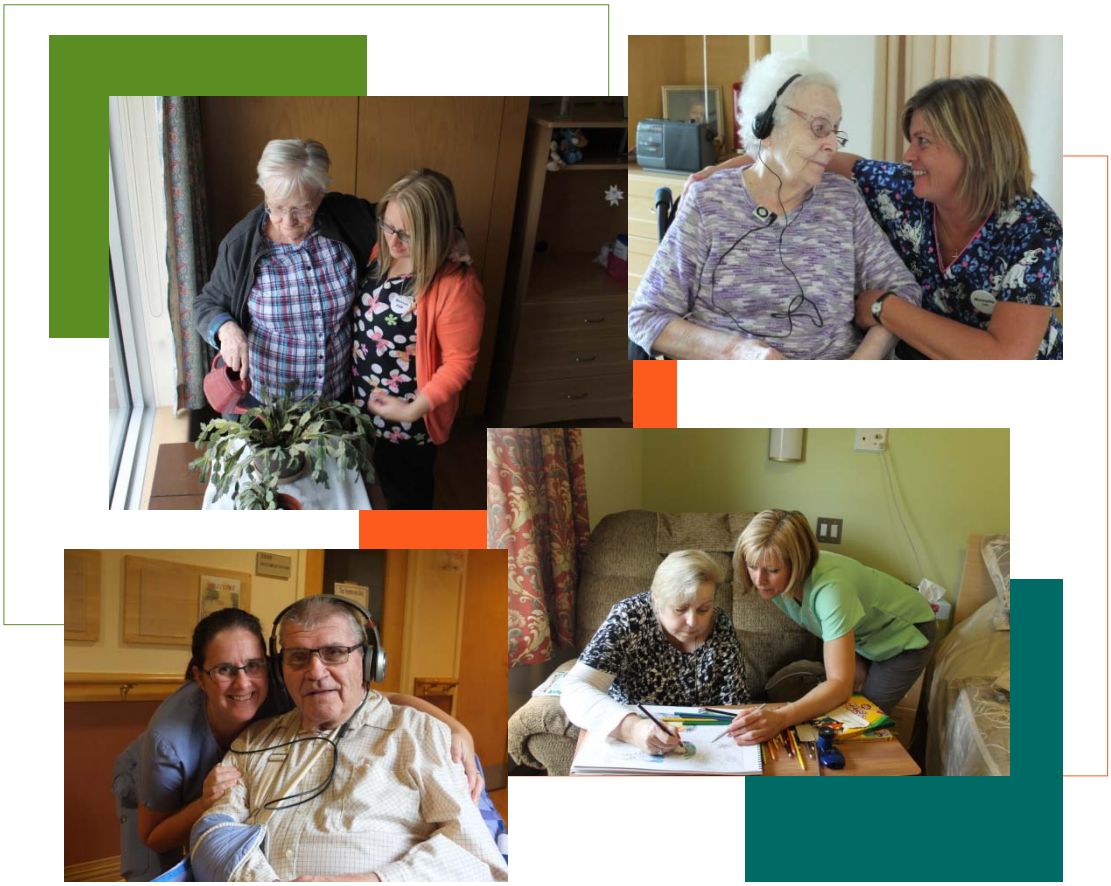
Reporting Suspected Abuse and Neglect, Whistle-blowing Protection: Long-Term Care Video

Discussion Guide

June 2018



RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Woodingford Lodge ... an exceptional place to live & work

BPSO RNAO Best Practice Spotlight Organization Canada

LTC Long-Term Care Best Practices Program

Reporting Suspected Abuse and Neglect, Whistle-blowing Protection Long-Term Care Video Discussion Guide

This resource was developed by Woodingford Lodge together with support from the Registered Nurses' Association of Ontario (RNAO) and with funding from the Ministry of Health and Long-Term Care.

The purpose of this guide is to provide key areas to focus your discussion after watching the *Reporting Suspected Abuse and Neglect, Whistle-blowing Protection Long-Term Care* videos which is a supplement to the five *Preventing and Addressing Abuse and Neglect Long-Term Care* videos that depict interactions between staff and residents in a long term care setting. Questions and responses are used to guide the facilitator and are suggestions only. Facilitators are responsible for ensuring they provide accurate and up-to-date information regarding legislation and their own organization's policies.

The video can be found online at: http://rnao.ca/bpg/initiatives/reporting-suspected-abuse-and-neglect-whistle-blowing-protection-video

Authors
Judy Esseltine RPN, Project Nurse, Woodingford Lodge
Sue Sweeney, RN, LTC Best Practice Coordinator, Southwest LHIN, RNAO
Citlali Singh, Project Coordinator, LTC Best Practices Program, RNAO
Suman Iqbal, RN, MSN/MHA, GNC(C), Senior Manager, LTC Best Practices Program, RNAO
Heather McConnell, RN, BScN, MA(Ed), Associate Director, Guideline Implementation and Knowledge Transfer, RNAO

Date
June 2018

RNAO
Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Woodingford Lodge ... an exceptional place to live & work

BPSO RNAO BEST PRACTICE SPOTLIGHT ORGANIZATION CANADA

Ontario

This work is part of the RNAO LTC-BPSO® Designation program, funded by the Ontario Ministry of Health and Long-Term Care. For more information, please visit www.RNAO.ca.

Table of Contents

Introduction and Purpose

Woodingford Lodge, together with the Registered Nurses' Association of Ontario (RNAO), has created a video depicting interactions with a management team attending a morning meeting. It is a supplementary video to the five videos developed by Parkview Manor Health Care Centre in 2015, illustrating interactions between staff and residents in a long-term care (LTC) home.

The purpose of this video is to provide a fictional scene which can be viewed and then discussed as part of an educational program to raise awareness, prevent and address abuse and neglect of older adults, and allow for self-reflection. This video addresses whistle-blowing protection and the moral, ethical, professional and legal aspects of reporting suspected abuse and neglect. The goal of this video is to positively change the workplace culture to support the reporting of suspected abuse and neglect.

Since abuse and neglect are topics which are not always discussed openly, people may have different understandings of the definitions, possible signs of abuse and neglect and responsibilities about how to respond. Opening up dialogue between staff members in an LTC home can help ensure that everyone has a good understanding of what is considered abuse and neglect, what the policies and legislated requirements are surrounding this topic, and ways to work together to address problems.

Many different definitions of abuse and neglect have been developed over time; the definitions used in this guide align with the RNAO guideline *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*, 2014. Definitions of abuse can be found on page 5 of this discussion guide. Some forms of abuse such as physical, financial and sexual abuse may be better known, given that they are more frequently highlighted in the media. The more subtle forms of abuse such as emotional/psychological abuse and neglect may be less understood. All forms of abuse can be damaging to older adults. This video addresses the steps and processes that should take place after suspected abuse and neglect occur.

LTC staff are in a unique position to advocate for quality care and promote dignity, respect and safety for all residents. This is important because residents and their families rely on staff to protect them, without hesitation. Everyone has a moral obligation to respond to poor care and a legal obligation to report actual or suspected abuse or neglect of those in our care (legislation varies across Canada). Unfortunately, some individuals are hesitant to report suspected abuse and neglect for several reasons. This video will address these reasons.

Here are some recommended discussion points after watching this video:

1) expectations for reporting suspected abuse and neglect
2) review whistle-blowing protection
3) moral, ethical, professional and legal responsibilities for reporting suspected abuse and neglect

The video was created to generate conversation and promote critical thinking. Discussions can also include dialogue about the impact our own values, beliefs and attitudes may have on the care that is provided for residents. In some cases, this may lead to questions about your organizational policies or local legislation. In this case, you will need to seek out the information which is relevant to you as this varies from organization to organization and across Canada. Appendices and Resources are provided to support an informed discussion. It is important that you review the *duty to protect* legislation according to the LTC Homes Act, 2007 section 19 for those in Ontario (if outside Ontario, refer to your local legislation on how to report and to whom). This should also include discussion of the *whistle-blowing protection* that is part of the LTC Homes Act, 2007 section 26 (see Appendices A and B).

Facilitator Tip: Throughout the guide you will see boxes which indicate additional tips to help facilitate the discussion.

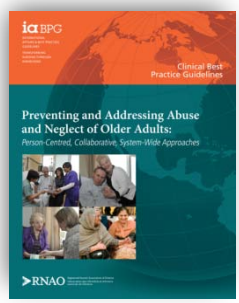
Here are some tips to consider before getting started:

- Preview the video in advance.
- Be familiar with the content of the guide, your organization's policies, procedures and jurisdictional legislation and have this information on hand.
- Consider setting ground rules with the group to make people feel more at ease to discuss sensitive issues.
- Prepare for strong emotional reactions and anticipate ways you can address these effectively.
- Be prepared to follow up on suggestions staff may have about ways to enhance quality care or to prevent or address abuse and neglect and enable more effective reporting.

You may want to provide handouts with the definitions of abuse and neglect, and whistle-blowing protection for participants to refer to throughout the discussion.

Definitions of Abuse and Neglect of Older Adults

This information is taken from Appendix D (page 97-99) in the RNAO guideline *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*, 2014. A complete list of references can be found in the guideline here: www.RNAO.ca/elder-abuse.



Overarching definitions of abuse and neglect

- "A single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person" (WHO, 2002, p.126).
- "Mistreatment of older adults refers to actions and/or behaviours, or lack of actions and/or behaviours that cause harm or risk of harm within a trusting relationship. Mistreatment includes abuse and neglect of older adults" (NICE, 2012, p.99).

Emotional/psychological abuse

"Severe or persistent verbal or non-verbal behaviour that results in emotional or psychological harm" (NICE, 2012, p.99).

Psychological, emotional and verbal abuse is also defined as "any action, verbal or nonverbal, that lessens a person's sense of identity, dignity and self-worth" (ESDC, 2011).

"Psychological, emotional and verbal abuse may include one or more of the following:

- words or actions that belittle an older adult, are hurtful, make the person feel unworthy;
- not considering an older adult's wishes;
- not respecting an older adult's belongings or pets;
- inappropriate control of activities, for example, denying access to grandchildren or friends;
- threatening an older adult with, for example, putting them in a "home";
- treating an older adult like a child;
- removal of decision-making power while the older adult is still competent;
- withholding affection;
- verbal aggression, humiliation, isolation, intimidation; and
- name-calling"

(ESDC, 2011).

Financial/material abuse

"An action or lack of action with respect to material possessions, funds, assets, property, or legal documents, that is unauthorized, or coerced, or a misuse of legal authority" (NICE, 2012, p.99).

"Any improper conduct, done with or without the informed consent of the older adult, which results in a monetary or personal gain for the abuser and/or a monetary or personal loss for the older adult. The misuse of another individual's funds or property through fraud, trickery or force is financial abuse" (ESDC, 2011).

Sexual abuse

"Direct or indirect involvement in sexual activity without consent" (NICE, 2012, p.99).

Sexual abuse "includes coercing an older person through force, trickery, threats or other means into unwanted sexual activity. Sexual abuse also encompasses sexual contact with older adults who are unable to grant consent. This includes inappropriate sexual contact between service providers and their older adult clients" (ESDC, 2011).

Physical abuse

"Actions or behaviours that result in bodily injury, pain, impairment or psychological distress" (NICE, 2012, p.99).

"Physical abuse may include one or more of the following, but is not limited to:

- pushing, shoving;
- hitting, slapping, poking;
- pulling hair, biting, pinching;
- spitting at someone; and
- confining or restraining a person inappropriately"

(ESDC, 2011).

Neglect

"Repeated deprivation of assistance needed by the older person for activities of daily living" (NICE, 2012, p.99).

Neglect is also defined as the "intentional or unintentional failure to provide for the needs of the older adult" (ESDC, 2011). Neglect can be divided into two categories: 1) Active neglect is "the deliberate or intentional withholding of care or the basic necessities of life"; and 2) Passive neglect is "the failure to provide proper care due to lack of knowledge, information, experience or ability" (ESDC, 2011).

Systemic abuse

Systemic abuse has multiple meanings. These may include:

- rules in a facility or at the government level that inadvertently cause harms;
- repeated patterns of substandard care;
- situations where employees are unaware that their behaviour is wrong and therefore there is no corrective action;
- failure of administration to effectively address incidents of abusive conduct; or
- system wide problems, such as inadequate resources or an institutional culture where staff fear consequences for reporting abuse (Spencer et al., 2008).

Violation of rights

"A violation of rights is defined primarily as the denial of a person's fundamental rights according to the Canadian Charter of Rights and Freedoms or the United Nations' Universal Declaration of

Human Rights. Conduct that denies an older adult's rights may include one or more of the following:

- censoring or interfering with a person's mail;
- withholding information to which the person is entitled;
- restricting liberties, not allowing the senior go out and/or socialize; and
- denying privacy, visitors, phone calls or religious worship/spiritual practice"

(ESDC, 2011).

Whistle-blowing Protection (as per Ontario LTC Homes Act, 2007)

No person shall retaliate against another person, whether by action or omission or threaten to do so because of the disclosure of information to an inspector or to the Director of LTC, or for giving evidence in any proceeding in connection with the enforcement of the Act (s.26.1) see Appendix B.

It is important that you review the legislation for reporting certain matters to the Director (s.24.1) according to the LTC Homes Act for those in Ontario (if outside Ontario, refer to your local legislation on how to report and to whom).

This should include a discussion of the whistle-blowing protection that is part of the Ontario legislation.

Video Discussion

While staff watch the video, ask them to write down any observations, comments or questions they may have regarding topics discussed in the video.

Sample Discussion Questions

What actions did the staff take in the process of reporting the abuse in Ed's case? (resident room video)

Possible responses:

- separating the resident from the abuser
- writing down as soon as possible objective facts about the situation
- staying with the resident to listen and reassure
- reporting to the manager immediately

Be familiar with any duties to report that may apply, according to your jurisdiction or your organization's policies. **Appendix A** is a good reference for Ontario LTC Homes. Be able to clarify to staff:

- ☐ What must be reported?
- ☐ Who is responsible for reporting?
- ☐ Who do you need to report to and what are the contact details?
- ☐ If you report, how are you protected by whistle-blowing protection?
- ☐ If you don't report, are there any repercussions?
- ☐ What occurs after suspected abuse and neglect is reported?

Note: It may be useful to have your abuse and neglect policies available for review during this educational opportunity.

What made the housekeeper report her concerns to the manager even though she was not involved in direct care of the resident? (hallway/bath video)

Possible responses:

- she was uncomfortable when she heard staff speaking negatively about the resident
- she witnessed staff being rough with the resident
- she had a legal, moral and ethical obligation to report what she witnessed

Be familiar with Whistle-blowing Protection as per your legislation and your organizational policy.

Appendix B (for Ontario LTC homes).

Would you feel comfortable reporting this situation if you were the housekeeper?

Possible responses:

- Yes – moral, ethical, professional and legal responsibility, priority is resident safety
- No – feel it is not my business/not my role
  – scared to get involved
  – scared of retaliation (review whistle-blowing legislation and your organizational policy)
- Maybe – depends on staff member involved and resident

Why didn't the volunteer report negative comments she overheard in the dining room? (dining room video)

Possible responses:

- she didn't understand the concept of pleasurable dining
- she thought this was the cultural norm of the home
- she was unsure about abuse and neglect
- she was afraid to say something because if staff found out they may treat her differently (retaliation).

You may want to review with your professional staff their responsibility to report abuse and neglect as part of their professional standard of care.

Be familiar with resources available to your staff. See Resources on page 13.

What concerns did the staff member have for her colleague in this situation? (report video)

Possible responses:

- burnout, inappropriate comments, even though she was joking
- resident overhearing

Be familiar with the factors that contribute to abuse and neglect in institutional settings, **Appendix E**. Discuss what types of actions someone might take if they are involved in a scenario like this or try role playing how this scene could have gone differently.

If staff are having difficulty with concepts of abuse and neglect, RNAO's e-learning *Preventing and Addressing Abuse and Neglect of Older Adults* is available free of charge for all staff: http://elearning.rnao.ca/.

What are some system factors that can contribute to resident abuse/neglect?

Possible responses:

- Inadequate number of staff/inappropriate staff mix to meet the needs of residents
- Staff who have not been adequately trained
- Rationing of supplies
- Organizational management culture
- Lack of supervision
- Overcrowding/congestion.

What can you do as a health-care provider to ensure the provisional of high quality care?

Possible responses:

- Reflect on your attitude towards older adults, your own cultural beliefs and values and consider how this impacts the care you provide
- Practice self-care
- Be aware of your role, laws, and responsibilities

Be familiar with the factors that contribute to caregiver burnout that potentially contributes to abuse and neglect in **Appendix F**.

What barriers do you see as a team that should be addressed with open and honest communication?

Possible responses:

- All staff may not be knowledgeable of the policy and reporting process
- Inadequate staffing levels to ensure appropriate supervision of staff members
- retaliation

Discuss your organization's practices regarding orientation related to your abuse and neglect policy and the expectations of reporting.

See **Appendix D** for a sample of internal reporting algorithm.

See **Appendix C** for a sample of the MOHLTC reporting algorithm (please note this may be updated so refer to this link to ensure that you are using the current version) www.ltchomes.net.

http://ltctoolkit.rnao.ca/clinical-topics/prevention-abuse-neglect?field_resource_type_updated_tid=98&items_per_page=10.

What can our organization do to ensure that reporting of suspected abuse and neglect occurs? How can we support staff more effectively through this process?

Possible responses:

- Reinforce residents' rights.
- Establish clear policies and procedures on "zero tolerance" of abuse and neglect.
- Establish no-blame policies (whistle-blowing protection) so staff will be more comfortable in reporting abuse and neglect.
- Ensure all staff, including supervisors and/or agency nurses, are aware of policies on abuse and neglect
- Ensure that all staff are knowledgeable and follow the algorithm on the reporting process, whistle-blowing protection and debriefing session.

Resources

Resource	Description	URL
ACE & Community Legal Education Ontario *Every Resident: Bill of Rights for people who live in Ontario long-term care homes*	A plain language, user friendly overview of the *Bill of Rights for people who live in Ontario long-term care homes.*	http://www.advocacycentreelderly.org/appimages/file/Every%20Resident%20-%20Bill%20of%20Rights.pdf
Advocacy Centre for the Elderly (ACE)	The Advocacy Centre for the Elderly provides direct legal services to low-income seniors, public legal education, and engages in law reform activities.	www.acelaw.ca
Alzheimer's Society Person Centred Language	Language used to describe Alzheimer's disease and other dementias has historically been largely negative, focusing on the losses experienced by the person living with dementia. The Alzheimer Society has developed language guidelines as a tool for anyone who lives with, supports or cares about a person living with Alzheimer's disease or another dementia.	http://www.alzheimer.ca/~/media/Files/national/Culture-change/culture_person_centred_language_2012_e.pdf
College of Nurses of Ontario (CNO) Therapeutic Nurse-Client Relationship Standard, Revised 2006	At the core of nursing is the therapeutic nurse-client relationship. The College's *Therapeutic Nurse-Client Relationship*, practice standard describes the expectations for all nurses in establishing, maintaining and terminating a therapeutic relationship.	http://www.cno.org/Global/docs/prac/41033_Therapeutic.pdf
College of Nurses of Ontario (CNO) Professional Standards, Revised 2002	The *Professional Standards* practice standard provides an overall framework for the practice of nursing and links with other practice standards, guidelines and competencies developed by the College of Nurses of Ontario.	http://www.cno.org/Global/docs/prac/41006_ProfStds.pdf
College of Nurses of Ontario (CNO) Abuse Prevention: One Is One Too Many	*One Is One Too Many* is a valuable tool for any organization employing nurses that is concerned about issues involving client abuse. It was created by the	http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/abuse-prevention/

Resource	Description	URL
	College in response to a government directive that all health colleges provide member education about abuse.	
Community Legal Education Ontario	Useful information about understanding resident rights. Includes examples.	www.cleo.on.ca
Ontario Long Term Care Homes Act	All long-term care homes in Ontario are governed by one piece of legislation: the Long-Term Care Homes Act, 2007. The LTCHA is designed to help ensure that residents of long-term care homes receive safe, consistent, high-quality, resident-centred care.	http://www.ontario.ca/laws/regulation/r10079
Registered Nurses' Association of Ontario Healthy Work Environment Best Practice Guidelines	Guidelines to provide evidence-based recommendations on establishing healthy work environments.	www.RNAO.ca/bpg/guidelines/hwe-guidelines
Registered Nurses' Association of Ontario Addressing Abuse of Older Adults Initiative	Access to: • RNAO Best Practice Guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches* • A four module eLearning course • A *Best Practice Success Kit* (includes the *Taking Action Toolkit*, *Organizational Self Assessment Tool* and more)	www.RNAO.ca/elder-abuse
Registered Nurses' Association of Ontario *Person-and Family-Centred Care* Best Practice Guideline	The *Person- and Family-Centred Care* Best Practice Guideline (formerly Client Centred Care) was developed to promote evidence-based practices associated with person- and family-centred care to assist nurses and other health-care providers acquire the knowledge and skills necessary to practice person-and family-centred care.	http://rnao.ca/bpg/guidelines/person-and-family-centred-care

Appendix A: Long-term Care Homes Act 2007 (section 19)

https://www.ontario.ca/laws/statute/07l08#bk27

Prevention of Abuse and Neglect

Duty to protect

19 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

If absent from the home

(2) The duties in subsection (1) do not apply where the resident is absent from the home, unless the resident continues to receive care or services from the licensee, staff or volunteers of the home. 2007, c. 8, s. 19 (2).

Note: On July 1, 2018, the day named by proclamation of the Lieutenant Governor, section 19 of the Act is amended by adding the following subsection: (See: 2017, c. 25, Sched. 5, s. 3)

Offence

(3) Every licensee who contravenes subsection (1) is guilty of an offence. 2017, c. 25, Sched. 5, s. 3.

Section Amendments with date in force (d/m/y)

Policy to promote zero tolerance

20 (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Contents

(2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,

(a) shall provide that abuse and neglect are not to be tolerated;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;

(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Communication of policy

(3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers. 2007, c. 8, s. 20 (3).

Appendix B: Long-term Care Homes Act 2007 (section 26)

https://www.ontario.ca/laws/statute/07l08#bk27

Whistle-blowing protection

26 (1) No person shall retaliate against another person, whether by action or omission, or threaten to do so because:

(a) anything has been disclosed to an inspector;

(b) anything has been disclosed to the Director including, without limiting the generality of the foregoing,

(i) a report has been made under section 24, or the Director has otherwise been advised of anything mentioned in paragraphs 1 to 5 of subsection 24 (1),

(ii) the Director has been advised of a breach of a requirement under this Act, or

(iii) the Director has been advised of any other matter concerning the care of a resident or the operation of a long-term care home that the person advising believes ought to be reported to the Director; or

(c) evidence has been or may be given in a proceeding, including a proceeding in respect of the enforcement of this Act or the regulations, or in an inquest under the *Coroners Act*. 2007, c. 8, s. 26 (1).

Interpretation, retaliate

(2) Without in any way restricting the meaning of the word "retaliate", the following constitute retaliation for the purposes of subsection (1):

1. Dismissing a staff member.
2. Disciplining or suspending a staff member.
3. Imposing a penalty upon any person.
4. Intimidating, coercing or harassing any person. 2007, c. 8, s. 26 (2).

No retaliation against residents

(3) A resident shall not be discharged from a long-term care home, threatened with discharge, or in any way be subjected to discriminatory treatment because of anything mentioned in subsection (1), even if the resident or another person acted maliciously or in bad faith, and no family member of a resident, substitute decision-maker of a resident, or

person of importance to a resident shall be threatened with the possibility of any of those being done to the resident. 2007, c. 8, s. 26 (3).

Interpretation, discriminatory treatment
(4) Without in any way restricting the meaning of the term "discriminatory treatment", discriminatory treatment for the purposes of subsection (3) includes any change or discontinuation of any service to or care of a resident or the threat of any such change or discontinuation. 2007, c. 8, s. 26 (4).

May not discourage reporting
(5) None of the following persons shall do anything that discourages, is aimed at discouraging or that has the effect of discouraging a person from doing anything mentioned in clauses (1) (a) to (c):

1. The licensee of a long-term care home or a person who manages a long-term care home pursuant to a contract described in section 110.
2. If the licensee or the person who manages the home is a corporation, an officer or director of the corporation.
3. In the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129.
4. A staff member. 2007, c. 8, s. 26 (5).

May not encourage failure to report
(6) No person mentioned in paragraphs 1 to 4 of subsection (5) shall do anything to encourage a person to fail to do anything mentioned in clauses (1) (a) to (c). 2007, c. 8, s. 26 (6).

Protection from legal action
(7) No action or other proceeding shall be commenced against any person for doing anything mentioned in clauses (1) (a) to (c) unless the person acted maliciously or in bad faith. 2007, c. 8, s. 26 (7).

Offence
(8) Every person is guilty of an offence who does anything prohibited by subsection (1), (3), (5) or (6). 2007, c. 8, s. 26 (8).

Complaint to Ontario Labour Relations Board
27 (1) Where a staff member complains that an employer or person acting on behalf of an employer has contravened subsection 26 (1), the staff member may either have the matter dealt with by final and binding settlement by arbitration under a collective agreement, if any, or file a complaint with the Board in which case any rules governing the

practice and procedure of the Board apply with all necessary modifications to the complaint. 2007, c. 8, s. 27 (1).

Inquiry by Board
(2) The Board may inquire into any complaint filed under subsection (1) and section 96 of the *Labour Relations Act, 1995*, except subsection (5), applies with all necessary modifications as if that section, except subsection (5), is enacted in and forms part of this Act. 2007, c. 8, s. 27 (2).

Same
(3) On an inquiry by the Board into a complaint filed under subsection (1), sections 110, 111, 114 and 116 of the *Labour Relations Act, 1995* apply with all necessary modifications. 2007, c. 8, s. 27 (3).

Onus of proof
(4) On an inquiry by the Board into a complaint filed under subsection (1), the burden of proof that an employer or person acting on behalf of an employer did not act contrary to subsection 26 (1) lies upon the employer or the person acting on behalf of the employer. 2007, c. 8, s. 27 (4).

Board may substitute penalty
(5) Where, on an inquiry by the Board into a complaint filed under subsection (1), the Board determines that a staff member has been discharged or otherwise disciplined by an employer for cause and the contract of employment or the collective agreement, as the case may be, does not contain a specific penalty for the infraction, the Board may substitute such other penalty for the discharge or discipline as to the Board seems just and reasonable in all the circumstances. 2007, c. 8, s. 27 (5).

Interpretation
(6) In this section,

"Board" means the Ontario Labour Relations Board; ("Commission")

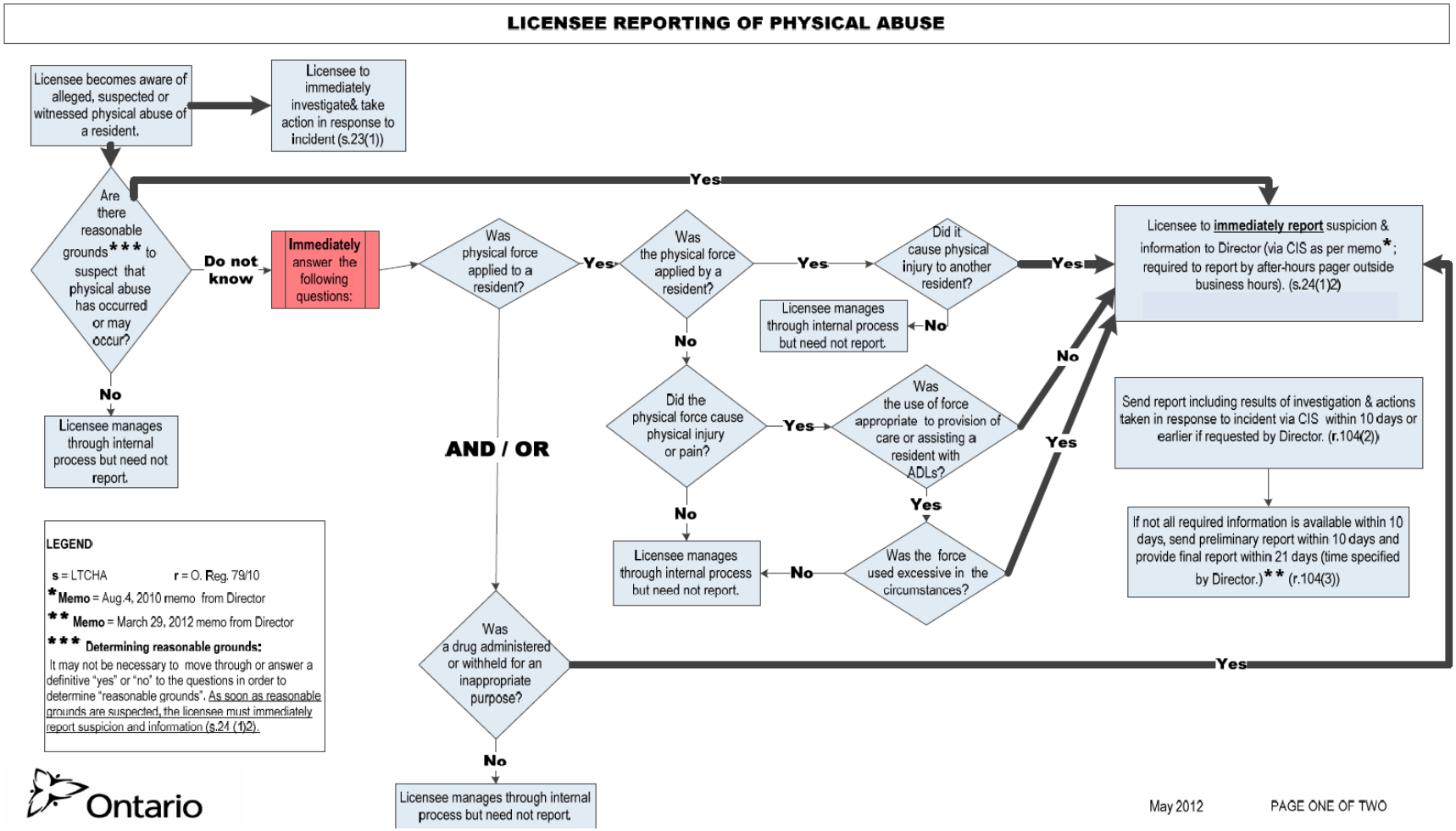
"employer", in relation to a staff member, means,

(a) where the staff member is an employee of a licensee or a person who works at a long-term care home pursuant to a contract or agreement with a licensee, the licensee, or

(b) where the staff member works at a long-term care home pursuant to a contract or agreement between the licensee and an employment agency or other third party, the employment agency or third party. ("employeur") 2007, c. 8, s. 27 (6).

Appendix C: Reporting Decision Tree MOHLTC

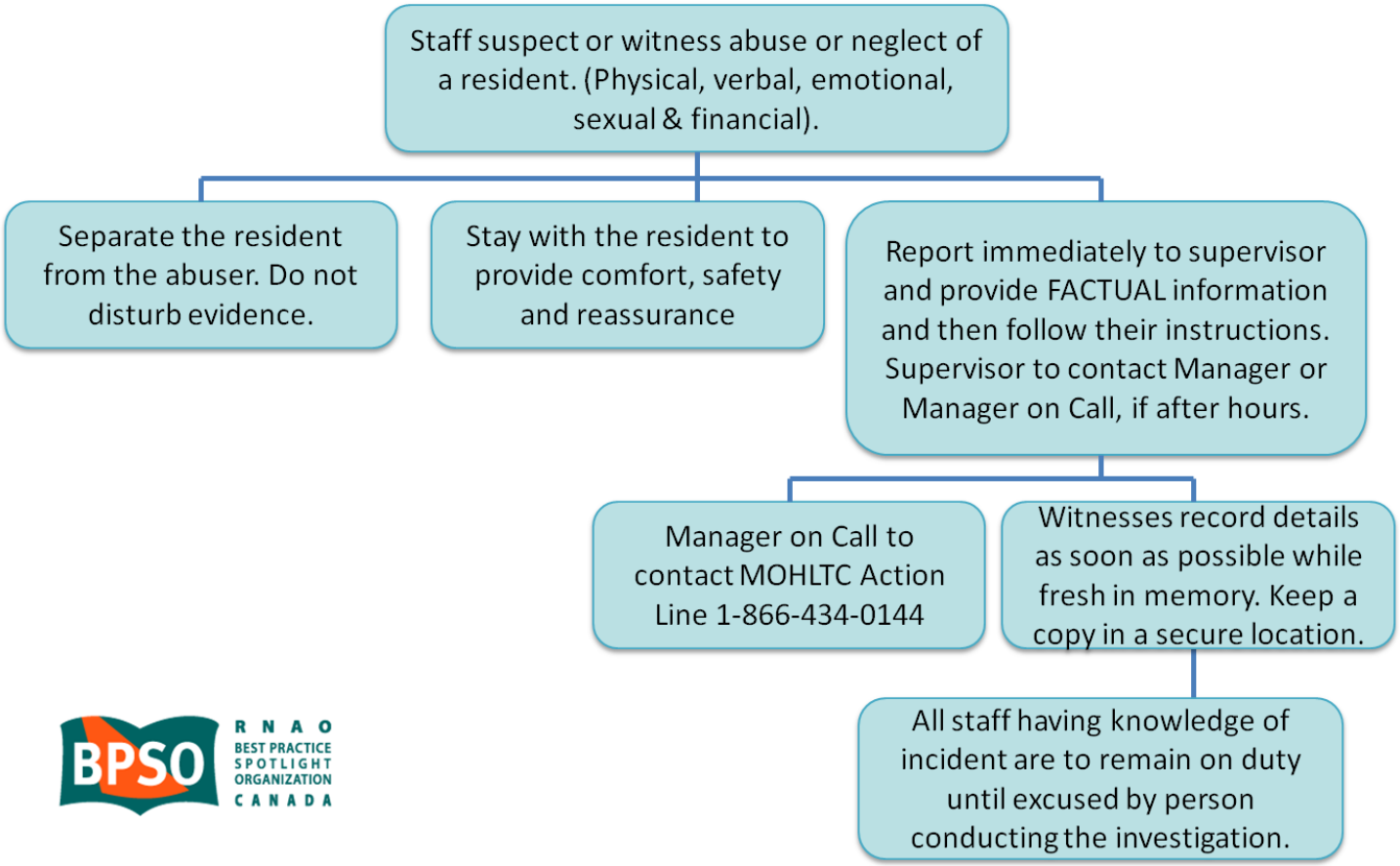
For most up to date version please go to: https://www.ltchomes.net/LTCHPortal/Login.aspx. Log-in is required.



Appendix D: Sample Internal Reporting Algorithm

Created by Woodingford Lodge – Woodingford, Tillsonburg and Ingersoll

Abuse Reporting Algorithm



Appendix E: Factors and Conditions that Contribute to Abuse and Neglect in Institutions

This table is from page 53 in the RNAO guideline *Addressing and Preventing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*. The guideline can be found online at http://rnao.ca/bpg/guidelines/abuse-and-neglect-older-adults.

Table 5: Factors and Conditions that Contribute to Abuse and Neglect in Institutions

ORGANIZATIONAL FACTORS
■ inadequate number of staff/inappropriate staff mix[G] to meet the needs of residents ■ staff who have not been adequately trained (e.g., no training in dementia care, transient staff) ■ rationing of supplies ■ culture or regime of institution (e.g., set bed times, assembly line caregiving) ■ lack of supervision ■ overcrowding/congestion
STAFF FACTORS
■ burnout/emotional/physical exhaustion ■ disempowered staff ■ personal stress such as performing "double duty" (i.e., providing care at work and at home) ■ alcohol or substance abuse ■ personal history of abuse ■ attitudes: ageism, condoning abuse and neglect
RESIDENT FACTORS
■ dependency based on physical limitations ■ communication difficulties ■ cognitive impairment ■ physical or social isolation (e.g., few visitors, no family involvement)
(Buzgova & Ivanova, 2009; Goergen, 2004; Long-Term Care Task Force on Resident Care and Safety, 2013; McDonald et al., 2012; Phillips & Ziminski, 2012; Shinan-Altman & Cohen, 2009; Spencer, 2006; Spencer et al., 2008)

Appendix F: Self-Care Strategies to Help Avoid Caregiver Burnout

These tips are from Module 2 (*Working with Older Adults and Their Families*) of the RNAO eLearning course *Preventing and Addressing Abuse and Neglect of Older Adults* which can be found online at http://elearning.rnao.ca/

Caregiver Burnout

When you are emotionally and physically exhausted, your energy, attitude and overall health may shift downwards.

You may experience fatigue, stress, anxiety and depression. You might withdraw from friends and family. Your sleep patterns may change as well as your appetite and/or weight.

Caregiver burnout is also a factor that contributes to abuse and neglect.

What can you do to help yourself?

- Eat nutritious food and stay hydrated
- Go for a 15 minute walk during lunch or your break
- Get lots of rest and recognize your own signs of needing more sleep
- Be social, spend time with family and friends
- Address your feelings and attitudes about your work environment and look for solutions
- Educate yourself on signs of burnout and stress
- Take advantage of counseling services for staff or other employee assistance programs offered by your employer
- Take entitled breaks and support colleagues to do the same
- Limit overtime hours worked

(Public Health Agency of Canada, 2011; RNAO, 2011)

References

Ministry of Health and Long Term Care. (2012). *Licensee Reporting of Physical Abuse*. Retrieved from www.ltchomes.net.

Ministry of Health and Long Term Care. *Long-Term Care Homes Act, 2007, S.O. 2007, c.8.* Retrieved from: http://www.ontario.ca/laws/statute/07l08

Ministry of Health and Long Term Care. *Ontario Regulations 79/10*. Retrieved from: http://www.ontario.ca/laws/regulation/r10079

Registered Nurses' Association of Ontario. (2014). *Addressing and Preventing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*. Toronto, ON: Registered Nurses' Association of Ontario. http://rnao.ca/bpg/guidelines/abuse-and-neglect-older-adults.

Registered Nurses' Association of Ontario. (2015). *Preventing and Addressing Abuse and Neglect of Older Adults* eLearning course. Retrieved from http://elearning.rnao.ca/

Registered Nurses' Association of Ontario. (2015). *Preventing and Addressing Abuse and Neglect Long-Term Care Videos.* Retrieved from http://rnao.ca/bpg/initiatives/abuse-and-neglect-older-adults-pan-canadian-best-practice-guideline-initiative/videos

Registered Nurses' Association of Ontario. (2017). *Prevention of Abuse and Neglect*. Long-Term Care Best Practices Toolkit, Second Edition. Retrieved from http://ltctoolkit.rnao.ca/clinical-topics/prevention-abuse-neglect.