



# When Home Is Not a Home

*Abuse and Neglect in Long-Term  
Care — A Resident's Perspective*





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Care — A Resident's Perspective*

Our mission is to help the people of Canada  
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*When Home Is Not a Home: Abuse and Neglect in Long-Term  
Care — A Resident's Perspective* was prepared by Jean Kozak and  
Teresa Lukawiecki for the Family Violence Prevention Unit, Health  
Canada.

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de soins de longue durée — Le point de vue des pensionnaires*

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The content of this document is a synthesis of the material and products produced during the various phases of the APL project.

Kozak, J.F. & Lukawiecki, T. (1997). *Abuse Prevention in Long Term Care: Educational Package*.

Kozak, J.F. & Lukawiecki, T. (1997). *Final Report of the APL Project*. Report submitted to New Horizons — Partners in Aging, Health Canada.

Kozak, J.F., Lukawiecki, T., & Dalle, D. (1998). *Final Report of the Abuse Prevention in Long Term Care Train-the-Trainer Project*. Report submitted to the Population Health Fund, Health Canada.

Lukawiecki, T., Kozak, J.F., Wahl, J., & Dalle, D. (1998). *Policy and Procedures Guidelines for Responding to and Preventing Resident Abuse and Neglect in Long Term Care*.

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## Introduction

This monograph is the first of a three-part series on abuse and neglect from the perspective of residents and others who live and work within Canada's long-term care (LTC) sector.

This series of monographs was funded through the Family Violence Prevention Unit (FVPU) of Health Canada. Through the FVPU, Health Canada leads the Family Violence Initiative (FVI), coordinating the relevant activities of 13 federal Departments and three central agencies that are formally involved in the Initiative. Under the current FVI, Health Canada remains committed to addressing family violence issues, including the abuse of older adults. In consultation with the Division of Aging and Seniors, the FVPU undertakes research on the consequences of abuse and neglect of older adults to enhance treatment and prevention. The FVPU has developed and revised a number of resources on the abuse of older adults for dissemination through the National Clearinghouse on Family Violence.

For almost 20 years, public awareness of abuse and neglect of older adults (also referred to as elder mistreatment in the literature) has been increasing. Research and community service-based initiatives on abuse and neglect within Canada have focussed primarily upon seniors living in their communities and not in institutions.

To date, no systematic surveys have been conducted on the extent to which abuse or neglect occurs within institutional settings caring for older Canadians. What research there is, both in Canada and internationally, is typically limited to retrospective chart audits or staff surveys. This paucity of information severely limits our understanding of abuse and neglect of seniors residing in Canadian institutional settings and, in turn, affects our ability to design and implement effective intervention and prevention programs.

The purpose of this series of monographs is to present the findings from two national educational projects known as Abuse Prevention in Long-Term Care (APL) in an attempt to begin addressing this gap in knowledge. These projects were funded by Health Canada through the **New Horizons — Partners in Aging Fund** and by the **Population Health Fund**. During the life of the projects, from 1995 to 1998, information was collected from residents, long-term care (LTC) staff, families and

advocates as to their perceptions of abuse and neglect, the dynamics behind the occurrence of abuse and neglect, and how one can both stop and prevent abuse and neglect from occurring. The monographs are not meant to be a review of the published literature on abuse and neglect. Those seeking such a review are referred to publications such as the excellent Canadian Association on Gerontology's *Abuse and Neglect of Older Canadians: Strategies for Change* (1995) and Health Canada's *Abuse and Neglect of Older Adults in Institutional Settings: A Discussion Paper Building from English Language Resources* by Charmaine Spencer (1994).

Although we are unable to provide any indication of the extent of the problem (prevalence and incidence), the information contained herein can be used to understand how older individuals residing in LTC perceive and describe abuse and neglect, and to provide directions about how this complex problem could be addressed. It is critical to understand that although anyone can intentionally or unintentionally be the cause of abuse or neglect, the focus of this monograph is on how this issue is viewed from a *resident's* perspective.

This first monograph, *When Home Is Not a Home: Abuse and Neglect in Long-Term Care — A Resident's Perspective*, summarizes primarily the perceptions of LTC residents from across Canada as to what they feel constitutes abuse and neglect. The purpose of this monograph is to provide some understanding of the myriad factors and dynamics that residents feel underlie abuse and neglect situations.

The second monograph, *Stand by Me: Preventing Abuse and Neglect of Residents in Care Settings*, explores comments made by LTC residents, staff, families, advocates and others on how they believe individuals and facilities can best stop and prevent abuse and neglect from happening to older residents.

The third monograph, *Returning Home: Fostering a Supportive and Respectful Environment in the Care Setting*, explores the major factors identified by residents, staff, families, volunteers and advocates that minimize the dynamics that contribute to the abuse and neglect of older residents. This monograph explores the mechanisms, attitudes and beliefs that, according to those who live, work or visit LTC, must be present if we are to move toward the ideal of an abuse-free environment for all.

The ultimate goal of the three monographs is to stimulate discussion and action. As well, they are meant to encourage people to work toward fostering an environment that promotes the well-being of residents and is supportive and respectful of everyone. Although the documents primarily reflect a resident's



perspective, they are written for all people associated with LTC who wish to address the issue of resident abuse and neglect. This includes both individuals within facilities (e.g. residents, staff, families and volunteers) and those external to facilities (e.g. advocates and representatives of government regulatory agencies and professional associations).

## **1.1 SUMMARY OF KNOWLEDGE ON ABUSE AND NEGLECT OF SENIORS RESIDING IN INSTITUTIONS**

It is currently estimated that from 9% to 11% of seniors reside in institutional settings across Canada (Mental Health Division, Health Canada, 1994). Even with the current trend toward home-based care, there will still be a substantial number of seniors who require institutional care. The projected increase in the number of seniors requiring institutional care (e.g. Bélanger and Dumas, 1997) means that quality of life issues must be addressed as soon as possible, including the prevention of the abuse and neglect of older adults in LTC facilities.

Within the context of institutional care, seniors can be found in a spectrum of residences that ranges from non-medical residential settings to nursing homes to acute and chronic care facilities. Although abuse and neglect of seniors residing in the community has been the focus of much research and discussion in Canada, little is known about the problem in institutional settings. According to national and international research, the prevalence of abuse and neglect among community-dwelling seniors (those not living in institutions) ranges from 1% to 20%, depending on how abuse and neglect are defined and the methodology used to investigate it (Kozak, Elmslie and Verdon, 1995).

Only one methodologically sound study has been done on the type of abuse and neglect faced by seniors residing in institutional settings. In a randomized sample of 577 nursing staff (RNs and RNAs) from 31 nursing homes, Pillemer and Moore (1989) studied the number of physical and psychological abuse cases reported by nursing staff in a U.S. city. The authors reported that physical abuse of older patients was seen by 36% of the staff: use of restraints (21%), pushing, grabbing, shoving and pinching (15%), and slapping and hitting (15%). Eighty-one percent of the staff reported seeing or hearing forms of psychological abuse.

In Canada (Table 1), some smaller studies have attempted to explore the issue of abuse and neglect in Canadian institutions. However, many limitations in these studies have been identified in the literature (Kozak, Elmslie & Verdon, 1995; Beaulieu & Bélanger, 1995). Bélanger et al. (1981) reported that in a survey of 140 professionals, 35.5% of the known incidents of abuse or neglect reported by

**TABLE 1 — ABUSE AND NEGLECT IN CANADA**

INVESTIGATOR	SAMPLE	METHOD	FINDINGS
Bélangier (1981) (Quebec)	Social service workers	Questionnaire (32% response rate)	Psychological (55.0%) Civil rights (25.0%) Material (24.0%) Physical (21.0%)
Shell (1982) (Manitoba)	105 Professionals	Interview (402 unique reports)	Financial (40.2%) Psychosocial (37.4%) Physical (21.0%)
King et al. (1984) (Manitoba)	Hospital visits (1981-1984)	Screened by staff	19 confirmed cases
Haley (1984) (Nova Scotia)	Social services survey	281 seniors in community	48.7% cases reported
Stevenson (1985) (Alberta)	422 Social services workers	Questionnaire (67% return, but 1/3 unusable)	498 cases
Lamont (1985)	6 Service workers	Interview	498 cases
Ministry of Community and Social Services (1985) (Ontario)	Service providers	Questionnaire (9.3% return)	213 cases
Bélangier et al. (1986) (Quebec)	Professionals	Surveyed at a symposium	Psychological (73%) Abusive situation (5%)
Grandmaison (1988) (Quebec)	Centre of Social Services	Review of active cases	40/1,000 cases
Podnieks et al. (1989) (National)	2,008 community- dwelling seniors	Telephone interview	40/1,000
Concerned Friends (Ontario)	Reported complaints from care facilities	56 Self-reported cases	Almost 50% sufficient to warrant criminal charges
Ontario Nurses Association (1993)	Association members	Questionnaire (low response rate)	25%-84% report seeing abuse or neglect

their sample occurred in institutional settings, whereas 28.4% occurred either in private institutional settings or the home. Respondents in the survey reported that over 57% of the acts of abuse and neglect were committed by staff or other care providers.

In Manitoba, Shell (1982) reported that of 402 incidents reported by professionals whom she surveyed in institutional settings, 40.2% were financial abuse, followed by 37.4% psychosocial and 22.4% physical. In a more recent study by the College of Nurses of Ontario (1993), 804 RNs and RNAs were surveyed about abuse of residents by staff. Nearly half of the respondents reported witnessing one or more events, with 85% of the reports coming from hospitals, 29% from nursing homes and 7% from homes for the aged.

Although the true extent of abuse and neglect in Canadian institutions where care toward seniors is provided is unknown, it is evident from the above that — as in the community — seniors in the institutional sector are also at-risk of abuse and neglect. Moreover, it is obvious that the voice of residents have not been used in any consistent manner to identify either the nature of abuse and neglect from their perspective, or to identify methods for dealing effectively and sensitively with the problem.

How abuse and neglect is experienced and perceived by seniors in LTC, and how the problem could be addressed, were the subject of the APL projects.

## **1.2 APL PROJECT OVERVIEW**

### **Abuse Prevention in Long-Term Care Project (1995–96)**

In 1995, funding was obtained from *New Horizons — Partners in Aging*, Health Canada, to develop a *resident*-focussed educational package that had the goals of:

- sensitizing people to the problem of abuse and neglect of older persons residing in institutional settings;
- generating discussion which can lead to further understanding and a commitment to find solutions;
- raising awareness of the need for a supportive and respectful environment for seniors in institutional settings and ways to foster such an environment.

In the first phase of the project, focus groups were held with 494 LTC residents, staff (clinical and administrative), institutional volunteers, family members and advocates in British Columbia, Alberta, Manitoba, Ontario (French and English),

Quebec (French and English) and Newfoundland. Because of health limitations of some residents, individual interviews were conducted where necessary.

In the sessions or interviews, participants were asked to share their thoughts and experiences along the following themes:

- What institutionalization means to a resident;
- Definitions of abuse and neglect from a resident's perspective;
- Perceived causes of abuse and neglect of residents;
- Intervention and prevention of abuse and neglect of residents; and
- What constitutes a supportive and respectful environment.

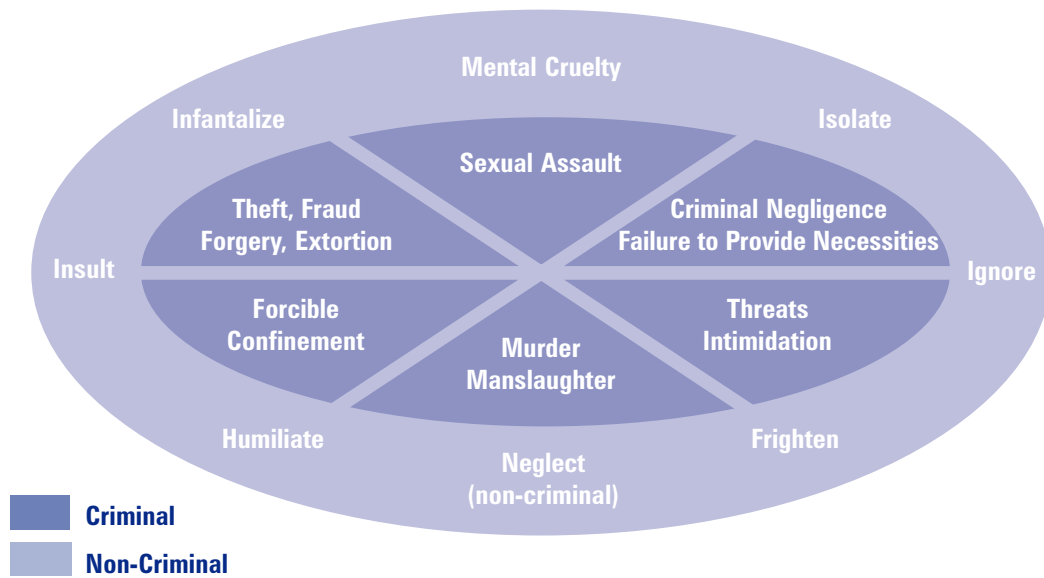
From the information provided in these sessions, a national expert panel (consisting of LTC residents, care staff, volunteers/advocates, administrative staff, family members and researchers) developed the *Educational Package for Abuse Prevention in Long-Term Care*. This unique package consists of two videos and nine discussion modules. It fosters a supportive and respectful environment from a resident's perspective.

The *Educational Package* was submitted for independent critical review and underwent pilot training/evaluation sessions in Vancouver, Winnipeg, Ottawa, Montreal and St. John's. It was very well received and positively rated by residents, staff, family members and volunteers alike. Based on feedback from the pilot groups, the package was revised and then distributed across the country. Appendix A contains information about the APL project teams and sites.

### **Abuse Prevention in Long-Term Care — Train the Trainer Project (1997-98)**

Building on the success of the original project, funding was obtained from the **Population Health Fund**, Health Canada, to train trainers in the use of the educational package. Six hundred and sixty-five people across Canada were trained in the use of the *Educational Package*. The workshops were developed with the intent of training trainers who would become resources for their communities on the issue of abuse and neglect of older residents in LTC. Training occurred in the Yukon and Northwest Territories and all of the Canadian provinces except Prince Edward Island.

More than 97% of the participants evaluated the training workshops as either good or excellent. They indicated that they would be returning to their communities to train others on abuse and neglect and lend their expertise in working toward solutions. In a one-month follow-up survey, more than half of the respondents contacted had already used what they learned, with the remaining participants



Reproduced from Advocacy Centre for the Elderly. (1988). *Elder Abuse: The Hidden Crime*.

reporting that they had not had enough time to implement the workshop information since their training.

During this second phase, participants provided educational facilitators with additional insights into the problem of abuse and neglect and shared innovative ways of dealing with the issue. In addition, a national steering committee of the APL project also developed policy and procedure guidelines<sup>1</sup> to assist facilities in developing sensitive and appropriate institutional policies for dealing with abuse and neglect of residents. The information contained in this series of monographs has been prepared from the findings of these two phases.

### Terminology

Within this document, LTC is defined as any publicly funded facility that provides basic nursing care to older adults. The facilities may range from residential homes for the aged, to nursing homes, to extended care facilities located within hospital settings.

For the focus groups, the resident groups included people more than 55 years of age. Family groups were composed of family members and advocates. Staff groups

1. Lukawiecki, T., Kozak, J., Wahl, J., & Dalle, D. (1998). *Policy and Procedures for Preventing Abuse and Neglect within LTC Institutions*. Dept. of Research, SCO Health Services, Ottawa, Ontario.

included direct care staff (RN, RPN/LPN/CA), non-direct care staff (social work, pastoral care, psychology, administration) and volunteers.

The term “participant” is generally used to refer to a person who participated in the focus group discussions, pilot testing or train-the-trainer workshops.

## Abuse and Neglect

Definitions are important because they help people identify when a situation is abusive or neglectful. Abuse and neglect are not easy to define because an event viewed as abusive or neglectful by one person may not be viewed as such by another. Culture, religious beliefs and personal values are some of the factors that affect how people perceive events. Because of these differences, it is not unexpected that residents, staff and families may have different perceptions of what action or lack of action constitutes abuse or neglect.

Generally speaking, abuse or neglect is any action or inaction that jeopardizes the health or well-being of another individual. The misuse of power underlies most situations of abuse and neglect. The term “abuse” is used to apply to situations in which people use their power to take advantage of another person or persons. A misuse of power can occur between individuals or at a systemic or policy level.

Abuse and neglect are also more likely to occur when people who interact with the resident focus on the task to be done rather than the resident. Paternalism toward a care recipient can erode the confidence residents have in their ability to take care of some of their own personal needs. Staff, other residents, family and volunteers who do too much for a resident can be *unintentionally* abusive. On the other hand, *not* attending to needs that older persons cannot meet themselves is a form of neglect.

Abuse and neglect can take many forms, ranging from the psychological to the physical (Figure 1), and can be:

- criminal or non-criminal;
- a single action or a pattern of behaviour;
- intentional or unintentional;
- subtle, seemingly insignificant acts or serious acts;
- committed by an individual, a group or an organization (systemic abuse).

Criminal behaviours are outlined in the *Criminal Code*. Some include assault, sexual assault, neglect and forcible confinement. In most instances, for a behaviour to be considered a criminal act, the person responsible must have had the intent to do harm. For example, it is an assault when a cognitively aware resident hits

another person. However, when this same action is taken by a resident who is cognitively impaired and suffers from a mental disorder, the resident is not held to be criminally responsible. Staff in the facility, however, still have the responsibility to try to implement measures to ensure that the behaviour is stopped. As well, even if the abuser is cognitively impaired, the person who was abused may still wish to make a formal complaint which may lead to charges being laid.

In some instances, institutional or governmental policies and regulations can create, facilitate or even perpetuate harmful situations for residents. Typically, when a harmful situation occurs, it is a by-product of a procedure or procedures designed to provide care. Often, these procedures *appear* legitimate or are so deeply ingrained in the day-to-day activity of the facility that people do not question whether or not the procedures are appropriate for all residents in LTC. For example, conflict may arise between a resident's eating habits and policies regarding meal times. Residents with a lifelong habit of eating either a late or no breakfast may become frustrated when a morning meal is available only at certain times or are compelled to eat it because of institutional policies.

## **2.1. DEFINITIONS OF ABUSE AND NEGLECT**

The majority of the comments made about the sources of abuse and neglect focussed primarily on the interaction between residents and staff (68% of comments), followed by procedures and policies in LTC (27%), other residents (20%) and family (16%). Because participants in all of the focus groups were asked to discuss abuse and neglect toward residents, 78% of all comments made were on this issue. Some of the focus groups (composed of residents, staff, family and advocates) made comments regarding abuse and neglect of staff (17%) and family (6%). Participants within these groups recognized that the phenomenon of abuse and neglect is highly complex and could be directed to anyone by anyone. It must be stressed that great caution is needed when reporting percentages as the lack of a comment does not necessarily mean that it is not important to an individual or a group of individuals.

Only a small number of the comments made by residents and staff identified what would be acknowledged by most people as overt acts of aggression or sexual abuse toward residents. Although this finding may reflect sensitivity or fear in reporting such incidents, residents participating in the two projects stated that the abuse or neglect that characterized their day-to-day experiences and those of others in LTC was less overt.



In the opinion of the participants, the major forms of abuse and neglect arose from three basic factors:

- poor attitudes or personality dynamics;
- lack of competence; and
- systemic or institutional processes that create and foster a power imbalance between residents and staff.

Overall, perceptions of what constituted abuse and neglect could be categorized according to the definitional model developed in *Abuse and Neglect of Older Adults in Institutional Settings: Discussion Paper Building on English Language Resources*<sup>2</sup>. The major forms of abuse and neglect identified were:

- Medical
- Financial
- Physical
- Civil/Human rights
- Psychological
- Systemic
- Sexual

Participants defined abuse and neglect as the omission or commission of an act that harmed, denied or placed a resident at risk. The perceived effects of these actions or inactions ranged from loss of dignity and respect to the failure to meet basic needs. Staff clearly identified forms of abuse and neglect but tended to imbed statements within perceived reasons (e.g. difficult behaviour problems, families and institutional process). Families discussed neglect and more complex forms of abuse (psychological, civil/human rights, systemic) rather than overt, obvious indications of physical abuse. Physical abuse (e.g. rough handling) was likely to be perceived by participants who had greater amounts of contact with residents (e.g. staff, volunteers).

*“The first night I arrived I called the nurse because I didn’t feel well. She said: ‘I don’t have time, when the aide comes back from break she’ll come to you.’ I began to cry like a child and I said [to myself] this is the nursing home.” (resident)*

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2. Mental Health Division, Health Canada. (1994). *Abuse and Neglect of Older Adults in Institutional Settings: Discussion Paper Building on English Language Resources*. Ottawa: Minister of Supply and Services.

## Neglect

Neglect was frequently mentioned by all groups as occurring within LTC, with volunteers and advocates making the most frequent comments about it (80%). The majority commented that neglect was unintentional but caused individuals to feel helpless. Participants said that forms of neglect included being ignored or forgotten, having call bells or lights left unanswered, and the failure of staff to attend to their needs. Residents and families identified leaving residents alone (during staff breaks) on toilets, lying/sitting in soiled clothes, and infrequent physician contact as other forms of neglect (and disrespect).

### PERCENTAGE OF COMMENTS ON NEGLECT BY RESPONDENT

TYPE OF RESPONDENT	%
Residents	40
Clinical staff	29
Administration	50
Family	43
Volunteers/Advocates	80

A small number of residents identified active forms of neglect: being locked in rooms; withholding of food, bathing, medications; and not receiving assistance when staff were told of uncomfortable positions. Active neglect was not identified by APL participants who were staff or families.

Staff identified neglect by families as a problem for both residents and themselves. Staff reported having to handle the emotional consequences of family members forgetting promises of visits or leaving residents and never returning. Clinical, “bedside” staff made fewer comments about neglect (29%) than administrative staff (50%).

*“Sitting on the toilet where you did your pee, dressed, waiting... and they’ve forgotten about you.” (resident)*

*“They’ll just wheel them in [to their room] and just leave them facing the wall. I mean would you spend the next three hours staring at a wall?” (family)*

*“You don’t have time to wait for them [toilet]. You have no time to stay and have a chat. I have another resident and I have to go.” (staff)*

## **Physical Abuse**

Residents across the regions repeatedly stressed that they have never experienced overt physical abuse. No group reported seeing signs of obvious physical abuse (bruises or abrasions). Discussing overt physical abuse was difficult for residents, whereas “inconsiderate” handling was easily discussed.

### **PERCENTAGE OF COMMENTS ON PHYSICAL ABUSE BY RESPONDENT**

TYPE OF RESPONDENT	%
Residents	16
Clinical staff	24
Administration	—
Family	43
Volunteers/Advocates	20

Very few residents stated that they knew or saw someone being slapped, and when they did, the action was said to result from what was perceived to be aggressive or inappropriate behaviour of a resident (e.g. resident was slapped by a staff member because she [resident] was unable to stop crying). Residents acknowledged that physical abuse, as well as psychological abuse, was a “two-way street” and staff may only be reacting to residents who were aggressive or abusive.

*“I’ve never been hit by any of the staff, but I was handled pretty rough by one.” (resident)*

*“I stepped into a hall and a staff member was screaming at a resident. I looked at the [nursing] desk... and I realized they couldn’t hear what was happening. So I stepped back and spoke to my friend [resident] and she said ‘I think that Mrs. So-and-So hit the intern.’” (advocate)*

*“I’ve never seen somebody hit somebody else, but I’ve seen staff members who are very rough with patients. They will go in the middle of the night, rip off the covers, push them over to turn them and then say, ‘I’m going to turn you now.’ Like a sack of potatoes.” (staff)*

## **Psychological Abuse**

Participants identified psychological abuse, resulting in loss of dignity or self-respect, as a common form of abuse. Residents said some forms of psychological

abuse included being treated like children, talked down to, taken advantage of, not being taken seriously, demeaned, humiliated, disrespected or made to feel like a nuisance. More serious forms of psychological abuse included being restricted to rooms when staff escorts were unavailable or not being able to make phone calls. These comments were echoed by staff and families.

#### PERCENTAGE OF COMMENTS ON PSYCHOLOGICAL ABUSE BY RESPONDENT

TYPE OF RESPONDENT	%
Residents	40
Clinical staff	53
Administration	50
Family	71
Volunteers/Advocates	80

Verbal abuse, as a form of psychological abuse, was frequently discussed by participants and included incidences such as name calling, swearing, “talking nasty” and yelling. Shouting, intimidation, verbal threats and gossiping about residents in front of others were also identified as forms of abuse by families and residents.

Families indicated that another form of psychological abuse was residents being treated like children or enemies by staff. Volunteers felt that a similar antagonistic relationship existed between themselves and staff.

*“The nurse will say, ‘I’ll let you brush your teeth.’ They treat me like a child, like I’m four years old.” (resident)*

*“And after a while you get a name for yourself. When you come in they’ll say, ‘Here comes the Bitch.’ But what are you supposed to do.” (family)*

*“A resident hearing something being said about them by staff such as, ‘I’m not bathing her tonight. I hate her.’ The resident shrivelled up.” (staff)*

### **Sexual Abuse**

Only a small number of residents identified sexual abuse as a form of abuse that might occur in LTC. The types of abuse mentioned were rape and sexual harassment by other residents (males to females). One resident raised the concern of residents who harass children of visiting family members.

Although not identified as sexual abuse, comment was made about female residents discomfort with receiving personal care (bathing, dressing, toileting) from male staff. Staff raised the issue of inappropriate touching and touching without permission (touching in general and not in a sexual manner).

**PERCENTAGE OF COMMENTS ON SEXUAL ABUSE BY RESPONDENT**

TYPE OF RESIDENT	%
Residents	2
Clinical staff	6
Administration	—
Family	—
Volunteers/Advocates	—

*“I don’t like it. Let a woman go to a woman and a man to a man. When you got to ask a man to put a diaper on you, it’s not nice.”  
(resident)*

*“One of the residents does not like me, she does not like me touching her when I try to care for her... so only the female staff go to her.”  
(male staff)*

**Financial Abuse**

Reference to financial abuse was made only by residents. The comments referred to theft of property and money; having funds given out “like an allowance”; lack of access by residents to their funds; and staff breaking things, or using personal property without permission. Residents mentioned that other residents would enter rooms to rifle through and remove personal belongings. Comments were also made about receiving fewer services and food, and the differential treatment for residents based on ability to pay (e.g. private versus shared rooms). When specifically asked, staff and others agreed that financial abuse did occur, but that the cause tended to be theft by family members or strangers. Removal of items by other residents was not perceived as theft by staff. Instead, staff believe such actions are unintended acts resulting from a disease process such as Alzheimer’s.

## PERCENTAGE OF COMMENTS ON FINANCIAL ABUSE BY RESPONDENT

TYPE OF RESIDENT	%
Residents	6
Clinical staff	—
Administration	—
Family	—
Volunteers/Advocates	—

*“Never bring your best to an institution.” (resident)*

## Possible Civil/Human Rights Abuse

All participants commented on the feelings of confinement and restriction faced by residents in LTC. A major complaint was the lack of respect for privacy. Examples in which there were the possibility of human rights violations included staff entering rooms without knocking or introducing themselves; basic needs, such as toileting and bathing, done without consideration for privacy; and staff freely discussing in front of others matters that residents considered to be personal.

## PERCENTAGE OF COMMENTS ON POSSIBLE CIVIL/HUMAN RIGHTS ABUSE BY RESPONDENT

TYPE OF RESPONDENT	%
Residents	14
Clinical staff	12
Administration	—
Family	14
Volunteers/Advocates	20

Residents, staff and families all identified the withholding of information from residents as another possible violation of civil/human rights. Residents stated they felt left out and treated as “second class citizens.” Families felt they were not fully informed about care issues. In a similar vein, staff commented that families often request that the resident not be approached about care decisions. This appeared to be more typical of residents suffering from moderate to severe cognitive impairment.

*“I’m not allowed down unless my family is with me. I listen to the sounds around me and think ‘My God, if I’m not insane, I’ll be insane if I live here another minute.’ And then I go to my room and find a good program on TV.” (resident)*

*“There’s no one around who can tell you what is happening and why.” (family)*

*“We try to inform the family and resident, but at times it is hard to get the family to come and the resident does not understand. On top of this, we are running around trying to meet the needs of everyone.” (staff)*

## **Medical Abuse**

Residents and families identified the perceived overuse of medication as a form of medical abuse. Examples of medical abuse identified by APL participants include errors in medication; medications that were not updated; the lack of or sporadic contact with physicians; and the use of chemical restraints. A small number of residents felt so strongly about their problems in living with other residents with severe behavioural problems (wandering, verbal and physical aggression) that they suggested chemical restraints should be used to manage these residents.

### **PERCENTAGE OF COMMENTS ON MEDICAL ABUSE BY RESPONDENT**

TYPE OF RESPONDENT	%
Residents	16
Clinical staff	29
Administration	50
Family	57
Volunteers/Advocates	20

Staff, both clinical and administrative, felt that there was an over-reliance on medication to deal with problems that might arise with residents (e.g. agitation) and that alternative approaches should be explored. Moreover, the use of restraints in LTC was of concern to both groups. Staff felt that there needed to be greater vigilance regarding the use of restraints and were concerned about unlicensed facilities which were not subject to ongoing evaluations or bound by professional codes of ethics. Both families and volunteers/advocates felt that staff are too likely to medicate residents.

*“They give you these pills to calm you down when you just want to cry.” (resident)*

*“One of my mother’s bed [room] partners was over-medicated. She was given the wrong medication, but they never admitted it.”  
(family)*

*“Sometimes they don’t want to take the medication, but it is ordered and so we have to give it.” (staff)*

## **Systemic Abuse**

Systemic abuse was one of the major issues commented on (75% of comments). Examples included residents being called “patients”; residents being forced to live in small rooms; the inability to control noise; rigid adherence to schedules; rushing through meals or toileting; constant waiting for care; and discontinuity in care because of part-time staffing. As would be expected of a population residing in an institutional setting, many of their comments focussed on the poor quality of food and the inability to eat what was wanted when the person wanted it. As stated by a staff member, “why shouldn’t a 90-year-old diabetic have a chocolate if she wants one?”

Staff felt that the admission process, involving many different staff members asking questions continuously, was tiring and upsetting for residents. As well, staff commented that the odd room colours (“surgical green”) contributed to an institutional rather than homey feeling.

### **PERCENTAGE AND TYPE OF COMMENTS ON SYSTEMIC ABUSE**

<b>TYPE OF RESPONDENT</b>	<b>%</b>
Policy and procedures	47
Grouping by function	27
Staffing levels	22
Care and spirituality	20
Scheduling	17

Many participants commented that it is the use of inflexible policies and procedures that creates situations in which the individual need and dignity of a resident is not respected. For example, policies on the scheduling of meals make it difficult to accommodate individuals who have never eaten breakfast and prefer a light mid-morning meal. A policy on moving residents to other rooms in other units can be highly disruptive to the resident as it does not recognize the possibility that



social relationships on that unit were formed and are now being broken. Moreover, staff indicated that policies may inadvertently cause conflict by contradicting what procedures take precedence over others. Great care is needed in examining how policies interact and the consequences that may result.

Residents and staff also stated that grouping residents based on functional level or disease categories creates problems, especially when some residents are younger than others. For example, residents complained about having to share rooms with other residents who were severely cognitively impaired or who were much older, making it difficult to communicate or share common experiences with one another. In addition, all participants mentioned several conditions that interact to create situations in which individual rights and needs can come into conflict with the systemic process of providing care. These conditions include low staffing levels; the perceived lack of available, consistent care; inadequate access to spiritual support (other than the availability of chapels or weekly services); and conflicts in scheduling (e.g. appointments with professional services only in the morning, causing nursing staff to rush patients).

*“Little things affect you more when you’re old. When they told me I had to change rooms, I cried. It’s hard to take things when you’re 90.” (resident)*

*“... you are in a sort of power relationship when that happens. It’s an abuse of power. And I think it’s insidious, I don’t think a lot of people actually recognize it — the enforced control.” (advocate)*

*“They might perceive it as abuse, but we might just perceive it as the way in which we can get our work done.” (staff)*

## **2.2. PERCEIVED CAUSES OF ABUSE AND NEGLECT**

Focus group participants identified the following as major causes or contributing factors with regard to abuse and neglect within LTC:

- Attitude/Personality
- Lack of competence
- Systemic or institutional processes
- Cognitive and communication deficits

## **Attitude/Personality**

Residents and staff/volunteers all recognized that a poor attitude toward older adults among staff in LTC is a significant contributor to abuse and neglect. Seventy percent of the comments on perceived contributing factors made by all groups related to poor attitudes or personality conflicts.

Staff who did not value the resident as an individual, or just focussed on the financial aspects of their job, were identified as being inconsiderate, disrespectful and less caring. Conflict was also seen to arise from personality incompatibilities between residents and staff.

Participants in the APL project, especially residents, stated that stereotyping of residents by others as disabled and dependent resulted in treating residents like “children,” incapable of performing tasks or making decisions on their own. This process, in turn, leads to the dependency of residents for day-to-day functions and places care providers in positions of power over residents. This imbalance in power was acknowledged by all as a major contributing factor in creating conflicts that could escalate into situations of abuse and neglect.

Residents felt strongly that staff “talked down” to them and used phrases such as “dearie” in a patronizing manner. Even though residents recognize that the use of such a term was meant to reflect warmth toward them, they nevertheless feel that it more often is indicative of a perception that they are helpless children.

## **Lack of Competence**

Participants stressed a need for staff to be qualified in the delivery of care as well as understanding disease processes and their management and interventions (e.g. behavioural problems associated with Alzheimer’s disease). Staff and residents alike identified the need to train staff using an approach that recognizes and values the individual, and not one that focusses on technical care alone.

Concern was also raised by APL participants regarding the use of temporary part-time staff. Although it was recognized that financial constraints have forced facilities to rely on lower paid replacement workers, participants were concerned that these workers — although able to provide basic nursing care — would not have received appropriate training in disease processes, abuse and neglect, or the other myriad issues important for the provision of good, sensitive care. Many comments were made that facilities should adopt a policy whereby hiring of replacement staff would be done only with those private employment services that demonstrate that their personnel are trained or receive training in these issues.

## **Systemic or Institutional Processes**

All participants identified the institutional process, beginning at admission, as a major potential contributor to situations that may lead to abuse and neglect. Many were concerned that staff cutbacks and the increased time burdens for the remaining staff were major limitations in the delivery of quality care, limitations that result in inadequate care and increased frustrations. For example, residents saw the long delays in attending to their needs as a direct result of insufficient staff. Staff commented on the growing institutional emphasis on time accountability rather than quality patient care as a major source of frustration and burn-out.

Residents commented that part-time staffing affected continuity of care. The use of part-time help meant frequently dealing with new personnel who did not know preferences or specific care needs. Moreover, residents felt they had to accept personal care from strangers.

All participants agreed that the institutional process was one that forced residents to adhere to rigid, time-constrained schedules and did not encourage staff to take time to sit and talk to residents. All stated that the rigid adherence to schedules or orders reduced opportunities to respect individual wishes or enhance individuality within the facility. For example, staff had to wake and feed all residents at set times even if some did not want to eat — “If I do not want to get up I can stay in bed.” One staff member observed, “Here, they [residents] have no choice.”

The taking of medication, because it was ordered by a physician and not agreed to in consultation with the resident, was also cited as a problem that led to confrontations between direct care staff and residents.

## **Cognitive and Communication Deficits**

Cognitively impaired residents and those who had difficulty communicating were perceived by all to be more at risk for abuse and neglect than more capable residents. While there may be no intent to cause abuse, the lack of communication could result in abuse and neglect as staff are unaware of what the resident actually wants. “People who can’t speak, can’t let us know,” said one staff member.

Staff stressed the need to communicate by other means, or to perceive what the resident wanted through careful observation. It was seen to be vital that staff take the time to understand a resident’s wishes. The lack of time to do so and the use of part-time help unfamiliar with the resident were seen by staff as factors that might lead to abuse and neglect.

Despite the importance of spending time to become aware of a resident's individual needs, staff across Canada indicated they were hard-pressed to find time to spend with residents. Extra time spent with residents who cannot easily communicate their needs resulted in less time for others, leading to situations of resentment and frustration among residents waiting for a care aide or nurse.

## Conclusion

The purpose of the APL projects was to explore the meaning of abuse and neglect, primarily from the perspective of residents living in Canadian LTC facilities, and to explore all practical ways of both stopping and preventing abuse and neglect.

From a resident's perspective, abuse and neglect that occur most frequently involve day-to-day interactions: a word, a gesture or a lack of action. It stems from having to rely on others to meet basic needs. And when those needs are unmet — regardless of the reason — the resident feels neglected.

Abuse and neglect are also perceived as the result of being devalued, of having to submerge personal lifelong habits or possessions to meet inflexible regulatory guidelines within which staff and facilities operate. It is the end result of understaffing, of the use of unskilled personnel and of patronizing or negative attitudes by all concerned.

Because of the complexity of what is perceived as abuse or neglect, and our inability to protect against unforeseen intentional criminal acts, it is probably impossible to obtain a totally abuse-free environment for anyone. Nevertheless, it is imperative that we strive to make abuse and neglect “zero-tolerated” occurrences. To do so requires active, ongoing interaction and communication among residents, staff, families, volunteers and the community at large, as we are all part of the problem as well as the solution.

It is our belief that the solution to abuse and neglect of seniors residing in LTC lies in a focus on the residents themselves. This is not meant to diminish the fact that abuse and neglect can happen to anyone. It can be perpetrated by residents themselves, families, front-line staff and administrators, volunteers and others. Moreover, it can often be reciprocal for many reasons, such as simple misunderstandings. Residents themselves reported that abuse can arise from the aggressive actions of residents toward staff.

The goal of this monograph is to focus on improving the life of older adults in LTC by approaching the problem of abuse and neglect from their perspective. By doing so, through effective and sensitive policies and procedures, effective education and training programs, and the fostering of a respectful and supportive environment, we will move toward the development of caring environments for all — for those who reside, work or visit a LTC facility.

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## APPENDIX A

### Structure of APL

The two *Abuse Prevention in Long-Term Care* projects were funded through the following Health Canada agencies:

*Abuse Prevention in Long-Term Care Project* funded through **New Horizons — Partners in Aging Program**, Health Canada

*Abuse Prevention in Long-Term Care — Train-the-Trainers Project* funded through **Population Health Fund**, Health Canada

The coordinating sites for the project were:

#### Central Site

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British Columbia	St. Vincents' Hospitals, Vancouver
Manitoba	Riverview Health Centre, Winnipeg
Quebec	Regroupement des Trois Rives, Vaudreuil
Newfoundland	Hoyles-Escasoni Complex, St. John's

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Newfoundland	Hoyles-Escasoni Complex, St. John's, Anne Morrison/Pat Amos

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