SUBMISSION OF CAW-CANADA TO

THE LONG-TERM CARE TASK

FORCE ON RESIDENT CARE & SAFETY

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CANADA

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INTRODUCTION

We welcome this opportunity to share our views in respect of the Task Force mandate to develop an action plan that addresses the imperative need for abuse prevention. The CAW-Canada represents approximately 12,500 long term care workers throughout Ontario; largely employed in the for-profit or corporate nursing home and retirement home sectors but also at various municipal and charitable homes for the aged. Since 2003, our CAW Ontario Health Care Council has conducted a ***Dignity is a Minimum Standard*** campaign. The campaign advocates for a culture of dignity and respect in long-term care as manifested by a true commitment to quality of care and enhanced staffing levels in this sector.

Our campaign is informed by the front line perspective of our members. They are acutely aware of the challenges in this sector to ensure quality care is delivered through a mutual exchange characterized by dignity and respect for both care giver and care recipient. For almost a decade Ontario has pursued various regulatory solutions in an effort to prevent abuse; as well as to restore quality of care and public confidence. To the extent that abuse and neglect remain we are well advised to learn and correct the mistakes and misdirection of the recent past.

LEARNING FROM THE PAST

We strongly recommend the Task Force critically examine the past legislative and regulatory actions (or inactions) of Government in this sector since the 2004 *Commitment to Care* report by Monique Smith, MPP was released. *Commitment to Care* advocated for staff education; staff screening; duty to report; home reporting procedures when specifically addressing elder abuse, although abuse and neglect were only one of many shortcoming the report addressed in long-term care.

These recommendations were of course grounded in a considerably broader perspective to ensure an appropriate philosophy of care – "a dignified, nurturing home environment" and to improve staffing through high standards of care:

> Quality of life depends on ensuring our seniors receive high standards of care and be treated with dignity. There must be clear, measurable, enforceable, resident-focused standards.
> **Commitment to Care: A Plan for Long-Term Care in Ontario, Spring 2004**

We remain convinced that any initiative to prevent abuse and neglect must continue to be linked with concurrent workplace innovations to create quality 'home-like' work environments that encourage and sustain transformative change to realize a philosophy of care based on respect and dignity.

A COMMITMENT TO CHANGE

A critical re-think is long overdue in terms of the dominant corporate paradigm concerning the management; organization and delivery of care to frail seniors in these homes. Current woefully inadequate staffing and crushing workloads are clearly counter-productive in creating a caring environment. Inadequate staffing leads to declining quality of care and work-life

outcomes; in a vicious downward cycle of indifference, withdrawal or apathy; as greater injury rates and absenteeism lead to further frustration or dysfunctional or demeaning behaviour – resulting in considerable job dissatisfaction and stress and employee turnover. In a work environment in which care providers and recipients are both socially de-valued and demeaned in the absence of respect and dignity; abuse and neglect of others as well as self-abuse and self-neglect can only become more prominent manifestations.

ZERO TOLERANCE OF ABUSE AND NEGLECT

The CAW advocates and supports a policy of zero tolerance of abuse, violence and harassment in all workplaces. Since we have been representing long-term care workers in Ontario in 2000, we have negotiated collective agreement provisions concerning both resident and staff abuse; violence against women and anti-harassment provisions – and all flow consistently from our Union's policies and broader social commitment to recognize, strengthen and enforce the right of all individuals to be treated with dignity and respect and work/live in an environment free from abuse or neglect; discrimination and/or harassment.

We also firmly believe that the first priority of public policy in addressing elder abuse or neglect must be to ensure PREVENTION of such abuse or neglect. The second priority of public policy then must be a robust commitment to an inclusive MULTI-AGENCY and MULTI-SECTORAL approach (police, social workers, health providers, community service agencies, resident councils and advocacy groups) that addresses the systemic or structural features of elder abuse and neglect; including self-abuse, regardless of location.

PREVENTION OF ABUSE AND NEGLECT

One of the defining elements of the fundamental principle animating Bill 140 was the focus on ensuring the dignity and respect of residents - as the fundamental principle explicitly set out in Part I at section 1 and as the first of the rights enumerated in Part II at section 3.(1)(a). If the laudable goal of ensuring the respect and dignity of residents were to be truly realized through the legislative and regulatory framework governing long-term care facilities in Ontario however, the positive affirmation of the right to be treated with dignity and respect would be expressly grounded throughout the statute and regulation in specific and substantive rights and responsibilities and program standards.

> Preventing abuse and neglect, and intervening when it does occur, begins with respect: respect for the rights and responsibilities of all — residents, staff, families and others. … respect is the cornerstone of building and maintaining a supportive and healthy environment. Although we will never totally irradicate [sic] abuse that is committed intentionally, as in the case of criminal actions (e.g. theft), designing intervention and prevention programs based on respect will move us toward the ideal of zero abuse and neglect.
> **Stand By Me: Preventing Abuse and Neglect of Residents in Long-Term Care Settings,** Health Canada, 2001

Regrettably, the recommendations expressed in the Monique Smith report regarding minimum care levels was eventually dismissed by Shirlee Sharkey in her *Report of the Independent Review*

of Staffing and Care Standards for Long-Term Care Homes in Ontario in 2008. This subsequent report recommended against any regulation to provide for a provincial staffing or care standard in favour of "provincial guidelines" and home-specific staffing plans with annual evaluations.

Regrettably, the Sharkey process represents a failed opportunity to achieve the transformative cultural change advocated by Monique Smith through regulatory initiatives to establish a minimum care standard. Rather than a pragmatic dialogue amongst stakeholders around ensuring adequate direct care staffing, recent initiatives have largely ignored the obvious relationship between staffing and quality care in preventing abuse and neglect.

> **Adequate Direct Care Staffing**
> Another prevention strategy is ensuring adequate direct care staffing. Many facilities are understaffed or inadequately staffed because of the use of unskilled temporary or part-time staff — a practice resulting usually from a loss of adequate funding levels. Inadequate direct care staffing can lead to perceived incidents of abuse or neglect. For example, the reduction in the number of direct care staff means residents have to wait longer to have their most basic care needs met. In many instances, this can be considered neglectful and is indeed perceived as such by residents.
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> A related concern is that direct care encompasses not just physical needs but also the emotional, psychological and spiritual needs of residents. For staff to provide this kind of support to residents, administrators and government regulatory bodies need to recognize staff's responsibility to spend high-quality time with residents and build it into the work schedule and funding formula.
> **Stand By Me: Preventing Abuse and Neglect of Residents in Long-Term Care Settings,** Health Canada, 2001

ACHIEVING QUALITATIVE CHANGE IN LONG-TERM CARE

We acknowledge that the methods through which direct care staff are organized, supervised, and motivated is also a factor in ensuring quality care. It is recognized that simply adding more staff when existing staff are poorly organized; poorly supervised or poorly motivated may not produce the desired or most effective improvement in quality of care and/or work environment. However, it is our view that the adequacy of staffing levels today is the single largest influential or contributing factor to our ability to provide quality care to residents.

Direct care providers have intimate insight into the attributes of quality care and the key factors hindering high-quality care. Direct care providers perceive quality care for older people as holistic, individualized and focused on promoting independence and choice[i]. Care providers, residents and family members define close care provider-resident relationships differently but all speak about the need for connectedness, and recognize that inadequate staffing and workload as barriers to care providers being able to create time for meaningful one-on-one relationships[ii].

THE CONTRADICTIONS OF CARE

The *Commitment to Care* report noted that in many homes care was not individualized; resident choice and involvement in decision making was limited; and in some areas care actually engendered dependency with staff. Certainly the quality of staff-resident interaction and relationships are prominent aspects as well of resident's perception of quality care. Continuing inattention to staff-patient ratios and continuity in staffing can only further undermine potential improvements in both facilities and programs[iii].

The evidence is clear that residents define quality care in potentially any of three dimensions:

- as 'service' - focused on the instrumental aspects of care as measured through the parameters of efficiency, competence, and value;
- as 'comfort' - allowing or maintaining or enhancing physical comfort; or
- as 'relational' - care that emphasizes the social and affective aspects of care, demonstrating compassion, friendship, connection and reciprocity[iv].

Clearly care-as-relating is the dimension that is immediately sacrificed to the exigencies of under-staffing, although comfort and service dimensions decline as well.

LISTENING TO THE FRONT LINES

A recent study emphasized that "staffing shortages and heavy workloads posed significant challenges to developing and maintaining a caring style"[v]. The study consisted of interviews with 48 staff members at 10 Ontario nursing homes. Another survey evaluating efforts to promote 'best practices' found the most common concern voiced amongst participants was the need for higher staffing levels and appropriate staffing qualifications[vi]. Without addressing the critical issue of inadequate staffing and onerous workloads, our province will continue to fail to realize the true potential of our organizational capacities to provide quality care. We will also fail to truly plump the depth of compassion and commitment of our front line direct care staff.

One recent study by York University researchers found a disturbing level of violence being reported by personal support workers on a daily basis; and noted the correlation between levels of workplace violence and heavy workloads burdening staff – the violence engendered by a lack of sufficient staff or time to ensure the dignity and respect of residents during intimate acts and the shared personal space of daily care activities. The El-Roubi/Lopez Inquest Jury at item #18 recommended that the Ministry set standards to ensure long-term care homes were sufficiently staffed with appropriately skilled, regulated health professional with the expertise and at staffing levels to ensure such "behaviours can be managed without risk of harm to self and others."

Surprisingly, even though staffing standards remain for administrator; director of nursing; food service supervisor; therapy services coordinator; registered dietician; and recreation and leisure services as well as food service staffing, the previous direct care minimum staffing requirement has not been restored. In consequence, despite significant resources being committed to long-term care since 2004, there have been only inconsequential changes recently in Ministry-

funded staffing levels once adjusting for increased resident acuity levels and program requirements.

Everyone has a role to play in preventing and intervening in cases of abuse and neglect and the right to be free of abuse and neglect. And everyone's right to be treated with respect and dignity is balanced by the responsibility of home administrators, staff, family and volunteers to maintain a safe environment for all, and a corresponding obligation to treat others with respect and dignity. Staff members also have a right and responsibility to learn to recognize abuse and neglect, and to participate in policy development on abuse and neglect, and to report suspected incidents of abuse or neglect[vii].

DUTY TO REPORT

We welcome this opportunity and have continually recommended that there be broad stakeholder involvement in not only examining and addressing elder abuse and neglect. We also welcome the opportunity for broad stakeholder involvement in developing education, training, and policies for both provincial and facility initiatives but would always caution that reporting is but only one form of intervention.

Our goal can only be to ensure there is no further abuse or neglect to report; rather than to ensure that all abuse and neglect is reported. Reporting, whether as a mandatory obligation or a voluntary act, nonetheless presumes the continued occurrence of abuse and neglect. The duty to report therefore cannot substitute or supplant other effective preventative responses – including immediate action to prevent abuse; as well as resident-centered engagement; and sufficient resources to ensure effective documenting and investigating of report.

PREVENTING VERSUS REPORTING ABUSE

Any legislative or regulatory mandate requiring reporting of abuse from our perspective has a more limited and potentially ineffectual response given the necessary range and diversity of potential interventions at the interpersonal, facility and societal level. According to a US General Accounting Office (GAO) report in 1991:

> Most experts consider reporting laws – whether mandatory or voluntary - much less effective than other factors in maximizing the number of elder abuse cases identified, prevented and treated. A high level of public and professional awareness is considered the most effective factors for identifying elder abuse victims.
> **GAO, 1991 Elder Abuse: Effectiveness of Reporting Laws and Other Factors**

The approaches mentioned by the GAO such as broad public awareness campaigns and specific training for professionals likely to interact with the elderly were not only more effective; they were also far more simple and cost-effective compared to programs that sought to increase abuse detection, prosecution and sanctioning.

ADEQUATE STAFFING TO PREVENT ABUSE

More recent studies have found significant correlation between higher reporting rates and public education regarding abuse (Jogerst, 2003) as well as suggesting that the most preventable causes of institutional elder abuse and neglect are staff shortages and inadequate staff training (Freeman, 2002). The task of preventing elder abuse is considerably broader that ensuring the effectiveness of reporting laws:

> Both mandatory and voluntary reporting are ineffective if there is no public education program to inform people about the rights of older adults, the potential for abuse of those rights and the moral responsibility toward abused or neglected people.
> **National Clearinghouse on Family Violence, Family Violence Handbook, Health Canada, 1994**

Given the competing demands for resources, we continue to advocate for a fundamental preventative strategy of education and public awareness as critical elements in any comprehensive approach to the abuse and neglect of older adults. As a feature of such an approach, the Task Force should consider the following as recommended by *Stand By Me: Preventing Abuse and Neglect of Residents in Long-Term care Settings*:

<u>Preventative strategies at provincial/community level</u>

- adequate funding to ensure appropriate direct care staffing
- resident and family council and community involvement, including advocates
- stronger voice for frail older adults including facility and sector ombudspersons

<u>Preventative strategies mandated at facility level</u>

- establish abuse prevention program addressing systemic abuse:
- establish preventative strategies and supportive and respectful environment
- develop and implement appropriate policies and procedures;
- provide ongoing staff training on prevention; appropriate resident care; aggressive residents

In addition and particularly relevant is the recommendation to adopt the 'Ombudsperson' strategy – as an advocate for frail older adults and staff alike with a mandate governing the interaction of seniors regardless of whether they reside in the community or in health institutions. A key role of such an ombudsperson role is to challenge the stigma and ageism that flows from the stereotyping and discrimination experienced by older persons; that contributes to the devaluing of older adults as full citizens; as well as the devaluing of care provided older citizens.

Regrettably, the promise held out in the legislative and regulatory consultations surrounding *Bill 140: An Act respecting long-term care homes* has diminished for lack of an operative definition of abuse or neglect that incorporates this element of the role of respect and dignity in thwarting abuse and neglect. Rather than working to locate the cornerstone of respect and dignity at the base of the building for our strategies to improve and strengthen care, a policy choice was made to pursue a punitive and myopic preoccupation with only staff abuse or neglect.

> Paternalism, "administrative efficiency," "risk management," as well as everyday practices ("the way things are done here"), and lack of sensitivity may create abusive or neglectful situations for older adults in long-term care facilities. Systemic forms of abuse or neglect may occur in these settings (eg, "routine use" of incontinence briefs instead of helping the senior to the washroom). The practices may develop for staff convenience or frequently because the facility does not have enough staff. **Systemic neglect will be commonplace in institutional settings where there is insufficient staffing to meet the residents' needs. (our emphasis)**
> **Abuse and neglect in long-term care facilities, Charmaine Spencer, 2005**

The preceding excerpt is from a commentary by Charmaine Spencer, LL.M., posted to the Concerned Friends website at http://www.concernedfriends.ca/iabuse.htm. The excerpt is a relevant and useful reminder that abuse and neglect often become systemic in institutions suffering from inadequate staffing.

CONCLUSION

Abuse and neglect are a far cry from the fundamental principle set out in section 1 of the *Long-Term Care Homes Act*. The continuing presence of abuse and neglect demonstrates how the lofty goal of ensuring dignity and respect will succumb to the harsh reality of ensuring the mundane and minimal activities of daily living for residents. We cannot as a province banish abuse or neglect without truly appreciating the relationship between dignity and respect on the one hand, and abuse and harm on the other. The single most critical factor in preventing abuse and neglect is ensuring adequately trained and motivated staff.

If a licensee or the Ministry through policy or practice demonstrates a lack of respect for the dignity of any of those residing, employed, visiting or volunteering in LTC homes, eventually this lack of respect translates into an alienating, non-supportive and unhealthy environment in which abuse and neglect by those exercising power become the observed paradigm.

To conclude, the laudable goal of ensuring zero tolerance of abuse and neglect must set aside the stereotype that only staff members are capable of committing abuse or condoning neglect. Abuse and neglect are a far more pervasive societal issue of ageism and represent the other ignoble side of the same coin minted with dignity and respect. Our appreciation as a province of the fundamental respect and dignity that ought to be accorded residents must flow from a deep affirming commitment to afford dignity and respect to all.

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[i] K Murphy, A qualitative study explaining nurses' perceptions of quality care for older people in long-term care settings in Ireland, Journal of Clinical Nursing (2007) Mar: 16(3): 477-85. The for-profit Irish Nursing Homes Organisation in February 2006 published Review of Nursing Homes Legislation and the Development of National Minimum Standards for Nursing Homes which concurred and agreed that internationally, around 3.45 to 4.1 HPRD have been identified as being required, and calling on the government of Ireland to move to a minimum standard of 3.45 by no later than 2010.

[ii] KS McGilton, VM Boscart, Close care provider-resident relationships in long-term care environments, Journal of Clinical Nursing (2007) November 16(11):2149-57.

[iii] R Coughlan & L Ward, Experiences of recently relocated residents of a long-term care facility in Ontario: Assessing quality qualitatively, International Journal of Nursing Studies. 2007 Jan; 44(1):47-57.

[iv] BJ Bowers, B Fibich & N Jacobson, Care-as-service, care-as-relating, care-as-comfort: Understanding nursing home resident's definitions of quality, Gerontologist (2001) August 41(4): 539-45.

[v] E Wiersma & S Dupuis, The role of caring and non-caring styles in managing responsive behaviours, Canadian Nursing Home (2007) Vol. 18 No. 2 June.

[vi] CA McAiney, P Stolee, LM Hillier, D Harris, P Hamilton, L Kessler, V Madsen & JK Le Clair, Evaluation of the sustained implementation of a mental health learning initiative in long-term care, International Psychogeriatrics (200& October 19(5): 842-58.

[vii] Stand by Me: Preventing Abuse and Neglect of Residents in Long-Term Care Settings, Jean Kozak and Teresa Lukawiecki, Family Violence Prevention Unit, Health Canada, 2001 available at http://publications.gc.ca/collections/collection_2008/hc-sc/H72-21-175-2000E.pdf