telestaff records shows that the percentage of total shifts when nobody was available to work was relatively small as a percentage of total available shifts. Vacancies

on weekends were reported as most problematic. The night shift appears to be the most stable shift across all homes. Although the numbers are low, the indicators suggest that the following nursing classifications and shifts need to be analyzed for possible improvements.

- RN evening shift and PSW day shift at Carleton Lodge;
- RN evening shift and PSW day shift at Centre d'accueil Champlain;
- RPN day shift and PSW evening shift at Garry J. Armstrong; and
- RN day shift and PSW day shift at Peter D. Clark.

Further questioning revealed that overtime was frequently approved to fill as many unfilled shifts as possible. This is not the best way to staff from both cost and quality of work perspectives.

Telestaff rejected and skipped shift data highlights the following indicators needing a closer look and analysis.

- Part-time casual staff from all classifications consistently rejecting shifts and unavailable for work at all homes;
- West Carleton and Nepean at CL;
- Fifth floor at CAC;
- Bradford 3 at GJA; and
- Elm at PDC.

The following five tables provide summary information related to an analysis of the City of Ottawa Service Delivery Model (scheduled nursing staff hours) compared to provincial statistics and an external survey. Recommendations for nursing staff increases are evidence-based.

- Table 7 provides nursing hours per resident per day for City vs. 2016 Ontario Averages.

- Table 8 provides nursing hours per resident per day by classification for City vs. comparators.

- Table 9 provides Personal Support Worker to Resident Ratios for City Versus Comparators

- Table 10 provides Nursing Hours per Resident per Day for City Versus Municipal and Charitable

- Table 11 provides increased Personal Support Worker staff and cost to achieve the 2016 Ontario non-profit average.

Table 7: Nursing Hours per Resident per Day for City vs. 2016 Ontario Averages

	PSW	RN	RPN	Total
Non-profit homes	2.15	0.26	0.59	3.00
For-profit homes	2.24	0.29	0.52	3.05
City homes	1.89	0.41	0.40	2.70
Carleton Lodge	1.81	0.47	0.52	2.80
Centre d'accueil Champlain	1.88	0.38	0.38	2.64
Garry J. Armstrong	1.83	0.50	0.26	2.59
Peter D. Clark	2.02	0.30	0.45	2.77

Table 8: Nursing Hours per Resident per Day by Classification for City vs. Comparators

Home	PSWs	RN	RPN
Carleton Lodge	1.81	0.47	0.52
Centre d'accueil Champlain	1.88	0.38	0.38
Garry J. Armstrong	1.83	0.50	0.26
Peter D. Clark	2.02	0.30	0.45
City Average	*1.89*	*0.41*	*0.40*
#1 Charitable	2.43	0.31	0.46
#2 Municipal	1.89	0.36	0.47
#3 Charitable	1.99	0.17	0.55
#4 Municipal	2.28	0.38	0.31
#5 Municipal	2.03	0.23	0.64
#6 Municipal	1.96	0.39	0.71
#7 Charitable	2.32	0.48	0.35
Comparator Average	*2.13*	*0.33*	*0.50*

Table 9: Personal Support Worker to Resident Ratios for City Versus Comparators

Resident Home Area	Shift	1 Staff to # Residents City	1 Staff to # of Residents Comparator Homes	Variance
Dementia/Special Care Weekdays	Days	9.0	7.5	1.5
	Evenings	10.6	8.8	1.7
	Nights	22.8	20.8	1.9
Physical Functional Decline Weekdays	Days	8.5	8.3	0.2
	Evenings	10.6	9.8	0.8
	Nights	29.3	23.0	6.3

Table 10: Nursing Hours per Resident per Day for City Versus Municipal and Charitable

Resident Home Area	City	Municipal	Charitable
Dementia/ Special Care Weekdays	2.70	3.28	3.09
Dementia/ Special Care Weekends	2.60	3.22	3.03
Physical/ Functional Decline Weekdays	2.67	2.85	2.99
Physical/ Functional Decline Weekends	2.66	2.83	2.98

* Source: Ontario MOHLTC 2016 Staffing Report Summary

Table 11: Increased PSW Staff and Cost to Achieve Ontario 2016 Non-Profit Average

	Annual Hours Required to Match Ministry Average	FTEs Required to Match Ministry Non-Profit Average	Increased Total Compensation*
Personal Support Worker	68,043	35	$2,327,510

* Salary and benefits

Nursing and Personal Care Recommendations

Staffing

- Increase the long-term care home budget by approximately $2.3 million to add a minimum of 35 full-time equivalent Personal Support Worker staff to increase to the Ontario 2016 non-profit long-term care home average.

- Increase by 5.5 full-time equivalent registered staff to match the non-profit Ontario 2016 average.

- Implement increased Personal Support Worker hours temporarily in 2018. This will provide time to develop a new nursing staff service delivery model for PSWs, RNs, and RPNs prior to permanent changes. Permanent additional PSW hours should be approved for 2019, and implemented at the same time as RN and RPN changes.

- Eliminate the least desirable PSW short shifts or minimized as much as possible in the 2019 service delivery model.

Suitability

- Develop screening methods for testing applicants' attitudes and English and French communication to determine suitability for long-term care.

- Assess the pattern of shifts not replaced by nursing classification to determine the number of permanent float RN, RPN and PSW for each site that should be scheduled to minimize overtime and shifts not replaced.

- Create a nursing staff recruitment plan.

- Introduce permanent changes to RN and RPN hours after a new service model is well planned for each home. Any positions that become vacant in 2018 should be filled temporarily until December 31, 2018. This will help move through the change more quickly with less disruption to staff and care.

- Negotiate additional high wage funding with the MOHLTC in 2019.

- Use discretionary revenues such as preferred accommodation and a portion of the annual funding increases to top-up nursing hours so that at least the average nursing hours in the non-profit sector are reached and maintained.

- Earmark a portion of annual provincial increases for capital costs, including furniture and equipment.

- Purchase of additional beds and one and two person lifts should be a priority.

- Review the Accommodation funding envelope to determine why surplus funds are not achieved in this funding envelope similar to many other long-term care homes. Surplus funds should be available for staffing or capital pressures.

- Assess resident level of care and nursing staffing levels at least annually. The impact of annual budgeting and staffing decisions should be explained to the CPSC and ultimately Council. This was not done between 2015-2017.

- Request Ministry of Health and Long-Term Care annual provincial staffing summary information by June of each fiscal year, to prepare the following year's nursing and personal care budget.

- Implement a float pool for RN, RPN and PSW by shift based on 80 percent of usual vacancies. This should reduce overtime to an emergency level versus a method to fill vacant shifts.

Education

- Consider PSWs for peer-to-peer education for PSW resident care tasks. PSWs must be replaced when providing training.

- Provide addition dementia care education to staff and families.

- Make the Ministry abuse and neglect inspection protocols available for regular use by nursing staff.

<u>Engagement/Re-engagement</u>

LTC home staff has been emotionally affected by the two incidents of abuse and neglect in 2017, which were widely publicized over a long period of time. Nursing and personal care staff has been most affected. Many loyal and caring staff has lost pride as a City employee and in their work, are afraid of losing their jobs, have lost trust, and are tired.

The approach to PSW care has been traditional. PSWs need to be more engaged and offered opportunities beyond the daily care they provide. Engagement in activities such as leading training related to aspects of PSW care would be positive. Recent work on posting care plan summaries in the closets in residents' rooms has been received positively by staff, residents and families. All opportunities for PSW engagement/re-engagement should be explored, including care planning and incident reporting.

Engagement/Re-engagement Recommendations:

- Assess and implement increased opportunities for PSW engagement and staff development.

- Involve PSWs in care planning and critical incident reporting to reinforce accountability. PSW flow sheets are currently too long and unreliable.

Scheduling/Sick Leave/Modified Duties/Temporary Duties

Recommendations:

- Enter into a partnership to develop a City PSW certificate course providing earlier exposure of PSWs to residents' care needs, especially dementia care, and to provide a pool of new graduates for City homes.

- Create stability in the Peter D Clark Staffing Coordinator position, which had 6 different staff working in the position from 2015-2017.

- Increase the Behaviour Supports Ontario hours in the future enhanced service delivery model.

- Eliminate, or reduce to a bare minimum, the number of short shifts in the nursing staffing model/schedule. (Ongoing difficulty filling these less desirable short shifts, especially the 5-9 PM shift)

- Consider shifts that overlap shift changes when planning the new staffing model. (Shift change report time is a high-risk time for resident-to-resident abuse when few or no staff is available for residents and families.)

- Audit 30 minutes before and after shift change to verify residents have been cared for appropriately (Continence care is a high risk area for neglect.)

- Stop PSW movement between homes for temporary postings.

- Review non-monetary Collective Agreement language that is affecting staff scheduling and identify short and long-term areas for improvement. Some improvements should be within management control to change quickly. Others may need to be negotiated.

- Review Telestaff data regarding rejected or skipped shifts. Part-time casual staffs that do not make themselves available should be terminated.

- Review Telestaff un-replaced shift indicators to assess if there is a pattern related to resident home area staff, residents, families, or others. Take corrective action where indicated.

- Continue the reduction of sick leave and modified duties to promote improved staffs' health and additional funding for staffing.

<u>New Resident Assessment Instrument/Minimum Data Set and Electronic Medication Administration Record (2018)</u>

Management has decided to replace the resident assessment instrument in 2018 due to many issues with the current software affecting timely and comprehensive staff assessment, resident care, and outcome quality monitoring. An Electronic Medical

Administration Record (EMAR) is also planned. These changes are long overdue and supported.

Point of Care hardware and software are being discussed for implementation in 2019.

RAI/MDS and EMAR implementation will take a great deal of staff education and time over an extended period, likely 6 months or more. Additional staff will be required for implementation.

Resident Assessment Instrument (RAI) Recommendations:

- Up-staff for a RAI/MDS and EMAR implementation team in 2018.
- Implement a RAI/MDS team approach following implementation.

Resident Mix

Admission statistics were reviewed for 2015-2017. There were minor variances in admissions over the 3 years. The average annual new admission rate is 212 residents. Thirty percent of residents change every year. GJA and CAC had 45 % (N=96; 2 admissions per week) of the annual admissions and CL and PDC had 55 % (N=116; 2.25 admission per week).

The resident mix on resident home areas is a significant factor that may influence the risk of abuse and neglect, especially for resident-to resident abuse.

There is a difference between City homes regarding internal transfers from secure dementia RHAs and bed offers to the LHIN. There is a perception that the LHIN has the power to decide who is admitted next. The assumption that all long-stay beds offered to the LHIN for admission are the same is false. In order to fulfil the City's duty of care to all residents, the mix of residents with different needs must be considered before offering a bed for a new admission.

There were 4 Social Workers at PDC from 2015-2016. This instability affects relationship development with residents and families, which is key to building trust.

Continence care is a high-risk area for neglect, as is mealtime. Many comments were received about concerns in these areas. The Reviewer observed feeding assistance practices which need improvement. The quality of the resident dining experience varies within and between homes. The Ontario Long-Term Care Act regulations provide clear direction. Inspection protocols exist for auditing. The City volunteer department has produced an excellent training document that translates regulation requirements into meaningful language that promotes positive resident dining, which could also be used for staff training.

The average age of residents is 85, with residents living at the homes for 2-3 years. There are minor variances between homes, however 5 percent of residents are under 65 years of age at GJA and PDC compared to 3 percent at CAC and CL.

Some residents expressed concern about the increase in young people being admitted. At 4%, there are close to 30 residents under 65 years of age who are residing throughout the homes. Mixing these populations has consequences.

Creating and maintaining a balance of residents with specialized needs on RHAs is critical when offering a bed to the LHIN. Grouping some residents with special needs may help staff develop and maintain specialized skills for various types of care and programs.

The High Intensity Needs Fund is appropriately accessed for 1 to 1 staff assignment for residents with behaviours that may put others or themselves at risk. This is especially important to prevent resident-to-resident physical, verbal and sexual abuse by other residents affected by a dementia. This fund is increasing in 2018.

At a minimum, the following list of "special high intensity needs" criteria should be assessed by the appropriate multidisciplinary staff prior to offering a bed for admission.

Complexity of the individual being considered for admission
Behaviour/mental health/dementia and addictions
Meal and feeding assistance required
Transfer/weight bearing status - 1 and 2 person mechanical lifts
Wound care
VAC dressing
Bariatric care
Dialysis
Ostomy or special bowel routine
Tracheostomy (Mature)
PICC Line
Intravenous therapy

Resident Mix Recommendations

- Develop program descriptions and criteria for balancing the number of residents with special needs for each RHA. Time should be taken to develop the program descriptions involving staff from the multidisciplinary team and residents and families. A six-month timeframe would be reasonable to develop program descriptions. Dementia program descriptions should be given priority.

- Develop and maintain a model for the maximum number of residents with each special need on each RHA, to be used when offering a bed to the LHIN. There may be

push back to admit people with special needs according to the LHIN's perceived legislated mandate and priorities.

- Change the Social Worker role. Current application liaison with the LHIN of the Champlain LHIN and extensive involvement in the administrative process of admissions is not the best use of this professional resource. Change the Social Worker role to focus on supporting families and SDMs of residents affected by dementia. This includes support of staff in developing relationships with residents and promoting proactive strategies for abuse prevention.

- Establish 1.5-2 Admissions Coordinator positions, one responsible for CAC and GJA (45 % of annual admissions) and one responsible for CL and PDC (55 % of annual admissions). Candidates should have a good understanding of LTC and special needs, and have the fortitude to deal with external pressures to admit residents with special needs on a priority basis. The Admissions Coordinators would work with the appropriate staff at each home for admissions.

- Reduce the male resident population at PDC or establish a RHA for men.

- Continue use of the High Intensity Needs Fund (HINF) to the maximum level possible, especially due to the lower than average nursing staffing levels. Consider advocating for City control of the 2018 HINF amount for interventions for a one-year trial.

Specialized Dementia Care

The four City homes provide specialized care for residents who need a secure resident home area due to wandering, exit seeking, and other symptoms and behaviours of various types of dementia. The risk of abuse and neglect is greatest for this level of care.

There are likely nursing staff working on these secure dementia areas without the knowledge, experience, skills or interest in this level of care. The lack of interest in working with residents in early to mid stages of dementia is not negative, assuming staffs have a choice of where they are assigned. A re-alignment would be helpful.

CAC and CL have higher nursing staffing levels for secure Resident Home Areas. CL continues pilot a new approach to the nursing staffing model, increasing RPN supervision and decreasing RN oversight. GJA and PDC have lower levels of nursing staff on secure RHAs. A review of City Case Mix Indices (CMI) showed that the CMI was not a predictor of staffing levels at City homes.

Six of 7 comparator homes had higher nursing staffing levels on secure RHAs for residents affected by dementia. There is a general understanding that the CMI does not

always adequately measure behaviours of many residents affected by dementia, which may require more nursing staff interventions.

The City of Ottawa provides 6 secure RHAs (See Table 12). For various reasons, City homes currently lack the resources to provide the number of RHAs for this level of care.

Table 12: Dementia Secure Resident Home Areas (RHA)

Long-term Care Home	Dementia Secure RHAs
CAC	2nd Floor
CL	Rideau
GJA	2nd - Allan 3rd - Bradford
PDC	Willow The Bungalows

CAC has a 93 % francophone resident population. 75 % of residents are diagnosed with dementia.

The CL resident population is representative of provincial trends, however higher at 87 % of residents with a dementia diagnosis.

18 % of the resident population at GJA is francophone, with a more linguistically and culturally diverse resident population than the other three homes. GJA also has the lowest number of residents with a dementia diagnosis, at 61 %. This is lower than the provincial trend.

At PDC 38 % of residents are male, an unusually high number compared to Ontario long-term care homes. 86 % of residents have a dementia diagnosis, higher than provincial trends.

There were a high number of comments from staff and families that dementia care is not fully understood and more education is needed. A Carleton Lodge RPN suggested providing the Gentle Persuasion approach to family members to reduce conflict with PSWs using this approach for care.

Some families are more worried about resident-to-resident abuse than staff-to-resident abuse, especially on secure RHAs focussed on caring for people affected by dementia. Shift change report is a particular concern, when staff numbers for monitoring and preventative interventions on the RHA are low or non-existent.

The approved Long-term Care Service Accountability Agreement between the Champlain Local Health Integration Network and City of Ottawa approves 717 “regular long stay beds”. It is a long-term care operator’s decision how they allocate secure and non-secure RHAs. No approval is required for changes, although reasonable notice to

the LHIN of at least 3 months is suggested. Waiting list statistics were out of scope of the review and should be considered in decisions about the types of care to be provided, if additional staffing is put in place.

The location of resident incidents is not reported consistently in MOHLTC critical incident reports, and no other incident location data existed to track location trends.

Specialized Dementia Care Recommendations

- Negotiate a special PSW designation for postings for secure dementia resident home areas.

- Change the 2nd floor at CAC to support residents with physical functional decline, including both capable residents and people in later stages of dementia. This should continue until nursing staffing rises to the provincial level for non-profit homes, RN leadership is stabilized, and issues with relationships between staff are improved.

- Retain the Rideau secure RHA at CL and move forward in fully implementing a new nursing staffing service delivery model with a change in the RN and RPN mix.

- Transition one of the two secure RHAs at GJA for francophone residents. Otherwise, decrease one secure RHA at GJA, transitioning it to provide care to people with physical functional decline and later stages of dementia.

- Consider establishing a female RHA at GJA. (70% of GJA residents being female.)

- Transition the Willow RHA at PDC from a secure RHA for people affected by dementia to an RHA to support residents with physical functional decline and later stages of dementia.

- Retain The Bungalows at PDC as secure RHAs for people affected by dementia. Improved the aesthetic maintenance of The Bungalows.

- Consider a male designated RHA at PDC.

- Establish a resident home area for younger residents at one of the four homes.

- Negotiate a one-time voluntary exchange between nursing staff working on dementia and physical functional decline RHAs, especially PSWs, with a goal of realigning staff preferring to work in each type of care. This should be done in conjunction with implementation of a new service delivery model.

- Establish critical incidents statistics for trending for assessment and recommendations to improve care. (Date, time, incident description, RHA location, location on RHA, location in home if not RHA, staff involved.) This should be incorporated into current data collection.

Communication

Communication is one of the most important aspects in providing daily care. The best care is about relationship building with residents and families. Non-verbal communication is equally important. Civility goes a long way. Many care issues arise from poor communication.

Transparent internal and external communication is critical for accountability.

Both realms of communication impact how people understand the care and programs provided for residents' well-being; quality improvement and risk management priorities and results; current issues affecting care (such as outbreaks and RHA closures); strategic planning priorities; Accreditation and satisfaction survey results; media releases; management and service contact information; and much more.

Resident Care

Many PSWs need training on how to effectively communicate with residents and families. Issues escalate quickly if there is poor communication. Communication is not only a PSW issue, however it is the largest direct caregiving group interacting with residents, SDMs and families.

Abrupt communication resulting from a task-focussed approach affected by workload; insensitive directives to residents; disrespectful comments; speaking a different language with colleagues while providing care; not speaking in a way residents can understand; lack of sensitivity to linguistic and cultural needs of some residents; and non-supportive body language were some of the communication concerns raised and observed throughout the Review.

Personal Support Worker suitability for long-term care was a concern for residents and families. Several family members estimated 30% of Personal Support Worker staff were there "only for the money".

The Reviewer observed shift change reporting at each home. Effectiveness needs improvement. Rooms where report is given are too small and staffs are not always in hearing range.

Housekeeping staff actively participated in a shift report at CAC. This should be a standard practice as housekeeping staff is with residents longer while cleaning rooms and other areas.

Communication between staff was also raised as an issue, with a high level of relationship issues amoung nursing staff at CAC.

Public Accountability and Relations

The website for the four City homes needs to be improved. Public accountability information should be added, such as quality and risk information. Comprehensive websites are the norm for Ontario long-term care homes.

There is no internal newsletter for residents, families and visitors. This is also a best practice in LTC homes.

The lack of effort in updating the City LTC home website and developing internal newsletters suggests a lack of priority for City LTC homes, and appears to be indicative of larger communication issues.

Communication Recommendations

- Develop a staff to resident/family communication-themed module for training. Focus on communication training for PSW staff in 2018-2020.
- Incorporate a “civility” component in communication training.
- Carry out a quality improvement activity to improve the effectiveness of the shift change report. Explore different methods to the traditional model.
- Develop and implement effective screening for suitability. Attitude and language are two priority areas.
- Implement home-specific internal newsletters, and engage staff, residents, families and volunteers in contributing to their success.
- Develop a comprehensive website for each City home, including quality and risk information.

Volunteer Base

Volunteer hours, number of volunteers and assignment by major programs were three indicators reviewed related to volunteer support. There was a decrease of 4,500 volunteer hours between 2015-2017 for the 4 homes. GJA saw the largest decline in volunteer hours, followed closely by CAC.

There were several changes to Program Managers responsible for Recreation and Volunteers at GJA and PDC throughout 2015-2017. This had an impact. Volunteers stated they did not know who to go to for direction. CAC and CL Program Managers were consistent in the three years covered by this Review.

There is considerable variability between the homes in the percentage of time volunteers contribute to each major program. This may partially relate to differences in resident needs.

Thirty-nine percent (N=280) of residents require assistance with feeding. This ranged from 33% of residents at GJA (N=60) 37% at CAC (N=59), 45% (N=72) at CL, and 44% (N=89) at PDC. Many residents were observed falling asleep at mealtime, including breakfast.

The need for volunteer support assisting and feeding residents was noticeable. Extended time is required to feed some residents with respect. This should be a key area for volunteer support, in addition to the support provided by family and private care providers (9 % of residents, N=65; range of 5 % CAC, 7 % CL, 10 % PDC and 13 % GJA). GJA and CL dedicated an average of 10% of time compared to other major volunteer programs. CAC and PDC averaged 7%.

At GJA, the number of active volunteers is significantly lower than the trend at the other 3 homes.

Two critical times when there is an increased risk of neglect are mealtime and shift change. Additional effort is needed to enhance volunteer support at these times.

Shift change, especially at 3 PM, is a time for an increased risk of abuse and neglect between residents. Staffs were not available during report time. An increased presence of volunteers at shift change would assist in observing residents to reduce the risk of resident-to-resident abuse. Volunteers could monitor residents to identify any interactions that may need immediate staff assessment and interventions.

The risk of neglect related to continence care is also higher around mealtimes and shift changes. Additional volunteer support at these times is needed for monitoring so that staff may focus on care needs.

CAC had a much lower number of volunteers assisting with recreation programs and a significantly higher number of volunteers operating the tuck shop/tea room.

The Reviewer did not assess the impact of recreation on reducing the risk of abuse and neglect as this was beyond the scope of the Review. A review of recreational programming may be warranted. Increased innovation should provide enhanced support to residents. Music and dance therapy should be explored, which are particularly helpful for residents affected by dementia. Recreation programming at peak times when the risk of abuse and neglect are greatest should be a focus.

There was noticeable variability in the resident dining programs on the RHAs visited.

Volunteer Recommendations

- Recruit additional volunteers to feed residents at meal times.
- Deploy more volunteers at the 3 p.m. shift change, for monitoring and resident activities.
- Review opportunities for growth of the volunteer program at GJA.
- Increase volunteer involvement in recreation programs at CAC.
- Consider innovative programming such as music and dance therapy for people affected by dementia.
- Review the dining program to ensure the philosophy and requirements of the LTC Homes Act regulations are implemented.
- Assess the prevalence of residents falling asleep at mealtime to determine if changes are needed.

Failure to Report

There are several reasons why failure to report abuse and neglect can, and has been, an issue.

Understanding the behaviours that constitute abuse and neglect that must be reported is critical. The training in the Fall of 2017 has been effective to address this concern and needs to continue annually.

Management instability and approach were cited as reasons that some staff fail to report alleged abuse and neglect. Several staff expressed frustration with follow-up when concerns were raised. “Why bother?” was a repeated sentiment.

Peer pressure not to report, sometimes through dominant and bullying personalities, has been reported.

Nursing staff rotation is not the norm in City homes. PDC was reported to have some rotation.

Some staff, residents and families may not initially support rotation due to concerns about continuity of care. It is important to clearly explain how the continuity and the quality of care should improve with rotation, including for residents affected by dementia.

There are many positive impacts to regular staff knowing the needs of all residents residing on the RHA. Rotation should instill a better commitment to the care of all residents on the RHAs. Staff rotation also helps with staff workload and stress by sharing the care for all residents with different levels of care and need.

There must be defined levels of authority for RN and RPN supervisory responsibilities. RPNs must have the authority to supervise PSWs, and know what to report and who to report to. The primary purpose of the supervision should be supportive and assist PSWs in adhering to the care plan.

Some indicators to monitor staff with potentially higher risk of abuse and neglect include poor attendance; involvement in critical incidents with injuries to the staff member and resident; a pattern of discipline and counseling; and poor interaction with peers.

Failure to Report Recommendations

- Implement a consistent approach to rotation of staff on Residential Home Areas. Rotation should take place for short periods of time, as frequently as weekly. Each staff member should work with a different member of the RHA care team during the rotation.

- Review physician ordering practices. If indicated, recommended changes that would reduce RPNs’ time with medications and provide additional time for PSW supervision.

Design and Essential Equipment

Design

Design is vitally important to care of people affected by dementia, especially on a secure RHA. It can increase the risk of resident-to-resident abuse.

At least two RHAs at each home were visited. Design was not thoroughly assessed for each home, however several RHAs visited had obvious design issues for care of today's residents. Of particular concern is the 2nd floor RHA at CAC, which is secure for people affected by dementia. These residents may wander or have aggressive verbal or physical behaviours towards other residents and staff.

Equipment

Beds and lifts are essential equipment for long-term care. Bed replacement has fallen behind. On one RHA visited, a two-person mechanical lift needed repair. The PSW needed to go to another RHA to borrow one. This time could have been devoted to resident care.

The annual capital budget for resident equipment is $350,000, which is inadequate for the four homes.

Design and Equipment Recommendations

- Complete a high level design review of RHAs to identify any changes that should be planned, especially on secure RHA for people affected by dementia to reduce the risk of resident-to-resident abuse.

- Transition CAC 2nd floor to provide care to residents with physical functional decline and later stages of dementia.

- Renovate the CAC 2nd floor RHA to create two separate RHAs if it remains focussed on serving people affected by dementia with exit-seeking and other behaviours. Given the location of the dining room, this option may not be feasible.

- Study the re-purposing of at least 1 LTC home to supportive housing for seniors. This should be done during long-range strategic planning in 2019

- Review the adequacy of a $350,000 annual capital budget by comparing to the 10-year capital plan. Prepare a submission for the 2019 budget.

- Assess the number of one and two-person lifts for each RHA. A lift to resident ratio of 1 to 20 residents for one-person weight bearing lifts and 1 to 10 for sling two-

person lifts for non-weight bearing residents. Consider at least one two-person replacement lift per home to use when lifts are out of service for repair.

Information Technology and Care Plan

One of the most important technologies in long-term care is the automated Resident Assessment Instrument (RAI). Ontario LTC homes invested significant funding in software and hardware for the RAI after provincial transformation in long-term care in 2010. The care plan is developed based on a minimum data set. The RAI generates quality indicators.

The City has fallen behind in investing in new RAI software. As well, the City has limited its options by only considering bilingual RAI software.

A decision was made to proceed with new software in 2018. The City has chosen one of the leading RAI technologies. Implementing the new software will require focus in 2018, so risk needs to be well managed over about 3-6 months of implementation.

Many benefits will be derived from the new software. Inputs, such as reducing the length and complexity of PSW flow sheets, will require attention. Input will be faster. Care planning should improve.

Future software and hardware advances in resident care should be studied, such as Point of Care documentation.

Information Technology Recommendations

- Complete a 10-year information technology plan, to be included in the 2020 budgeting process.
- Consider implementing Point of Care software in 2019.

7. Other Information and Strategies

A literature review, summaries and other analyses and information are provided in the appendices. Strategies should be considered and implemented where appropriate. The information can also be used for professional development and training.

8. Conclusion

Abuse and neglect are symptoms of a multitude of factors that require governance and transformational change management to minimize risk and fulfill the City's duty of care.

The cost of additional PSW staff to reach the 2016 provincial average is $2.3 million. Six additional positions are recommended, which would cost approximately $600,000 annually. A total budget increase of $2.9 million is recommended.

If the staffing recommendations from this review are approved, the City contribution to long-term care home operations would increase from $14.5 to $17.3 million annually. Costs related to increasing registered staff to the Ontario average need further study and would be additional.

9. Recommendation Summary

Major Influencing Factors

Governance Recommendations:

- Create a Long-term Care Board of Directors:
  - Co-chaired by two Councillors from the CPSC, at least 1 francophone/bilingual Co-Chair.
  - Create a skill-set matrix for up to 6 appointments from the community-at-large.
  - Adopt terms of reference with a quality and risk management focus initially for 2018-2019, in addition to financial and regulatory oversight.
  - Meet every two months with a minimum of 6 times annually.
  - Add an annual budget resident impact assessment.
  - Add reporting to CPSC in 2018-19 based on the Health Quality Ontario Quality Improvement Narrative for Health Care Organizations in Ontario and Goldcare quality and risk indicators.
  - Report to the CPSC at least twice per year, with a quality and risk report by June 30, 2019.
  - Add long-term care strategic planning in 2019, including strategic partnerships.
  - Approve a policy to increase and maintain nursing staffing levels based on the average Ontario nursing staffing hours.
  - Approve at least 50% of Ministry of Health and Long-Term Care annual funding increases for staffing, with the remaining 50% to offset cost of living expenses.

Management Recommendations:

- Review position description qualifications for the Director of Long-Term Care. This position is the CEO of the Long-Term Care department and should be occupied by a person with a Master-level management qualification combined with 10-years' long-term care experience. Experience should also be elevated with more emphasis on CEO level experience such as strategic planning, stakeholder development and collaborative partnerships, public and government relations, funding negotiations, and effective succession planning.

- Ensure that the Director and Administrator positions are recruited at least Canada-wide. Internal applicants should be given the opportunity to compete.

- Establish at least an undergraduate degree, regulated health profession background and/or five years' multidisciplinary healthcare experience in a long-term care setting, and management education for the Administrator position. Experience in seniors care is too general. Administrators who do not have long-term care experience should be supported by managers that do. Similarly, Administrators with strong long-term care experience could work with managers who have worked in other multidisciplinary work environments. Both models are appropriate.

- Limit temporary movement within and between management positions and between homes to short-term support in emergencies. The Director and Administrator positions should not be used as training positions for succession planning.

- Increase the senior management team by a nursing practice manager dedicated to the homes.

- Shift the Director of Long-term Care focus to CEO-level accountability for strategic planning, government relations, support to the CPSC, financial advocacy, change management, etc.

- Provide more autonomy for Administrators to operate within the City and long-term care mission, vision, policies, procedures, budgets, and other approved parameters. This is supported by the City's "Let managers manage" objective.

- Reduce functional meetings between homes to provide more time for on-site responsibilities.

Human Resource Leadership Recommendations:

- Establish a dedicated senior human resources manager for City homes responsible for leading HR planning, implementation and operational support. Labour relations support should decrease as a result.

- Set standard response times for Labour Relations, audit performance, and take corrective action to improve support to managers.

- Assign an experienced staff development position to improve staff relationships. A minimum 2-year assignment should be considered

Nursing and Personal Care Recommendations

Staffing Recommendations

- Increase the long-term care home budget by approximately $2.3 million to add a minimum of 35 full-time equivalent Personal Support Worker staff to increase to the Ontario 2016 non-profit long-term care home average.

- Increase by 5.5 full-time equivalent registered staff to match the non-profit Ontario 2016 average.

- Implement increased Personal Support Worker hours temporarily in 2018. This will provide time develop a new nursing staff service delivery model for PSWs, RNs, and RPNs prior to permanent changes. Permanent additional PSW hours should be approved for 2019, and implemented at the same time as RN and RPN changes.

- Eliminate the least desirable PSW short shifts or minimized as much as possible in the 2019 service delivery model.

Suitability Recommendations

- Develop screening methods for testing applicants' attitudes and English and French communication to determine suitability for long-term care.

- Assess the pattern of shifts not replaced by nursing classification to determine the number of permanent float RN, RPN and PSW for each site that should be scheduled to minimize overtime and shifts not replaced.

- Create a nursing staff recruitment plan.

- Introduce permanent changes to RN and RPN hours after a new service model is well planned for each home. Any positions that become vacant in 2018 should be filled temporarily until December 31, 2018. This will help move through the change more quickly with less disruption to staff and care.

- Negotiate additional high wage funding with the MOHLTC in 2019. If the City homes were deemed financially unsustainable the closure of long-term care beds in the City of Ottawa would have a serious impact on accessibility to long-term care in Ottawa. The MOHLTC should be an equal partner in resolving this ongoing financial issue or bare part of the responsibility for future City bed or home closures.

- Use discretionary revenues such as preferred accommodation and a portion of the annual funding increases to top-up nursing hours so that at least the average nursing hours in the non-profit sector are reached and maintained.

- Earmark a portion of annual provincial increases for capital costs, including furniture and equipment.

- Purchase of additional beds and one and two person lifts should be a priority.

- Review the Accommodation funding envelope to determine why surplus funds are not achieved in this funding envelope similar to many other long-term care homes. Surplus funds should be available for staffing or capital pressures.

- Assess resident level of care and nursing staffing levels at least annually. The impact of annual budgeting and staffing decisions should be explained to the CPSC and ultimately Council. This was not done between 2015-2017.

- Request Ministry of Health and Long-Term Care annual provincial staffing summary information by June of each fiscal year, to prepare the following year's nursing and personal care budget.

- Implement a float pool for RN, RPN and PSW by shift based on 80 percent of usual vacancies. This should reduce overtime to an emergency level versus a method to fill vacant shifts.

Education Recommendations

- Consider PSWs for peer-to-peer education for PSW resident care tasks. PSWs must be replaced when providing training.

- Provide addition dementia care education to staff and families.

- Make the Ministry abuse and neglect inspection protocols available for regular use by nursing staff.

Engagement/Re-engagement Recommendations

- Assess and implement increased opportunities for PSW engagement and staff development.

- Involve PSWs in care planning and critical incident reporting to reinforce accountability. PSW flow sheets are currently too long and unreliable.

Scheduling/Sick Leave/Modified Duties/Temporary Duties Recommendations

- Enter into a partnership to develop a City PSW certificate course providing earlier exposure of PSWs to residents' care needs, especially dementia care, and to provide a pool of new graduates for City homes.

- Create stability in the Peter D Clark Staffing Coordinator position, which had 6 different staff working in the position from 2015-2017.

- Increase the Behaviour Supports Ontario hours in the future enhanced service delivery model.

- Eliminate, or reduce to a bare minimum, the number of short shifts in the nursing staffing model/schedule. (Ongoing difficulty filling these less desirable short shifts, especially the 5-9 PM shift)

- Consider shifts that overlap shift changes when planning the new staffing model. (Shift change report time is a high-risk time for resident-to-resident abuse when few or no staff is available for residents and families.)

- Audit 30 minutes before and after shift change to verify residents have been cared for appropriately (Continence care is a high risk area for neglect.)

- Stop temporary PSW movement between homes for temporary postings.

- Review all non-monetary Collective Agreement language that is negatively affecting staff scheduling and identify short and long-term areas for improvement. Some improvements should be within management control to change quickly. Others may need to be negotiated.

- Review Telestaff data regarding rejected or skipped shifts. Part-time casual staffs that do not make themselves available should be terminated.

- Review Telestaff un-replaced shift indicators to assess if there is a pattern related to resident home area staff, residents, families, or others. Take corrective action where indicated.

- Continue the reduction of sick leave and modified duties to promote improved staffs' health and additional funding for staffing.

Resident Assessment Instrument (RAI) Recommendations

- Up-staff for a RAI/MDS and EMAR implementation team in 2018.
- Implement a RAI/MDS team approach following implementation.

Resident Mix Recommendations

- Develop program descriptions and criteria for balancing the number of residents with special needs for each RHA. Time should be taken to develop the program descriptions involving staff from the multidisciplinary team and residents and families. A six-month timeframe would be reasonable to develop program descriptions. Dementia program descriptions should be given priority.

- Develop and maintain a model for the maximum number of residents with each special need on each RHA, to be used when offering a bed to the LHIN/CCAC. There may be push back to admit people with special needs according to CCACs' perceived legislated mandate and priorities.

- Change the Social Worker role. Current application liaison with the CCAC of the Champlain LHIN and extensive involvement in the administrative process of admissions is not the best use of this professional resource. Change the Social Worker role to focus on supporting families and SDMs of residents affected by dementia. This includes support of staff in developing relationships with residents and promoting proactive strategies for abuse prevention.

- Establish 1.5-2 Admissions Coordinator positions, one responsible for CAC and GJA (45 % of annual admissions) and one responsible for CL and PDC (55 % of annual admissions). Candidates should have a good understanding of LTC and special needs, and have the fortitude to deal with external pressures to admit residents with special needs on a priority basis. The Admissions Coordinators would work with the appropriate staff at each home for admissions.

- Reduce the male resident population at PDC or establish a RHA for men.

- Continue use of the High Intensity Needs Fund to the maximum level possible, especially due to the lower than average nursing staffing levels. Consider advocating for City control of the 2018 HINF amount for interventions for a one-year trial.

Specialized Dementia Care Recommendations

- Negotiate a special PSW designation for postings for secure dementia resident home areas.

- Change the 2nd floor at CAC to support residents with physical functional decline, including both capable residents and people in later stages of dementia. This should continue until nursing staffing rises to the provincial level for non-profit homes, RN leadership is stabilized, and issues with relationships between staff are improved.

- Retain the Rideau secure RHA at CL and move forward in fully implementing a new nursing staffing service delivery model with a change in the RN and RPN mix.

- Transition one of the two secure RHAs at GJA for francophone residents. Otherwise, decrease one secure RHA at GJA, transitioning it to provide care to people with physical functional decline and later stages of dementia.

- Consider establishing a female RHA at GJA. (70% of GJA residents being female.)

- Transition the Willow RHA at PDC from a secure RHA for people affected by dementia to an RHA to support residents with physical functional decline and later stages of dementia.

- Retain The Bungalows at PDC as secure RHAs for people affected by dementia. Improved the aesthetic maintenance of The Bungalows.

- Consider a male designated RHA at PDC.

- Establish a resident home area for younger residents at one of the four homes.

- Negotiate a one-time voluntary exchange between nursing staff working on dementia and physical functional decline RHAs, especially PSWs, with a goal of realigning staff preferring to work in each type of care. This should be done in conjunction with implementation of a new service delivery model.

- Establish critical incidents statistics for trending for assessment and recommendations to improve care. (Date, time, incident description, RHA location,

location on RHA, location in home if not RHA, staff involved.) This should be incorporated into current data collection.

Communication Recommendations

- Develop a staff to resident/family communication-themed module for training. Focus on communication training for PSW staff in 2018-2020.

- Incorporate a "civility" component in communication training.

- Carry out a quality improvement activity to improve the effectiveness of the shift change report. Explore different methods to the traditional model.

- Develop and implement effective screening for suitability. Attitude and language are two priority areas.

- Implement home-specific internal newsletters, and engage staff, residents, families and volunteers in contributing to their success.

- Develop a comprehensive website for each City home, including quality and risk information.

Volunteer Recommendations

- Recruit additional volunteers to feed residents at meal times.

- Deploy more volunteers at the 3 p.m. shift change, for monitoring and resident activities.

- Review opportunities for growth of the volunteer program at GJA.

- Increase volunteer involvement in recreation programs at CAC.

- Consider innovative programming such as music and dance therapy for people affected by dementia.

- Review the dining program to ensure the philosophy and requirements of the LTC Homes Act regulations are implemented.

- Assess the prevalence of residents falling asleep at mealtime to determine if changes are needed.

Failure to Report Recommendations

- Implement a consistent approach to rotation of staff on Residential Home Areas. Rotation should take place for short periods of time, as frequently as weekly. Each staff member should work with a different member of the RHA care team during the rotation.

- Review physician ordering practices. If indicated, recommended changes that would reduce RPNs' time with medications and provide additional time for PSW supervision.

Design and Equipment Recommendations

- Complete a high level design review of RHAs to identify any changes that should be planned, especially on secure RHA for people affected by dementia to reduce the risk of resident-to-resident abuse.

- Transition CAC 2nd floor to provide care to residents with physical functional decline and later stages of dementia.

- Renovate the CAC 2nd floor RHA to create two separate RHAs if it remains focussed on serving people affected by dementia with exit-seeking and other behaviours. Given the location of the dining room, this option may not be feasible.

- Study the re-purposing of at least 1 LTC home to supportive housing for seniors. This should be done during long-range strategic planning in 2019

- Review the adequacy of a $350,000 annual capital budget by comparing to the 10-year capital plan. Prepare a submission for the 2019 budget.

- Assess the number of one and two-person lifts for each RHA. A lift to resident ratio of 1 to 20 residents for one-person weight bearing lifts and 1 to 10 for sling two-person lifts for non-weight bearing residents. Consider at least one two-person replacement lift per home to use when lifts are out of service for repair.

Information Technology Recommendations

- Complete a 10-year information technology plan, to be included in the 2020 budgeting process.

- Consider implementing Point of Care software in 2019

Appendices

Appendix A Abbreviations and Terms

CPSC	Community and Protective Services Committee
EMAR	Electronic Medication Administration Record
FTE	Full-time equivalent
LTC	Long-Term Care
RAI/MDS (Goldcare)	Resident Assessment Instrument and Minimum Data Set
Review	LTC Homes Third Party Independent Review
Telestaff	Automated scheduling system
OLTCHA	Ontario Long-Term Care Homes Act and its regulations
Service Delivery Model	Nursing daily staffing patterns
SDM	Substitute Decision-Maker
RHA	Resident home areas, sometimes referred to as “units”
RQI	Resident Quality Inspection completed annually by provincial Compliance Inspectors

APPENDIX B Abuse and Neglect Definitions

Ontario Long-Term Homes Act Regulations

"Abuse" — definition

2. (1) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act,

"emotional abuse" means,

(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or

(b) any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences; ("mauvais traitement d'ordre affectif")

"financial abuse" means any misappropriation or misuse of a resident's money or property; ("exploitation financière")

"physical abuse" means, subject to subsection (2),

(a) the use of physical force by anyone other than a resident that causes physical injury or pain,

(b) administering or withholding a drug for an inappropriate purpose, or

(c) the use of physical force by a resident that causes physical injury to another resident; ("mauvais traitement d'ordre physique")

"sexual abuse" means,

(a) subject to subsection (3), any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or

(b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member; ("mauvais traitement d'ordre sexuel")

"verbal abuse" means,

(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident, or

(b) any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences. ("mauvais traitement d'ordre verbal") O. Reg. 79/10, s. 2 (1).

(2) For the purposes of clause (a) of the definition of "physical abuse" in subsection (1), physical abuse does not include the use of force that is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances. O. Reg. 79/10, s. 2 (2).

(3) For the purposes of the definition of "sexual abuse" in subsection (1), sexual abuse does not include,

(a) touching, behaviour or remarks of a clinical nature that are appropriate to the provision of care or assisting a resident with activities of daily living; or

(b) consensual touching, behaviour or remarks of a sexual nature between a resident and a licensee or staff member that is in the course of a sexual relationship that began before the resident was admitted to the long-term care home or before the licensee or staff member became a licensee or staff member. O. Reg. 79/10, s. 2 (3).

"Neglect" — definition

5. For the purposes of the Act and this Regulation,

"neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s. 5

APPENDIX C Literature Review

By Andrea Liu, MHA, Researcher Analyst

Literature Review: Staff-to-Resident and Resident-to-Resident Abuse

Introduction

Older adults are the fastest growing population segment in Canada. In Ontario, in 2016, there were 2.3 million seniors 65 years or older (16.4% of the population), with this number estimated to grow to approximately 4.6 million (25% of the population) in 2041 (Ontario Government, 2017). With the aging population, the number of older adults requiring long term care in a facility is rapidly increasing (Trottier, Martel, Housel, Berthelot & Lègaré, 2000). With several cases of resident abuse recently highlighted in the media, families may be worried about their loved ones being subjected to abuse in a long term care home. Abuse can include physical abuse, psychological or emotional abuse, sexual abuse, financial exploitation, and neglect, with abuse being inflicted by staff or by other residents (Pillemer, Burnes, Riffin & Lachs, 2016). Neglect and psychological/emotional abuse are the most common forms of abuse in an institutional setting (Goergen, 2004; Lindbloom, Brandt, Hough & Meadows, 2007)

In terms of prevalence, according to a national survey, 7.5% of community-dwelling older adults in Canada experience abuse (National Initiative for the Care of the Elderly, 2015). There are a lack of studies in the literature that accurately report the prevalence of resident abuse in Canadian long term care homes (McDonald et al., 2012). In fact, much of the literature on elder abuse focuses on domestic abuse. An investigation by CBC recently reported that there were 2,198 incidents of staff-to-resident abuse in 2016, representing a 148% increase from the 888 incidents in 2011 (Pedersen, Manicini & Ouellet, 2018). CBC worked with 2 statisticians to analyze critical incident reports submitted between 2011-2016 from Ontario long term care homes, and compiled a list of the top 20 homes with the highest reported rates of staff-to-resident abuse and the highest reported rates of abuse between residents (Ouellet & Brown, 2018). Staff-to-resident abuse rates ranged from 9.62-44.53 incidents per 100 beds and the resident-to-resident rates ranged from 15.82-39.58 incidents per 100 beds. In terms of resident-to-resident abuse, McDonald et al. (2015) examined a redacted Canadian data set from 2011 on reported abuse cases from long term care homes, with the analysis revealing that resident-to-resident abuse compromised approximately 1/3 of reported abuse cases.

With increasing incidents of elder abuse, it is imperative to gain a deeper understanding of contributing factors to resident abuse and what strategies can be used to minimize abuse incidents. A review of the literature was completed to determine risk factors for staff-to-resident and resident-to-resident abuse and suggested strategies for prevention.

Staff-to-Resident Abuse

The majority of the original research studies on staff-to-resident abuse was qualitative or mixed methods, predominately involving interviews with direct care staff. Quantitative studies predominately involved surveys administered to long term care home staff, with a small number of studies surveying family members of a resident in a long term care institution. Risk factors for staff to resident abuse can be broadly categorized into systemic/organizational factors, staff factors, and resident factors. A summary of staff-to-resident abuse contributing factors can be found in Table 1.

Systemic/Organizational Risk Factors

For systemic/organizational factors, staffing shortages was most frequently mentioned (Baker & Heitkemper, 2005; Buzgova & Ivanova, 2009; Castle, Ferguson-Rome & Teresi, 2015; Cooper, Dow, Hay, Livingston & Livingston, 2013; Goergen, 2001; Lindbloom et al., 2007; McDonald et al., 2012; Registered Nurses' Association of Ontario, 2014; Shaw, 1998; Spencer et al., 2008; Wangmo, Nordstrom & Kressig, 2017). Staffing shortages were often reported to be related to increased workload and time pressure to complete resident care, with a lack of time to converse and socially engage with residents. In an Ontario-based survey on Long-Term Care Resident Care and Safety answered by almost 2,000 individual and group stakeholders from the sector, when asked what kind of factors lead to abuse and neglect in long term care homes, the most frequent response was quality of work life, which included issues like staff shortages, turnover of staff, and a high workload (Long-Term Care Task Force on Resident Care and Safety Ontario, 2012). Overcrowding of residents was also correlated with reports of resident abuse (Goergen, 2004; Registered Nurses' Association of Ontario, 2014), with a higher volume of residents potentially reflecting higher workloads for staff.

Another factor related to theme of staffing was a poor fit between the skill set of the staff and resident needs (Goergen, 2004; Spencer et al., 2008). The average care needs of residents in long term care homes is increasingly becoming heavier and more complex, with more behavioural issues, increasing rates of dementia, and other complex medical conditions requiring heavy transfers. In Ontario, almost half of residents exhibit aggressive behaviours associated with cognitive impairment or a mental health condition (Ontario Long Term Care Association, 2018). In addition to the issue of staff shortages, staff are ill equipped to fully meet these demands due to lack of education and training or due to an inappropriate mix of profession types (Baker & Heitkemper, 2005; Buzgova & Ivanova, 2009; Castle et al., 2015; Goergen, 2004; Registered Nurses' Association of Ontario, 2014; Spencer et al., 2008; Wangmo et al., 2017). Spencer et al. (2008) deems the discrepancy between increasing care needs and decreasing staff resources as the "care gap". In terms of training, identified training needs were predominately in the area of abuse recognition and reporting, and managing aggressive behaviour in residents.

Under the theme of staffing, another factor mentioned was an unstable workforce, which entails high turnover or frequent use of variable casual or part-time staff (Spencer et al., 2008). A lack of stability in staffing makes it difficult for caregivers to become familiar with a resident's life story, daily routine, and personal preferences

for care (Baines & Armstrong, 2016; Sharkey, 2008). Moreover, it is important for residents, especially those with dementia to be familiar with those that are providing care to minimize agitation and confusion (Sharkey, 2008). A good relationship between caregivers and residents can minimize the risk of staff-to-resident aggression (Braaten & Malmedal, 2017; DeHart, Webb & Cornman, 2009). In fact, a central tenant of the report *Promising Practice in Long Term Care: Ideas Worth Sharing* (Baines & Armstrong, 2016), was the notion of promoting caring relationships as a means of ensuring meaningful, respectful and dignified care. Work conditions are often a source of high stress for direct care staff, which can compromise the quality of care and lead to staff burnout. Relevant stressors related to staff-to-resident abuse include a heavy workload, time pressures, long hours or mandatory overtime, low wages, lack of job stability, a lack of sick leave benefits, and equipment shortages or insufficient equipment to meet needs of residents (Baker & Heitkemper, 2005; Castle et al., 2015; Cooper et al., 2013; Goergen, 2001; Lindbloom et al., 2007; Registered Nurses' Association of Ontario, 2014; Shaw, 1998; Shinan-Altman & Cohen, 2009; Spencer et al., 2008; Wangmo et al., 2017). Related to the sub-theme of time pressures is the report from direct care staff that there are too many administrative duties, including documentation, that take away from direct care time with residents, including time spent conversing and developing relationships with residents, which staff find makes their jobs more meaningful (Cooper, et al., 2013; Wangmo et al., 2017). Time pressures can lead to the provision of care that is rushed and limited to the task at hand, which can promote aggressive or responsive behaviours in residents (Lindbloom et al., 2007). A qualitative study using interviews and questionnaires with nurses in German nursing homes found that subjects commonly reported that reasons for resident abuse and neglect could include the reduction of work load and the release of pent-up aggression (Goergen, 2001).

The culture of the workplace also has significant impact on quality of care, staff resiliency and susceptibility to abuse. Pickering, Nurenberg and Schiamberg (2017) suggest that unsafe institutional cultures may be more prominent risk factors for resident abuse than individual qualities of caregivers. In their study, they describe the process of how learning the culture of a toxic workplace (e.g., bullying, unsafe care practices, lack of support, poor teamwork) can lead to losing trust in other team members and administrators, and reconciling expectations of good and proper care for residents, resulting in the development of negative patient and worker safety outcomes, including staff aggression and abuse to residents. Some compensatory strategies staff mentioned were keeping silent about reporting work safety issues, reprioritizing care activities by only completing care deemed essential instead of all required care, and disengaging by removing themselves emotionally or physically from care. Some aspects of an organizational culture that can affect the quality of care include poor team culture with a lack of support and information sharing about resident care and a lack of interprofessional approaches, such as integrating personal support workers into care planning (Pickering et al., 207; Shawn, 1998; Spencer et al., 2008). Also, a more staff-oriented culture that is focused more on what is more convenient for staff instead of what is best for the resident, or strictly adhering to an institutional care regime (e.g., forcefully waking up residents by a

certain time when they are not ready, or taking away meals when meal time is over even when residents are not done eating) increases the likelihood of abuse. Other aspects of organizational culture concern the tolerance of abuse. A culture desensitized to violence and accepting of unsafe resident practices is less likely to report abuse or implement strategies to prevent abusive incidents from occurring (Pickering et al., 2017; Spencer et al., 2008). In terms of reporting abuse, in several studies, staff have reported reluctance in reporting colleagues engaging in resident abuse due to fears of retaliation (e.g., being blamed or bullied), not wanting to report on colleagues that are friends, uncertainty about whether a witnessed event was abuse or not, or feeling that nothing would be done by administrators (Malmedel et al., 2009; McCool, Jogerst, Daly & Xu, 2009; Pickering et al., 2017; Spencer et al., 2008). One study found that a higher education level and a younger age of nurses was related with a more positive attitude towards being willing to report witnessed incidents of abuse, with less fear of negative repercussions (Malmdel, Hammervold & Britt-Inger, 2009). However, there still exists a lack of consistency with long term care staff reporting resident abuse. In an anonymous, national on-line survey of care workers in Canadian nursing homes, of 677 respondents, predominately from Ontario, 38% reported witnessing a colleague abusing a resident, with only 51% stating they reported the abuse to a manager or administrator (Sourtzis & Bandera, 2015).

Management practices also shape the culture of a workplace. Several studies have reported a lack of administrative and supervisory oversight as a factor enabling ongoing staff-to-resident abuse in long term care homes (Baker & Heitkemper, 2005; Castle et al., 2015; Registered Nurses' Association of Ontario, 2014; Spencer et al., 2008). A lack of appreciation from management for staff was found to be a significant stressor contributing to poor job satisfaction (Cooper et al., 2013; Shaw, 1998). Moreover, staff reported a lack of support from management in dealing with resident aggression, which can be a trigger for staff-to-abuse (Shaw, 1998; Shaw, 2004). Staff described being expected to deal with aggressive resident behaviours without appropriate resources or training, and a lack of support when trying to implement self-care strategies such as taking a time-out when angry or upset with a resident (Shaw, 2004).

Staff Factors

Caregiver stress is frequently listed as a contributor in staff-to-resident abuse. Staff burnout was the most frequently listed factor in the literature, and is often attributed to staff shortages, heavy workloads, and time pressures to complete care (Baker & Heitkemper, 2005; Buzgova & Ivanova, 2009; Lindbloom et al., 2007; McDonald et al., 2012; Registered Nurses' Association of Ontario, 2014; Shinan-Altman & Cohen, 2009). Other work-related sources of stress include low job satisfaction (Castle et al., 2015; Goergen, 2001; Goergen, 2004; Lindbloom et al., 2007; Shaw, 1998), fatigue and emotional exhaustion (Castle, Ferguson-Rome & Teresi, 2015; Goergen, 2001; Goergen, 2004; Shaw, 1998), and lack of satisfaction with management (Goergen, 2004). Personal factors related to staff-to-resident abuse susceptibility include a lack of stability with personal life, a history of experience with domestic abuse, stress related to immigration, mental illness, drug or alcohol dependence, working multiple jobs and having a prior criminal record

(Buzgova & Ivanova, 2009; Cohen & Shinan-Altman, 2011; Goergen, 2001; Lindbloom et al., 2007; Pillemer et al., 2016; Registered Nurses' Association of Ontario, 2014; Shaw, 1998). Lastly, having an attitude of ageism, a lack of respect for residents, or condoning abuse or neglect was also correlated with a higher tendency to engage in abuse (Cohen & Shinan-Altman, 2011; Lindbloom et al., 2007; Registered Nurses' Association of Ontario, 2014; Shinan-Altman & Cohen, 2009). High work stressors and burnout was found to be a factor contributing to attitudes of condoning abusive behaviours in nursing aides (Cohen & Shinan-Altman, 2011; Shinan-Altman & Cohen, 2009). One study examined abuse and neglect risk factors for caregivers specifically in the area of incontinence care (Ostaszkiewicz, 2017). Contributing risk factors for abuse within the context of incontinence care (e.g., physical or verbal coercion, chastisement, or neglect) include frustration around the unpredictability of incontinence care, disgust due to physical contact with urine and feces, and limited knowledge and skills about incontinence.

Several studies have shown that nursing aides are more susceptible to resident abuse than other nursing home staff because of the larger volume they comprise in the workforce and the nature of their work (Shinan-Altman & Cohen, 2009). Nursing aides assist residents with activities of daily living, transfers, and mobility, and may take basic vital signs under the supervision of a licensed health care professional, often a registered nurse. Their role has some similarities to personal support workers in the Canadian context. There tends to be a poor understanding of the role personal support workers can play on a team, and limited involvement of personal support workers in care conferences and care planning discussions (Long-Term Care Task Force on Resident Care and Safety Ontario, 2012; Sharkey, 2008). This can result in personal support workers feeling undervalued, and can compromise resident care due to poor care planning communication (Shaw, 1998). Some risk factors specific to the personal support worker role include long hours, low wages, low status, lack of autonomy, poor job stability, limited upward mobility, and physically exhausting work (Shinan-Altman & Cohen, 2009). Moreover, obtaining a job as a personal support worker may sometimes be less due to choice and more due to limited job options, especially for immigrant women who have difficulty finding jobs reflective of their education and experience. A Toronto-based study on the precarious work experiences of racialized immigrant women found that several of the university-educated participants were unable to find jobs in their original occupations in teaching or health care due to several barriers and were working as personal support workers, with a lower rate of pay, lower level of skill requirements, and a higher degree of risk and job insecurity as compared to their previous occupations (Premji et al., 2014). Furthermore, personal support workers are highly subjected to violence from residents on a daily basis, often with a lack of support from management (Banerjee et al., 2008), with abuse from residents being a factor increasing the likelihood of reacting aggressively (Castle, et al., 2015; Cooper et al., 2013; Goergen, 2004; Shaw, 1998; Shaw, 2004). In a survey answered by 415 personal support workers from Manitoba, Ontario and Nova Scotia, 43% of personal support workers reported experiencing physical violence on a daily basis, with 14.3% experiencing unwanted sexual attention and 6.1% receiving racist comments also on a daily basis (Banerjee et al., 2008).

Resident Factors

For resident characteristics, the most frequently mentioned factor in the literature was behavioural issues, including aggression and socially inappropriate behaviours (Baker & Heitkemper, 2005; Buzgova & Ivanova, 2009; Conner et al., 2011; Cooper et al., 2013; Goergen, 2001; Lindbloom et al., 2007; Schiamberg et al., 2012; Wangmo et al., 2017; Zhang et al., 2011). Other health and functional conditions included cognitive impairments with some studies specifying dementia, physical impairments, mental health issues , communication difficulties, certain medical conditions such as diabetes or UTI resulting in an exacerbation of behaviours, and limitations in activities of daily living (Baker & Heitkemper, 2005; Buzgova & Ivanova, 2009; Conner et al., 2011; DeHart et al., 2009; Malmedal, Iversen & Kilvik, 2015; Pillemer et al., 2016; Registered Nurses' Association of Ontario, 2014; Schiamberg et al., 2012; Spencer et al., 2008; Wangmo et al., 2017; Zhang et al., 2011). One study examining risk factors of staff physical abuse in nursing homes found that of all activities of daily living limitations, the limitation of "need help moving" was the only significant predictor of staff physical abuse, which may be due to the fact that assistance may occur at any time or place in an unpredictable manner (Schiamberg et al., 2012). Another area of assistance with activities of daily living that may be associated with abuse and neglect is around incontinence care, particularly if the resident has cognitive impairments, rejects care, or has a history of previous physical or psychological trauma (Ostaszkiewicz, 2017). Furthermore, resident abuse to staff, either through physical or verbal aggression (including racism), can be a factor in staff retaliating aggressively to residents (Castle, et al., 2015; Cooper et al., 2013; Goergen, 2004; Shaw, 1998; Shaw, 2004). Shaw (1998) used a grounded theory approach to describe the process of nursing home staff responding to abusive behaviour from residents. Shaw uses the term "developing immunity" to describe the social psychological process of deflecting the impact of abuse from residents in order to resist responding in ways detrimental to the residents or themselves. The development of immunity by staff can be eroded by personal factors and also workplace conditions, which have been described in previous sections.

Previous victimization from non-staff perpetrators (e.g., other residents, family members) is another risk factor for resident abuse, and may reflect characteristics or behaviours that increase the likelihood of being victimized or a poorly managed environment where abuse is tolerated (Schiamberg et al., 2012; Zhang et al., 2011). One study examining risk factors for neglect in Michigan nursing homes found that victims of resident-to-resident abuse are 4 times more likely to experience neglect from staff (Zhang et al., 2011). Furthermore, social isolation, with residents having few or no visitors, can be another factor increasing resident vulnerability to abuse (Buzgova & Ivanova, 2009; Registered Nurses' Association of Ontario, 2014; Shaw, 1998; Spencer et al., 2008). With regular family support, residents were more likely to have a source of advocacy, and assistance in communicating residents' needs to staff (Spencer et al., 2008). However, another study found no strong evidence that social support received by residents lowered the risk of neglect by staff (Zhang et al., 2011).

Table 1. Summary of Risk Factors for Staff-to-Resident Abuse

Systemic/Organizational Risk Factors	Staff Factors	Resident Factors
-Staffing shortages -Skill set of staff not aligned with needs of residents -Lack of education or training -Staffing mix -Lack of stability in workforce -Overcrowding of residents -Heavy workload -Time pressures to complete care -Long hours -Low wages -Lack of job stability -Lack of sick leave benefits -Equipment shortages -Insufficient equipment to meet needs of residents -Overload of administrative duties taking away from direct care time -Workplace bullying -Poor teamwork -Lack of integration of personal support workers with care planning -Lack of resident-centred culture -Organizational desensitization to violence -Lack of support and follow-up for reporting abuse -Lack of administrative and supervisory oversight -Lack of management appreciation for staff -Lack of management support for staff dealing with aggressive behaviours from residents	-Burnout -Low job satisfaction -Fatigue -Emotional exhausation -Lack of satisfaction with management -Lack of stability with personal life -History of experience with domestic abuse -Stress related to immigration -Mental illness -Drug or alcohol dependence -Working multiple jobs -Attitude conveying low level of respect for residents	-Behavioural issues -Cognitive impairments -Dementia -Physical impairments -Mental illness -Communication difficulties -Limitations in activities of daily living -Heavy incontinence care required -Abuse to staff -Previous victimization from non-staff perpetrators -Social isolation

Strategies for Prevention

Staffing

A sufficient supply of qualified staff was frequently mentioned in the literature as a strategy to prevent resident abuse and neglect (Baines & Armstrong, 2016; Long Term Care Task Force on Resident Care and Safety Ontario, 2012; Shaw, 1998; Shaw, 2004; Spencer et al., 2008; Wangmo et al., 2017). Practical means of ensuring sufficient staffing could include setting direct care staffing at a minimum of 4 hours per day and setting a mandated ratio of care providers to residents (Baines & Armstrong, 2016; CBC Marketplace, 2018; Long Term Care Task Force on Resident Care and Safety Ontario, 2012; Sharkey, 2008). In Ontario, Bill 33 (Time to Care Act) would mandate a minimum of four hours of nursing services and personal support services per resident (Legislative Assembly of Ontario, 2018). The bill is in the process of being reviewed before it can be passed. The bill would amount to approximately 15 million hours of additional nursing, personal support and therapeutic care for residents. Ensuring sufficient staffing could also involve a more effective deployment of staff during peak activity periods, such as during meal time, morning and night care when care is often rushed (Sharkey, 2008). Another important factor about staffing is aligning staff skill sets to residents' needs, which is essential given the rising acuity and complexity of residents and the rapidly increasing rates of dementia (Baines & Armstrong, 2016; Ontario Long Term Care Association, 2018; Sharkey, 2008; Spencer et al., 2008). Given the gaps in the current skill set of many care providers in managing aggressive and responsive behaviours, the Ontario Long Term Care Association recommends that there be an in-home Behavioural Supports Ontario team in every long term care home to help provide support and consultation about responsive behaviours and offer training to staff (Ontario Long Term Care Association, 2018). It can also be helpful to improve hiring and screening protocols to hire more qualified staff and care providers that find the work meaningful (Cooper et al., 2013; Registered Nurses' Association of Ontario, 2014; Wangmo et al., 2017). However, this may involve systematic changes in making the long term care sector more attractive for highly skilled and motivated care providers to want to work in (Long Term Care Task Force on Resident Care and Safety Ontario, 2012). For example, some challenges include compensation being generally lower compared to other health sectors, limited advancement opportunities, lack of full time employment, lack of exposure to the long term care sector during training, perception of the sector as lagging in innovation, and work in long term care being perceived as less valuable than work in other sectors.

Lastly, having a stable workforce with minimal staff turnover and a higher proportion of full time permanent staff and regular part time staff is recommended as another staffing strategy to address staff-to-resident abuse (Baines & Armstrong, 2016; Braaten & Malmedal, 2017; Long Term Care Task Force on Resident Care and Safety Ontario, 2012). With a permanent team, staff are able to become more familiar with residents and build meaningful relationships with them and their families, which improves the quality of care (Baines & Armstrong, 2016). It is especially important for residents with dementia to know who is providing their care on a consistent basis. A stable workforce also facilitates teamwork with staff being able to build deeper relationships with each other. For example, working in

pairs or switching residents that care providers are responsible for can help staff feel less burned out when working with more challenging residents (Shaw, 2004; Wangmo, Nordstrom & Kressig, 2017). In order to ensure that the mix of staffing is well aligned to the needs of residents, it is recommended to have an annual staffing review with a broad range of stakeholder consultation (e.g., staff, resident and family council, union representatives, community partners) [Sharkey, 2008].

Education

Education is frequently mentioned as a strategy for addressing the issue of resident abuse. Suggested topics include recognizing resident abuse, the process of reporting abuse, working with residents with cognitive impairments and dementia, managing behavioural issues, strategies for dealing with resident to staff abuse, stress and anger management, and conflict resolution (Baines & Armstrong, 2016; Braaten & Malmedal, 2017; Cooper et al., 2013; DeHart et al., 2009; Lindbloom et al., 2007; Registered Nurses' Association of Ontario, 2014; Shaw, 1998; Shaw, 2004; Spencer et al., 2008; Wangm et al., 2017; Zhang et al., 2012). Based on interviews with nursing home staff, policy makers and related professionals, DeHart et al. (2009) compiled a list of training competencies for direct care staff with several competencies listed under the broad categories of definitions and policies, risks for mistreatment, communication and respect in relationships with residents, and the development of a cooperative work environment. To optimize the ability of staff to participate in training, education should be during paid time, with funding provided for backfill staff coverage to avoid staff shortages on units (Baines & Armstrong, 2016; Sharkey, 2008; Spencer et al., 2008). Education is more effective if it involves in-person group interactions and is frequent enough to keep up with changing populations and needs (Baines & Armstrong, 2016). It is also important to regularly assess staff competencies in the recognition and prevention of resident abuse (Long Term Care Task Force on Resident Care and Safety Ontario, 2012).

In terms of some education resources in Ontario, the College of Nurses of Ontario has an abuse prevention program titled "One is One Too Many". The program includes a video, a self-directed nurses' workbook and a facilitator's guide for group learning that has modules on recognizing different types of abuse, developing healthy boundaries in a therapeutic relationship, and actions to stop abuse (College of Nurses of Ontario, 2017). AdvantAge Ontario has a training presentation for organizations to use that provides an overview of the Long Term Care Homes Act on zero tolerance of resident abuse and neglect and on whistle blowing protection (AdvantAge Ontario, 2017). The Registered Nurses' Association of Ontario is working on revising the curriculum for the national Prevention of Elder Abuse Centres of Excellence (PEACE) initiative that was piloted between 2010-2012 in 10 long term care homes across Canada, in order to cater the curriculum to an Ontario-specific context (RNAO, 2018). The original training package covered issues like understanding and recognizing elder abuse, learning the law around elder abuse and reporting, developing strategies for intervention, and understanding the connection between workplace factors and abuse. The Ontario Centres for Learning, Research, and Innovation in Long-Term Care also offers several education resources and webinars about dementia and responsive behaviours (Ontario Centres for Learning, Research, and Innovation in Long-Term Care, 2018). The Ontario

Government also recognizes the importance of staff training and has implemented a Strategy to Combat Elder Abuse, with one of the three key priorities being to facilitate training for service providers, with the non-profit organization Elder Abuse Ontario focusing on supporting the implementation of this strategy (Ontario Government, 2018).

Education is also important for residents and families (Long Term Care Task Force on Resident Care and Safety Ontario, 2012; Registered Nurses' Association of Ontario, 2014; Wangmo, Nordstrom & Kressig, 2017). Topics like recognizing and preventing abuse, understanding the residents' bill of rights and sections of the Long Term Care Homes Act relevant to abuse and neglect, using the Long Term Home Care ACTION line for complaints, working effectively with administration, and monitoring the well-being of relatives in facilities can empower residents and families. The Long Term Care Task Force on Resident Care and Safety Ontario (2012) also suggests that the resident and family councils in each LTC home be encouraged to identify tangible steps for preventing abuse and neglect on an annual basis.

Management/Administration

It is important to improve administrative and supervisory oversight to minimize staff-to-resident abuse and set the tone for an organizational culture that achieves this. A leadership development strategy for advancing the growth of skilled administrators and managers through education programs was recommended by the Long-Term Care Task Force on Resident Care and Safety Ontario in 2012. From this recommendation, the Seniors Administrator Leadership Program offered by AdvantAge Ontario was created with the collaboration of several organizations. Topics include strategic and operational planning, communications, care management, ethics and values, legal and regulatory management, human resources management, and client-centred care amongst others. Furthermore, administrators can also influence the improvement of work conditions by ensuring fair wages for staff, adequate benefits for permanent staff, appropriate equipment for resident needs, and streamlining administrative duties required by frontline staff where possible (Baines & Armstrong, 2016; Registered Nurses' Association of Ontario, 2014; Shaw, 1998).

Managers and administrators are instrumental in acting as role models in demonstrating desired attitudes and values, helping shape the culture of the organization (Braaten & Malmedal, 2017). Given that a lack of appreciation for staff is a significant workplace stressor, management can find different ways to express that staff members are highly valued (Cooper, Dow, Hay, Livingston & Livingston, 2013; Pickering et al., 2016; Shaw, 1998). Demonstrating concern for the well-being of staff is a means of recognizing the challenging work of caregivers. Management should strive to develop awareness of indicators of employee well-being including high turnover, resident-to-staff aggression rates, absenteeism, presenteeism, high stress levels, burnout, and mental health issues (Pickering et al., 2017). Preventing burnout can include supporting staff to engage in self-care strategies whether through structured programs at work, or in practical on-the-job means, such as allowing staff to take breaks to calm down when feeling upset or angry with a resident, or encouraging a rotation of care providers if a team member is having

difficulty with a certain resident (Shaw, 2004; Shinan-Altman & Cohen, 2009). It is helpful to empower staff as contributors and leaders in improving workplace quality of life. The Long-Term Care Task Force on Resident Care and Safety Ontario (2012) recommends homes to develop a collaborative employee-management group discussing issues affecting quality of work life and implementing solutions to address them. Management can also promote a more effective culture of team-based care, where there is a high level of respect for one another, where staff feel safe asking others for help, and where there are cooperative efforts to ensure high quality care (Braaten & Malmedal, 2017; Cooper et al., 2013; DeHart et al., 2009). It can also be helpful to facilitate the discussion of ethical dilemmas with the team, and to facilitate a safe and open environment for staff to discuss mistakes as lessons learned. Part of encouraging more effective teamwork is improved integration of personal support workers as part of the team.

In terms of resident-oriented organizational culture, resident safety should be a priority (Long Term Care Task Force on Resident Care and Safety Ontario, 2012). The board of directors of a long term care home can play an important role in influencing the quality and safety culture of the organization (Pomey, Denis, Baker, Préval & Macintosh-Murray, 2008). For example, the board can contribute to the development of a vision in which strategic and operational goals for quality and safety can be aligned, budget adequate resources to meet quality and safety goals (e.g., staff training, staff recruitment, adequate equipment), focus quality improvement committees on the prevention of resident abuse, encourage the tracking of indicators of abuse and neglect, and utilize experience from the long term care sector or quality/safety expertise from other sectors to inform new ideas for abuse prevention. A culture shift in the nature of resident care should also be considered. Long term care in North America tends to be more medicalized with a focus on clinical interventions, whereas exemplary long term care homes in certain European countries focus more on social care, with an emphasis on relationships (Baines & Armstrong, 2016). A focus on relationships in these homes may involve care workers socializing with residents during meals or coffee breaks, and all workers, including non-clinical staff stopping to converse with residents. In the context of trusting care relationships between staff and residents, assisted by systemic factors such as appropriate staffing, resident abuse is less likely to occur (Braaten & Malmedal, 2017; Cooper et al., 2013). A culture shift is also recommended in terms of adhering to care standards, and not standardization (Baines & Armstrong, 2016). In *Promising Practice in Long Term Care: Ideas Worth Sharing*, the difference between the two is defined as, "Standards establish principles, the basis on which individual care providers can make decision in an equitable and evidence-informed manner. Standardization means one right way, ignoring the individual needs of residents and removing the right to decide from care providers" (Baines & Armstrong, 2016, p.75). For example, standardization might mean that incontinence diapers are only changed when the blue line indicates saturation, even if the resident is uncomfortable and wants the diaper changed prior to this point. Veering away from standardization can help enforce a culture of resident-centred care, in which the resident's needs, priorities and preferences

helps shape his/her care, and where homes can use standards as the basis for adapting care in a way that best fits their context and resident population.

Reporting

Reporting of abuse helps establish an understanding of the prevalence of abuse, ensures follow-up actions can be made as appropriate, and can give a better understanding of contributing factors. While mandatory reporting of abuse is legislated in the Long Term Care Homes Act, reporting is fairly inconsistent with abuse often going underreported (Long-Term Care Task Force on Resident Care and Safety Ontario, 2012; Sourtzis & Bandera, 2015). It is important to establish no-blame policies for staff, families and visitors to feel safe in reporting resident abuse, and ensure reporting does not lead to negative consequences such as being seen as disloyal towards colleagues (Braaten & Malmedal, 2017; Registered Nurses' Association of Ontario, 2014). It is also essential for administrators to take prompt action in responding to abuse. In a broader scale of reporting, reporting abuse incidents to the Ontario Ministry of Health and Long Term Care (MOHLTC) should not be perceived as punitive. However, the reporting system often results in MOHLTC inspections and potential citations which could be seen as a deterrent. It may be helpful for these inspections to involve an advisory component with inspectors sharing knowledge on how to improve resident safety and discussing promising practices from other homes (Long Term Care Task Force on Resident Care and Safety Ontario, 2012). Lastly, publicly available information sharing about indicators of abuse, neglect and quality of life can help with strengthening accountability and learning from other organizations.

Direct Care Strategies

Some strategies suggested in the literature for direct care staff to prevent resident abuse include building trusting relationships with residents and their families (Braaten & Malmedal, 2017; Cooper et al., 2013). This may include using verbal and nonverbal communication strategies for rapport building (e.g., pleasant tone of voice, nonthreatening posture, conversing about resident's interests) [DeHart et al., 2009]. As part of the communication strategy, the pace of care should be slowed down to minimize conveying stress and frustration or being rough during rushed care, which will result in less agitation from residents (Braaten & Malmedal, 2017). Building trust can also involve using a person-centred approach by engaging the resident in his or her own care, such as by providing choices, talking through procedures and addressing resident complaints (Braaten & Malmedal, 2017; DeHart et al., 2009). By knowing residents' preferences and interests well, creative solutions can be used to de-escalate aggressive behaviour, such as by using music enjoyable to the resident (Braaten & Malmedal, 2017). A better understanding of reasons for aggressive behaviours in residents including unmet needs, the impact of cognitive impairments and health conditions, and generational issues impacting communication and social expectations (e.g., racism) can help staff in interpreting behaviours to minimize reactively retaliating (DeHart et al., 2009). A study by Shaw (2004) examined strategies from nursing staff in managing resident aggression to avoid reacting in aggressive ways, with some proactive strategies involving practicing vigilance by being on guard for verbal and nonverbal indicators of aggression, and using experience with residents' behaviours to intuitively provide

care to the resident at the optimal time, with the best fit of care provider on staff, while avoiding triggering situations. Some specific strategies used while providing care included creating physical or emotional distance when residents were exhibiting aggression towards staff, exchanging residents that staff were assigned to care for, taking a time-out when angry or upset, providing care in pairs, and ensuring problematic behaviours were well documented and communicated to the manager.

Resident-to-Resident Abuse

The majority of original research studies on resident-to-resident abuse were qualitative in nature and predominately involved interviews with direct care staff. Risk factors for resident-to-resident abuse can be broadly categorized into systemic/organizational factors, perpetrator factors and victim factors. A summary of resident-to-resident abuse contributing factors can be found in Table 2.

Systemic/Organizational Risk Factors

Organizational factors influencing resident-to-resident aggression include environmental factors, such as architectural features, interior design and ambient features (Benbow, 2016). Architectural features include aspects like unit size and rooms, with larger units and a larger proportion of shared rooms being associated with more incidents of aggression. Higher density and crowding of long term care facilities can especially be a trigger for residents with cognitive impairments (Ellis et al., 2014; Rosen, Pillemer & Lachs, 2008). The availability of private rooms meets residents' needs for privacy, offers a safe place to escape overstimulation that may result in agitation and minimizes aggressive incidents that result from roommate conflicts. Interior design features that exacerbate wandering or wayfinding confusion are another trigger for resident-to-resident aggression, particularly if it involves inadvertently wandering into another resident's personal space or room. In terms of ambient features, noise disruption or overstimulation, poor lighting, and uncomfortable temperatures can increase levels of confusion and agitation, resulting in more incidents of resident-to-resident aggression.

Another systemic risk factor is if staffing levels in terms of quantity and qualification level do not match the behavioural needs of residents (Office of the Seniors Advocate British Columbia, 2016; Robinson & Tappen, 2008). A study reviewing 304 residential care facilities in British Columbia found that facilities reporting a higher incident of resident-to-resident aggression tended to have residents with more complex needs, but without an increase in direct care hours (Office of the Seniors Advocate British Columbia, 2016). Furthermore, facilities with aggressive incidents had slightly lower direct care hours (3.08) as compared to facilities that did not report any aggressive incidents (3.13). A study by Capsi (2015) reported that verbal aggression between residents occurred more often when staff were not present to diffuse the situation, such as during high periods of staff activity (e.g., morning care). Similar findings were noted by the Officer of the Seniors Advocate British Columbia (2016) in an analysis noting that the most frequent period for aggressive incidents to occur was between 4:00-8:00 PM, which coincides with meal time and shift change. In one study that interviewed 282 certified nursing assistants about their

responses to resident-to-resident elder mistreatment, staff reported taking no action for nearly one quarter of residents involved in an altercation (Rosen et al., 2016). The authors suggest that the lack of response may have been due to an attitude of regarding aggression between residents as a normal, unavoidable aspect or that the nursing assistants did not known how to respond, which could have been addressed with appropriate training.

Furthermore, a lack of activities for residents can increase the likelihood of resident-to-resident aggression (Benbow, 2016; Caspi, 2015; Snellgrove, Beck, Green & McSweeney, 2013; Snellgrove, Beck, Green & McSweeney, 2015). In a qualitative interview examining triggers of resident-to-resident violence, all certified nursing assistants who participated in the study reported that during weeks were there were special events and additional activities, there were fewer episodes of aggression (Snellgrove et al., 2013).

Lastly, documentation is lacking for resident-to-resident aggression (Office of the Seniors Advocate British Columbia, 2016; Rosen, 2016). A study interviewing 282 certified nursing assistants from 5 nursing homes in New York on their responses to resident-to-resident mistreatment found that staff only documented 2.2% of residents involved in incidents in a behaviour log (Rosen et al., 2016). A lack of documentation in charts or incident reports makes it difficult for other team members to collaborate on a care plan or utilize strategies for preventing future aggressive incidents. Moreover, there is a lack of standardization in reporting for resident-to-resident aggression, which makes it difficult to benchmark data (Office of the Seniors Advocate British Columbia, 2016).

Perpetrator Factors

From a study on certified nursing assistants' perceptions of resident characteristics related to resident-to-resident abuse, residents that initiate aggression are more likely to be more cognitively intact and to have strong personalities, a short temper, pre-morbid racial and stereotypical opinions; and limited empathy and patience for other residents (Sifford-Snellgrove, Beck, Green & McSweeney, 2012). Other studies have found severe mental illness (Grimm, Chowdbury & Castle, 2016; Rosen, Pillemer & Lachs, 2008) and abuse by staff (Schiamberg, von Heydrich, Chee & Post, 2015) to be contributing factors. Experiencing any form of abuse from staff is associated with involvement in resident abuse, with one study hypothesizing a social learning model with residents mimicking caregivers who resolve frustrating situations with aggression (Schiamberg et al., 2015). In addition, age has been found to be inversely and significantly related to resident-to-resident aggression both in terms of involvement as a perpetrator and victim (Schiamberg et al., 2015; Zhang, Page, Connor & Post, 2012). For residents with dementia, a literature review of risk factors for resident-to-resident aggression found that verbal aggression was associated with more intact cognitive functioning or delusions and affective disorders, whereas physical aggression was associated with cognitive impairments (Rosen et al., 2008b). Some perpetrator-related characteristics pertaining specifically to the likelihood of sexual aggression include being male, being a registered sex offender, having cognitive impairments, or having dementia that affects the frontal or temporal lobes (Rosen, Lachs & Pillemer, 2010).

Some specific situational triggers that can initiate resident-to-resident aggression include invasion of personal space, unwanted entry into room, territoriality, challenges with adjusting to communal living, communication barriers, loneliness, jealousy, impatience, boredom, fatigue, inability to compromise preferences, environmental issues (e.g., crowding, television volume/channel, room temperature, lighting), disruptive behaviours, seating arrangement, conflicts between roommates, competition for resources, and racial comments or slurs (McDonald et al., 2015; Rosen et al., 2008; Snellgrove et al., 2013).

Victim Factors

Victims of resident-to-resident abuse are more likely to be more physically mobile and have cognitive impairments, dementia, wandering tendencies with invasion of other residents' space, disruptive and socially inappropriate behaviours, communication barriers, and functional limitations (Ellis et al., 2014; Grimm et al., 2016; McDonald et al., 2015; Pillemer et al., 2011; Rosen et al., 2008a; Rosen et al., 2008b; Rosen et al., 2010; Schiamberg et al., 2015; Shinoda-Tagawa et al., 2004; Sifford-Snellgrove et al., 2012; Snellgrove et al., 2013; Zhang et al., 2012). One study found that residents in a dementia-specific unit were 3 times more likely to be injured from resident-to-resident abuse as compared to those from other units (Shinoda-Tagawa et al., 2004). Victims of staff abuse are also more likely to be abused by residents, with one study reporting a 4.59 time increase in likelihood (Zhang et al., 2012). For resident-to-resident sexual aggression, risk factors for victims include being cognitively and physically impaired, with the majority of victims being women (Rosen et al., 2010). Interestingly, while family support has been found in some studies to be a protective factor against staff-to-resident abuse (Spencer et al., 2008), one study found that close emotional ties with family increased the likelihood of resident-to-resident abuse, potentially due to jealousy (Schiamberg et al., 2015)

Table 2. Summary of Risk Factors for Resident-to-Resident Abuse

Systemic/Organizational Risk Factors	Perpetrator Factors	Victim Factors
-Overcrowding -Higher proportion of shared rooms -Environmental factors aggravating exacerbating wandering or wayfinding confusion -Ambient features increasing confusion or agitation (e.g., noise disruption, poor lighting, poor temperature control) -Staffing quantity and skill set do not meet needs of residents -Lack of activities for residents -Lack of documentation for incidents of resident-to-resident aggression	-Strong personality -Short temper -Pre-morbid racial and stereotypical opinions -More cognitively intact -Little empathy and patience for other residents -Severe mental illness -Prior abuse by staff -Cognitive impairments (related to sexual aggression) -dementia affecting frontal or temporal lobes (related to sexual aggression) -Being a registered sex offender (related to sexual aggression)	-Physically mobile -Prone to wandering -Cognitive impairments -Dementia -Disruptive and socially inappropriate behaviours -Communication barriers -Functional limitations -Prior abuse by staff

Strategies for Prevention

Environmental Interventions

Environmental interventions can assist with minimizing wandering, wayfinding confusion, overstimulation, sensory discomfort, lack of personal space and boredom, which are triggers for resident-to-resident aggression (Benbow, 2016; Ellis et al., 2014; Office of the Seniors Advocate British Columbia, 2016; Rosen et al., 2010; Shinoda-Tagawa et al., 2004; Snellgrove et al., 2013). Specific strategies for wandering to minimize unwanted entry into other residents' rooms include creating wandering paths away from resident rooms, having access to secure outdoor spaces, using soft barriers (e.g., velcro nets, bright yellow rubberized fabric bands fastened with strong magnets) or stop signs on resident room doors, and using an alert system that gives notification when a resident enters another resident's bedroom (Benbow, 2016; Snellgrove et al., 2013; Shinoda-Tagawa et al., 2004). Some strategies for sensory moderation include providing space for residents who are overstimulated to escape from noise, having moveable seating in communal areas so residents can move away from overstimulating noise, using noise-reducing finishes, using optimal lighting levels, and ensuring a comfortable indoor climate for residents (Benbow, 2016; Snellgrove et al., 2013). Individuals with dementia can have an altered sensitivity to environmental conditions such as temperature, and

staff could ensure adequate clothing for residents feeling too cold and fans for those feeling too hot. In terms of enhancing privacy and personal space, units with a smaller number of residents and a higher proportion of private rooms are optimal, with adequate space in congregate settings to avoid overcrowding (Benbow, 2016; Ellis et al., 2014; Snellgrove et al., 2013). Lastly, to address boredom in residents, because resources do not always permit structured activities with trained staff every day, self-initiated activity stations can be set up throughout the unit, including things like puzzles or rummage boxes (Benbow, 2016).

Education

Staff education on the recognition, management and reporting of resident-to-resident abuse is recommended (Ellis et al., 2014; Office of the Seniors Advocate British Columbia, 2016; Robinson & Tappen, 2008; Teresi et al., 2012). From the literature, the SEARCH approach is an example of a structured education program to manage resident-to-resident abuse (Ellis et al., 2014). SEARCH is an acronym representing the following steps: Support (support injured residents until help arrives), Evaluation (evaluate what actions are needed), Act (seek medical treatment when indicated), Report (initiative investigation of serious incidents when warranted), Care Plan (formulate a plan for both the initiator and victim), and Help to Avoid (use strategies for avoiding future cases of resident abuse). A study examining the impact of a training intervention for certified nursing assistants on resident-to-resident elder mistreatment that incorporated the SEARCH approach used a cluster randomized trial with a sample of 1405 residents from 37 different nursing homes (Teresi et al., 2012). It was found that at 6 and 12 months post-intervention, staff from the experimental units had increased knowledge and increased frequency of resident-to-resident abuse reporting as compared to control unit. Staff education on managing aggressive behaviours in residents is also recommended (Robinson & Tappen, 2008). Some common training courses include P.I.E.C.E.S. and the Gentle Persuasion Approach (GPA) for residents with dementia. It is also recommended to educate families on recognizing, reporting and preventing resident abuse (Zhang et al., 2012), as well as educating resident on dementia-specific behaviours to build understanding around disruptive or socially inappropriate behaviours from others (Ellis et al., 2014).

Care Planning

In terms of care planning to manage aggressive resident-to-resident behaviours, it is essential for staff to know the resident well in order to make a personalized resident-centred plan that considers the characteristics, needs and triggers of the resident and takes into account the environment and situational context (Caspi, 2015; McDonald et al., 2015; Snellgrove, Beck, Green & McSweeney, 2015; Pillemer et al., 2012). When care planning, an interprofessional approach should be used (McDonald et al., 2015), with the incorporation of different team members, including allied health professionals, physicians, nurses, personal support workers and pharmacists as appropriate. Aggressive behaviours should be consistently documented in the resident's chart and in a behavioural log if applicable (Rosen et al., 2016). Lastly, setting up organized activities and encouraging resident participation can be a useful strategy in minimizing aggressive incidences between

residents (Benbow, 2016; Caspi, 2015; Snellgrove, Beck, Green & McSweeney, 2013; Snellgrove, Beck, Green & McSweeney, 2015).

Frontline Staff Response

Several suggestions have been made in the literature about how staff should react during an abusive incident between residents. These suggestions include physically separating involved residents, temporarily moving residents from the environment, re-directing residents with other activities or switching conversations topics, verbally intervening in a calm manner, identifying unmet needs, encouraging compromise between the residents, and seeking help from other staff members (Caspi, 2015; Rosen et al., 2008a; Rosen et al., 2010; Rosen et al., 2016; Snellgrove et al., 2015). In terms of preventative measures, suggestions include separating residents who are known to have negative interactions with each other by changing resident rooms or making strategic seating arrangements; greater staff vigilance of signs and symptoms of abuse, especially with those at risk of resident-to-resident abuse, creating organized activities for residents; and to the extent possible, ensuring residents sit in preferred and pre-designated seats during meals or programs to maximize routine and a sense of control (Caspi, 2015; Rosen et al., 2008a; Rosen, 2010). Other strategies involve assisting the resident in transitioning from private to communal living, and may include explaining the nature of communal living, or taking inventory of residents' belongings to assist residents in maximizing control over their belongings (Rosen et al., 2008a; Snellgrove et al., 2013). A strategy specific to sexual aggression was increasing sensory stimulation for residents at risk of perpetrating abuse, such as through the use of live pets, stuffed animals, baby dolls, and encouraging affection from family members and also avoiding television or radio programs that may provide excessive stimulation (Rosen et al., 2010). One study described how certified nursing assistants in one home had developed an attitude described as "Putting Residents First" as a strategy for preventing and managing resident-to-resident violence, and involved making a conscious effort to place themselves or a family member in place of the residents they were providing care for (Snellgrove et al., 2015).

Staffing

At a systemic level, it is recommended to consider the adequacy of staffing ratios for residents with more complex needs especially during peak periods of activity (e.g., meal time, morning care) [Office of the Seniors Advocate British Columbia, 2016; Robinson & Tappen, 2008]. It would be helpful to have specific guidelines around staffing levels that appropriately reflect the behavioural needs of residents (McDonald et al., 2015). At an organizational level, the use of trained volunteers and managers being present during peak periods of staff activity may be helpful in detecting and preventing resident-to-resident altercations (Caspi, 2015).

Reporting

In terms of reporting, it has been recommended to establish clear guidelines on when authorities should be called in to investigate cases of abuse between residents (McDonald et al., 2015). It has also been recommended to establish a national-level publicly available minimum data set to further understand the incidence and prevalence of resident-to-resident abuse in Canada (McDonald et al., 2015)

APPENDIX D Risk Factor and Strategy Summary

Risk Factors Increasing Susceptibility for Staff to Resident Abuse

Systemic	**LTC Staff**	**Resident**
Staffing	Burnout	Behavioural issues (e.g., aggression)
Staffing shortages	Low job satisfaction	Cognitive impairments
Unstable workforce (e.g., high turnover, high use of casual and part-time variable staff)	Low level of respect for residents	Dementia
Skill set of staff do not match residents' needs	Fatigue	Physical impairments
Inadequate hiring and screening protocols	Emotional exhaustion	Mental health issues
	Lack of stability with personal life	Communication difficulties
Work Conditions	Stress related to immigration	Previous victimization by non-staff perpetrators
Heavy workload	History of experience with domestic abuse	Social isolation
Lack of time for staff to develop relationships with residents	Mental illness	Physical isolation
Lack of job stability	Drug or alcohol dependence	Racism to staff
Lack of paid sick leave	Working multiple jobs	Abuse to staff
Low wages	Prior criminal record	Economic vulnerability (lack of care choices elsewhere)
Equipment shortages or insufficient equipment to meet needs of residents	Ageism	
	Attitude condoning abuse or neglect	
Education	Provision of care that is rushed and limited to task at hand	
Lack of effective training on resident abuse		
Management		
Lack of appreciation for staff		
Lack of administrative and		

supervisory oversight		
Lack of support for staff self-care strategies		
Culture		
Staff-oriented culture (vs. resident-oriented culture)		
Institutional care regime dictating prescribed care schedule for residents		
Lack of integration of PSWs as members of health care team		
Environment		
Overcrowding of residents		

Risk Factors Increasing Susceptibility for Resident to Resident Abuse

Systemic	**Perpetrator**	**Victim**
Crowding (high volume of residents)	Pre-morbid racial and stereotypical opinions	Cognitive impairments
Congested environment	Strong personality	Wandering
Staffing levels do not match behavioural needs of clients	Short temper	Invasion of personal space
Lack of activities for residents	More cognitively intact	Disruptive and socially inappropriate behaviours
Lack of reporting of resident-to-resident abuse	Little empathy and patience for other residents (especially those that are cognitively impaired)	Communication barriers
Lack of interdisciplinary collaboration for care planning around minimizing aggressive behaviours in resident	More likely to be male	Physical impairments (for sexual aggression)
	Challenges with adapting to communal living	More likely to be female (especially for sexual aggression)
	Territoriality	Situated in dementia unit
	Jealousy	
	Boredom	
	Previous criminal record	

Strategies for Decreasing Resident Abuse

EDUCATION

-Appropriate training and education for LTC staff (e.g., recognizing resident abuse, managing behavioural issues, working with residents with cognitive challenges, strategies for dealing with resident to staff abuse, stress and anger management, conflict resolution, process of reporting suspected abuse
-Create an abuse prevention education strategy for residents and families
-Regularly assess staff competencies in recognizing and preventing abuse
-Develop coaching team to help homes in reducing incidents of abuse and neglect

STAFFING

-Ensure appropriate staff mix based on resident needs
-Improve deployment of staff during peak activity periods
-Promote stable workforce (e.g., minimize staff turnover, have more full time permanent staff and regular part time staff)
-Improve attractiveness of working in LTC sector to attract highly skilled and motivated staff
-Match skill set of employees to resident needs
-Improve hiring and screening protocols
-Develop local staffing and evaluation plans

MANAGEMENT/ADMINISTRATION

-Improve administrative and supervisory oversight
-Enhanced communication and collaboration between administration and direct care staff
-Advance development of skilled administrators and managers
-Increased awareness of staff burnout levels
-Systemic support of residents with specialised needs
-Improve accountability for outcomes by linking resource provision to resident outcomes (measured with standardized assessments)
-Support for staff self-care strategies during shifts
-Support programs for staff for job stress, burnout
-Recognition and appreciation of staff

REPORTING

-Track indicators of abuse, neglect and quality of life and report publicly
-Establish no-blame policies for people to feel safe in reporting resident abuse
-Enforce whisteblower protection
-Improve arbitration process for resident abuse cases
-Empower residents and families to have a stronger voice in preventing abuse and neglect

CULTURE

-Ensure resident care and safety in number one priority
-Create a culture of promoting care as a relationship (includes ensuring staff have enough time to communicate with residents)

-Ensure integration of PSWs as part of health care team
-Promote more effective team-based care

WORK CONDITIONS
-Improve working conditions (e.g., appropriate wages, sick leave)
-Ensure adequate equipment for resident need

Specific Strategies for Decreasing Resident-to-Resident Abuse

EDUCATION
-Staff education on recognition, management and reporting of resident-to-resident abuse (e.g., SEARCH framework) [Ellis et al., 2014]
-Training staff in managing aggressive behaviours in residents
-Educate families about recognizing resident abuse and coping with inappropriate or difficult behaviours
-Educate residents about dementia-specific behaviours

FRONTLINE STAFF RESPONSE
-Separate residents who are engaging in resident-to-resident abuse or are known to have negative interactions with each other (e.g., re-directing them with other activities, changing resident's room, temporarily moving residents from environment, physically intervening)
-Verbally intervene in a calm manner to diffuse situation
-Encourage compromise between residents
-Environmental modifications to prevent wandering (e.g., soft barriers, familiar symbols, safe wandering paths away from resident rooms)
-Spend quality time with residents
-Assist residents in transitioning from private to communal living
-Take inventories of residents' personal belongings
-Greater monitoring of those at risk of resident-to-resident abuse

CARE PLANNING
-Know resident well (e.g., triggers, preferences, favourite calming activities) in order to personalize care plan
-Consistent documentation of resident-to-resident aggression
-Use an interprofessional approach for care planning to manage aggressive resident-to-resident behaviours
-Care planning should take a personalized resident-centred approach that considers the needs and characteristics of the resident and reflects environmental and situational factors present in the facility
-Make organized activities available for residents

ENVIRONMENT
-Avoid crowding people and equipment into small spaces
-Have adequate space in congregate settings
-Provide spaces for residents who are over stimulated to escape from nois

APPENDIX E

Comparative Summary:
Literature Review vs. City Engagement vs. Review

Common themes for contributing factors to resident abuse amongst the literature review, City of Ottawa Stakeholder engagement and independent review include the following:

Staffing

-Inadequate staff ratios (most commonly mentioned)
    -Results in heavy workload for staff and time pressures to complete care
    -Results in poor quality rushed care and limited time for staff to develop rapport with residents
    -Need for more staff on evenings, weekends, overnights, holidays
    -Need for more staff during peak activity periods (e.g., meal time)
-Shift changes create gaps in service and care
-Inconsistency in staff
-High staff turnover
-Disrespectful staff attitudes
-Language barriers with staff not understanding what residents are trying to communicate
-Need for more volunteers to help with activities or help manage care gaps

Education

-Lack of training for staff
    -Recommended topics: dementia care, managing aggressive behaviours (e.g., gentle persuasive approach, non-violent crisis intervention), recognition and reporting of abuse, communication, conflict resolution, anger management, stress management, managing harassment and bullying, training on basic care techniques,
    -Improved accessibility (e.g., paid training) and format of training required (e.g., in person training instead of online)
-Families require education on dementia behaviours, abuse policies, recognizing and reporting abuse

Management

-Lack of management supervision presence
-Lack of supervision especially during nights and weekends with more part-time and casual staff
-Poor follow up in managing and being proactive about complaints
-Lack of recognition and appreciation for staff

Culture

-Poor quality and safety culture
-Lack of resident-centred culture
-Culture of blame
-Limited focus on employee well-being and mental health

Reporting
-Reporting of abuse incidents limited due to fear of retaliation (e.g., negative consequences to staff, or negative consequences for resident)
-Reporting process is unclear
-Improved documentation of abuse incidents required

Equipment
-Inadequate supplies of equipment

Communication/Teamwork
-Lack of communication at all levels (e.g., between management, staff, families, residents, volunteers)
-Communication especially needs to improve between nurses and PSWs
-Poor communication amongst staff within shift changes
-Poor teamwork

Care Planning
-Limited incorporation of PSWs into care planning
-Care plans are not readily accessible, updated, and visible

Daily Care
-Lack of activities on evenings, weekends, holidays

Staff Work Conditions
-Frequent resident-to-staff abuse
-Lack of management support with following up on incidents or communicating with families
-Workplace bullying between staff

APPENDIX F Annotated Bibliography

Andrea Liu, MHA, Researcher Analyst

AdvantAge Ontario. (2017). *LTCHA Implementation Resources*. Retrieved from: https://www.advantageontario.ca/MediaCentre2/LTCHomesActCentralseeSiteNavigation/LTCHA_Resources.aspx

The LTCHA Implementation Resources section of the AdvantAge Ontario website contains resources developed during the fall and winter of 2010/11 for long term care homes in Ontario to assist with implementing the requirements of the Long-Term Care Homes Act.

Baines, D. & Armstrong, P. (2016). Promising Practice in Long Term Care: Ideas Worth Sharing. Retrieved December 28, 2017 from https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2015/12/Promising_Practices_in_Long_Term_Care.pdf

This book examines promising practices of quality long term care in countries with a Gross Domestic Product similar to Canada's. The investigation team visited 25 long term care homes in 10 different jurisdictions, including countries like Germany, Norway, Sweden, United Kingdom, and the United States in addition to Canada. The first section of the book presents statistical information on the studied countries, including long term care expenditures, long term care beds per 1000 persons, and health expenditures as a % of GDP. The second section of the book includes vignettes from the different exemplary homes drawn from observations, interviews, and document reviews. The third section summarizes common themes, with a central notion of care relationships being integral to high quality long term care. The following recommendations discussed in further detail: promoting care as a relationship requires adequate staff and an appropriate staff mix; promoting care as a relationship requires a stable workforce; promoting care as a relationship requires times, which is not the same as staffing levels; promoting care as a relationship requires standards, effectively enforced; promoting care as a relationship requires appropriate training and education; promoting care as a relationship requires appropriate working conditions; promoting care as a relationship requires an integrated system; and promoting care as a relationship means tolerating some risk.

Baker, M.W. & Heitkemper, M.M. (2005). The roles of nurses on interprofessional teams to combat elder mistreatment. *Nursing Outlook*, *53*, 253-259.

This article aims to describe the roles nurses can play on professional elder mistreatment teams. Prevalence, incidence, and risk factors are discussed for both domestic elder mistreatment and institutional elder mistreatment. Risk factors for abuse susceptibility include living arrangement, social isolation, dementia, and abuser characteristics. Characteristics of residents who are at high risk of neglect include physical and cognitive impairments as well as behavioural symptoms. Situational risk factors include stressful working conditions (e.g., staffing shortages), staff burnout (e.g., from mandatory overtime), aggressive resident behaviour, lack of training on managing aggressive behaviour, poor hiring and screening practices, and lack of administrative and supervisory oversight. The current roles of nurses in the recognition and management of elder mistreatment is reviewed, and other potential roles nurses can play are described, including education, case consultation and follow-up, research, public policy, and community service.

Banerjee, A., Daly, T., Armstrong, H., Armstrong, P., Lafrance, S. & Szebehely, M. (2008). "Out of Control": Violence against Personal Support Workers in Long-Term Care. Retrieved from: https://www.longwoods.com/articles/images/Violence_LTC_022408_Final.pdf

This report describes the violence experienced by personal support workers in long-term care setting in Canada. The report draws on data from an international study comparing long-term institutional care in three Canadian provinces (Manitoba, Nova Scotia, and Ontario) and four Nordic European countries (Denmark, Finland, Norway and Sweden). Personal support workers in Canada experience constant and ongoing violence in the form of physical, verbal and sexual abuse. Personal support workers in Canada are almost seven times more likely to experience violence on a daily basis than workers in Nordic countries. Most incidents of violence go unreported due to lack of time to complete paperwork, fear of blame, and lack of support from management. Personal support workers link violence with poor working conditions, especially the factor of working short-staffed, which almost half of the personal support workers report doing on a daily basis. A number of recommendations are discussed in the areas of addressing insufficient staffing, creating an empowering work environment, documenting violence, and providing appropriate training.

Benbow, B. (2016). Environmental interventions to mitigate resident-to-resident aggression. *Canadian Nursing Home*, *27*(2), 4-11

This study involves a literature review of environmental interventions to mitigate resident-to-resident aggression. Environmental features are discussed in terms of architectural features (e.g., household/unit size, rooms size, crowdedness), interior design features (e.g., wandering/wayfinding confusion, activity areas, color and contrast), and ambient features (e.g., noise, lighting, temperature). Some mitigation strategies include a higher proportion of private

rooms, smaller resident unit size, moveable seating, meaningful activities, safe wandering pathways, use of noise-reducing finishes, enhanced lighting, facilitating wayfinding, and minimizing residents wandering into other residents' rooms (e.g., soft barriers, signs, vigil alert system).

Braaten, K.L. & Malmedal, W. (2017). Preventing physical abuse of nursing home residents-as seen from the nursing staff's perspective. *Nursing Open*, *4*, 274-281.

The purpose of this qualitative study was to obtain information from nursing staff on their experience of prevention of physical abuse of nursing home residents and what measures they consider useful to implement. The data collection process consisted of focus groups with 14 informants from 3 nursing homes conducted from Dec 2015-Feb 2016. Responses were organized and discussed in the following themes: communication, building trust, skills and competence, and work environment.

Buzgova, R., & Ivanova, K. (2009). Elder abuse and mistreatment in residential settings. *Nursing Ethics,*
16(1), 110-126.

The purpose of this qualitative study was to describe employees' and residents' lived experiences of elder abuse. Methodology for data collection consisted of unstructured interviews with 26 employees and 20 residents from 4 nursing homes in Ostrava, Czech Republic and an analysis of elder abuse complaints filed with Ostrava Municipal Authority. Categories of causes of elder abuse were discussed in the themes of institutional characteristics (with subthemes of poor organization of work, regimen in an institution, staff shortages), employee characteristics (with subthemes of employee burn out, employees' personal problems, inadequate education) and residents' characteristics (with subthemes of residents' personal characteristics and isolation from family members).

Caspi, E. (2015). Aggressive behaviors between residents with dementia in an assisted living resident. *Dementia*, *14*(4), 528-546.

The purpose of the study was to identify the circumstances, sequences of events, and triggers that lead to aggressive behavior between residents with dementia. Methods included extensive observations following 12 different residents, review of clinical records, and semi-structured interviews with care staff and managers from a non-profit dementia residence in Massachusetts. Data was analyzed using a grounded theory analysis. In the high functioning unit, close to 2/3 of incidents took place when residents were not participating in structured activities. Verbal aggression between residents often occurred when staff were not present to defuse situations. Seating arrangements can also be a trigger for aggression. Twelve prevention strategies are discussed, including being informed about previous incidents of aggressive behaviour for residents, separating residents who are

demonstrating aggression towards each other, using redirection, and seeking help from other staff members.

Castle, N., Ferguson-Rome, J.C. & Teresi, J.A. (2015). Elder Abuse in Residential Long-Term Care: An Update to the 2003 National Research Council Report. *Journal of Applied Gerontology*, *34*(4), 407-443.

This literature review examined the existing body of research on abuse in long term care homes. Articles were divided into following categories: defining abuse, theories and conceptual models addressing abuse, prevalence rates of abuse, outcomes and costs of abuse, resident abuse by staff and resident-to-resident abuse. The review discusses the methodological and content limitations of existing research. In terms of contributing factors to abuse susceptibility, caregiver stress is a commonly mentioned theory in the literature. Factors contributing to caregiver stress include decreased satisfaction, long hours, low pay, physical demands, staff shortages, and minimal education and training, which can be compounded by dealing with residents with behavior problems or decreased physical functionality. Resident-to-staff abuse is also discussed as another factor that increased caregiver stress due to the potential for aggressive retaliation.

CBC Marketplace (Producer). (2018, Jan 26). Hidden Camera Investigation: Nursing Home Abuse, Violence [Video file]. Retrieved from: https://www.youtube.com/watch?v=gk5iEo-s_6M

This CBC Marketplace episode discussed the rising rates of resident abuse in nursing homes. Staffing as a contributing factor is extensively discussed in the areas of staff shortages, no provincial mandated ratio of caregivers to residents, staff not being equipped to meet the needs of a changing population, and a lack of specialized training for staff. Also discussed are the rising rates of elderly individuals with dementia, which is linked to increased incidents of aggression. Video clips are included of interviews with residents, the President of Ontario Personal Support Workers Association, the staff lawyer and institutional advocate at Advocacy Centre for the Elderly, family members that have been affected by resident abuse, and Erik Hoskins, amongst others. There are also video clips that show various cases of staff-to-resident abuse as well as a poorly managed case of resident-to-resident abuse.

CBC Marketplace. (2018, January 25). 40 Ontario Nursing Homes with the Highest Rates of Reported Abused [Blog post]. Retrieved from: http://www.cbc.ca/marketplace/blog/40-ontario-nursing-homes-with-the-highest-rates-of-reported-abuse

CBC worked with 2 statisticians to analyze critical incident reports from long term care homes in Ontario and calculated abuse rates per 100 beds from

data. The article lists the top 20 homes with highest reported rates of resident-to-resident abuse and the top 20 homes with highest reported rates of staff-to-resident abuse. CBC Marketplace reached out to each home and most homes sent in a response. Almost half of the homes pointed out that seniors suffering from dementia or cognitive impairment can demonstrate aggressive behaviour, resulting in high levels of violent incidents. According to Ontario's Long-Term Care Association, approximately 90 per cent of nursing home residents have some level of cognitive impairment. Several homes described abuse prevention training their staff are undergoing and detailed support received from Behavioural Supports Ontario.

Cohen, M. & Shinan-Altman, S. (2011). A cross-cultural study of nursing aides' attitudes to elder abuse in nursing homes. *International Psychogeriatrics*, *23*, 1213-1221.

The purpose of the study was to examine whether nursing aides' attitudes to elder abuse is affected by cultural and situational context (e.g., immigration), in association with demographic and work-related factors. Three group were examined: veteran Israeli Jews, Israeli Arabs and new immigrants. The nursing aides completed questionnaires on work stressors, attitudes to elder abuse, sociodemographic and work-related characteristics, and the Maslach Burnout Inventory. New immigrant nursing aides reported a higher tendency to condone abusive behaviors than the other two groups. Greater condoning of elder abuse was associated with belonging to the new immigrant group, being unmarried and reporting higher work stressors. Higher work stressors were related to a stronger tendency to condone elder abuse in the new immigrant group than in the veteran Jewish and Arab groups. Attitudes condoning elder abuse are related to work stressors, and may be accelerated by the additional stressors on new immigrant nursing aides (e.g., communication difficulties, change in family system, economic stress, reduced professional status, social isolation, uncertainty regarding future). Interventions with new immigrant nursing aides should focus on broadening their knowledge of caring for elderly, and increasing knowledge of identifying elder abuse and coping with complicated situations that may arise in the interaction with older patients

College of Nurses of Ontario. (2017, July 31). *Abuse Prevention: One is One Too Many*. Retrieved from: http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/abuse-prevention/

This section of the College on Nurses of Ontario website describes one of the educational tools created to provide training on abuse prevention. There are links to the nurses' workbook and facilitator's guide as well as several videos.

Conner, T., Artem, P., Page, C., Fang, Y., Xiao, Y. & Post, L.A. (2011). Impairment and Abuse of Elderly by Staff in Long-Term Care in Michigan: Evidence from Structural Equation Modeling. *Journal of Interpersonal Violence*, *26*(1), 21-33.

> This study examined correlations between physical impairment, cognitive impairment, age and behavior problems on susceptibility to abuse among elderly in long term care homes. Data was obtained from random digit dial survey administered to households in Michigan, with 1,002 respondents that were knowledgeable relatives of, or adults responsible for a person in long term care. The survey asked about cognitive/physical functioning and behavior problems, and functioning with ADLS and IADLS, and asked respondents to report incidences of abuse over last 12 months. A structural equation model was used to demonstrate relationships between variables. Physical impairment (0.455) and behavior problems (0.231) were found to be directly correlated to susceptibility to abuse. Cognitive impairment was strongly correlated to behaviour problems (0.438) and therefore had an indirect relationship to abuse susceptibility.

Cooper, C., Dow, B., Hay, S., Livingston, D. & Livingston, G. (2013). Care workers' abusive behavior to residents in care homes: A qualitative study of types of abuse, barrier and facilitators to good care and development of an instrument for reporting of abuse anonymously. *International Psychogeriatrics*, *25*, 733-41.

> This qualitative study aimed to explore barriers and facilitators to good care in relation to abusive behaviour from care workers to residents. Qualitative focus groups were held with 36 workers from 4 care homes in London, asking about abuse they witnessed or perpetrated. Care workers also commented on relevance of a newly developed scale to anonymously report abuse and neglect in care homes (Care Home Conflict Scale). Reported abuse was categorized into 3 categories: 1) Situations which care workers thought were due to insufficient resources or competing demands; 2) Instances when staff acted in potentially abusive ways, which they judged better for residents than alternatives; 3) Situations related to institutional practices. Contributing factors that made abuse more or less likely were discussed in the categories of institutional factors, care worker conditions and resident factors.

DeHart, D., Webb, J. & Cornmna, C. (2009). Prevention of Elder Mistreatment in Nursing Homes: Competencies for Direct-Care Staff. *Journal of Elder Abuse & Neglect*, *21*, 360-378.

> The purpose of the study was to identify direct staff training needs for the prevention of elder mistreatment in nursing homes. Methods included interviews with nursing home staff, policy makers and related professionals. A number of competencies essential for caregiver training were identified in the following categories: definitions and policies, risks for mistreatment,

communication and respect in relationships with residents, and development of a cooperative work environment.

Ellis, J.M., Teresi, J.A., Ramirez, M., Silver, S., Boratgis, G., Kong, J., Eimicke, J.P., Sukha, G., Lachs, M.S. & Pillemer, K.A. (2014). Managing Resident-to-Resident Elder Mistreatment in Nursing Homes: The SEARCH Approach. *The Journal of Continuing Education in Nursing*, *45*(3), 112-121.

This article describes an educational program used to manage resident-to-resident elder mistreatment (RREM) using the SEARCH (support, evaluate, act, report, care plan and help to avoid) approach. Three case studies are used to demonstrate application of the SEARCH approach.

Goergen, T. (2001). Stress, conflict, elder abuse and neglect in German nursing homes: A pilot study among professional caregivers. *Journal of Elder Abuse & Neglect*, *13*(1), 1–26.

The purpose of the mixed methods study was to gather data from long term care staff's experiences with abuse, to develop subjective theories of the causes of abuse and neglect. Methodology included qualitative interviews, and a questionnaire survey filled out by 80 nurses from 9 different homes in Germany. The authors also analyzed known reported cases of elder abuse and neglect. Subjects most commonly attributed abuse and neglect to staff shortages and work overload. Subjects proposed reasons for abuse and neglect as instrumental acts to reduce work load and as effects of pent-up aggression and inner tensions. Different types of neglect and verbal/psychological abuse were most commonly reported. Stress factors identified by the survey were listed ranked from most to least stressful, with staff shortages, time pressures and few experiences of success being the top three most stressful factors. Those who report high numbers of offences describe themselves as burnt out, overstrained, worn out, and emotionally exhausted.

Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing homes. *Journal of Adult Protection*, *6*(3), 15–25.

The purpose of this mixed methods study was to analyse conditions leading to abusive and neglectful behaviour in German nursing homes. Methodology included qualitative interviews in a randomly selected sample of 8 nursing homes, questionnaire surveys distributed to nursing staff, and an analysis of cases of elder abuse and neglect in nursing homes known to law enforcement and nursing home control agencies. Possible predictors of abuse and neglect based on correlation with self-reported incidents of abuse and neglect were grouped into the categories of structural properties of nursing home/ward, satisfaction/burnout, maladaptive coping, and aggressive behaviour by residents.

Grimm, G., Chowdhury, S. & Castle, N. (2016). Resident Aggression and Abuse in Assisted Living. *Journal of Applied Gerontology*. Advanced online publication. https://doi-org.proxy.bib.uottawa.ca/10.1177/0733464816661947

The purpose of the study was to estimate the prevalence and identify risk factors of resident aggression and abuse in assisted living facilities. Methods include a multivariate analysis of resident-level data from an analytic sample of 6,848 older Americans in the 2010 National Survey of Residential Care Facilities. Dementia and severe mental illness were significant risk factors for physical, verbal and sexual aggression. The following factors increase the likelihood of physical abuse: male, greater number of functional limitations, depression, dementia (fivefold increase), and severe mental illness (threefold increase). The following factors increase the likelihood of verbal abuse: greater number of functional limitations, dementia (fourfold increase), and severe mental illness (threefold increase). The following factors increase the likelihood of sexual abuse: male, greater number of functional limitations, dementia (twofold increase), and severe mental illness (threefold increase).

Legislative Assembly of Ontario. (2018). *Bill 33, Time to Care Act (Long-Term Care Homes Amendment, Minimum Standard of Daily Care), 2017*. Retrieved from: http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=4195

Bill 33 describes the proposal to increase nursing and personal support services to 4 hours per day per resident.

Lindbloom, E. J., Brandt, J., Hough, L. D., & Meadows, S. E. (2007). Elder mistreatment in the nursing home: A systematic review. *Journal of American Medical Directors Association*, *8*, 610-616.

This literature review focused on types of elder mistreatment, risk factors and markers for mistreatment, and interventions aimed at reducing the incidence of mistreatment. Literature is discussed in categories of Physical Abuse and the Staff-Resident Dynamic, Sexual Abuse, Psychological Abuse, Neglect and Poor Care Quality, Violation of Personal Rights and Financial/Material Issues, Markers and Associated Findings, Identification and Prevention Strategies, Oversight and the Role of the Ombudsmen, and Suspicion and Reporting. In terms of physical abuse, residents' aggressive behaviour can sometime provoke aggressive reactions from staff, and is more likely to occur when staffing is low and care is rushed. Other factors increasing susceptibility for abuse include lower job satisfaction, high workload, burnout, trouble managing professional and personal demands, viewing residents as childlike, having a history of domestic violence or mental illness, and drug or alcohol dependence. In terms of sexual abuse, this form of abuse most often occurs between residents. In terms of psychological

abuse, this form of abuse is more prevalent than physical abuse. Factors associated with higher likelihood of psychological abuse include aggressive residents, and a stressful work environment. Work stress may be more closely related to psychological abuse than to physical abuse. In terms of identification and prevention, several education programs are discussed with positive results on staff attitudes, job satisfaction, decreased abuse rates, including courses focused on care of elderly with cognitive impairments, conflict resolution and stress management training and training involving discussion and role-playing regarding elder mistreatment in nursing homes

Long-Term Care Task Force on Resident Care and Safety Ontario. (2012). An Action Plan to Address Abuse and Neglect in Long-Term Care Homes. Retrieved January 3, 2018 from http://longtermcaretaskforce.ca/images/uploads/LTCFTReportEnglish.pdf

In November, 2011, the Ontario Long Term Association, the Ontario Association of Non-Profit Homes and Services for Seniors, the Ontario Association of Residents' Council and Concerned Friends of Ontario Citizens in Care Facilities created the Long-Term Task Force on Resident Care and Safety in response to media reports of abuse and neglect in LTC homes. The task force conducted work from Jan-Apr 2012 (survey, targeted interviews/meetings, visits to 6 LTC homes, review of data and reports). This report identifies 18 actions to improve care and safety of residents in LTC homes (11 actions focused on LTC sector leadership, 6 actions focused on leadership by MOHLTC, and final action of commitment to implement). Recommendations related to actions where the long term care sector can play a leadership role: a) Make resident care and safety the number one priority in LTC homes over the next year and a top priority in years to come; b) Commit to reduce incidents of abuse and neglect in long-term care homes and be accountable for achieving results; c) Advance development of strong skilled administrators and managers; d) Strengthen ability of staff to be leaders in providing excellent and safe care; e) Empower residents and families with a stronger voice and education. Recommendations for actions that require leadership from the Ministry of Health and Long Term Care include the following: a) Develop coaching teams to help homes improve; b) Address direct-care staffing in homes; c) Support residents with specialised needs to ensure their safety and the safety of others; d) Address legislative requirements and processes that detract from resident care and may be driving abuse and neglect underground.

Malmedal, W., Hammervold, R. & Britt-Inger, S. (2009). To report or not report? Attitudes held by Norwegian nursing home staff on reporting inadequate care carried out by colleagues. *Scandinavian Journal of Public Health*, *37*, 744-750.

> The purpose of the study was to describe attitudes held by nursing home staff on reporting acts of inadequate care (including abuse and neglect) committed by colleagues, and to investigate whether nursing staff have different attitudes depending on age, education, and length of experience working in healthcare services. Data was collected from a questionnaire survey with nursing staff in 16 nursing homes (n=616, response rate=79%). In terms of results, compared with younger staff, older staff seemed to be more reluctant to report colleagues, to feel less brace, to be more afraid of what would happen to them if they reported and to agree that it was best to deal with such matters internally. Furthermore, a higher education level of nurse was related with a more positive attitude towards a willingness to report and less fear of negative sanctions. Long term care facilities must develop mechanisms for understanding and evaluating acts of inadequate care and encouraging staff to speak out on behalf of residents rather than be punished for doing so

Malemedal, W., Iversen, M.H. & Kilvik, A. (2015). Sexual Abuse of Older Nursing Home Residents: A Literature Review. *Nursing Research and Practice*, *2015*, 1-7.

> The purpose of this literature review was to assess the state of knowledge on the subject of sexual abuse of older nursing home residents. Common victim characteristics include being female, cognitively impaired, having a psychiatric diagnosis and/or being physically frail, and having somatic illnesses. Common perpetrator characteristics include cognitive impairment, psychiatric diagnosis, substance abuse, criminal history (or previously committed sexual abuse), and scoring low on social competence, with perpetrators being predominately male. Some problematic responses from institutions to sexual assault include most homes delaying reporting to authorities, a lack of documentation of the abuse, and failing to provide medical assistance to the victim and protecting the victim from the perpetrator.

McCool, J. J., Jogerst, G. J., Daly, J. M., & Xu, Y. (2009). Multidisciplinary reports of nursing home mistreatment. *Journal of the American Medical Directors Association*, *10*(3), 174-180.

> The purpose of this mixed methods study was to learn about nursing home employees' knowledge and perspectives on mandatory reporting of elder abuse. Data collection entailed personal interviews and questionnaires distributed to staff at two nursing facilities in Iowa. Of the 49 employees that returned the questionnaire, 53% admitted suspicions of abuse but only 35% reported it. From the 22 employees that participated in interviews, four

themes emerged: a) Need for more staff education/ training on the subject of elder abuse; b) Difficulty in making judgments about whether the situation needs to be reported; c) Barriers to reporting (e.g., fear of retaliation, not wanting to report on friends they work with, Iowa Department of Inspections and Appeals finding deficiencies in facility reporting abuse); d) Sense that some abuse situations may occur because the staff is overworked, inexperienced, and/or frustrated from dealing with difficult residents.

McDonald, L., Beaulieu, M., Harbison, J., Hirst, S., Lowenstein, A., Podnieks, E. et al. (2012). Institutional abuse of older adults: What we know, what we need to know. *Journal of Elder Abuse & Neglect, 24*(2),138-160.

This literature review focused on abuse in institutions. Much of the research on elder abuse focuses on domestic abuse. Of the Canadian research, there were four qualitative studies and one quantitative study of abuse and neglect in institutions. There were no incidence or prevalence studies of abuse and neglect in Canadian institutions.

McDonald, L., Sheppard, C., Hitzig, S.L., Spalter, T., Mathur, A. & Mukshi, J.S. (2015). Resident-to-Resident Abuse: A Scoping Review. *Canadian Journal on Aging*, *34*(2), 215-236.

This scoping review aims to 1) characterize the nature and extent of resident-to-resident abuse in LTC homes; 2) examine factors that increase risk of initiating or becoming victim to resident-to-resident abuse; 3) identify the frequency with which resident-to-resident abuse occurs in LTC homes; 4) identify strategies for minimizing resident-to-resident abuse; 5) identify gaps in knowledge. A redacted Canadian data set from 2011 on alleged and reported cases of abuse in Canadian LTC homes was also analyzed, and suggests resident-to-resident abuse compromises approximately 1/3 of reported abuse cases. The review discusses initiator and victim characteristics, triggers of resident-to-resident abuse, staff responses to resident-to-resident abuse and intervention. The secondary data analysis of the redacted Canadian data set indicated that the most prevalent types of resident-to-resident abuse were physical abuse, followed by physical and verbal abuse, followed by sexual abuse and verbal abuse. Recommendations on a policy level include a national strategy to address resident-to-resident abuse in Canada. Recommendations for practice include the use of patient-centred interventions and the use of interdisciplinary approaches.

National Initiative for the Care of the Elderly. (2015). Into the Light: National Survey on the Mistreatment of Older Canadians 2015. Retrieved from: https://cnpea.ca/images/canada-report-june-7-2016-pre-study-lynnmcdonald.pdf

This study estimates the prevalence of five forms of elder mistreatment in a large, representative, nation-wide sample of community dwelling, older Canadians through direct respondent interviews.

Office of the Seniors Advocate British Columbia. (2016). Resident to Resident Aggression in B.C. Care Homes. Retrieved from: https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/06/SA-ResidentToResidentAggressionReview-2016.pdf

This report involved a review of 304 residential care facilities in B.C. with a focus on resident-to-resident aggression. The circumstances of resident-to-resident abuse incidents were examined, with analyses summarized in terms of factors like facility profile, resident-level findings, time and location of incidents, gender, and reporting. Recommendations were made around standardizing report, reviewing the adequacy of staffing for residents with more complex needs specifically during peak activity times like meal time or morning care, providing more education and training for staff, and adopting strategies and design features known to be effective in mitigating aggressive behaviours

Ontario Centres for Learning, Research, and Innovation in Long-Term Care. (2018). *About Us.* Retrieved from: http://clri-ltc.ca/about-us/

This section of the Ontario Centres for Learning, Research, and Innovation in Long-Term Care website describes the goals of the CLRI program.

Ontario Government. (2017). Aging with Confidence: Ontario's Action Plan for Seniors. Retrieved from: https://files.ontario.ca/ontarios_seniors_strategy_2017.pdf

This report describes Ontario's Action Plan for Seniors. The initial section presents demographic statistics about the older adult population. The action plan describes progress to date and next steps for supporting seniors in the following categories: seniors at all stages, seniors living independently in the community, seniors requiring enhanced supports at home and in their communities and seniors requiring intensive supports.

Ontario Government. (2018). Information about elder abuse. Retrieved from: https://www.ontario.ca/page/information-about-elder-abuse#section-4

This website describes Ontario's Strategy to Combat Elder Abuse.

Ontario Long Term Care Association. (2018). More Care. Better Care. Retrieved from: https://s3-us-west 2.amazonaws.com/oltca/bsc2018/OLTCA_Budget_Submission_2018.pdf

This report describes recommendations for improving the quality of long term care in order to influence the provincial long term care budget. Relevant recommendations include "More Care with More Staff", which suggests increased funding for registered staff and personal support workers given that the acuity of residents has been steadily increasing without any changes in funding over the past 5 years to support hiring additional staff. Given that funding for residents is provided on a per-resident basis, with smaller homes receiving less overall subsidy, it is recommended that there be more flexibility for smaller homes in how they apply the funding. Another recommendation is "Better Care with Behavioural Supports in Every Home". Given that 9 out of 10 residents exhibit some form of cognitive decline, with almost half of residents demonstrating some form of aggressive behaviour, support from Behavioural Support Ontario (BSO) is essential. The model of an in-home BSO team for every long term care home is recommended, given the benefits of an in-home team over a mobile team in terms of better understanding of the residents and serving as a training resource for staff. Another recommendation is "Better Care by Modernizing Long Term Care Homes", which describes the need for more modern infrastructure, and outlines problems with the Long-Term Care Home Renewal Strategy.

Ostaszkiewicz, J. (2017). A conceptual model of the risk of elder abuse posed by incontinence and care dependence. *International Journal of Older People Nursing*. Advance online publication. doi:10.1111/opn.12182

The purpose of this study was to describe and analyze factors behind the association between incontinence, care dependence, and elder abuse. Findings from sociology, psychology and nursing were analysed to inform the design of a conceptual model, "Model of Attributes of Dependent Elders in Continence care" that describes these associations. Caregiver factors, care recipient factors and social factors increasing the likelihood of elder abuse are described. Some caregiver factors may include physical and emotional exhaustion, frustration due to the unpredictable nature of incontinence, resentment of care dependence, disgust with contact with urine/feces, and limited knowledge and skills about incontinence. Care recipient factors may include frequent and severe incontinence, cognitive impairment, rejection of care and a history of trauma.

Pedersen, K., Mancini, M. & Ouellet, B. (2018, January 18). Staff-to-resident abuse in long term care homes up 148% from 2011. *CBC News*. Retrieved from: http://www.cbc.ca/news/business/elderly-care-violence-marketplace-investigates-1.4493215

Based on an analysis of critical incident reports from Ontario long term care homes, staff-to-resident abuse has increased 148% from 2011 to 2016. In 2011, there were 888 reported incidents, and in 2016, there were 2,198 incidents. The number of reported incidents is listed for every year from 2011-2016.

Pickering, C.E.Z., Nurenberg, K. & Schiamberg, L. (2017). Recognizing and Responding to the "Toxic" Work Environment: Worker Safety, Patient Safety, and Abuse/Neglect in Nursing Homes. *Qualitative Health Research*, *27*(12), 1870-1881.

The purpose of this qualitative study was to examine how the certified nursing assistant (CNA) understands and responds to bullying in the workplace using a grounded theory approach. Telephone interviews were conducted with 22 CNAs who experienced bullying while employed in a nursing home. A grounded theory methodology with constant comparative analysis was used to analyze the data. Participants reported that within a "toxic" work environment, bullying contributes to the overall culture and can lead to negative patient and worker safety outcomes. This process occurs in steps, described as follows: a) Step 1: Learning the Toxic Workplace; b) Step 2: Losing Trust; c) Step 3: Reconciling Expectations; d) Step 4: Development of Patient and Worker Safety Outcomes. Some negative resident outcomes include abuse, resident-to-resident aggression, missed nursing care, and poor hygiene. Some negative worker outcomes include absenteeism, high turnover, stress, and mental health issues.

Pillemer, K., Chen, E.K., Van Haitsma, K.S., Teresi, J., Ramirez, M., Silver, S., Sukha, G. & Lachs, M.S. (2011). Resident-to-Resident Aggression in Nursing Homes: Results from a Qualitative Event Reconstruction Study. *The Gerontologist*, *52*(1), 24-33.

The purpose of the study was to gain a better understanding of the major types of resident-to-resident aggression (RRA) found in nursing homes. Methodology included a Qualitative event reconstruction with RRA events identified in 3 nursing homes in New York City over a 2 week period. In terms of results, 13 major forms of RRA were grouped under 5 themes: 1) invasion of privacy or personal integrity; 2) roommate problems; 3) hostile interpersonal interactions; 4) unprovoked actions; 5) inappropriate sexual behavior. The authors emphasize the need for a person-centred approach for intervention.

Pillemer, K., Burnes, D., Riffin, C. & Lachs, M.S. (2016). Elder abuse: Global situation, risk factors and prevention strategies. *The Gerontologist*, *56*, S194-S205.

> The purpose of this scoping literature review was to obtain information on elder abuse prevalence, risk factors, and prevention strategies. The review was restricted to high quality studies, with population-based elder abuse prevalence studies using random or exhaustive sampling and that collected data directly from older adults. Victim-level risk factors with strong strength of evidence including the following: functional dependence/disability, poor physical health, cognitive impairments, poor mental health, and low income/socioeconomic status. Perpetrator risk factors with strong strength of evidence include mental illness, substance abuse, and abuser dependency. There is a lack of reliable evaluation data on elder abuse prevention strategies.

Pomey, M-P, Denis, J-L, Baker, G.R., Préval, J. & Macintosh-Murray, A. (2008). Appendix 1: Review of the Literature on the Role of the Board in The Improvement of Quality and Safety in Healthcare Organizations. Canadian Health Services Research Foundation & Canadian Patient Safety Institute. Retrieved from: http://www.cfhi-fcass.ca/sf-docs/default-source/commissioned-research-reports/GRossBaker_appendix_FINAL.pdf?sfvrsn=0

> This literature review focuses on the role of board of directors can play in quality and safety improvements in a healthcare organization. Aspects of governance in terms of vision, resourcing and skills development, relationship management, and control and monitoring are discussed in terms of their relation to quality and safety culture development.

Premji, S., Shakaya, Y., Spasevski, M., Merolli, J., Athar, S. & Immigrant Women and Precarious Employment Core Research Group. (2014). Precarious Work Experiences of Racialized Immigrant Women in Toronto: A Community-Based Study. Just Labour: A Canadian Journal of Work and Society, *22*, 122-143.

> The purpose of this study was to examine the precarious work experiences of largely university-educated racialized immigrant women in Toronto, Ontario. Semi-structured interviews were conducted with 30 racialized immigrant women representing a diversity of cultural backgrounds, length of stay in Canada, occupation, education, and household composition. The findings were that participants frequently had to resort to low paying, low skilled jobs with high levels of job insecurity and instability and reduced benefits and protections due to being unable to find jobs in their original occupation or similar jobs reflective of their education and experience. Barriers to finding employment in their original occupation included a lack of Canadian work experience, a lack of employer recognition of foreign credentials and education, language barriers, limited professional networks, and racialized discrimination.

Registered Nurses' Association of Ontario. (2014). Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches. Retrieved from: http://rnao.ca/sites/rnao-ca/files/Preventing_Abuse_and_Neglect_of_Older_Adults_English_WEB.pdf

This report describes clinical practice recommendations, education recommendations, and policy, organizational and system recommendations for preventing and addressing elder abuse. Select policy, organization and system recommendations include securing appropriate staffing, screening potential employees and hiring the most qualified employees, providing proper supervision and monitoring in the workplace, providing mandatory training, supporting the needs of individuals with cognitive impairments, establishing no-blame policies for individuals who report abuse, educating older adults and families on abuse and resident rights, and establishing and maintain person-centred care and a health work environment. A review of the literature was completed to describe factors and conditions that contribute to abuse and neglect in institutions in the categories of organizational factors, staff factors and resident factors. Organizational factors include inadequate numbers of staff/inappropriate staff mix to meet the needs of residents, staff who have not been adequately trained, rationing of supplies, culture or regime of institution, lack of supervision and overcrowding/congestion. Staff factors include burnout/emotional/physical exhaustion, disempowered staff, personal stress, alcohol or substance abuse, personal history of abuse and attitudes of ageism and condoning abuse and neglect. Resident factors include dependency based on physical limitations, communication difficulties, cognitive impairment and physical or social isolation.

Registered Nurses' Association of Ontario. (2018). *Promoting the Awareness of Elder Abuse in Long-Term Care*. Retrieved from: http://rnao.ca/bpg/initiatives/promoting-awareness-elder-abuse-longterm-care

This section of the Registered Nurses' Association of Ontario (RNAO) website outlines the Prevention of Elder Abuse Centres of Excellence (PEACE) initiative from 2010-2012 that involved ten long-term care homes across Canada. The RNAO Long-Term Care Best Practices Initiative is revising the curriculum specifically for an Ontario long term care context.

Robinson, K.M., & Tappen, R.M. (2008). Policy recommendations on the prevention of violence in long-
term care facilities . *Journal of Gerontological Nursing*, *34*(3), 10-14.

This article offered a commentary on underlying factors contributing to resident-to-resident and resident-to-staff violence in long-term care homes

and recommends potential solutions and policy recommendations. Factors contributing to violence include dementia, physical distress from physiological needs, psychosocial factors, and environmental triggers. Potential solutions are discussed around the areas of recruitment initiatives, training for staff, sufficient staffing, culture change, resident-centred care, and further research.

Rosen, T., Lachs, M.S., Bharucha, A.J., Stevens, S.M., Teresi, J.A., Nebres, F. & PIllemer, K. (2008a).

Resident-to-Resident Aggression in Long-Term Care Facilities: Insights from Focus Groups of Nursing Home Residents and Staff. *Journal of the American Geriatrics Society*, *56*(8), 1398-1408.

The purpose of this qualitative study was to more fully characterize the spectrum of resident-to-resident aggression (RRA). Methods include the use of 16 focus groups with 96 staff members and 7 residents from a large urban long term care facility. More than 35 types of physical, verbal, sexual RRA described, with screaming or yelling being the most common type. Participants described the following reasons or triggers for RRA: calling out or making noise; territoriality or challenges with communal living; roommate inability to compromise preferences; impatience; loneliness, abandonment or frustration with institutionalization; jealousy; and dementia, cognitive impairment or disinhibition. The following self-initiated strategies were used by staff to address RRA: notify social services or change resident room; physically intervene or separate residents; remove residents from dining room or public area or change seating arrangements; try to convince residents to compromise; redirect or distract residents; explain to residents the nature of communal living; and notify a nurse or certified nursing assistant.

Rosen, T., Pillemar, K., Lachs, M. (2008b). Resident-to-resident aggression in long-term care facilities: An understudied problem. *Aggression and Violent Behavior, 13*, 77-87.

This literature review focused on resident to resident aggression. Because of the limited available literature on the topic, relevant research from related areas was used including resident violence towards nursing staff, aggressive behaviour by elderly individuals and community elder abuse. Hypothesized risk factors were presented for aggressor, victim and nursing home environment. In older adults with dementia, verbal aggression is associated with intact cognitive function and delusions and affective disorders, whereas physical aggression is associated with cognitive decline. Nursing home residents with severe primary mental illness exhibit greater behavior problems than those without mental illness. There is also a growing percentage of younger residents under 65 years, with most of these individuals having psychiatric illness

Rosen, T., Lachs, M.S. & Pillemer, K. (2010). Sexual Aggression Between Residents in Nursing Homes: Literature Synthesis of an Underrecognized Problem. *Journal of the American Geriatrics Society*, *58*, 1070-1079.

> This literature review focused on resident-to-resident sexual aggression. Risk factors for perpetrators includes the following: men who are cognitively impaired; dementia affecting frontal or temporal lobe; hypersexuality occurring as a result of delusional psychosis brought on by medications; and having a history of being a registered sex offender. Risk factors for victims include cognitive impairment and physical impairment, with the majority of victims being women. Non-pharmacological strategies based on case series data were discussed including, increased staff vigilance, the use of distraction, strategic seating, providing sensory stimulation in more appropriate ways, the use of adapted clothing, and installing barricades with alarms to prevent wandering into other residents' rooms.

Rosen, T., Lachs, M.S., Teresi, J., Eimicke, J., Van Haitsma, K. & Pillemer, K. (2016). Staff-reported strategies for prevention and management of resident-to-resident elder mistreatment in long-term care facilities. *Journal of Elder Abuse & Neglect*, *28*(1), 1-13.

> The purpose of this study was to identify nursing home staff responses to resident-to-resident elder mistreatment (R-REM). Methods include interviews with 282 certified nursing assistants in 5 urban nursing homes in New York on their responses during the previous 2 weeks to R-REM behaviors of residents. There were 22 responses from the nursing assistants which were divided into 4 categories: 1) single incident management/reaction, 2) anticipation of future incidents/long-term prevention, 3) reporting/documentation/escalation for potentially definitive management, 4) no intervention/allowing behavior to continue. The most common responses were physically intervening/separating residents, talking calmly to settle resident down, no intervention and verbally intervening to defuse the situation. Staff reported taking no action in response to R-REM behavior of nearly ¼ of residents. Staff only documented 2.2% of residents in a behavior log.

Schiamberg, L. B., Oehmke, J., Zhang, Z., Barboza, G. E., Giffore, R. J., Von Heydrich, L., & Mastin, T. (2012). Physical abuse of older adults in nursing homes: A random sample survey of adults with an elderly family member in a nursing home. *Journal of Elder Abuse & Neglect*, *24*, 65-83.

> This study investigated the prevalence and risk factors of staff physical abuse (which also included sexual abuse) among elderly individuals receiving nursing home care in Michigan. A random sample of 452 adults with elderly

relatives in nursing homes were surveyed, with 24.3% of respondents reporting at least one incident of staff physical abuse. The logistic regression model identified the following risk factors for physical abuse: limitations in ADLs, behavioral difficulties, and previous victimization by nonstaff perpetrators. Of all ADL limitations, the specific limitation "Need Help Moving" emerged as the only significant or primary predictor of staff physical abuse. This may be due to the fact that mobility assistance may occur at almost any time and any place in an unpredictable manner.

Schiamberg, L., von Heydrich, L., Chee, G. & Post, L.A. (2015). Individual and contextual determinants of resident-on-resident abuse in nursing homes: A random sample telephone survey of adults with an older family member in a nursing home. *Archives of Gerontology and Geriatrics*, *61*, 277-284.

The purpose of the study was to examine risk factors for resident-to-resident aggression (RRA) from an ecological perspective. Methods include telephone interviews with family members who had an older adult receiving long-term care services in Michigan. In terms of results, residents having a greater number of limitations in performing both ADLS and IADLS predicts an increase in RRA. Staff abuse was found to be as latent factor increasing the likelihood of RRA. Age was inversely and significantly related to RRA- as nursing home residents age, they are less likely to be victimized or perpetrate violence. It was also found that close emotional ties with relatives increases the likelihood of RRA (may be due to jealousy from other residents).

Sharkey, S. (2008). People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes. Retrieved January 2, 2018 from http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=viewlink&link_id=5987&Itemid=109&lang=en

This report stems from a review of Ontario LTC homes from Oct 2007-Apr 2008 with extensive consultations and literature reviews to inform the decision making process. The report provides a comprehensive framework for determining human resources implications related to quality of care and quality of life of residents of Ontario LTC homes. Key findings and recommendations include strengthening staff capacity for better care (includes components of increasing staff capacity and developing local staffing plans and evaluation process) and strengthening accountability for outcomes. Sharkey recommends a broad approach that goes beyond setting staffing targets or a provincial staffing ratio, and that is catered towards the unique needs and circumstances of each LTC home. A recommendation was made to increase resident care up to 4 hours of care per resident per day.

Shaw, M.M.C. (1998). Nursing home resident abuse by staff: Exploring the dynamics. *Journal of Elder Abuse & Neglect*, *9*(4). 1–21.

> The purpose of the study was to explore dynamics of nursing home resident abuse by staff, with a focus on staff response to aggressive residents. The study presents partial finding from a grounded theory study. Semi-structured interviews were conducted with 15 nursing home staff and 6 abuse investigators and responses analyzed with a grounded theory approach. Staff frequently encounter aggressive or abusive behavior from residents, yet some staff are able to control reactive behaviours and not act aggressively back to resident, while other staff are not able to. The article describes three dimensions of developing immunity to abuse by residents: 1) staff who develop and sustain immunity; 2) staff who develop and lose immunity; 3) staff who never develop immunity. Work related conditions and personal characteristics affect one's ability to build and sustain immunity.

Shaw, MMC. (2004). Aggression toward staff by nursing home residents: Findings from a grounded theory study. *Journal of Gerontological Nursing, 30*(10), 43–54.

> The purpose of this qualitative grounded theory study was to explore nursing home staff responses to aggressive residents, as such aggressive behaviour may lead to resident abuse by staff. Semi-structured interviews were held with 15 nursing home staff from 6 facilities, and they described strategies staff use to prevent and manage aggression. To effectively deal with resident aggression, staff must become proactive, which involves practicing vigilance, intuiting, and strategizing. Various strategies included calm and fear-reducing strategies, time and pace-altering strategies, distancing strategies, and self-care strategies (e.g., switching, time-out, pairing up, covering)

Shinan-Altman, S. & Cohen, M. (2009). Nursing aids' attitudes to elder abuse in nursing homes: The effect of work stressors and burnout. *The Gerontologist*, *49*, 674-684.

> The purpose of the study was to assess nursing aides' attitudes that condone abusive behaviors toward elderly people, as well as the relationship of these attitudes to demographic variables, work stressors (role conflict, role ambiguity and work overload), burnout and perceived control. 208 nursing aides from 18 nursing homes in Israel completed a questionnaire and a case vignette questionnaire. The mean score of the attitudes condoning abusive behaviors was relatively high at 3.24 on a 1 – 4 scale. Condoning abusive behaviors were closely associated with higher levels of work stressors, burnout, and low income, with role ambiguity, role conflict and burnout being significant predictors. Combatting elder abuse at LTC facilities should start with changing work conditions to reduce work stressors. Burnout in workers should also be tracked and directly dealt with through support, education and supervision

Shinoda-Tagawa, T., Leonard, R., Pontikas, J., McDonough, J.E., Allen, D. & Dreyer, P.I. (2004). Resident-to-Resident Violent Incidents in Nursing Homes. *JAMA*, *291*(5), 591-598.

> The objective of the case-control study was to assess risk factors for violent injury to nursing home residents by other residents. Data was utilized from the Massachusetts Dept. of Public Health Complaint and Incident Reporting System and from the Minimum Data Set assessments for Massachusetts nursing home residents. In terms of results, injured residents were more likely to be cognitively impaired, exhibit symptoms of wandering, be verbally abusive, and have socially inappropriate behavior than the controls. Residents in an Alzheimer disease unit were 3x more likely to be injured than those on other units. Male residents were almost twice as likely to be injured than female residents. Residents classified as needing extensive assistance and being severely dependent in ADLs had a significant reduction in being injured by other residents. The most common site of resident-to-resident aggression was in residents' rooms, but hallways and the dining room were also common venues. Possible interventions were discussed including training nursing staff, environmental modifications (e.g., soft barriers, familiar symbols), music therapy, and organized activities.

Sifford-Snellgrove, S., Beck, C., Green, A. & McSweeney, J.C. (2012). Victim or Initiator? Certified Nursing Assistants' Perceptions of Resident Characteristics that Contribute to Resident-to-Resident Violence in Nursing Homes. *Research in Gerontological Nursing*, *5*(1), 55-64.

> The purpose of the qualitative study was to explore certified nursing assistants' perceptions of characteristics of both victims and initiators of resident-to-resident violence. Methods included semi-structured interviews with 11 certified nursing assistants from a not-for-profit nursing home in rural Mississippi. In terms of findings, initiators of resident-to-resident violence were perceived to be more cognitively intact, with strong personalities, a short fuse, racial and stereotypical prejudices, and a life history that made them prone to inflict harm on other residents. Initiators often did not understand the cognitive impairment of victims. Victims were perceived to be cognitively impaired, have communication issues (e.g., repetitive verbal communication, unable to express appropriate words, having severe hearing impairment), and be more physically mobile (more prone to wander into initiator's space).

Snellgrove, S., Beck, C., Green, A. & McSweeney, J.C. (2013). Resident-to-Resident Violence Triggers in Nursing Homes. *Clinical Nursing Research*, *22*(4), 461-474.

> The purpose of the study was to obtain a better understanding of triggers of resident-to-resident violence (RRV). Methods included semi-structured interviews with 11 certified nurse assistants in a rural nursing home in Northeast Arkansas to describe their perception of triggers of resident-to-

resident violence. In terms of finding, 2 categories of triggers emerged: active and passive triggers. Active triggers were defined as actions of other residents that were intrusive in nature. Subcategories included intrusion, environmental issues (e.g., temperature, light, tv), taking/touching possessions, and violence. Passive triggers related to internal and external environment of residents. Subcategories included boredom, competition for attention, and communication difficulties (e.g., difficulty with verbal expression, difficulty hearing). All participants indicated that during Nursing Home Week and Christmas holidays when residents were occupied with additional activities, there were fewer episodes of RRV

Snellgrove, S., Beck, C., Green, A. & McSweeney, J.C. (2015). Putting residents first: Strategies developed by CNAs to prevent and manage resident-to-resident violence in nursing homes. *The Gerontologist*, *55*(S1), S99-S107.

The purpose of the study was to explore strategies developed by certified nurses' assistants to prevent and manage resident-to-resident violence (RRV) in nursing homes. Methods included semi-structured interviews with 11 nurses' assistants at a not-for-profit nursing home. In terms of findings, there was an overriding theme of "Putting Residents First" which was described as a conscious effort to put themselves or a family member in the place of the resident while delivering care. Three subthemes were described in further detail: a) knowing the residents; b) keeping residents safe; c) spending quality time.

Sourtzis, L. & Bandera, S. (2015, April 10). W5 nursing home investigation reveals 1,500 cases of staff-to-resident abuse in one year. *CTV*. Retrieved from: https://www.ctvnews.ca/w5/w5-nursing-home-investigation-reveals-1-500-cases-of-staff-to-resident-abuse-in-one-year-1.2321287

W5 filed access-to-information requests with 42 provincial, territorial and regional health authorities seeking statistical information and incident reports of staff-to-resident abuse for the 2013 calendar year. They discovered at least 1,500 cases of staff-to-resident abuse (actual number is likely higher due to under-reporting of incidents). W5 also conducted an anonymous, national on-line survey of care workers in nursing homes overs a period of 4 months. They received 677 responses, with most coming from Ontario. From the respondents, 38% reported having witnessed one of their colleagues abusing a resident, yet only 51% said they reported abuse they had witnessed to a manager or administrator. More than 80% said that the staff member they had seen abusing a resident was still employed at the facility.

Spencer, C., Charpentier, M., McDonald, L., Beaulieu, M., Harbison, J., Hirst, S. et al. (2008). *National snapshot: Preventing abuse and neglect of older adults in institutions*. Retrieved from http://www.bcsla.ca/wp-content/ uploads/2013/10/preventing-abuse-institutions.pdf

> The purpose of this report was to: a) To identify key issues and themes underlying abuse and neglect in the range of care facilities in Canada as identified by key stakeholders; b) To examine relevant policies, laws, regulations, standards and practices that are currently used to: i) prevent and address abuse and neglect of residents ii) promote safe, supportive, respectful environments in long term care facilities. Methods included interviews with 65 stakeholders across Canada (advocates, educators, government representatives, retirement community and long term care industry, staff representatives). Relevant themes included "A Safe Place to Address the Issues" in which stakeholders felt there was not an institutional, social or political culture in which it was safe for people to report abuse and neglect and "Vulnerability" in which stakeholders comments on factors contributing to the potential for abuse in the areas of resident vulnerability, staff vulnerability, the care gap factor, environmental factors, and staffing. The last section states strategies in the abuse prevention literature and currently in use in some parts of Canada.

Teresi, J.A., Ramirez, M., Ellis, J., Silver, S., Boratgis, G., Kong, J., Eimicke, J.P., Pillemer, K. & Lachs, M.S. (2012). A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting: Results from a cluster randomized trial. *International Journal of Nursing Studies*, *50*, 644-656.

> The purpose of the study was to evaluate the impact of a newly developed resident-to-resident elder mistreatment (R-REM) training intervention for nursing staff on knowledge, recognition and reporting. This study was a prospective cluster randomized trial with randomization at the unit level with a sample of 1405 residents from 37 New York City nursing home units. The intervention involved training of certified nursing assistants on R-REM in 3 sessions: 1) recognition and risk factors, 2) management (involved teaching the SEARCH framework), 3) implementation of guidelines. Data collected at baseline, 6 and 12 months showed that staff on experimental units that completed the training had increased knowledge and increased frequency of R-REM reporting post-intervention compared to the control units

Trottier, H., Martel, L., Houle, C., Berthelot, J.M. & Lègaré, J. (2000). Living at home or in an institution: What makes the difference for seniors? *Health Reports*, *11*(4), 49-61.

This study examines some of the health and socio-demographic factors associate with living in long-term care facilities instead of living at home for elderly people with various levels of disability. The introduction discusses the increasing proportion of the elderly population living in long-term health care facilities.

Wangmo, T., Nordstrom, K. & Kressig, R.W. (2017). Preventing elder abuse and neglect in geriatric institutions: Solutions from nursing care providers. *Geriatric Nursing*, *38*, 385-392.

The purpose of this qualitative study is to explores how and why abuse and neglect occurs in geriatric institutions and present practical prevention measures. Methods include exploratory qualitative interviews with 23 nursing staff members from different long term care homes in Switzerland, with the use of thematic analysis. Factors resulting in abuse and neglect were discussed in the following categories: institutional structure, caregiver characteristics, older residents' limitations, institutional level and caregiver level.

Young, L. (2011). RNs Recognize/Respond to/Report Elder Abuse. *Registered Nursing Journal*. Retrieved from: http://rnao.ca/sites/rnao-ca/files/Elder_Abuse_Article_-_RN_Journal_Sept-Oct_2011.pdf

This article describes the Prevention of Elder Abuse Centres of Excellence initiative training package, and describes the training process and subsequent outcomes of rolling out the initiative in several Canadian long term care homes.

Zhang, Z., Schiamberg, L.B., Oehmke, J., Barboza, G.E., Griffore, R.J., Post, L.A., Weatherhill, R.P. & Mastin, T. (2011). Neglect of older adults in Michigan nursing homes. *Journal of Elder Abuse & Neglect*, *23*(1), 58-74 .

The purpose of the study was to examine the incidence of neglect amongst elderly in Michigan nursing homes and determine risk factors for neglect amongst this population. A cross-sectional telephone survey was randomly administered to adults with a relative in long-term care. Of the respondents, 21% of nursing home residents were neglected on one or more occasions in previous 12 months. Victims of resident-to-resident abuse are 4x more likely to experience neglect from staff, which could be due to characteristics/behaviors of the individual or to a poorly managed environment where abuse is tolerated. Functional impairments in ADLs

increases the odds of neglect, and with each additional ADL limitation, there is a significant increase in the risk of being neglected by 30%. Behavior problems are also associated with higher odds of neglect (p=0.078). The study did not find strong evidence that social support received by residents lowered risk of neglect. Practice and policy implications are discussed in terms of staff education, education for family members, more staffing, and improved communication of resident care needs.

Zhang, Z., Page, C., Conner, T., & Post, L.A. (2012). Family members' reports of non-staff abuse in Michigan nursing homes. *Journal of Elder Abuse & Neglect*, *24*(4), 357-369.

The purpose of the study was to examine nursing home resident mistreatment from the perspectives of family members. Data was collected with a cross-sectional survey of households with family members receiving long-term care services in Michigan. In terms of results, residents with behavioral problems report more incidences of non-staff abuse and are 1.8x more likely to be abused by non-staff. In addition, for one increase in functional ADLs by the resident, the odds of non-staff abuse increased by 16%. Victims of staff abuse report more instances of non-staff abuse and are 4.59 times more likely to be abused by non-staff. The resident being male decreased odds off non-staff abuse by almost 46%. Proposed interventions were discussed around providing education to family members of resident to resident abuse prevention, training staff to better help residents and visitors cope with behavioural issues, and greater staff monitoring of residents with behavioural problems.

Appendix G Internal and External Interview Participants

Internal

- Residents
- Substitute Decision Makers and Families
- 4 Presidents, Residents Councils
- 4 Presidents, Family Councils
- Nursing and Personal Care Staff (Registered Nurses, Registered Practical Nurses, Personal Support Workers
- 4 Resident Assessment Instrument Coordinators
- 4 Staffing Coordinators
- Housekeeping staff
- Food and Nutrition Staff
- Recreation Staff
- 4 Social Workers
- Volunteers
- David White, Deputy Solicitor General (Labour Relations)
- Bryan Babbs, Long-term Care Finance Coordinator
- Patrick Power, Account Manager, Financial Support Unit
- Carly Ouderkirk, Program Manager, LTC Special Projects
- Neil Fuller, Business Applications Support Specialist
- Bill MacPhee, Human Resources Strategist
- 4 Administrators
- 16 Program Managers
- 4 Medical Directors
- Janice Burelle, General Manager
- Dean Lett, Director of Long-term Care

External

- 4 Administrators and 1 Director of Care of 5 comparator homes (Anonymous for confidentiality)
- Dan Buchanan, Debbie Humphreys, Kathryn Pilkington, Bob Morton, AdvantAge Ontario
- Candice Chartier, Ontario Long-term Care Association
- Jamie Dunn, CIPP
- Barbara Foulds and Marlene Tosh, Algonquin College
- Akos Hoffer, CEO, The Perley and Rideau Veterans' Health Centre
- Cheryl Homuth, LTC Specialist
- George Langill, Executive in Residence, Master in Health Administration, Telfer School of Management, University of Ottawa
- Sargeant Linda Leung, Ottawa Police Elder Abuse Unit
- Brian Madden, CUPE
- Paul O'Krafka, LTC Management Consultant
- Karen Simpson and Carole Comeau, Ministry of Health and Long-ter

Appendix H Consultant Profile

Greg Fougere, MHA, CHE

Greg has 35 years of experience, from hospital orderly to Health Centre CEO. He is a University of Ottawa Master in Health Administration (MHA) graduate and a Certified Health Executive (CHE) with the Canadian College of Health Leaders. Greg was CEO of the Perley and Rideau Veterans' Health Centre for 17 years, until stepping down in 2013 for a career break. www.perleyrideau.ca
Greg's legacy at the Perley Rideau is its high reputation as a unique Seniors' Village providing care and services in the Centre's 450-bed long-term care home; 139 seniors' independent and assisted living apartments; 12-bedroom dementia respite bungalow, Seniors' Day Program, and community.

He is a specialist in organizing and integrating care and services to seniors. He is a generalist in a broad range of management and leadership skills and competencies. Greg has been extensively involved in seniors' initiatives at the local and provincial levels, working in areas such as long-term care policy, planning and funding; diverting seniors from hospitals; legislative compliance; and funding negotiations, reform and long-term care accountability.
Greg was awarded the 2015 Trudeau Medal from the University of Ottawa Telfer School of Management. He has been recognized for his leadership throughout his career, including awards from the Ontario Hospital Association, the Ontario Alzheimer Society, and the Ontario Association of Non-Profit Homes and Services for Seniors.

Greg's passion and expertise is in all facets of seniors' care and services. He also has a solid reputation in a broad range of competencies such as visioning and strategic planning; governance and management; partnering; facilitation; communications and government relations; media relations and negotiations. He enjoys teaching and mentoring MHA students, and helping others achieve personal and organizational goals.