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Preventing and Addressing Abuse and Neglect of Older Adults:

Person-Centred, Collaborative, System-Wide Approaches

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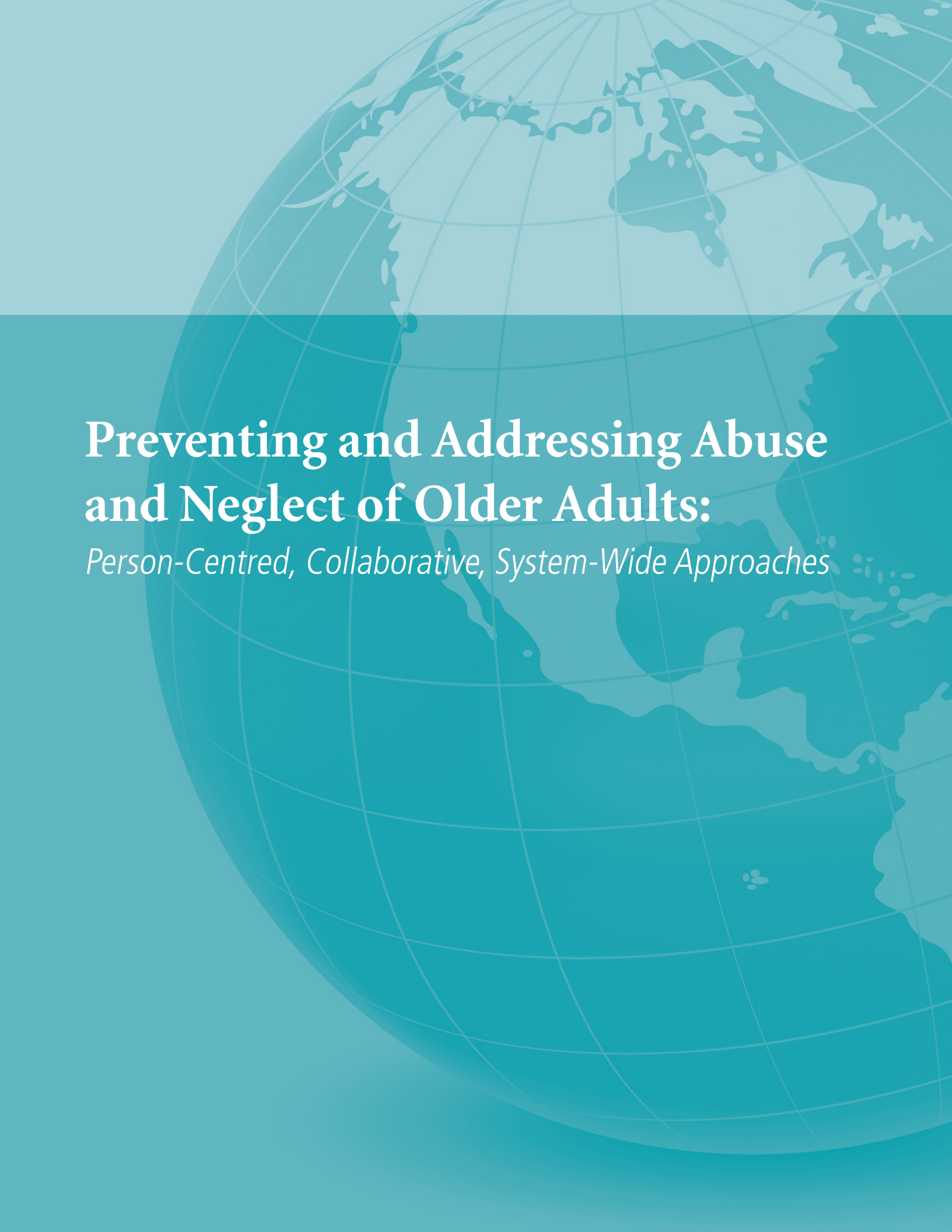


Preventing and Addressing Abuse and Neglect of Older Adults:

Person-Centred, Collaborative, System-Wide Approaches

Greetings from Doris Grinspun,

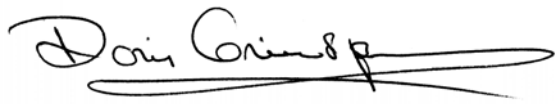
Chief Executive Officer, Registered Nurses' Association of Ontario

The Registered Nurses' Association of Ontario is delighted to present the first edition of the clinical best practice guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches.* Evidence-based practice supports the excellence in service that health professionals are committed to delivering every day. RNAO is delighted to provide this key resource.

We offer our heartfelt thanks to the many stakeholders that are making our vision for best practice guidelines a reality, starting with the Government of Canada's New Horizons for Seniors Program, for recognizing RNAO's ability to lead the program and for providing three-year funding; Dr. Irmajean Bajnok, director of the RNAO International Affairs and Best Practice Guidelines Centre and Dr. Monique Lloyd, the associate director, for their expertise and leadership. I also want to thank the co-chairs of the Expert Panel, Dr. Elizabeth Podnieks (Professor Emerita, Ryerson University) and Dr. Samir Sinha (Director of Geriatrics, Mount Sinai and University Health Network) for their exquisite expertise and stewardship of this guideline. Thanks also to RNAO staff Susan McNeill, Verity White, Diana An, Megan Bamford, Anastasia Harripaul, Tasha Penney, Sarah Xiao and the rest of the RNAO Best Practice Guideline Program Team for their intense work in the production of this guideline. Special thanks to the members of the Expert Panel for generously providing time and expertise to deliver a rigorous and robust clinical resource. We couldn't have done it without you!

Successful uptake of best practice guidelines requires a concerted effort from educators, clinicians, employers, policy makers and researchers. The nursing and health-care community, with their unwavering commitment and passion for excellence in patient care, have provided the expertise and countless hours of volunteer work essential to the development and revision of each guideline. Employers have responded enthusiastically by nominating best practice champions, implementing guidelines, and evaluating their impact on patients and organizations. Governments at home and abroad have joined in this journey. Together, we are building a culture of evidence-based practice.

We ask you to be sure to share this guideline with your colleagues from other professions, because we have so much to learn from one another. Together, we must ensure that the public receives the best possible care every time they come in contact with us – making them the real winners in this important effort!



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How to Use this Document

This nursing best practice guideline (BPG)[G*] is a comprehensive document providing resources for evidence[G]-based nursing practice. It is not intended to be a manual or "how to" guide but rather a template or tool to guide best practices in preventing and addressing abuse and neglect of older adults[G]. The guideline should be reviewed and applied in accordance with both the needs of the individual organizations or practice settings and the needs and preferences of the older adult. In addition, the guideline provides an overview of appropriate structures and supports for providing the best possible evidence-based care.

Nurses[G], other health-care providers[G] and administrators who lead and facilitate practice changes will find this document invaluable for developing policies, procedures, protocols, educational programs and assessments, interventions and documentation tools. Nurses and other health-care providers in direct care will benefit from reviewing the recommendations and the evidence that supports them. We particularly recommend that practice settings adapt these guidelines in formats that are user-friendly for daily use.

If your organization is adopting the guideline we recommend that you follow these steps:

1. assess your nursing and health-care practices using the guideline's recommendations,
2. identify which recommendations will address needs or gaps in services, and
3. develop a plan for implementing the recommendations. (Implementation resources, including the RNAO's *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (2012c), are available at www.RNAO.ca)

The RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story.

* Throughout this document, terms marked with a superscript G ([G]) can be found in the Glossary of Terms (**Appendix A**).

Purpose and Scope

Best Practice Guidelines are systematically developed statements designed to assist nurses and clients in making decisions about appropriate health care (Field & Lohr, 1990). Initial development of this guideline's purpose and scope included three teleconference focus groups with a total of 26 topic experts and health-care practitioners across Canada, and one in-person focus group with 20 older adults living in Ontario. The Expert Panel was then convened and determined the purpose of the guideline: To expand the awareness of abuse and neglect of older adults and provide evidence-based recommendations for preventing and addressing abuse and neglect in all health-care settings across the continuum of care in Canada.

The guideline provides best practice recommendations in three main areas: practice, education, and policy/organization/system. For optimal effectiveness, recommendations in these three areas should be implemented together.

- Practice recommendations[G] are directed primarily to nurses and other health-care providers in the interprofessional[G] team who provide direct care for older adults and their families in community and institutional settings[G].
- Education recommendations[G] are directed to those responsible for staff education, such as educators, quality improvement teams, managers, administrators and academic institutions.
- Policy, organization and system recommendations[G] apply to a variety of audiences, depending on the recommendation. Audiences include managers, administrators, policy makers, nursing regulatory bodies, and government bodies.

The scope of this guideline includes harms caused by the main forms of abuse and neglect. These are physical abuse, emotional/psychological abuse, sexual abuse, financial abuse/exploitation and neglect. This guideline also includes education and policy/organization/system recommendations that address resident-to-resident aggressive behaviour[G]. Harms inflicted by one resident (often an older adult with cognitive impairment who is living in a long-term care facility[G]) upon another resident, are distinctly different from the other forms of harm covered in this document. This content is included because institutions have the responsibility to provide safe, quality care for all residents. Furthermore, older adults living in institutions are in a relationship of trust[G] with the organization, and a trusting relationship is a key element in most definitions of abuse and neglect. Beyond the scope of this guideline is a comprehensive review of systemic issues that may increase vulnerabilities to abuse or neglect such as the structure of the health-care system, care delivery models, funding structures and public policies. Other forms of harm that are important to acknowledge, but are also beyond the scope of this guideline, include self-neglect and aggression from an older adult resident towards an institutional employee.

For more information about this guideline, including the guideline development process and the systematic review[G] and search strategy, refer to **Appendices B** and **C**.

Summary of Recommendations

PRACTICE RECOMMENDATIONS		LEVEL OF EVIDENCE
1.0 Assessment	Recommendation 1.1: Establish and maintain a therapeutic relationship with older adults, and families as appropriate, when discussing issues of abuse and neglect.	IV
	Recommendation 1.2: Ensure privacy and confidentiality when discussing issues of abuse and neglect unless legal obligations require disclosure of information.	V
	Recommendation 1.3: Be alert for risk factors and signs of abuse and neglect during assessments and encounters with the older adult.	V
	Recommendation 1.4: Carry out a detailed assessment in collaboration with the older adult, interprofessional team, and family, as appropriate, when abuse or neglect is alleged or suspected.	V
	Recommendation 1.5: Identify the rights, priorities, needs and preferences of the older adult with regard to lifestyle and care decisions before determining interventions and supports.	IV
2.0 Planning	Recommendation 2.1: Collect information and resources needed to respond appropriately to alleged or suspected abuse and neglect in ways that are compatible with the law, organizational policies and procedures, and professional practice standards.	V
	Recommendation 2.2: Collaborate with the older adult, family and interprofessional team, as appropriate, to develop an individualized plan of care to prevent or address harm.	IV

3.0 Implementation	Recommendation 3.1: Respond to alleged or suspected abuse and neglect according to legal requirements and organizational policies or procedures.	V
	Recommendation 3.2: Implement an individualized plan of care that incorporates multiple strategies to prevent or address harm, including ■ education and support for older adults and family members, ■ interventions and supports for those who abuse or neglect, ■ providing resources/referrals, and ■ development of a safety plan.	IV – V
4.0 Evaluation	Recommendation 4.1: Collaborate with the older adult, family and interprofessional team, as appropriate, to evaluate and revise the plan of care, recognizing that some instances of abuse and neglect will not resolve easily.	V

EDUCATION RECOMMENDATIONS		LEVEL OF EVIDENCE
5.0 Education	Recommendation 5.1: **All employees** across all health-care organizations that serve older adults participate in mandatory education that raises awareness about ■ ageism[G]; ■ the rights of older adults; ■ the types, prevalence and signs of abuse and neglect of older adults; ■ factors that may contribute to abuse and neglect; and ■ individual roles and responsibilities with regard to responding or reporting abuse or neglect.	V

EDUCATION RECOMMENDATIONS		LEVEL OF EVIDENCE
5.0 Education	Recommendation 5.2: **Nurses, other health-care providers, and supervisors** who work in health-care organizations that provide care and services to older adults participate in mandatory and continuing education opportunities that include ■ understanding issues of abuse and neglect; ■ assessing and responding to abuse and neglect; ■ roles, responsibilities and laws; ■ positive approaches to working with older adults; ■ effective strategies for challenging/responsive behaviours; and ■ fostering a safe and healthy work environment[G] and personal well-being.	IV – V
	Recommendation 5.3: Educational institutions incorporate the RNAO Best Practice Guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches* into curriculum for nurses and, as appropriate, for other health-care providers.	V
	Recommendation 5.4: To help nurses and other health-care providers build competence in preventing, identifying, and responding to abuse and neglect of older adults, education programs are designed to ■ address attitudes, knowledge and skills; ■ include multimodal and interactive/participatory strategies; and ■ promote an interprofessional approach.	IV – V

POLICY, ORGANIZATION AND SYSTEM RECOMMENDATIONS		LEVEL OF EVIDENCE
6.0 Policy, Organization and System	Recommendation 6.1: Organizations/institutions establish and support collaborative teams to assist with preventing and addressing abuse and neglect of older adults.	V
	Recommendation 6.2: Organizations/institutions establish policies, procedures and supports that enable nurses and other health-care providers to recognize, respond to, and where appropriate, report abuse and neglect of older adults.	V

POLICY, ORGANIZATION AND SYSTEM RECOMMENDATIONS		LEVEL OF EVIDENCE
6.0 Policy, Organization and System	Recommendation 6.3: Institutions* adopt a combination of approaches to prevent abuse and neglect of older adults, including ■ screening potential employees, hiring the most qualified employees, and providing proper supervision and monitoring in the workplace; ■ securing appropriate staffing; ■ providing mandatory training to all employees; ■ supporting the needs of individuals with cognitive impairment, including those with responsive behaviours; ■ upholding resident rights; ■ establishing and maintaining person-centred care and a healthy work environment; and ■ educating older adults and families on abuse and neglect and their rights, and establishing routes for complaints and quality improvement. *Note: may apply to other health-care settings.	V
	Recommendation 6.4: Organizations/institutions with prevention and health promotion[G] mandates (such as community and public health organizations) lead or participate in initiatives to prevent abuse and neglect of older adults.	V
	Recommendation 6.5: Organizations/institutions identify and eliminate barriers that older adults and families may experience when accessing information and services related to abuse and neglect.	IV
	Recommendation 6.6: Provincial and territorial nursing regulatory bodies provide accurate information on jurisdictional laws and obligations relevant to abuse and neglect of older adults across the continuum of care.	V
	Recommendation 6.7: Governments dedicate resources to effectively prevent and address abuse and neglect of older adults.	V
	Recommendation 6.8: Nurses, other health-care providers, and key stakeholders (e.g., professional associations, health service organizations, advocacy groups) advocate for policy/organization/system level changes, including the availability of necessary resources, to effectively prevent and address abuse and neglect of older adults.	V

Interpretation of Evidence

Levels of Evidence*

Ia	Evidence obtained from meta-analysis[G] or systematic reviews of randomized controlled trials[G], and/or synthesis of multiple studies primarily of quantitative[G] research.
Ib	Evidence obtained from at least one randomized controlled trial.
IIa	Evidence obtained from at least one well-designed controlled study[G] without randomization.
IIb	Evidence obtained from at least one other type of well-designed quasi-experimental study[G], without randomization.
III	Synthesis of multiple studies primarily of qualitative[G] research.
IV	Evidence obtained from well-designed non-experimental observational studies, such as analytical studies[G] or descriptive studies[G], and/or qualitative studies.
V	Evidence obtained from expert opinion or committee reports, and/or clinical experiences of respected authorities.

* *Levels of evidence* are assigned to study designs to rank how well that design is able to eliminate alternate explanations of the phenomena under study. The higher the level of evidence, the more confidence you can have that the relationships presented between the variables are true. Levels of evidence do not reflect the merit or quality of individual studies. This hierarchy of evidence was adapted from the Scottish Intercollegiate Guidelines Network (SIGN) (2012) and Pati (2011).

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Background

Defining abuse and neglect of older adults

Abuse and neglect of older adults is a health and social problem with profound consequences that affects people from all walks of life. To prevent and address it, committed effort on multiple levels is required. Several definitions for abuse and neglect of older adults have been developed over time, but two definitions are provided to guide the reader. The following definition, used by the World Health Organization (WHO) (2002) and the International Network for the Prevention of Elder Abuse, describes abuse and neglect as, "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". More recently, the National Initiative for Care of the Elderly (NICE) (2012) created the following definition for the Canadian context: "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[G]. Mistreatment includes abuse and neglect of older adults" (p.99).

Several different types of abuse are cited in the literature. The main types include physical abuse (e.g., slapping, pushing, inappropriate use of restraints[G]), emotional or psychological abuse (e.g., humiliating, threatening, treating like a child), financial or material abuse (e.g., misusing power of attorney[G], stealing, selling personal belongings without consent[G]), sexual abuse (e.g., any unwanted sexual activity), and neglect (e.g., failing to provide for basic health or medical needs, abandonment). Other types and subtypes of abuse and neglect that have been identified include violation of rights, systemic abuse, and spiritual abuse (refer to **Appendix D** for definitions of different types of abuse).

Prevalence

The prevalence of abuse and neglect of older adults, that is, the proportion of the population that is affected, is unclear. A systematic review of international studies indicates a prevalence rate of 3.2 percent to 27.5 percent and suggests that one in four vulnerable older adults (i.e., those dependent on others for care) is at risk for abuse (Cooper, Selwood, & Livingston, 2008). In Canada, the prevalence of abuse and neglect is believed to be at least four percent. This statistic is informed by a telephone survey of over 2000 randomly sampled community-dwelling older adults conducted in 1989 (Podnieks, 1992). In institutional settings the extent of abuse and neglect of older adults remains largely unknown (McDonald, 2011); however, research studies suggest it is a common occurrence (McDonald et al., 2012). For example, a large study conducted in Germany found that approximately 70 percent of nurses reported that they themselves had behaved in abusive or neglectful ways in the past year towards residents (Goergen, 2004). Lachs and Pillemer (2004) put the magnitude of the problem into perspective by suggesting that "a busy clinician seeing between 20 and 40 old [older] people per day could encounter at least one clinical or subclinical victim of elder abuse daily" (p.1264).

Consequences

The consequences of abuse and neglect are profound and pervasive. At the individual level, older adults who experience abuse and neglect face major quality of life issues. They could experience physical trauma, reduced self worth and dignity, a lost sense of safety and security and even an increased risk of early death (Dong et al., 2009; Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998). Other consequences cited in the literature are increased hospitalization (Covinsky, 2013), and economic costs from investigation procedures, health-care interventions, law enforcement and lost productivity (Hirst, 2002).

Factors that contribute to abuse and neglect

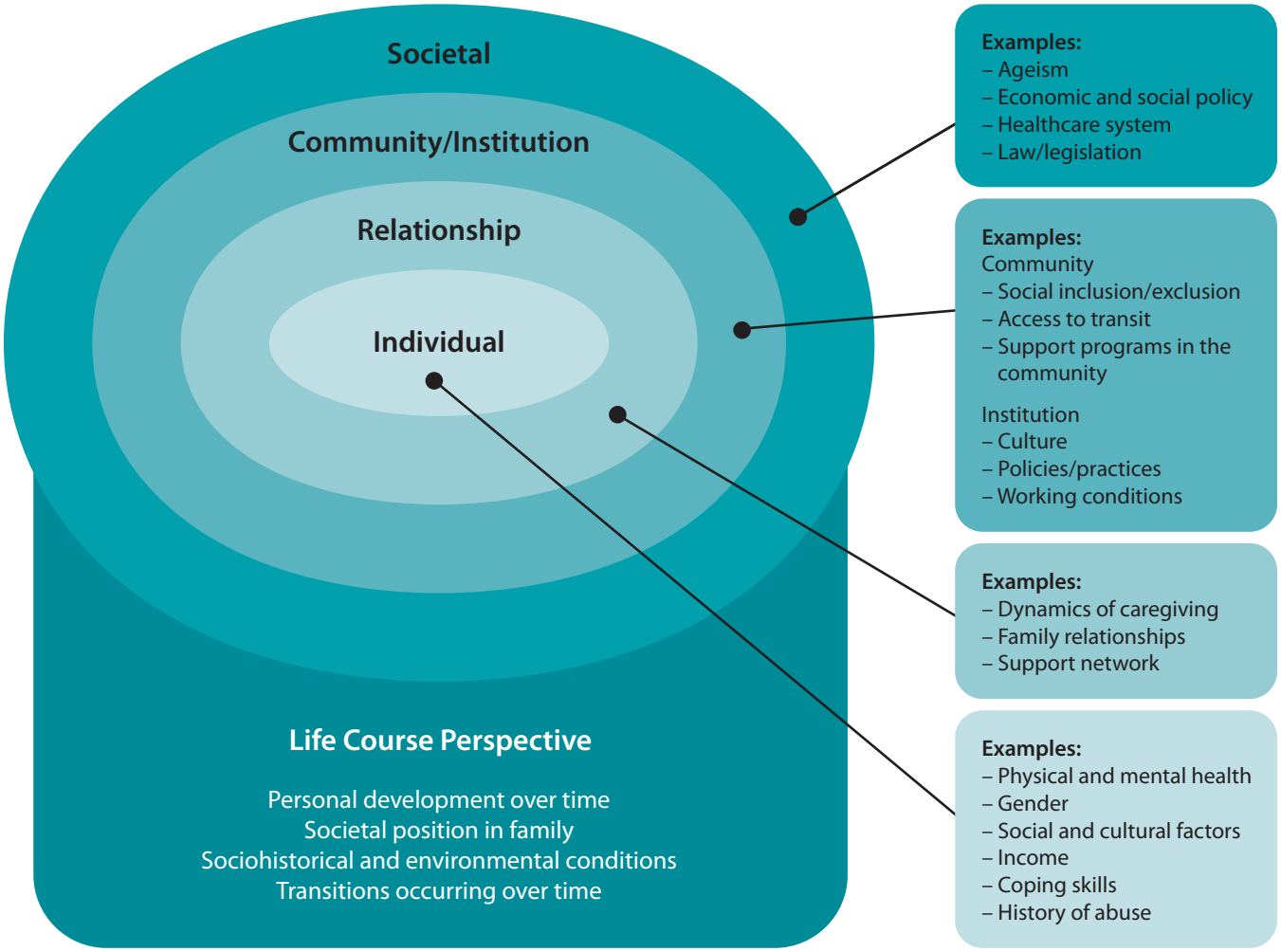
Several theories have been developed to explain the causes of abuse and neglect and various risk factors have been identified that may increase an older adult's vulnerability. For example, theories address the dynamics that occur between individuals, such as power and control, caregiver stress, and abusive behaviour that has been learned over time (refer to **Appendix E** for more details description about theories). At the individual level, risk factors for older adults include being dependent on care, having cognitive challenges, being socially isolated, and relying on caregivers who have alcohol or substance abuse problems or who themselves have a history of being abused (refer to Table 2: Risk Factors of Abuse and Neglect).

It is now recognized that the causes of abuse and neglect extend beyond the traits and circumstances of the older adult and the person who abuses or neglects them (Employment and Social Development Canada (ESDC), 2011). The social determinants of health[G] and discrimination based on factors such as such as age, gender, culture[G], and poverty are believed to compound one's vulnerability and may lead to abuse and neglect (ESDC, 2011; Podnieks, 2006; Public Health Agency of Canada, 2012b). Furthermore, there are some circumstances within institutions that contribute to abuse and neglect. For example, some institutional settings face chronic staff shortages and bed shortages and lack the capacity at a system level to address the increasingly complex needs of older adults. In these situations, older adults are particularly vulnerable. For more details refer to Recommendation 6.3 and Table 5: Factors and Conditions that Contribute to Abuse and Neglect in Institutions.

Understanding abuse and neglect of older adults

The ecological/life course model was applied to the context of abuse and neglect of older adults by the Expert Panel (McDonald & Thomas, 2013; Parra-Cardona, Meyer, Schiamberg, & Post, 2007; Schiamberg et al., 2011; Schiamberg & Gans, 2000; WHO, 2002). An ecological perspective shows that abuse and neglect is a complex problem that involves the interaction of factors and conditions at multiple levels. The model depicts the many factors that interact at four different levels: the individual, relationship, community or institutional and societal (refer to Figure 1). The factors at each level can either increase risk and hence vulnerability to abuse and neglect, or can be protective and help to reduce vulnerability. The inner circle in Figure 1, for example, represents the individual level. Factors at this level, such as physical and mental health and coping skills, could influence whether or not an older adult is, or may become at risk for, abuse and neglect. Next, the relationship level includes factors such as relationships in the household and the dynamics of care giving. Community or institutional factors are shown in the third level. For an older adult living in the community, the risk of abuse and neglect is influenced by factors such as access to transit, availability of support services, and social inclusion or exclusion. Older adults living or staying in an institution or care facility would be affected by factors such as the staff members' working conditions, the culture of that setting, as well as organizational policies and practices. In the outer circle, societal factors that influence risk of abuse and neglect include attitudes towards ageing and health and social policies. Finally, the ecological model is nested in the life course perspective. This perspective links life events and social conditions that have occurred over the older adult's lifetime; experiences that create accumulated advantages or disadvantages (McDonald & Thomas, 2013).

Figure 1: Ecological/Life Course Model



(McDonald & Thomas, 2013; Parra-Cardona, Meyer, Schiamberg, & Post, 2007; Schiamberg et al., 2011; Schiamberg & Gans, 2000; WHO, 2002)

How to use this model

The ecological/life course model shown in Figure 1 can be used to help understand the complexity of abuse and neglect and the interplay of factors that can either increase or decrease an individual's vulnerability. It can also be used as a framework for considering the various levels where prevention and intervention activities should be focused. These multiple, interconnected factors show that, to effectively prevent and address abuse and neglect of older adults, collaboration and coordination between the four levels (societal, community/institution, relationship and individual) are required.

Preventing and addressing abuse and neglect of older adults

Great efforts have been made to prevent and address the abuse and neglect of older adults in Canada since the 1980s, when the problem became a focus for research and emerged as a public policy concern. Organizations and networks have published reports, developed guidelines and created educational resources. Creative approaches have been implemented to raise awareness of the issue, such as intergenerational collaborations between youth and older adults, the use of the arts (e.g., theatre, dance, music) and financial literacy classes for older adults. Initiatives to address abuse and neglect of older adults in community settings include collaboration among diverse groups and individuals (e.g., police, faith communities, banks, health-care providers, cultural communities, and older adults themselves). In health-care settings, efforts to prevent and address abuse and neglect of older adults include the development and implementation of education programs for staff, screening and assessment tools, and policies and protocols.

Despite these efforts, there remains variability in practice, and in some cases, well-intentioned approaches may be inadequate, ineffective, or disrespectful (refer to Recommendations 1.3 and 5.2). This best practice guideline aims to address these shortcomings. It provides recommendations based on the best available evidence from a systematic literature review, supplemented with background literature, grey literature[G], other evidenced-based guidelines on abuse and neglect of older adults, and the opinion of the Expert Panel members. According to the levels of evidence criteria (refer to Interpretation of Evidence), most recommendations in this document are based on lower levels of evidence. This is the case for two reasons: 1) the nature of the topic does not lend itself to research methods such as randomized controlled trials, and 2) much of the literature on this topic is non-experimental.

Guiding Principles

The following guiding principles inform the concepts contained in this document and are based on various resources and Expert Panel opinion.

- Older adults are entitled to protection of their human rights and fundamental freedoms including full respect for their dignity, beliefs, needs and privacy (United Nations, 1991).
- Older adults are presumed to be mentally capable of making decisions about their own lives, unless demonstrated otherwise (Substitute Decisions Act, 1992).
- Older adults should, to the full extent that they are able, direct their plan of care and provide consent for decisions made about their care (Health Care Consent Act, 1996).
- All approaches to helping an older adult who has been abused or neglected should honour the person's uniqueness, preferences, values and beliefs, and be founded in a person-centred approach (RNAO, 2010a).
- Mentally capable older adults have the right to live their lives as they wish, provided they do not infringe upon the rights and safety of others.
- Abuse and neglect are complex, multifaceted issues that often take time, sensitivity and collaborative effort to prevent and address effectively.
- Older adults should be active participants in the development of programs meant to serve them.

Practice Recommendations

1.0 ASSESSMENT

RECOMMENDATION 1.1:

Establish and maintain a therapeutic relationship with older adults, and families as appropriate, when discussing issues of abuse and neglect.

Level of Evidence = IV

Discussion of Evidence:

A therapeutic relationship is essential when addressing issues of abuse and neglect. A therapeutic relationship involves caring attitudes and behaviours and "is based on trust, respect, empathy[G] and professional intimacy, and requires appropriate use of the power inherent in the care provider's role" (College of Nurses of Ontario (CNO), 2006). The literature outlines the need for this type of relationship with older adults experiencing abuse and neglect, but it should be noted that the characteristics of a therapeutic relationship are fundamental to nursing practice, which often involves family members. Therefore this recommendation is extended to include establishing a therapeutic relationship with family[G] members, if they are involved in the older adult's life or care (for further discussion of family involvement, including the complexities that may arise when working with families, refer to Recommendation 1.5).

Therapeutic communication and client-centred (person-centred) care[G] are two important elements of a therapeutic relationship (CNO, 2006). Therapeutic communication includes strategies such as establishing rapport, active listening, and adapting communication style to accommodate individual needs, such as literacy level or cognitive status (CNO, 2006). Furthermore, communication techniques may include "listening, silence, open-ended questions and statements, restating, reflecting, seeking clarification and validation, focusing, summarizing, awareness of verbal and non-verbal communication, and awareness of cultural differences related to communication" (RNAO, 2002, p.25). Client-centred (person-centred) care is "an approach in which clients are viewed as whole; it is not merely about delivering services where the client is located. Client-centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making" (RNAO, 2006a, p.2).

Literature specific to abuse and neglect of older adults supports the need for a therapeutic relationship. Zink, Jacobson, Regan, and Pabst (2004) conducted a qualitative study to understand the health-care needs of older women in abusive relationships. Many women described having negative experiences when they disclosed and sought to discuss experiences of abuse. These experiences included interactions with health-care providers who lacked empathy, who were visibly uncomfortable talking about abuse, or times when health-care providers interviewed women together with their abusive partners, instead of having a private, one-to-one conversation, resulting in missed opportunities to disclose abuse. Women reported positive experiences when health-care providers listened, showed empathy and took statements about abuse seriously. These therapeutic approaches are also supported by Cohen (2011) who suggests that when discussing issues of abuse, older adults need to feel that the health-care provider is trustworthy, empathetic, sensitive and nonjudgmental. Tetterton and Farnsworth (2011) point out that health-care providers need to take the time to establish trust and rapport, listen carefully, show openness, be nonjudgmental, and not appear shocked at disclosures of abuse.

The need for a therapeutic relationship is further supported by literature that outlines the barriers to disclosure of abuse and neglect. Nurses and other health-care providers who are sensitive to these barriers may be more effective in their interactions with older adults and with families. The following table outlines common barriers to disclosure of abuse and neglect. For communication strategies, refer to **Appendix F**.

Table 1: Common Barriers to Disclosure of Abuse and Neglect

Common barriers to disclosure of abuse and neglect include

- isolation of the older adult (e.g., infrequent contact with health-care providers or community supports);
- not wanting to turn against the person abusing or neglecting;
- reluctance to talk about "private family matters";
- feeling of shame or embarrassment;
- relationship with person who is abusing or neglecting (e.g., love, protection, fear of loss of contact);
- dependent on person who is abusing or neglecting for care/housing;
- low socioeconomic status (i.e., economic insecurity or dependence);
- concern about reprisal of family (e.g., shunning, denied access to grandchildren);
- concern about retribution from staff (including withdrawal of assistance) if abuse occurs in an institution;
- pressure not to speak out from religious, social or cultural community;
- difficulty speaking up or explaining abuse (e.g., cognitive challenges, language difficulties, aphasia);
- acceptance of abuse due to lifetime exposure to abuse;
- fear or mistrust of "authorities" (e.g., fear of being removed from the home, abuser being arrested, having to move to a long-term care facility);
- immigration issues (e.g., fear of being deported if sponsor is reported for abuse);
- gender related issues (e.g., less economic or social power, older men not taken seriously or ashamed to admit abuse); and
- past negative experiences with health-care providers when disclosing abuse.

(Begley, O'Brien, Anand, Killick, & Taylor, 2012; Schmeidel, Daly, Rosenbaum, Schmuch, & Jogerst, 2012; Spencer, 2006; Spencer, 2010; Zink et al., 2004)

RECOMMENDATION 1.2:

Ensure privacy and confidentiality when discussing issues of abuse and neglect unless legal obligations require disclosure of information.

Level of Evidence = V

Discussion of Evidence:

The Expert Panel recommends that nurses and other health-care providers maintain privacy and confidentiality regarding issues of abuse and neglect. This is important for two main reasons: issues of abuse and neglect are highly sensitive, and maintaining privacy and confidentiality is a professional and legal responsibility. The notion of privacy extends beyond the need for talking one-to-one with the older adult in a private location. Privacy can have many definitions and legal implications that will vary based on jurisdiction. The Canadian Nurses' Association (CNA) (2008) makes a distinction between physical privacy and informational privacy, which are both important with regard to abuse and neglect of older adults. Physical privacy is, "the right or interest in controlling or limiting the access of others to oneself," and informational privacy is, "the right of individuals to determine how, when, with whom and for what purposes any of their personal information will be shared" (CNA, 2008 p.27). Furthermore, confidentiality has important implications for nurses and other health-care providers working with older adults. The CNA (2008) states that confidentiality is, "the ethical obligation to keep someone's personal and private information secret or private" (p. 23).

Nurses and other health-care providers are encouraged to consider the following with regards to privacy and confidentiality:

- Laws and professional practice standards regarding privacy and confidentiality vary across jurisdictions. Nurses and other health-care providers must know and adhere to applicable laws and standards.
- It is important to obtain consent from the older adult or substitute decision maker[G] before sharing information with others. This may include consent for collaborations with family members and the interprofessional team.
- Sharing private and confidential information may be allowable in specific situations (e.g., emergency situations). For clarification, consult your local legislation and professional practice standards.
- Sharing personal information with other health-care providers may be necessary for the continuity of care but should be guided by local legislation and professional practice standards.

The following are examples of resources that can assist nurses and other health-care providers in maintaining privacy and confidentiality when discussing issues of abuse and neglect:

- Privacy legislation across Canada
  The Office of the Privacy Commissioner of Canada provides provincial and territorial links to Oversight Offices and government organizations: http://www.priv.gc.ca/resource/prov/index_e.asp
- Provincial or territorial professional practice standards
  Example: The College of Registered Nurses of British Columbia provides direction to registered nurses and nurse practitioners regarding privacy and confidentiality: https://www.crnbc.ca/Standards/Lists/StandardResources/400ConfidentialityPracStd.pdf

- Codes of ethics
  Examples:
  CNA Code of Ethics for Registered Nurses:
  http://www.cna-aiic.ca/~/media/cna/files/en/codeofethics.pdf
  Quebec Code of Ethics of Nurses: http://www2.publicationsduquebec.gouv.qc.ca/documents/lr/I_8/I8R9_A.htm
- Your organizational policies

RECOMMENDATION 1.3:

Be alert for risk factors and signs of abuse and neglect during assessments and encounters with the older adult.

Level of Evidence = V

Discussion of Evidence:

Assessments and encounters with the older adult provide a unique and important opportunity to identify risk factors and signs of abuse and neglect, especially when the older adult is isolated and controlled by the abuser (Cohen, 2011; Joubert & Posenelli, 2009; Zink et al., 2004). A holistic assessment may be the most comprehensive way to identify risk factors and signs of abuse and neglect because it involves assessing many different aspects of health, such as physical, emotional, mental, spiritual, cognitive, developmental, and environmental health, as well as the meaning of health to the individual (CNA, 2014b). However, brief assessments also provide opportunities to identify risk factors and signs of abuse and neglect. Importantly, both types of assessments – holistic and brief – should identify the older adult's strengths, capacities and effective coping techniques (CNA, 2014b).

Nurses and other health-care providers can also identify abuse and neglect during routine encounters with older adults (and others involved in their life and care), by paying attention to possible disclosures and using therapeutic communication techniques to enable discussion. Zink et al. (2004) found that older adult women in abusive relationships needed health-care providers to be alert to their "hints or signals that something was wrong" and needed help in "bringing up the subject of abuse" (p. 903). While this research pertains to older women living in community settings, nurses and other health-care providers in all settings should also pay attention to, and be open to disclosures of, abuse and neglect. Refer to **Appendix F** for tips and resources to support effective communication.

Table 2 and Table 3 list risk factors and possible signs of abuse and neglect of older adults, drawn from research studies, systematic reviews and grey literature sources.

Table 2: Risk Factors for Abuse and Neglect

Risk factors for abuse and neglect include

- isolation,
- lack of support,
- cognitive impairments (i.e., dementia),
- responsive behaviours[G] (e.g., verbal or physical aggression),
- living with a person who has a mental illness,
- living with people engaging in excessive consumption of alcohol or illegal drugs,
- dependency on others to complete activities of daily living (including banking),
- recent worsening of health, and
- arguing frequently with relatives.

(Cohen, Halevy-Levin, Gagin, Prilutzky, & Friedman, 2010; Davies et al., 2011; Lindbloom, Brandt, Hough, & Meadows, 2007; Perez-Carceles et al., 2009; Spencer, 2010; Wiglesworth et al., 2009)

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

Caution: The presence of risk factors or signs of abuse and neglect does not mean that a person is experiencing abuse or neglect.

Table 3: Possible Signs of Abuse and Neglect

POSSIBLE SIGNS OF ABUSE	POSSIBLE SIGNS OF NEGLECT
Physical/Psychological/Sexual ■ injuries to the upper extremity, trunk, head, neck and/or anogenital regions ■ depression, anxiety ■ change of behavior/mood in presence of the person abusing or neglecting ■ unexplained burns and bruises (may be in different stages of healing) ■ fractures (may be in different stages of healing) ■ evidence of sexual abuse (e.g., genital infections, trauma, bruising on inner thigh) ■ signs of hair being pulled ■ inadequate explanation or documentation of any injury (from employees) ■ evasive or defensive responses (from employees) **Financial** ■ irregularities in bank accounts and bills ■ living conditions that do not match income ■ missing money and personal belongings ■ payments to strangers or new "best friends" ■ inappropriate use of power of attorney authority ■ deception or coercion with regard to payments, gifts or change in wills	■ dehydration ■ malnutrition ■ low blood albumin level ■ pressure ulcers/sores ■ poor body and oral hygiene/grooming ■ depression ■ despair ■ unclean living conditions

(Erlingsson, Carlson, & Saveman, 2003; Lindbloom et al., 2007; Winterstein, 2012; Murphy, Waa, Jaffer, Sauter, & Chan, 2013; Perez-Carceles et al., 2009; Davies et al., 2011; Wiglesworth et al., 2009)

Caution: The presence of risk factors or signs of abuse and neglect does not mean that a person is experiencing abuse or neglect.

Screening and assessment tools

The value of using screening and assessment tools for abuse and neglect of older adults (including tools to assess caregivers) is controversial. Assessment and screening tools hold potential benefits for preventing and addressing abuse and neglect of older adults, but they also have the potential to cause unintentional harm. On the positive side, the tools can detect abuse and neglect and facilitate early intervention (Cohen et al., 2010; Cohen et al., 2007; Sandmoe, 2007). Spencer (2010), in a critical analysis of screening and assessment tools, explains that: "together, screening and assessment guide health-care providers and others through a systematic process of observation and documentation to ensure the manifestations of abuse will not be missed, and appropriate help is being offered" (p. 9). Done well, Spencer (2010) states, the use of tools can improve care, lead to other positive outcomes, and preserve the older adult's dignity.

On the other hand, potential harms and possible unintended effects from the use of screening and assessment tools include violations of privacy and confidentiality, intrusive and disempowering outcomes, labels of abuse, and inappropriate referrals or interventions when health-care providers lack the skills, time or resources to address the issues appropriately (Spencer, 2010). Furthermore, the content and wording of tools may not be appropriate for all cultures and geographical locations (Spencer, 2010).

A recommendation statement based on a systematic literature review raises important questions about the use of screening and assessment tools with older adults in terms of accuracy, benefits and outcomes (U.S. Preventive Services Task Force, 2013). Whereas the review did not find strong evidence of harms associated with assessment, it states that there is, "inadequate evidence on the accuracy of screening instruments" and "inadequate evidence that screening or early detection reduces exposure to abuse or reduces physical or mental harms or mortality" (U.S. Preventive Services Task Force, 2013, p. 497). The review concludes that "the benefits and harms of screening elderly adults for abuse are uncertain and that the balance of benefits and harms cannot be determined" (U.S. Preventive Services Task Force, 2013, p. 480). Similarly, a review of screening instruments in primary care found that studies did not address the potential adverse effects of screening, nor did they provide evidence that screening actually reduces harm, premature death or disability (Caldwell, Gilden, & Mueller, 2013).

As there is no clear evidence to support specific recommendations on whether or not to use tools to assess and screen older adults for abuse and neglect, it is recommended that organizations take a critical approach to determining if, when, and how to use these tools and provide direction and training to nurses and other health-care providers as necessary (refer to Recommendation 5.2). If the decision is made by an organization to use tools for assessment or screening, nurses and other health-care providers are encouraged to be mindful of the following points:

- Tools should not be used as a checklist.
- Screening and assessment tools are not diagnostic tools.
- Nurses and other health-care providers using tools must be appropriately trained (refer to Recommendation 5.2).
- The use of tools requires sensitivity and therapeutic communication skills (refer to **Appendix G**).
- Nurses and other health-care providers using tools should consider what follow-up support will be offered if abuse or neglect is identified.
- More than one tool may be required to identify different types of abuse and neglect (Cohen, 2011; Sandmoe, 2007).
- Nurses and other health-care providers should be mindful of cultural aspects and the unique needs of sub-populations of older adults during the screening process (Cohen, 2011).
- Few tools have been validated for languages other than English.

RECOMMENDATION 1.4:

Carry out a detailed assessment in collaboration with the older adult, interprofessional team, and family, as appropriate, when abuse or neglect is alleged or suspected.

Level of Evidence = V

Discussion of Evidence:

When abuse or neglect is alleged or suspected, nurses and other health-care providers should carry out a detailed assessment to facilitate treatment and support. The Expert Panel recommends that the assessment should be in collaboration with the older adult, and as appropriate, with the interprofessional team and family. Members of the interprofessional team, and family members who are involved in the life or care of the older adult, would participate in this process, so long as this aligns with the older adults' preferences (refer to Recommendation 1.5 for further discussion of the older adult's preferences and family involvement). Furthermore, nurses and other health-care providers should ensure informed consent prior to conducting detailed assessments and should share information with the interprofessional team and family members according to privacy and confidentiality regulations. For more information about privacy and confidentiality, refer to Recommendation 1.2.

A detailed assessment may include

- assessment of the older adults' immediate safety,
- diagnostic testing,
- use of assessment tool(s), and
- referrals and consultations.

Note: In some cases of abuse and neglect (e.g., abuse and neglect that occurs within an institution by a staff member) there may be additional assessments, an investigation or follow-up required by law or organizational policies or protocols. For more information about policies or protocols, refer to Recommendation 2.1.

Assessment of the older adult's immediate safety

The Expert Panel recommends that nurses and other health-care providers assess the safety of older adults to determine if there is immediate danger from a family member (e.g., spouse, son/daughter), health-care provider or other staff member, neighbour or, if he or she is in an institution, another resident. Immediate safety may also be a concern during transfer or discharge. For example, if an older adult was admitted to the hospital with signs of neglect or an injury such as a fracture, the health-care provider should determine if it is safe for them to return home. This safety assessment should also include identifying supports that may help reduce the older adult's risk of abuse or neglect. The RNAO guideline *Woman Abuse: Screening, Identification and Initial Response* (2012d) outlines best practices with regard to women (not specific to older adults) who are abused, including safety planning and questions that help a woman assess her level of safety. For further information about safety planning, refer to Recommendation 3.2. For guidelines on protecting the safety of nurses and other health-care professionals, refer to the RNAO guideline *Preventing and Managing Violence in the Workplace* (2009).

Diagnostic testing

A detailed assessment may include diagnostic tests to identify clinical indicators of abuse and neglect or to confirm injury. While some indicators may be associated with other health conditions, these should be taken seriously as potential signs of abuse or neglect. For example, low blood albumin levels may indicate malnutrition secondary to neglect (Cohen et al., 2010), and certain injuries may indicate physical or sexual abuse (refer to Table 3).

Use of assessment tool(s)

A detailed assessment may include the use of a screening or assessment tool(s); for more information and a discussion of the controversy around the use of tools, refer to Recommendations 1.3 and **Appendix G**.

Referrals and consultations

A detailed assessment may require consultations with other members of the interprofessional team. Furthermore, referrals or consultations with specialists may be appropriate. For example, case study reviews indicate that older adult victims of sexual abuse should receive care from professionals with specialized skills and training (Burgess & Hanrahan, 2004; Chihowski & Hughes, 2008). The RNAO guideline *Care Transitions* (2014b) offers recommendations for maintaining continuity of care that is applicable to times when referrals and consultations to other providers are made.

The following are examples of possible referrals or consultations, informed by the literature and Expert Panel opinion:

- case manager/care coordinator,
- ethicist/ethics board,
- forensic nurses[G],
- geriatric emergency management nurses (GEM nurse),
- geriatric outreach team,
- geriatric psychiatrist,
- geriatrician,
- lawyer,
- mental health worker working with older adults,
- occupational therapist,
- police abuse investigators,
- primary care providers,
- public guardian trustee[G],
- sexual assault nurse examiners (SANE)[G], or
- social worker.

Note: In rural and remote areas there may be limited direct access to specialists. The use of technologies such as Telehealth may be necessary.

RECOMMENDATION 1.5:

Identify the rights, priorities, needs and preferences of the older adult with regard to lifestyle and care decisions before determining interventions and supports.

Level of Evidence = IV

Discussion of Evidence:

To address abuse and neglect appropriately and effectively, nurses and other health-care providers must identify the rights, priorities, needs and preferences of the older adult with regard to his or her lifestyle and care decisions. Harbison, Coughlan, Karabanow, and VanderPlaat (2005) conducted a qualitative study with older adults in rural communities who were experiencing abuse and neglect. The study found that interventions were more likely to be successful if they aligned with cultural norms and were respectful of the older adults' rights and wishes. For example, some of the older adults stated that they wanted to preserve their independence, remain in the home, and allow neighbours to provide assistance instead of having strangers (e.g., professional services) in the home. Similarly, in a qualitative study with community-dwelling older adults, that looked at what supports are useful and necessary, the older adults reported it was important to them to maintain possession of their home and stay connected with their communities and friends (Begley et al., 2012).

Determining the rights, priorities, needs and preferences of older adults in the context of abuse and neglect aligns well with the concept of person-centred (client-centred) care. The RNAO guideline *Client Centred Care* (2006a) outlines processes for identifying concerns and needs that are applicable to working with older adults across the spectrum of care. Core processes include understanding the perspective of older adults; clarifying their wishes and strengths; supporting independence; following their lead in determining who will be involved in their care; and ensuring that their goals, concerns and needs are communicated, advocated for and documented. For more information on the rights of older adults, refer to the Guiding Principles, Recommendation 6.3 and The United Nations Principles for Older Persons (United Nations, 1991).

Caution: Organizational policies and laws such as mandatory reporting of abuse by employees may override older adults' preferences.

The Expert Panel points out that challenges may arise when trying to identify the priorities, needs, and preferences of the older adult. This includes times when the older adult lacks mental capacity[G], when language barriers or communication challenges exist and when there is conflict or there are complex dynamics within families. For a discussion of mental capacity, refer to Recommendation 2.1. For communication strategies, including working with translators, refer to **Appendix F**. The following discussion outlines important points identified by the Expert Panel regarding working with families.

Family involvement

Families are often central to the lives of older adults. Families are defined broadly as whomever the older adult considers as someone close in the circumstances, who they trust and feel is "like family." In some cases the older adult may want them to actively participate with information sharing, decision-making, or in the case of substitute decision makers, to speak on their behalf.

Family involvement is also often complex (e.g., conflicting perspectives, unsupportive or strained family dynamics). In some situations, family members may be abusing or neglecting the older adult, controlling the situation or speaking for the older adult without the authority to do so. As per other recommendations in this guideline, nurses and other health-care providers should maintain a therapeutic relationship with the older adult, be aware of immediate safety for the older adult (or themselves), and in some cases, involve other members of the interprofessional team to help support the older adult and family. Nurses and other health-care providers should also know the law with regards to decision-making authority (e.g., if there is a hierarchy of substitute decision makers in their province or territory for mentally incapable adults).

2.0 PLANNING

RECOMMENDATION 2.1:

Collect information and resources needed to respond appropriately to alleged or suspected abuse and neglect in ways that are compatible with the law, organizational policies and procedures, and professional practice standards.

Level of Evidence = V

Discussion of Evidence:

Nurses and other health-care providers should collect information and resources needed to respond appropriately to alleged or suspected abuse and neglect in ways that are compatible with the law, their organization's policies and procedures, and professional practice standards.

This includes adhering to professional practice standards and identifying

- laws that may mandate a particular action with regard to the alleged or suspected abuse and neglect,
- organizational policies and procedures that apply to the alleged or suspected abuse and neglect,
- persons to be involved in decision making (including the older adult), and
- resources that may be available to assist in responding appropriately (e.g., board of ethics, collaborative team that helps to address abuse and neglect in your organization etc.).

Identify laws and organizational policies and procedures

Nurses and other health-care providers must uphold their legal and professional responsibilities with regard to responding to abuse and neglect. The Government of Canada points out that in some jurisdictions and practice settings there may be laws, for example about adult guardianship/adult protection, family violence/family law, and protection for persons in care, that mandate particular actions (ESDC, 2011). For example, in Ontario there is mandatory reporting of abuse and neglect in long-term care facilities. The Ontario Ministry of Health and Long-term Care has developed decision trees, specific to the type of abuse, that outline the steps and actions that need to be taken when abuse or neglect is alleged or suspected. More detailed information is available through The Long-Term Care Task Force on Resident Care and Safety website, available at http://longtermcaretaskforce.ca/. The Advocacy Centre for the Elderly (ACE) suggests that if reporting

is required it is important to determine what must be reported, who has the duty to report, to whom the report must be made, and what other actions may be required (Wahl, 2013). Furthermore, in cases where mandatory reporting exists, nurses and other health-care providers should be aware that there may be legal protections (i.e., whistleblower protection) for people who report as well as penalties for not reporting (Wahl, 2013). Refer to Recommendation 6.6 for a discussion of how regulatory bodies can clarify these legal and professional responsibilities.

Workplaces may have mandatory reporting policies within the organization, for example, requiring employees to report a colleague who is committing abuse or other policies and procedures to address abuse and neglect. Nurses and other health-care providers should consult these organizational policies and procedures to determine appropriate responses. Furthermore, some forms of abuse and neglect may fall under the Criminal Code of Canada and, depending on the setting, police involvement may be appropriate or required. For an overview of Criminal Code offences that may apply to situations of abuse and neglect, refer to the Frequently Asked Questions section on the ACE website, available at http://acelaw.ca/elder_abuse_-_faq.php. Refer to Recommendation 6.2 for a discussion of how organizations can help nurses and other health-care providers uphold their responsibilities. Refer to Recommendations 5.2 and 6.2, respectively, for recommendations regarding mandatory education and nursing regulatory bodies.

It is important to note that reporting is not always required by provincial or territorial law or by organizational policy. Furthermore, reporting abuse or neglect of mentally capable adults may be inappropriate, and reporting harms without their consent may actually be a breach of the older adults' right to make their own decisions and their right to confidentiality. When reporting abuse is not required or appropriate, nurses and other health-care providers should determine what other supports can be offered to the older adult, such as providing emotional support or referrals to appropriate resources (refer to Recommendation 3.2 and **Appendix H**).

Identify persons to be involved in decision making

Nurses and other health-care providers need to determine the extent to which the older adult would like family members to be involved in developing a plan of care to address abuse or neglect (refer to Recommendation 1.5 for discussion about family member involvement). In some instances the older person may lack mental capacity to recognize the harm they are experiencing or to make the necessary decisions, and the situation may require a substitute decision maker to be involved.

Mental capacity

With regard to issues of mental capacity, nurses and other health-care providers are encouraged to be aware of the following key points. These are developed from two legal resources (Canadian Centre for Elder Law, 2011b; Wahl, 2013) and Expert Panel opinion.

- Mental capacity can fluctuate and may be situation dependent (e.g., a former diagnosis from previous records may not apply).
- Advanced age does not equate to lack of mental capacity.
- A diagnosis or clinical condition (e.g., Alzheimer's disease or mental illness) does not automatically mean a person lacks mental capacity.
- Mental capacity is not determined by any particular test, such as Mini Mental Status Examination.
- Competent older adults have the right to make choices that others may consider unwise or unsafe. Just because an older adult makes such a decision does not mean that they lack capacity.

- There are various ways to determine if someone lacks mental capacity. In some jurisdictions, this determination is made in consultation with physicians or a capacity assessor, but this does not always apply.
- Depression and delirium can sometimes be confused with lack of mental capacity

For a more in-depth review of mental capacity, refer to *Assessing Capacity Within a Context of Abuse and Neglect* (O'Connor, Hall, & Donnelly, 2009) and *Incapability Assessments: A Review of Assessment and Screening Tools* (O'Connor, 2009), available at http://www.trustee.bc.ca/documents/STA/Incapability_Assessments_Review_Assessment_Screening_Tools.pdf

Identify resources

When planning how to respond appropriately to alleged or suspected abuse and neglect of older adults, nurses and other health-care providers should identify resources that may be available to assist them. As discussed in Recommendation 5.2, abuse and neglect are complex issues and ethical dilemmas may arise. It is useful to know what resources and supports are available and may be of assistance, such as a board of ethics or a collaborative team that helps to address abuse and neglect in your organization. Other resources, such as the CNA Code of Ethics (2008), professional practice standards, and decision trees may also help with planning an appropriate response. Decision trees are used to help health-care providers determine what steps and actions to take when instances of abuse or neglect are suspected or identified. **Appendix I** provides an example of a decision tree along with considerations for using decision trees.

RECOMMENDATION 2.2:

Collaborate with the older adult, family and interprofessional team, as appropriate, to develop an individualized plan of care to prevent or address harm.

Level of Evidence = IV

Discussion of Evidence:

An individualized approach to developing a plan of care is essential because it addresses the uniqueness and the complex dynamics of each situation (Sandmoe & Kirkevold, 2013). An individualized approach has been identified as a priority for health-care providers (Sandmoe, Kirkevold, & Ballantyne, 2011) and has been found to be satisfactory for older adults (Harbison, Coughlan, Karabanow, & VanderPlaat, 2005). Developing an individualized plan of care incorporates empowering, person-centered approaches such as helping older adults to identify their existing resources and strengths, discussing and explaining options, helping them to set goals, and identifying which interventions they think would be most useful to them (Vladescu, Eveleigh, Ploeg, & Patterson, 2000; Cripps, 2001). Older adults should be actively involved in developing their plan of care because any decisions made could have a direct impact on their self determination and safety (Killick & Taylor, 2009). Additionally, there are times when family members, including those who may be at risk for abusing or neglecting the older adult, should be a part of care planning (Selwood, Cooper, Owens, Blanchard, & Livingston, 2009). Refer to Recommendation 3.2 for a discussion of interventions/supports for those who abuse or neglect the older adult. Members of the interprofessional team, and family members who are involved in the life or care of the older adult, would participate in developing an individualized plan of care so long as this aligns with

the older adults' preferences (refer to Recommendation 1.5 for further discussion of the older adult's preferences and family involvement).

The following resources are provided to assist nurses and health-care providers with developing an individualized plan of care;

- The RNAO guideline *Client Centred Care* (2006a) outlines a client-centred (person-centred) care approach to collaborating with older adults towards making decisions. This includes a framework for providing decision support.
- The approach of and tool *BLI: Being Least Intrusive – An Orientation to Practice for Front-Line Workers Responding to Abuse of Aboriginal Older Adults* provides health-care providers with key principles and concepts and a framework to support positive relationships with Aboriginal[G] older adults in a way that minimizes vulnerability and supports dignity (Struthers & Neufeld, 2011). This resource is available at http://www.nicenet.ca/tools-bli-being-least-intrusive-an-orientation-to-practice-for-front-line-workers-responding-to-abuse-of-aboriginal-older-adults
- The RNAO guideline *Supporting and Strengthening Families through Expected and Unexpected Life Events* (2006b) describes an empowering partnership with families that may be suitable if family involvement is desired and appropriate.
- The CNO practice guideline *Culturally Sensitive Care* (2009a) offers important cultural considerations that may be helpful when developing a plan of care. This guideline is available at http://www.cno.org/Global/docs/prac/41040_CulturallySens.pdf

3.0 IMPLEMENTATION

RECOMMENDATION 3.1:

Respond to alleged or suspected abuse and neglect according to legal requirements and organizational policies or procedures.

Level of Evidence = V

Discussion of Evidence:

Nurses and other health-care providers must uphold their legal and professional responsibilities with regard to responding to abuse and neglect. Given the diversity in practice settings and jurisdictional laws in Canada, it is beyond the scope of this guideline to provide specific recommendations for responding to abuse and neglect. Nurses and other health-care providers should respond according to relevant laws, policies and procedures as discussed in Recommendation 2.1. Refer to Recommendation 6.2 for a discussion of how organizations can help nurses and other health-care providers uphold these responsibilities and Recommendation 5.2 for educational programs.

In addition to upholding laws, policies, and procedures, nurses and other health-care providers are encouraged to

- recognize that reporting is not always mandated or appropriate (e.g., when a competent older adult chooses to remain in an abusive relationship);
- understand that the filing of a report is not the end of one's obligation to address abuse or neglect;
- determine what other supports can be offered to the older adult, such as emotional support and referrals (refer to Recommendation 3.2 and **Appendix H**); and

- determine what other follow-up may be required within your organization; and
- maintain documentation (refer to Recommendation 5.2 for suggested documentation).

RECOMMENDATION 3.2:

Implement an individualized plan of care that incorporates multiple strategies to prevent or address harm, including

- education and support for older adults and family members (Level of Evidence = IV),
- interventions and supports for those who abuse or neglect (Level of Evidence = IV),
- providing resources/referrals (Level of Evidence = IV) , and
- development of a safety plan (Level of Evidence = V).

Discussion of Evidence:

To date, strong evidence to support specific interventions to address abuse and neglect is not available because many interventions have not been formally evaluated. General categories of interventions that address abuse and neglect have been outlined in the literature. These include education, interventions for abusers, and providing resources and supports to older adults and family members. Ploeg, Fear, Hutchison, MacMillan, and Bolan (2009) conducted a systematic review to critically appraise the quality of existing studies regarding the effectiveness of interventions for abuse and neglect of older adults. Their findings suggest that there is currently insufficient evidence to support any particular intervention targeting older adults, perpetrators, or health-care professionals, and that there may be both positive and negative consequences of interventions.

Although strong evidence does not point to a particular intervention, there is support for an approach that includes applying multiple strategies or interventions. To address abuse and prevent its recurrence, a systematic review conducted by Public Health Research, Education & Development Program recommends interventions that include multiple strategies, for example education, counseling, and referrals, along with other broader approaches, such as community prevention and policing (Wilson & Micucci, 2003).

Education and support for older adults and family members and interventions and supports for those who abuse or neglect

Education and support has been identified as a strategy to prevent or address abuse for older adults and for family caregivers of older adults. Education may include providing information to the older adult about services and legal rights, explaining what abuse is, and discussing healthy aging (Vladescu et al., 2000). For caregivers of older adults with dementia, education should aim to help them understand dementia and factors that contribute to abuse and also provide advice about how to manage memory problems (Koch & Nay, 2003; Selwood et al., 2009). Begley et al. (2012) state that education and support are essential for family caregivers because they are often isolated, frustrated, and in need of guidance. The needs of those family caregivers who have been abusive or neglectful should also be addressed. Reay and Browne (2002) found that an education and anger management program reduced strain, depression, and anxiety for abusing caregivers and Selwood et al. (2009) highlight the importance of addressing caregiver needs, for example education, respite care or home care.

The following resources are provided to assist with education for older adults and families:

- The RNAO guideline *Facilitating Client Centred Learning* (2012a) provides recommendations on effective education strategies that are applicable to older adults and families. The guideline includes the L.E.A.R.N.S. Model, which describes how to support effective learning.
- Appendix T of the RNAO guideline *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression* (2010a) outlines behavioural interventions for the various manifestations of dementia at both early and late stages.

Providing resources/referrals

Another general category of interventions is to provide resources or referrals for older adults and families including those who abuse older adults. Two studies from the systematic literature review highlight this. Clancy, McDaid, O'Neill, and O'Brien (2011) reviewed cases of abuse, and the outcomes of particular interventions to address abuse, and concluded that a wide range of referrals complemented specialty services when addressing cases of abuse. However, providing resources and referrals should be a thoughtful process. Zink et al.'s (2004) research with older women who were victims of relationship violence, pointed out the importance of making referrals to counselors who are knowledgeable about abuse and to agencies that are focused on the particular challenges faced by women. Refer to **Appendix H** for examples of referrals that may be appropriate, depending on the unique situation, the culture and the priorities, needs, and preferences of the older adult. The RNAO guideline *Care Transitions* (2014b) offers recommendations for maintaining continuity of care that is applicable to times when referrals to other providers/services are made.

Caution: Be knowledgeable about the resources available in your area so you can discuss them with the older adult and family, as appropriate, and determine suitability.

Development of a safety plan

The Expert Panel suggests that an individualized plan of care may include developing a safety plan with the older adult. The systematic literature review conducted for this document did not return research results to inform safety planning. However, two grey literature sources outline safety plans that have been developed for older adults; examples from these documents are provided below.

Components of a safety plan may include

- having access to information and resources such as crisis line contact telephone numbers, legal and medical services, emergency shelters, and mental health services;
- talking to someone trustworthy about concerns;
- reviewing the living situation (e.g., how to leave, where to go, temporary living arrangements);
- having a bag with documents, supplies and contact information ready to take if leaving home suddenly (e.g., money, important papers, and documents extra clothes and medicine); and
- making arrangements for the care of pets, and maintaining the home, finances, and medical appointments.
  (Canadian Association of Occupational Therapists (CAOT), 2013; Siegel, 2013)

In addition to safety for the older adult, the health-care provider may need to consider his or her own safety. Appendix D of the RNAO guideline *Preventing and Managing Violence in the Workplace* (2009) provides suggestions for health-care providers preparing to meet with a potentially violent person.

4.0 EVALUATION

RECOMMENDATION 4.1:

Collaborate with the older adult, family and interprofessional team, as appropriate, to evaluate and revise the plan of care, recognizing that some instances of abuse and neglect will not resolve easily.

Level of Evidence = V

Discussion of Evidence:

Nurses and other health-care providers should collaborate with the older adult, and with the family and interprofessional team, as appropriate, to evaluate and revise the plan of care. Family members who are involved in the life or care of the older adult, and members of the interprofessional team, would participate in evaluating and revising the plan of care so long as this aligns with the older adults' preferences (refer to Recommendation 1.5 for further discussion of the older adult's preferences and family involvement). The CNA Core Competencies[G] for nurses include the importance of evaluating the plan of care in collaboration with the patient, identifying additional learning needs, and comparing actual outcomes to anticipated outcomes (CNA, 2014b). For examples of a person-centred approach to evaluating the plan of care, refer to page 24 of the RNAO guideline *Client Centred Care* (2006a).

It is important to note that some instances of abuse and neglect will not resolve easily; this is especially true for cases involving long-standing relationships. Cooper, Blanchard, Selwood, Walker, and Livingston (2010) conducted a longitudinal study to monitor abusive behaviour by caregivers over time and found that most abusive behaviour persisted or worsened, despite contact with specialist services. Similarly, Vladescu et al. (2000) analyzed outcomes of a case management program for competent, community-dwelling abused older adults. The researchers found that the longer abuse had occurred within a relationship, and the closer the relationship between the abuser and the abused, the less likely it was that the situation of abuse would resolve. This was echoed by Lithwick, Beaulieu, Gravel and Straka (2000) who reported that in cases of mistreatment between perpetrators and victims interventions reduced, rather than ended, the mistreatment. Given the complexity of these relationships and the difficulty in resolving them, Lithwick et al. (2000) propose an approach that focuses on the reduction of harms.

A focus on reducing harms and offering ongoing support may be the most appropriate plan of care in some situations. The Expert Panel points out that some older adults will decide to remain in abusive or neglectful situations/relationships and may decline interventions. While these decisions may be perceived as unwise or unsafe, the older adult has the right to make such decisions (so long as the law is observed and the older adult is competent). Regardless of these decisions, nurses and other health-care providers should maintain a therapeutic relationship, continue to offer service as needed, and be available if the older adult changes his or her mind. The importance of continued support like this is reflected in Zink et al.'s (2004) research with older women in violent relationships. One of the most valuable ways a care provider can help, these women said, is to respect a woman's decision to continue in the abusive relationship.

Education Recommendations

5.0 EDUCATION

RECOMMENDATION 5.1:

All employees across all health-care organizations that serve older adults participate in mandatory education that raises awareness about

- ageism;
- the rights of older adults;
- the types, prevalence and signs of abuse and neglect of older adults;
- factors that may contribute to abuse and neglect; and
- individual roles and responsibilities with regard to responding or reporting abuse or neglect.

Level of Evidence = V

Discussion of Evidence:

All employees across all health-care organizations that serve older adults need basic education so that they can contribute to preventing and addressing abuse and neglect of older adults within the organization. The Expert Panel recommends that this content be taught to all employees, at every level of the organizational hierarchy. A variety of registered professionals and other staff (e.g., dietary aides, volunteers, housekeeping, home support workers, personal support workers and health-care aides) interact with older adults and families in institutional and community settings and all are in positions to identify and respond to abuse and neglect. The Expert Panel recommends that this mandatory training be included as part of employee orientation, with annual follow-up and continuing education opportunities. For a review of this content, refer to Recommendation 5.2 and for factors that contribute to abuse and neglect, refer to Background, Figure 1, Table 2 and Table 5.

RECOMMENDATION 5.2:

Nurses, other health-care providers, and supervisors who work in health-care organizations that provide care and services to older adults participate in mandatory and continuing education opportunities that include

- understanding issues of abuse and neglect (Level of Evidence = IV);
- assessing and responding to abuse and neglect (Level of Evidence = IV);
- roles, responsibilities and laws (Level of Evidence = IV);
- positive approaches to working with older adults (Level of Evidence = IV);
- effective strategies for challenging/responsive behaviours (Level of Evidence = V); and
- fostering a safe and healthy work environment and personal well-being (Level of Evidence = V).

Discussion of Evidence:

Mandatory education programs should include core content required to prevent, identify and respond to abuse and neglect of older adults, as outlined in this guideline. Few research studies have evaluated the effectiveness of educational programs, focusing instead on measures of satisfaction and increased awareness (Alt, Nguyen, & Meurer, 2011). Other studies report mixed results of training (Cooper, Selwood, & Livingston, 2009). However, there is ample evidence that points to key content that should be included in training for nurses and other health-care providers. The Expert Panel recommends that the following content be included as a part of employee orientation, mandatory education programs, and ongoing professional development opportunities. Depending on the practice setting, some content will require more or less emphasis and content should be tailored to the scope of practice for the learners. Refer to Recommendation 5.3 for a discussion of educational design and Recommendation 6.2 for a discussion of mandatory education policy.

Understanding issues of abuse and neglect

Comprehensive education to help nurses and other health-care providers understand issues of abuse and neglect should include information about

- the prevalence of abuse and neglect of older adults (refer to Background);
- the different types of abuse and neglect (refer to **Appendix D**);
- theories and explanations of abuse and neglect (refer to Background, Figure 1 and **Appendix E**); and
- risk factors and signs of abuse and neglect (refer to Table 2 and Table 3).

Research findings indicate an overall lack of knowledge and understanding of abuse and neglect among physicians, nurses, and allied health staff who work in a range of settings (Almogue, Weiss, Marcus, & Beloosesky, 2010; Meeks-Sjostrom, 2013; Joubert & Posenelli, 2009; Schmeidel et al., 2012). More specifically, there is lack of awareness and clarity about what constitutes abuse and neglect of older adults. In the long-term care sector, Hirst (2002) found that there were varying perceptions and definitions of abuse. For example, some administrators said that they had never seen abuse, whereas a nurse stated that "it happens all the time," and "we just don't recognize it as abuse" (Hirst, 2002, p. 279). Goergen (2004) found that nursing home directors were ignorant of most cases of abuse and neglect and that some actions, such as the inappropriate use of restraints, go unnoticed, and Schmeidel et al. (2012) observed that many nurses working in clinic settings struggled to identify abuse unless there were obvious signs (e.g., bruises).

Assessing and responding to abuse and neglect

Several studies have identified that nurses and other health-care providers across the spectrum of care lack skills, or do not feel prepared to assess for, or respond to, abuse and neglect of older adults (Meeks-Sjostrom, 2013; Richardson, Kitchen, & Livingston, 2002; Schmeidel et al., 2012; Wong & Marr, 2002). Comprehensive education to prepare nurses and other health-care providers to assess for and respond to abuse and neglect should include information about

- appropriate assessment skills and techniques, including the use of screening or assessment tools, if directed by the organization to use them (refer to Recommendations 6.2 and 1.3 and **Appendix G**);
- appropriate resources and supports available to address abuse and neglect or reduce risk (refer to **Appendix H**);
- strategies for safety planning with the older adult (refer to Recommendation 3.2);
- awareness of common ethical dilemmas and strategies to address them (refer to discussion below); and
- documentation (refer to discussion below).

Ethical dilemmas

Educational content on the topic of assessing and responding to abuse and neglect should include a discussion of common ethical dilemmas and strategies used to address them. The CNO (2009b) states that an ethical conflict or dilemma exists when "two or more ethical values apply to a situation, but these values support diverging courses of action" (p. 4). Winterstein (2012) found that nurses struggle with complex ethical situations and need opportunities to discuss ethical dilemmas. Table 4 outlines common ethical issues related to abuse and neglect of older adults that can be addressed in educational programs.

Table 4: Ethical Issues Identified in the Literature

Ethical issues identified in the literature include

- complicated issues surrounding family and caregivers who abuse older adults (for example, health-care providers struggling to know whether intervening would be of benefit to the older adult who is emotionally attached to, and dependent on, the abuser);
- disagreement within the care team about the level of intervention required based on assessments of possible future risk of abuse and neglect;
- working with an older adult who wishes to return to the abusive situation despite the risk involved;
- concerns about raising the issue with the person suspected of abusing or neglecting the older adult since it may subject the older adult to further abuse;
- deciding who in the health-care team should be informed about suspected abuse for fear of creating prejudice against the alleged abuser before the claim is substantiated;
- ethical dilemmas that arise if the older adult does not want an investigation for abuse and neglect or refuses supportive services when abuse is suspected; and
- balance between doing what is right for the older adult and taking away their autonomy (e.g., having to make the decision to put an abused, cognitively impaired older adult in a nursing home due to the immediate danger of their living situation).

(Beaulieu & Leclerc, 2006; Joubert & Posenelli, 2009; Killick & Taylor, 2009; Winterstein, 2012)

Examples of resources that offer frameworks for ethical decision-making include the following:

- CNA *Code of Ethics for Registered Nurses* (2008),
- ethics practice standards outlined by provincial and territorial regulatory bodies, and
- *In Hand: An Ethical Decision-Making Framework* (Beaulieu, 2010), a tool which has been developed for experienced health and social service practitioners working in settings without adult protection law. This resource is available at http://www.nicenet.ca/files/In_Hands.pdf

Documentation

Education for nurses and other health-care providers should outline what to document with regard to abuse and neglect. Documentation is a standard for nursing care and other professions and requirements for documentation are usually outlined by organizational policies and by professional regulatory bodies. An example of documentation

standards for nurses in Ontario is available at http://www.cno.org/Global/docs/prac/41001_documentation.pdf. Suggested content for documentation specific to the topic of abuse and neglect of older adults includes the following:

- assessment findings – risk factors and signs of abuse and neglect;
- statements (direct quotes) or behaviour by the older adult or family;
- involvement of substitute decision makers;
- protective factors (e.g., strengths, capacities and effective coping techniques);
- priorities, needs and preferences of the older adult with regard to lifestyle and care decisions;
- plan of care/interventions that reflect the older adults' priorities and needs;
- collaborations with team members and referrals to specialists;
- applicable legal documents being relied on; and
- evaluation of plan of care/interventions.

Roles, responsibilities and laws

To respond appropriately to abuse and neglect, nurses and other health-care providers require education on relevant laws and on their own roles and responsibilities. The education program should include information on jurisdictional laws, organizational policies and procedures, and relevant professional practice standards. As well, it may include content on concepts that are often misunderstood in practice, such as consent, mental capacity, privacy, confidentiality, substitute decision making (personal directives, powers of attorney, guardianship/trustee). Refer to Recommendations 2.1 and 6.6 for further discussion.

A general lack of knowledge or appropriate action in response to abuse and neglect has been identified in several studies. An international survey found a key theme was that professionals have limited understanding of the laws to protect older adults (Podnieks, Anetzberger, Wilson, Teaster, & Wangmo, 2010). Other studies have found the same lack of knowledge of laws among nurses and physicians working in hospitals and long-term care facilities (Almogue et al., 2010), nurses working in clinic settings (Schmeidel et al., 2012), and physical therapists working in a variety of settings (Saliga, Adamowicz, Logue, & Smith, 2004). Further, Schmeidel et al. (2012) found that nurses were unclear on their roles and responsibilities with respect to reporting abuse and wrongly believed that it was the responsibility of a physician or social worker. Malmedal, Hammervold, and Saveman (2009) found that health-care providers did not uphold their responsibilities to report abuse committed by colleagues in long-term care.

Positive approaches to working with older adults

Nurses and other health-care providers need education that fosters positive approaches to working with older adults. In addition to a person-centred approach, this education should include the following content:

- ageism/attitudes and beliefs about older adults,
- attitudes about abuse and neglect of older adults,
- the rights of older adults,
- cultural sensitivity,
- therapeutic communication skills and empathy, and
- reflective practice[G].

Ageism/attitudes and beliefs about older adults and attitudes about abuse and neglect

Various studies have identified attitudes that may contribute to, or enable, abuse and neglect. Shinan-Altman and Cohen (2009) conducted research with nurse aides working in nursing homes and found a relatively high rate of attitudes that condoned abuse. The researchers concluded that education to modify attitudes was an important component to addressing the problem. Another study of interviews with nurses in long-term care identified that nurses often justified situations of neglect and placed the responsibility for neglect on circumstances outside of their control (Winterstein, 2012). Spencer et al. (2008) state that "societal ageism has a fundamental role in fostering and perpetuating abuse and neglect of residents in care facilities" and they recommend that education be aimed at "fostering respectful and compassionate attitudes among the staff towards the residents, and their co-workers" (p. 53).

Rights of older adults

Education that outlines the rights of older adults aligns well with education about attitudes towards older adults. For education resources to support content on the rights of older adults, refer to Guiding Principles, Recommendation 6.3 and The United Nations Principles for Older Persons (United Nations, 1991).

Cultural sensitivity

Nurses and other health-care professionals working with diverse cultural groups need to be sensitive to a variety of cultural differences when preventing and addressing abuse and neglect of older adults. These differences include variations in values, beliefs, care expectations, gender roles, language proficiency and level of acculturation and assimilation (Podnieks, 2008). The CNO encourages self reflection to build cultural sensitivity, stating that "self-reflection assists the nurse in identifying the values and biases that underscore her/his approach and interventions, and their impact on the client" (CNO, 2009a, p.4).

Therapeutic communication skills and empathy

Education is also recommended to help foster empathy and to develop therapeutic communication skills with older adults concerning issues of abuse and neglect. Zink et al.'s (2004) research with older women who had experienced abusive relationships identified a lack of empathy among some health-care providers who used labels such "high strung" or "complainers" to describe the women. Schmeidel et al.'s (2012) research findings point to the importance of training that helps build skills around talking about issues of abuse. The researchers found that nurses were passionate about caring for older adults and wanted to prevent and address abuse, but they were not comfortable dealing with it directly and looked for other reasons that might explain the signs of abuse. Refer to **Appendix F** for suggested communication strategies.

Reflective practice

Reflective practice may help nurses and other health-care providers gain insight into counterproductive attitudes and beliefs with regard to older adults and issues of abuse and neglect. Examples of topics for reflective practice include the following:

- ageism and other attitudes and beliefs about older adults (e.g., assuming older adults have mental decline);
- stereotypes and discrimination such as those linked with racialization[G], Aboriginal ancestry, immigration status,

sexual orientation, disability, gender identity and expression, socio-economic status, and stigma related to mental health or addictions issues;
- attitudes and stereotypes about families (e.g., assuming that all families are loving and supportive or, conversely, that an adult family member who lives with an older adult is exploitive);
- attitudes about independence, dependence and interdependence in relationships;
- attitudes and perceptions of abuse and neglect (e.g., condoning or justifying abuse); or
- power imbalances in relationships between care provider and older adult and family.

Examples of education resources to support reflective practice include the following:

- *Relating to Old People Evaluation (ROPE)* (Cherry & Palmore, 2008). This resource is available at http://www.nicenet.ca/tools
- *BLI: Being Least Intrusive – An Orientation to Practice for Front-Line Workers Responding to Abuse of Aboriginal Older Adults* (Struthers & Neufeld, 2011). This resource is available at http://www.nicenet.ca/tools
- The RNAO's guideline *Embracing Cultural Diversity in Health Care: Developing Cultural Competence* (2007).
- *Opening the Closet on Aging* (Senior Pride Network, 2009). This brochure is available at http://www.rainbowhealthontario.ca/resources/database.cfm
- *Improving the Lives of LGBT Older Adults* (LGBT Movement Advancement Project (MAP), & Services and Advocacy for Gay, Lesbian, Bisexual and Trangender Elders (SAGE), 2010). This resource is available at https://lgbtmap.org/improving-the-lives-of-lgbt-older-adults

Effective strategies for addressing challenging/responsive behaviours

Nurses and other health-care providers should be knowledgeable about how to handle challenging/responsive behaviours. While the systematic literature review did not locate studies that addressed this topic directly, appropriate management of these behaviours may help to promote better quality care and safety for older adults and those around them.

Examples of education resources to support content on challenging/responsive behaviours include the following:

- The RNAO guideline *Caregiving Strategies for Older Adults with Delirium, Dementia and Depression* (2010). This guideline provides resources and strategies for the management of dementia (e.g., music therapy, recreation, spiritual care, sensory enrichment).
- *Long-term Care Task Force on Resident Care and Safety* (2013) outlines approaches for managing challenging behaviours related to dementia (and in some cases mental health, addictions or other conditions), such as Gentle Persuasive Approaches, "Putting the P.I.E.C.E.S. Together", U-First!, and Behavioural Supports Ontario. This information is available at www.longtermcaretaskforce.ca
- The RNAO guideline *Promoting Safety: Alternative Approaches to the Use of Restraints* (2012b). This guideline provides recommendations and tools (e.g., violence checklists, safety plan interventions, de-escalation tips) to support individuals who are at risk for harming themselves or others.

Fostering a safe and healthy work environment and personal well-being

The Expert Panel recommends that all nurses, other health-care providers and supervisors are educated about how to foster a safe and healthy work environment, including taking care of their personal well-being. The RNAO (2014a) describes a healthy work environment as "a practice setting that maximizes the health and well-being of nurses and

other health-care providers, quality patient outcomes and organizational performance". Examples of training content on these topics may include creating an atmosphere of trust and cooperation and identifying caregiver burnout (New Brunswick Association of Nursing Homes, 2014). Furthermore, it is important to understand that addressing issues of abuse and neglect may have an impact on the health-care provider's own emotional health and well-being. Education should also include resources and suggestions to address these concerns.

Many organizations offer counseling for staff through the human resources department or an employee assistance program. Refer to the RNAO's Healthy Work Environment best practice guidelines as a resource to support a healthy work environment and personal well-being. These guidelines are available at www.RNAO.ca/bpg/guidelines/hwe-guidelines

Additional content to support mandatory training on abuse and neglect of older adults

The Expert Panel suggests that nurses and other health-care providers are educated on a variety of other content areas to support effective work in preventing and addressing abuse and neglect of older adults. Depending on the practice setting and the learners' baseline education, the following content may need to be included in training on abuse and neglect, or provided through other education programs:

- gerontology/normal ageing;
- Alzheimer's disease and other dementias;
- cultural competence;
- domestic violence, mental health, and addictions;
- the social determinants of health; and
- strategies for collaboration with interprofessional team.

RECOMMENDATION 5.3:

Educational institutions incorporate the RNAO Best Practice Guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches* into curriculum for nurses and, as appropriate, for other health-care providers.

Level of Evidence = V

Discussion of Evidence:

Integrating this guideline into curricula for nurses and other health-care providers is an important way to help prevent and address abuse and neglect of older adults. An international survey that included Canada and other developed nations found that lack of training was a barrier to recognizing and addressing abuse and neglect of older adults in part because the subject was not included in standardized curriculum or embedded within professional credentialing (Podnieks et al., 2010). Furthermore, Curran, Barrett, Hollett, and Barrett (2009) recommend that content on abuse and neglect be introduced into the curricula of health sciences, social work and other applicable academic programs. Other health and social disciplines may incorporate content of this guideline into curricula so long as it is tailored to the scope of practice for the particular discipline. For information on recommended educational content, refer to Recommendations 5.1 and 5.2 and for further information and resources on designing effective education programs, refer to Recommendation 5.4.

RECOMMENDATION 5.4:

To help nurses and other health-care providers build competence in preventing, identifying, and responding to abuse and neglect of older adults, education programs are designed to

- address attitudes, knowledge and skills (Level of Evidence = V);
- include multimodal and interactive/participatory strategies (Level of Evidence = IV); and
- promote an interprofessional approach (Level of Evidence = V).

Discussion of Evidence:

To effectively prevent, identify and respond to abuse and neglect of older adults, nurses and other health-care providers need education that addresses attitudes (e.g., ageism), and builds knowledge (e.g., about types of abuse and neglect) and skills (e.g., effective communication and the use of screening or assessment tools). Education on abuse and neglect described in the literature does not adequately match these needs. Existing training has been described as anecdotal and inefficient (Podnieks et al., 2010), centered around passive learning techniques (Jogerst, Daly, Dawson, Brinig, & Schmuch, 2003), and inadequate and impractical (Schmeidel et al., 2012). The need for training that addresses attitudes, knowledge and skills is further supported by the learning needs described earlier in this guideline (refer to Recommendations 5.1 and 5.2).

Address attitudes, knowledge and skills and include multimodal and interactive/participatory strategies

Education that addresses attitudes, knowledge and skills should include the use of multimodal strategies and interactive approaches. Where possible, face-to-face education is preferred over written material (Cooper et al., 2009; Richardson et al., 2002) and may be supplemented by a "blended learning" approach that combines face-to-face learning with distance education (Curran, Barrett, Hollett, & Barrett, 2009). Recommended teaching strategies include the use of film, discussion, and activities that promote critical thinking (Teresi et al., 2013). Learners should also have opportunities to work through the complexities of abuse and neglect. This includes realistic situations and strategies for managing difficult situations (Dow et al., 2013), having time to talk openly about sensitive issues (Strumpel & Hackl, 2011) and receiving education that offers emotional support for participants (Hsieh, Wang, Yen, & Liu, 2009). Education should also be pragmatic and strengthen practical knowledge (Schmeidel et al., 2012). Practical tools such as a pocket guide or patient educational brochure can enhance learning (Mills et al., 2012).

Examples of resources to assist with the development of effective educational programs include the following:

- The RNAO's *Educator's Resource: Integration of Best Practice Guidelines* (2005) provides educators with information and tools to plan, implement and evaluate education. Examples of content include principles of adult learning, a description of various teaching strategies, and lesson plan templates.
- *Identification of Best Practices to Educate and Train Health Professionals in the Recognition, Intervention and Prevention of Violence Against Older Persons* provides an inventory of over 71 educational and training resources. Educators are encouraged to evaluate these materials to determine accuracy and relevancy for their sector and jurisdiction (Curran et al., 2009). This resource is available at http://www.gov.nf.ca/vpi/publications/vaop_final_report.pdf

Promote an interprofessional approach

An interprofessional education approach where various professionals participate in education programs together, fosters a greater understanding of roles and responsibilities, enables participants to learn from one another, and improves service for older adults who have experienced abuse and neglect (Curran et al., 2009). Furthermore, interprofessional education that extends participation beyond those who provide direct care reinforces training on a variety of levels within an organization (Teresi et al., 2013). Overall, interprofessional education helps to improve collaboration, practice, quality, and person-centred care (RNAO, 2013b).

Policy, Organization and System Recommendations

6.0 POLICY, ORGANIZATION AND SYSTEM

RECOMMENDATION 6.1:

Organizations/institutions establish and support collaborative teams to assist with preventing and addressing abuse and neglect of older adults.

Level of Evidence = V

Discussion of Evidence:

Collaborative teams play a pivotal role in preventing and addressing abuse and neglect of older adults. To be effective, an integrated approach is required, which may include collaboration and coordination among different professionals, departments or agencies (Curran et al., 2009).

Examples of members of the collaborative team, informed by the literature and Expert Panel opinion, may include

- adult protective services;
- clergy/faith leaders;
- community leadership such as Chief and Band Council in First Nations communities;
- community workers;
- dentists;
- domestic violence advocates;
- geriatric mental health services;
- lay workers, informal caregivers;
- nurse managers;
- nurses;
- older adults, families, caregivers;
- personal support workers;
- physicians;
- police;
- prosecutors, lawyers;
- public guardians;
- representatives from financial institutions;
- resident councils[G] and family councils[G] (in long-term care);
- social workers; and
- unions.

Benefits of formal collaborative teams comprised of these professionals are reported in the literature. For example, Lawrence and Banerjee (2010) found that a home support team, which included a nurse, a community psychiatric nurse and a social worker, improved communication among staff, promoted staff development, engagement and confidence, and improved the overall quality of care for residents in long-term care, thereby helping to prevent abuse and neglect. Other benefits of teams include improved care for older adults, assistance on challenging cases, and improved cooperation and understanding among team members (Teaster, Nerenberg, & Stansbury, 2003). Examples of collaborative teams in Canada and the United States reporting positive outcomes include a Neglect Assessment Team (Fulmer et al., 2003); an Elder Abuse Forensic Center (Wiglesworth, Mosqueda, Burnight, Younglove, & Jeske, 2006); a home assessment team, involving a nurse practitioner, geriatrician, physician and social worker (Heath, Kobylarz, Brown, & Castano, 2005); a PROJECT CARE team involving professionals and paraprofessionals (Nahmiash & Reis, 2000); an Elder Abuse Response Team (Groh & Linden, 2011); and a Vulnerable Adult Protective Service team (Mosqueda, Burnight, Liao, & Kemp, 2004). For additional information on collaborative teams refer to the RNAO guideline *Developing and Sustaining Interprofessional Health Care: Optimizing Patients/Clients, Organizational, and System Outcomes* (2013b). For a discussion of privacy and confidentiality that is relevant to working in collaborative teams, refer to Recommendation 1.2.

There is also evidence to support an informal collaborative team approach and teams involving nonprofessionals. For example, Harbison et al. (2005) found that informal collaboration between professional and lay workers helped to fill gaps in the health-care system to provide effective, culturally appropriate support to older adults suffering from abuse and neglect. Collaboration involving diverse individuals and groups is integral to a coordinated community response approach to addressing abuse and neglect. For more information and resources about coordinated community responses, refer to Recommendation 6.4.

RECOMMENDATION 6.2:

Organizations/institutions establish policies, procedures and supports that enable nurses and other health-care providers to recognize, respond to, and where appropriate, report abuse and neglect of older adults.

Level of Evidence = V

Discussion of Evidence:

Organizations/institutions need to provide clear policies and procedures and adequate supports to enable nurses and other health-care providers to recognize, respond to and, where appropriate, report abuse and neglect of older adults. Organizations/institutions should

- provide direction to nurses and other health-care providers around which, if any, screening or assessment tools should be used;
- develop and implement clear policies, procedures, roles and responsibilities for responding to abuse and neglect that are compatible with the law and professional standards (this may include developing reporting procedures);
- establish no-blame policies for people who report abuse or neglect when reporting is mandated by policy or law;
- establish and maintain a culture that supports staff to improve quality care; and
- establish mandatory and continuing education policies that address core content outlined in Recommendations 5.1 and 5.2.

Provide direction on the use of screening or assessment tools

Nurses and other health-care providers need direction on whether or not they should be using screening and assessment tools. This is because there are both benefits and drawbacks to using tools, evidence about the use of tools is inconclusive and numerous tools exist (refer to Recommendation 1.3 and **Appendix G**). Organizations/institutions should weigh the pros and cons of tools and determine the suitability of the tool for the practice setting. They should consider the context of use, as well as the purpose, reliability, validity, and ease of administration of the tool (Spencer, 2010). Given the complexity of decision making around the use of tools, it may be appropriate to convene a team, or task group, to weigh these considerations. Refer to Chapter 2a in the RNAO *Toolkit: Implementation of Best Practice Guidelines (2nd ed)* (2012c) for discussion and an example of how an interprofessional team approach was used to decide on an assessment tool. It should be noted that given the complexity of abuse and neglect, one tool may provide an incomplete assessment and a variety of assessment methods or tools may be required (Cohen, 2011;Cohen et al., 2007; Fulmer et al., 2003; Sandmoe, 2007). If the decision is made to use tools, nurses and other health-care providers must be sufficiently educated on when and how to use these tools. For more information about assessment/screening tools, refer to Recommendation 1.3 and **Appendix G**.

Develop and implement clear policies, procedures, roles and responsibilities

When considering how to respond to abuse and neglect of older adults, nurses and other health-care providers need access to policies and procedures that clearly outline their role and responsibilities. Numerous studies have found that nurses and other health-care providers lack knowledge and clarity about roles and responsibilities, including legal responsibilities and procedures for reporting abuse and neglect of older adults (Almogue et al., 2010; Malmedal, Hammervold, & Saveman, 2009; Podnieks et al., 2010b; Saliga et al., 2004; Schmeidel et al., 2012). Provincial and territorial regulatory bodies provide professional practice standards which can be used to guide the development of policies and procedures. Refer to **Appendix I** for a sample decision tree, a tool that is used to guide appropriate responses to abuse or neglect.

Policies and procedures should

- be compatible with the law and professional practice standards;
- be made explicit to staff;
- provide explicit directions, responsibilities and contact information, where reporting is mandated by law;
- outline what to do when no reporting is required;
- align with principles such as those outlined in the Background section of this guideline; and
- be reviewed and updated, reflecting best practices.

Establish no-blame policies for people who report abuse or neglect

Nurses and other health-care providers, older adults, and families need organizational/institutional policies to make it easier for them to speak up about abuse and neglect. There may be a hesitancy to speak up, even in places where mandatory reporting exists (Almogue et al., 2010; Harbison et al., 2005; Ko & Koh, 2012; Malmedal et al., 2009; McCool, Jogerst, Daly, & Xu, 2009; Rodriguez, Wallace, Woolf, & Mangione, 2006; Saliga et al., 2004; Wong & Marr, 2002). Key reasons for not reporting include a fear of negative outcomes, especially when abuse and neglect involves a colleague (Malmedal et al., 2009) or uncertainty about protection for those who report (Ko & Koh, 2012). Family members and residents may also keep quiet about abuse and neglect because they fear repercussions such as a loss of visiting privileges and concerns about what will happen when family members leave (Spencer et al., 2008). Therefore, organizations/institutions should ensure that people who report abuse and neglect, whether staff, family, resident or others, should be protected by no-blame policies.

Establish and maintain a culture that supports staff to improve quality care

Along with a no-blame policy for people who report abuse, organizations/institutions should focus on building a culture of that supports staff to improve quality care. Research has shown that non-punitive models for addressing abuse and neglect in long-term care facilities have been effective in engaging staff and improving quality of care (Lawrence & Banerjee, 2010). Spencer et al. (2008) state that caring environments – where there is a supportive instead of a blaming stance, and where people are encouraged to talk about abuse issues and the needs of staff, families and residents – will help to bring abuse and neglect into the open rather than allowing it to be ignored or minimized. The RNAO guideline *Developing and Sustaining Nursing Leadership (2nd ed.)* (2013c) provides guidance on how to develop transformational leadership practices that align with this recommendation, such as building relationships and trust, creating an empowering work environment and creating a culture that supports high-quality care.

Establish mandatory and continuing education policies

Nurses and other health-care providers need formal education on how to effectively recognize and respond to abuse and neglect of older adults. The Expert Panel recommends that organizations/institutions establish policies for mandatory and continuing education that help to ensure staff are adequately trained, and help to enforce attendance and accountability. Furthermore, these policies will be better sustained if organizations/institutions ensure staff receive protected time and pay for educational opportunities (refer to Recommendations 5.1 and 5.2).

RECOMMENDATION 6.3:

Institutions* adopt a combination of approaches to prevent abuse and neglect of older adults, including

- screening potential employees, hiring the most qualified employees, and providing proper supervision and monitoring in the workplace;
- securing appropriate staffing;
- providing mandatory training to all employees;
- supporting the needs of individuals with cognitive impairment, including those with responsive behaviours;
- upholding resident rights;
- establishing and maintaining person-centred care and a healthy work environment; and
- educating older adults and families on abuse and neglect and their rights, and establishing routes for complaints and quality improvement.

*Note: The research in this discussion of evidence refers mainly to long-term care facilities but the Expert Panel recommends that these recommendations are applicable to many other health-care settings across the spectrum of care.

Level of Evidence = V

Discussion of Evidence:

Abuse and neglect in institutional settings is a complex and multifaceted issue that requires a combination of strategies at various levels to prevent it from occurring (McDonald et al., 2012; Spencer, 2006). Table 5 provides an overview of factors and conditions that contribute to abuse and neglect in institutions.

Two comprehensive reports outline a multipronged approach to preventing abuse and neglect in institutional settings. The Long-Term Care Task Force on Resident Care and Safety (2013) addresses factors at various levels in long-term care that contribute to abuse and neglect and identifies 18 actions to prevent abuse and neglect in these facilities and Spencer et al. (2008) outline various categories for prevention of abuse and neglect. These include general mechanisms to assure general quality of care, mechanisms focusing on staff before and during employment, oversight, mechanisms to identify and respond to problems or concerns, and mechanisms to empower residents. The prevention strategies outlined in this recommendation are based on the above reports as well as background literature that describe factors and conditions related to abuse and neglect in institutional settings.

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)

Screening potential employees, hiring the most qualified employees, and providing proper supervision and monitoring in the workplace

Risk factors for abuse and neglect of older adults include staff related issues, such as staff who lack qualifications, training and supervision (Goergen, 2004; Spencer et al., 2008). Screening potential staff prior to hiring (including conducting criminal record checks) and only hiring the most qualified people, are suggested ways to help prevent abuse and neglect (Long-Term Care Task Force on Resident Care and Safety, 2013; Spencer et al., 2008). Once employees are hired, ongoing supervision and monitoring should occur; this includes checking up on staff who work in isolation (Goergen, 2004) and monitoring competencies (Long-Term Care Task Force on Resident Care and Safety, 2013).

Securing appropriate staffing

Inappropriate staffing levels and lack of qualified staff have been associated with an increased risk of abuse and neglect (Buzgova & Ivanova, 2009; Goergen, 2004; Long-Term Care Task Force on Resident Care and Safety, 2013; Phillips & Ziminski, 2012). More specifically, Goergen (2004) found that low staff levels, and an inappropriate ratio of residents to registered nurses increased the risk of abuse. Similarly, Phillips & Ziminski (2012) found that inappropriate staffing was associated with more neglect. Overall, appropriate direct-care staffing addresses complex care needs, improves quality of care and is an important approach to reducing abuse and neglect (Long-Term Care Task Force on Resident Care and Safety, 2013).

Given the variability and complexity of practice settings, universal standards for the quantity of staff or nurse-to-patient ratios are difficult to determine (Harris & McGillis Hall, 2012). There are, however, recommended staffing levels for some sectors. For example, RNAO (2014c) states that "evidence-based legislated minimum standards of care should be adopted in long-term care (LTC) homes, including funding for no less than an average of 4.0 hours of nursing care per resident, per day and no less than .59 RN hours per resident, per day; with greater acuity requiring more hours of care" (p. 6).

The following resources offer recommendations and tools for decision making around staff mix and appropriate staffing:

- *Staff Mix Decision-Making Framework for Quality Nursing Care* offers a framework for determining the appropriate mix of health-care providers for safe quality care that can be applied to any clinical setting (CNA, 2012). This resource is available at http://www.nurseone.ca/docs/NurseOne/KnowledgeFeature/StaffMix/Staff_Mix_Framework_2012_e.pdf
- The RNAO guideline *Developing and Sustaining Effective Staffing and Workload Practices* (2007) provides decision-making tools and best practice recommendations for organizations, health systems, accreditation bodies and governments.

Providing mandatory training to all employees

For a discussion of mandatory training policies, refer to Recommendation 6.2. For a description of recommended mandatory education, refer to Recommendations 5.1 and 5.2.

Supporting the needs of individuals with cognitive impairment, including those with responsive behaviours

Older adults who have specialized needs, such as those with cognitive impairment and those who demonstrate responsive behaviours, need to be appropriately cared for to ensure their own safety and the safety of those around them. Emerging research in the area of resident-to-resident aggressive behaviour highlights the need for staff training

on managing responsive behaviours (Allen, Kellett, & Gruman, 2003; Snellgrove, Beck, Green, & McSweeney, 2013), for modification of the environment (e.g., reduce crowding), for providing person-centred care (Pillemer et al., 2011), and for ensuring adequate staffing and resources to monitor residents' behaviour (Allen et al., 2003). Furthermore, the Long-term Care Task Force on Resident Care and Safety (2013) recommends that long-term care homes should provide specialized units with adequate staffing, and staff with specialized skills to care for residents who have high needs. Also, there should be ongoing evaluation of the appropriateness of placements to long-term care, and transfers should be arranged if the needs of residents can be better met in another facility (Long-Term Care Task Force on Resident Care and Safety, 2013). Various resources are available to help support the needs of individuals with cognitive impairment and responsive behaviours (refer to Recommendation 5.2).

Upholding resident rights

Organizations should establish an overall positive culture for residents and staff to prevent abuse and neglect. This includes establishing and clearly communicating resident's rights (Buzgova & Ivanova, 2009; Spencer et al., 2008). Buzgova and Ivanova (2009) suggest that policies can enforce residents' rights and, as a result, contribute to an organizational culture that respects ethical principles.

The following are examples of bills of rights for residents:

- *Every Resident: Bill of Rights for people who live in Ontario long-term care homes* (ACE & Community Legal Education Ontario, 2008). This resource is available at http://www.acelaw.ca/appimages/file/Every%20Resident%20-%20Bill%20of%20Rights.pdf
- *British Columbia – Resident's Bill of Rights* (B.C.Government, 2009). This resource is available at http://www.health.gov.bc.ca/ccf/pdf/adultcare_bill_of_rights.pdf

Establishing and maintaining person-centred care and a healthy work environment

Similarly, a person-centred approach, that recognizes and respects the uniqueness of each older adult, is recommended to help prevent abuse and neglect, and organizations should develop a supportive culture for employees (Long-Term Care Task Force on Resident Care and Safety, 2013; Spencer et al., 2008). A healthy work environment that recognizes the importance of the emotional well being of employees may address important factors that contribute to abuse and neglect by staff (refer to Table 5). To create such a culture, the Long-term Care Task Force on Resident Care and Safety (2013) recommends capacity building for administrators and employees. The following resources are provided to support this recommendation:

- The RNAO guideline *Client Centred Care* (2006) provides more information about person-centred care.
- The RNAO's Healthy Work Environment best practice guidelines provide resources on establishing healthy work environments. These guidelines are available at www.RNAO.ca/bpg/guidelines/hwe-guidelines

Educating older adults and families on abuse and neglect, their rights, and establishing routes for complaints and quality improvement

Another prevention strategy involves empowering residents and families through education, resident and family councils, and procedures for reporting concerns (Long-Term Care Task Force on Resident Care and Safety, 2013; Spencer et al., 2008). Education for residents and families could include creating awareness about issues of abuse and neglect (e.g., types,

signs and contributing factors), about resident rights, and about strategies for managing responsive behaviors (refer to Recommendation 3.2). In the long-term care setting, the involvement of family councils may also help to prevent abuse and neglect (Long-Term Care Task Force on Resident Care and Safety, 2013; Spencer et al., 2008). Residents and families can be empowered by knowing who to call with concerns/complaints (Spencer et al., 2008), and having opportunities to provide feedback about care issues through mechanisms such as family and resident satisfaction reviews (Long-Term Care Task Force on Resident Care and Safety, 2013). There should also be appropriate follow up to address concerns that are raised.

RECOMMENDATION 6.4:

Organizations/institutions with prevention and health promotion mandates (such as community and public health organizations) lead or participate in initiatives to prevent abuse and neglect of older adults.

Level of Evidence = V

Discussion of Evidence:

Organizations/institutions with prevention and health promotion mandates are well positioned to take an active role in preventing abuse and neglect of older adults in a variety of ways. This includes

- developing public awareness and education programs,
- addressing the social determinants of health,
- supporting "age-friendly" approaches, and
- participating in coordinated community responses.

Developing public awareness and education

Public awareness and education are important for preventing abuse and neglect of older adults. Podnieks et al. (2010) conducted a worldview environmental scan on abuse and neglect of older adults and found that among developed countries, better awareness was one of the most important changes needed to effectively address abuse and neglect. Focus group results also highlight the importance of raising awareness and education in the community. Some of the strategies suggested include media campaigns; placing advertisements in community gathering places such as pharmacies, churches and postal outlets; caregiver education; dementia education; and multi-generational programs that promote respect for older adults (Begley et al., 2012).

A wide range of public education and awareness programs have been developed in Canada and around the world. Target audiences include, among others, older adults themselves, family caregivers, youth, the general public, and specific sectors. For example, faith communities have been identified as one sector that holds great promise for raising awareness and for support of older adults (Podnieks & Wilson, 2003; Podnieks & Wilson, 2004; Proehl, 2012). For a sample public education program, refer to *"It's Not Right!"– Neighbours, Friends and Families for Older Adults* (Centre for Research and Education on Violence Against Women and Children, 2014). Information about the program can be found at http://itsnotright.ca/ For an example of intergenerational approaches to public awareness and education, refer to http://www.intergenerational.ca/

Although numerous education programs and services are available, few have been published or rigorously evaluated. Several documents have attempted to fill this gap by describing and cataloguing existing programs. For more information on such programs and services refer to the following resources:

- *Outlook 2007 Promising Approaches in the Prevention of Abuse and Neglect of Older Adults in Community Settings in Canada* (Canadian Network for the Prevention of Elder Abuse, 2007). This resource is available at http://www.cnpea.ca/Promising%20Approaches%20Final%20%202007.pdf
- *An Environmental Scan of Abuse and Neglect of Older Adults in Canada: What's Working and Why?* (Beaulieu, Gordon, & Spencer, 2003). This resource is available at http://www.seniorscouncil.net/uploads/files/For_Service_Providers/Senior%20Abuse%20Enviromental%20Scan.pdf
- *Identification of Best Practices to Educate and Train Health Professionals in the Recognition, Intervention and Prevention of Violence Against Older Persons* (Curran et al., 2009). This resource is available at http://www.gov.nf.ca/vpi/publications/vaop_final_report.pdf

Addressing the social determinants of health

The social determinants of health include factors, such as low income level and social exclusion, that are associated with vulnerability and risk of abuse and neglect. Podnieks et al. (2010a) conducted an international survey to understand the nature and response to abuse in individual countries worldwide. Results indicated that social isolation was a major contributor to abuse. Furthermore, Begley et al. (2012) found that staying connected with friends and family was of paramount importance for older adults. The need for connection included access to transportation, enabling the older adult to maintain their independence and, for example, collect their own pensions and attend social and educational programs. For house-bound individuals, connections come from receiving home visits from churches, public health nurses or volunteers. For an explanation of how the social determinants of health are associated with vulnerabilities to abuse and neglect of older adults, refer to Podnieks (2006).

While further research is needed to explore the relationship between the social determinants of health and abuse and neglect of older adults (refer to Research Gaps and Future Implications), addressing the social determinants of health is widely accepted as a sound strategy for preventing and addressing health and social issues (Public Health Agency of Canada, 2001). This entails a comprehensive approach that applies health promotion strategies, such as strengthening community action, building healthy public policy, creating supportive environments, developing personal skills and reorienting health services (Public Health Agency of Canada, 2001).

For more information on how to address social determinants of health refer to the following resources:

- National Collaborating Centre for the Determinants of Health: http://nccdh.ca/
- Public Health Agency of Canada: http://cbpp-pcpe.phac-aspc.gc.ca/public-health-topics/social-determinants-of-health/
- World Health Organization: http://www.who.int/social_determinants/en/
- *Social Determinants of Health: The Canadian Facts* (Mikkonen & Raphael, 2010). This resource is available at http://www.thecanadianfacts.org/The_Canadian_Facts.pdf
- Health Providers Against Poverty: http://www.healthprovidersagainstpoverty.ca/Primary%20Care%20Toolkits

Supporting "age-friendly" approaches

The age-friendly community/city movement is an example of an approach that addresses the social determinants of health and may help to prevent abuse and neglect of older adults who live in the community. The Public Health Agency of Canada (2012a) states that: "In an age-friendly community, the policies, services and structures related to the physical and social environment are designed to help seniors 'age actively.' In other words, the community is set up to help seniors live safely, enjoy good health and stay involved".

More information on age friendly communities/cities is available at the following websites:

- Public Health Agency of Canada, Age-Friendly Communities in Canada: Community Implementation Guide and Toolbox: http://www.phac-aspc.gc.ca/seniors-aines/publications/public/afc-caa/guide/index-eng.php
- WHO *Global Network of Age-friendly Cities and Communities*: http://www.who.int/ageing/age_friendly_cities_network/en/

Participating in coordinated community responses

Coordinated community responses involve groups and individuals working together toward a common goal to prevent and address abuse and neglect of older adults. This approach aims to strengthen networks, decrease duplication, fill gaps in services and address the needs of communities. Strategies may include education and awareness, promoting social engagement of older adults, advocacy, and intervention strategies (Alberta Council of Women's Shelters, 2011).

For more information on coordinated community responses refer to the following resources:

- Local elder abuse networks (refer to **Appendix J**)
- National Initiative for the Care of the Elderly (NICE) http://www.nicenet.ca/tools-ccr-coordinated-community-response-to-abuse-of-seniors-a-whole-community-approach
- *Abuse of Older Adults: Guidelines for Developing Coordinated Community Response Models* (Alberta Council of Women's Shelters, 2011). This resource is available at http://www.acws.ca/sites/default/files/AbuseofOlderAdultsReport.pdf

RECOMMENDATION 6.5:

Organizations/institutions identify and eliminate barriers that older adults and families may experience when accessing information and services related to abuse and neglect.

Level of Evidence = IV

Discussion of Evidence:

It is important that information and services are freely accessible to those who need them. Older adults face barriers when seeking resources and interventions aimed at preventing and addressing abuse and neglect. Barriers include cultural and language issues, literacy, stigma, lack of mobility, lack of funding, and insufficient familiarity with, or lack of access to, the internet (Podnieks et al., 2010a). Lack of access to meeting sites is also an important barrier for older adults seeking support (Wolf, 2001).

The Expert Panel also recommends that organizations and institutions be sensitive to, and improve accessibility for, older adults who may experience discrimination or social exclusion. Examples include First Nations, Inuit or Métis people, lesbian, gay, bisexual, transsexual and transgender older adults, new immigrant populations, refugees, people with disabilities or with cognitive decline, and older adults with mental health issues and addictions. If health-care providers or other staff are sensitive and welcoming, older adults are more likely to access the resources they need.

More information on addressing barriers is available in the documents found at the following websites:

- *Prevention of Elder Abuse Policy and Program Lens* (Prevention of Elder Abuse Working Group, 2008). This resource is available at http://www.seniors.gov.on.ca/en/elderabuse/docs/ElderAbuse_Engl_web.pdf
- *National Strategy to Prevent Abuse in Inuit Communities and Sharing Knowledge, Sharing Wisdom: A Guide to the National Strategy* (Pauktuutit Inuit Women of Canada, 2006). This resource is available at http://pauktuutit.ca/wp-content/blogs.dir/1/assets/InuitStrategy_e.pdf
- *Promising Approaches for Addressing/Preventing Abuse of Older Adults in First Nations* (Struthers, Martin, & Leaney, 2009). This resource is available at http://www.bccrns.ca/WebLibrary/General/Resources/First%20Nations/Public20130425160252.pdf

RECOMMENDATION 6.6:

Provincial and territorial nursing regulatory bodies provide accurate information on jurisdictional laws and obligations relevant to abuse and neglect of older adults across the continuum of care.

Level of Evidence = V

Discussion of Evidence:

Information about laws and obligations is not always easily accessible to nurses when they need it most. Nursing regulatory bodies, in their role to ensure that the public receives safe and ethical care from competent, qualified, registered nurses (CNA, 2014c), are the appropriate body to provide accurate, up-to-date, comprehensive information on the laws and obligations that registered nurses need to uphold their legal and professional responsibilities. This is important because laws and obligations relevant to abuse and neglect of older adults vary across jurisdictions in Canada and are subject to change. Examples of content could include

- information about particular laws that may be applicable, namely: adult protection or protection for persons in care laws, reporting laws (e.g., long term care), family violence law, freedom of information and privacy laws, human rights laws;
- informed consent;
- mental capacity;
- substitute decision making (personal directives, powers of attorney, guardianship/trustee); and
- advance care planning.

The CNA provides a listing of the regulatory bodies in Canada (CNA, 2014d). For an example of a nursing regulatory body that has taken steps to incorporate legal content, such as consent and substitute decision making, refer to the CNO learning modules and their program, *Abuse Prevention: One Is One Too Many*. This information is available at http://www.cno.org/en/learn-about-standards-guidelines/educational-tools/learning-modules/ and http://www.cno.org/learn-about-standards-guidelines/educational-tools/abuse-prevention/

RECOMMENDATION 6.7:

Governments dedicate resources to effectively prevent and address abuse and neglect of older adults.

Level of Evidence = V

Discussion of Evidence:

The focus of this recommendation is to outline the support needed to fulfill other recommendations in this document. While it is beyond the scope of this document to suggest a full range of recommendations for governments to prevent and address and abuse and neglect, it is important to acknowledge that governments have the obligation to respect, protect and fulfill human rights for their citizens. This includes protecting older adults' right to health and well being through appropriate health and social systems, programs, services and policies (Office of the United Nations High Commissioner for Human Rights, 2008; Office of the United Nations High Commissioner for Human Rights, 2014).

Governments can help prevent and address abuse and neglect of older adults by

- ensuring sufficient funding and human resources,
- ensuring appropriate oversight and accountability of institutions to ensure safety and quality care, and
- addressing issues related to the social determinants of health to reduce the older adults' vulnerability to abuse and neglect.

Ensuring sufficient funding and human resources

The risk of abuse and neglect of older adults is closely related to insufficient funding of health-care services in institutions (e.g., an inadequate number of qualified staff to meet the complex needs of older adults in long-term care) and of health and social services in the community (refer to Recommendation 6.3). Governments have a responsibility to secure sufficient economic and human resources because long work hours, heavy workloads and staff shortages contribute to, and have an adverse impact on, client safety (RNAO, 2011). There is increasing demand to provide sufficient and sustainable funding for adequate staffing and for programs to address abuse and neglect (Jogerst, Daly, & Ingram, 2001). Furthermore, lack of adequate funding prevents countries from advancing, implementing, and improving programs and initiatives (Podnieks et al., 2010a).

Ensuring appropriate oversight and accountability

Governments must ensure that institutions caring for older adults are providing safe, quality care. Governments should review and implement best practices for oversight and accountability of facilities that take care of vulnerable older adults. Two approaches that may provide additional protection for vulnerable older adults are unannounced inspections, or "spot checking" (Begley et al., 2012; Spencer, 2006) and public reporting of inspections (Long-Term Care Task

Force on Resident Safety, 2013). For more comprehensive recommendations for governments, refer to *National snapshot: Preventing abuse and neglect of older adults in institutions* (Spencer et al., 2008) and The Long-term Care Task Force on Resident Care and Safety (2013).

Addressing the social determinants of health

Circumstances related to the social determinants of health, such as lack of social support networks (often secondary to lack of transportation, among other causes), poverty, and low level of education, have been associated with increased vulnerability to abuse and neglect (Podnieks, 2006). Furthermore, the social determinants of health include broader system level factors such as social and health policy and the delivery of the health-care system (Commission on the Social Determinants of Health, 2008) which may affect an older adults' vulnerability to abuse and neglect (refer to Figure 1). While research on the social determinants of health specific to abuse and neglect of older adults was not found in the systematic literature review (refer to Research Gaps and Future Implications) the importance of addressing the social determinants of health to address complex health and social problems at the government level is well established (Commission on the Social Determinants of Health, 2008). Numerous reports provide guidance to governments to address the social determinants of health in ways that may reduce vulnerability to abuse and neglect.

Examples of documents that provide direction and outline government responsibilities for addressing these issues include the following:

- WHO: *Commission on Social Determinants of Health Final Report*. This resource is available at http://www.who.int/social_determinants/thecommission/finalreport/en/
- WHO: *Rio Political Declaration on Social Determinants of Health*. This resource is available at http://www.who.int/social_determinants/implementation/Rio_political_declaration_en.pdf
- National Advisory Council on Aging: *Seniors on the Margins: Aging in Poverty in Canada*. This resource is available at http://publications.gc.ca/collections/Collection/H88-5-3-2005E.pdf
- Special Senate Committee on Aging: *Canada's Aging Population: Seizing the Opportunity*. This resource is available at http://www.parl.gc.ca/Content/SEN/Committee/402/agei/rep/AgingFinalReport-e.pdf
- Standing Committee on Social Affairs, Science and Technology Subcommittee on Cities: *In from the Margins: A Call to Action on Poverty, Housing, and Homelessness*. This resource is available at http://www.parl.gc.ca/Content/SEN/Committee/402/citi/rep/rep02dec09-e.pdf

RECOMMENDATION 6.8:

Nurses, other health-care providers, and key stakeholders (e.g., professional associations, health service organizations, advocacy groups) advocate for policy/organization/system level changes, including the availability of necessary resources, to effectively prevent and address abuse and neglect of older adults.

Level of Evidence = V

Discussion of Evidence:

The Expert Panel recommends that nurses, other health-care providers, stakeholders that have advocacy mandates, such as professional nursing organizations, and other groups can help prevent and address abuse and neglect of older adults through advocacy efforts. The CNA states:

> Advocacy involves engaging others, exercising voice and mobilizing evidence to influence policy and practice. It means speaking out against inequity and inequality. It involves participating directly and indirectly in political processes and acknowledges the important roles of evidence, power and politics in advancing policy options (CNA, 2014a).

Examples of advocacy efforts may include promoting healthy public policy, advocating for changes in health-care systems, strengthening organizational policies, and supporting additional research on abuse and neglect of older adults. Other efforts might focus on advocating for the resources needed to effectively prevent and address abuse and neglect, such as sufficient funding for appropriate staffing levels in institutional settings, or for abuse and neglect prevention programs in the community.

Research Gaps and Future Implications

The RNAO and the Expert Panel, in reviewing the evidence for the guideline, identified priority areas for research (see Table 6). They are broadly categorized into practice, outcome and health-system research.

Table 6: Priority Practice, Outcomes and Health-System Research Areas

CATEGORY	PRIORITY RESEARCH AREA
Practice research	Implications and outcomes of screening older adults for abuse and neglect.
	Necessary components of a safety assessment/safety plan with older adults who are at risk for, or are experiencing, abuse and neglect.
	Effective interventions for older adults who are at risk for, or are experiencing, abuse and neglect.
Outcomes research	Educational programs for nurses and other health-care providers that are effective at preventing and addressing abuse and neglect of older adults.
	Community-based programs that are effective at preventing and addressing abuse and neglect of older adults.
	Outcomes of health-care providers working within interprofessional and intersectoral teams to prevent and address abuse and neglect of older adults.
Health-system research	Effective prevention of resident-to-resident aggressive behaviour at the organizational and system level.
	The benefits and harms of grouping people with cognitive and behavioural challenges in one designated living arrangement (i.e., having a designated Dementia Unit in long-term care).
	Organizational and government policies that affect older adults' vulnerability to abuse and neglect.
	The structure of the health-care system and models for delivery of care that affect older adults' vulnerability to abuse and neglect.
	The influence of the determinants of health on older adults' vulnerability to abuse and neglect. Effectiveness of addressing the social determinants of health as a means to prevent abuse and neglect of older adults.

This list, though not exhaustive, is an attempt to identify and prioritize the research needed in this area. Many of the recommendations are based on quantitative and qualitative research evidence. Other recommendations are based on expert opinion or grey literature sources. Further substantive research is required to validate some of these recommendations. Better evidence will lead to improved practice and outcomes for older adults at risk for, or experiencing, abuse and neglect.

Implementation Strategies

Implementing guidelines at the point of care is multifaceted and challenging; it takes more than awareness and distribution of guidelines to get people to change how they practice. Guidelines must be adapted for each practice setting in a systematic and participatory way, to ensure recommendations fit the local context (Harrison, Graham, Fervers & Hoek, 2013). The RNAO *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (2012c) provides an evidence-informed process for doing that.

The *Toolkit* is based on emerging evidence that successful uptake of best practice in health care is more likely when

- leaders at all levels are committed to supporting guideline implementation;
- guidelines are selected for implementation through a systematic, participatory process;
- stakeholders for whom the guideline is relevant are identified and engaged in the implementation;
- environmental readiness for implementing guidelines is assessed;
- the guideline is tailored to the local context;
- barriers and facilitators to using the guideline are assessed and addressed;
- interventions to promote use of the guideline are selected;
- use of the guideline is systematically monitored and sustained;
- evaluation of the guideline's impact is embedded in the process; and
- there are adequate resources to complete all aspects of the implementation.

The *Toolkit* uses the "Knowledge-to-Action" framework (Straus, Tetroe, Graham, Zwarenstein, & Bhattacharyya, 2009) to demonstrate the process steps required for knowledge inquiry and synthesis. It also guides the adaptation of the new knowledge to the local context and implementation. This framework suggests identifying and using knowledge tools such as guidelines, to identify gaps and to begin the process of tailoring the new knowledge to local settings.

RNAO is committed to widespread deployment and implementation of our guidelines. We use a coordinated approach to dissemination, incorporating a variety of strategies, including the Nursing Best Practice Champion Network®, which develops the capacity of individual nurses to foster awareness, engagement and adoption of BPGs; and the Best Practice Spotlight Organization® (BPSO®) designation, which supports implementation at the organization and system levels. BPSOs focus on developing evidence-based cultures with the specific mandate to implement, evaluate and sustain multiple RNAO best practice guidelines. In addition, we offer capacity-building learning institutes on specific guidelines and their implementation annually (RNAO, 2012c).

Information about RNAO implementation strategies can be found at

- RNAO Best Practice Champions Network®: www.RNAO.ca/bpg/get-involved/champions
- RNAO Best Practice Spotlight Organizations®: www.RNAO.ca/bpg/bpso
- RNAO capacity-building learning institutes and other professional development opportunities: www.RNAO.ca/events
- RNAO's nursing order sets[G] as a tool to facilitate BPG implementation, please email BNOS@RNAO.ca

Evaluating and Monitoring this Guideline

As you implement the recommendations in this guideline you should consider how you will monitor and evaluate its implementation and impact.

Table 7 is based on a framework outlined in the RNAO's *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (2012c) and illustrates some specific indicators for monitoring and evaluating of this guideline.

Table 7: Structure, Process and Outcome Indicators for Monitoring and Evaluating This Guideline

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Objectives	To evaluate the supports available in the organization/ system that allow nurses and the interprofessional team to integrate into their practice the BPG, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide approaches.*	To evaluate the changes in practice that lead towards improved efforts to prevent and address abuse and neglect of older adults.	To evaluate the impact of implementing the guideline recommendations.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
System *Governments*	Governments have a mandate that includes preventing and addressing abuse and neglect of older adults and supporting safe, quality care for older adults in health-care settings. Governments have personnel available to review BPG.	Enhancement or maintenance of funding for ■ programs to address abuse and neglect of older adults, and ■ human resources needed to maintain safety and quality care for older adults. Revision or maintenance of methods for oversight and accountability of institutions to ensure safety and quality of care for older adults. Enhancement or maintenance of programs or initiatives to address the social determinants of health associated with vulnerabilities to abuse and neglect.	% of programs for abuse and neglect that are operational and effective. % of institutions that have sufficient funding for appropriate staffing. # of critical incidents and reports of abuse or neglect. # of programs or initiatives that address the social determinants of health related to reducing older adults' vulnerability to abuse and neglect.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
System *Provincial and territorial nursing bodies*	Provincial and territorial nursing bodies have personnel available to review BPG and revise information for members that aligns with BPG recommendations. Legal support available to review jurisdictional laws.	Development or revision of information about jurisdictional laws and obligations relevant to abuse and neglect of older adults. Development of ■ methods to communicate information to members, ■ methods for monitoring uptake of information, and ■ methods for keeping information up-to-date.	% of members with access to accurate, up-to-date, comprehensive information. # of members accessing information.
System *Advocacy groups*	Advocacy role or mandate established (for the nurse, health-care provider or stakeholder).	Needs assessment completed regarding changes required (e.g. changes to public policy), and resources needed (e.g., funding for prevention programs), to effectively prevent and address abuse and neglect of older adults. Development of advocacy initiative, including communication plan and plan for monitoring effectiveness of advocacy efforts.	% of target audience receiving advocacy messages. # of changes in policy, organization or system attributable to advocacy efforts. # of programs, services or resources available to prevent and address abuse and neglect of older adults. # of media hits (media traction). # of visits to website (web analytics).

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Organization /Institution	Organizational committee(s) available to review BPG and support implementation of BPG. Educator(s) available to review BPG and develop or revise content and design of education program to align with best practices. Resource people (e.g., educators or champions) available for consultation and ongoing support during and after the initial implementation period.	Revision or development of ■ organizational policies and procedures; ■ mandatory and continuing education programs; and ■ information and education resources for staff, older adults and families. Development or enhancement of ■ collaborative team(s) for preventing and addressing abuse and neglect; ■ practices to support a healthy work environment; ■ practices for screening, hiring, supervision and monitoring staff; ■ practices for maintaining appropriate staffing levels; and ■ approaches to reduce or eliminate barriers older adults and families may face when accessing information and services.	# of policies and procedures developed and implemented. # of mandatory and continuing education programs offered. % of staff aware of ■ organizational policies and procedures, and ■ information and resources to prevent or address abuse and neglect. % of older adults and families awareness of ■ rights, ■ education and resources to prevent or address abuse and neglect, and ■ routes for complaints and quality improvement. # of older adults and families satisfied with delivery of care. % of staff satisfied with ■ clarity of policies and procedures, ■ education programs, ■ levels of support for preventing and addressing abuse and neglect, ■ staffing levels, and ■ work environment. % of older adults and families accessing information and services. % of critical incidents or reports related to abuse and neglect of older adults.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Organization /Institution *Educational institutions*	Committee(s) available to review BPG and develop or revise curriculum to align with BPG recommendations.	Educational programs developed or revised to incorporate recommended core content.	% of students who receive core content on preventing and addressing abuse and neglect of older adults. % of students satisfied with training. % of students who have improved knowledge, attitudes and skills post training.
Organization /Institution *Organization/ institution with prevention and health promotion mandates*	Organization/ institution with prevention and health promotion mandates have committee(s) available to review existing prevention efforts and partnerships with other organizations.	Revision or development of prevention programs or initiatives. Development or strengthening of collaborations with partners (e.g., Collaborative Community Responses).	# of public reports indicating raised awareness of abuse and neglect of older adults. # of programs, initiatives or resources developed or strengthened. % of target audience satisfied with programs or initiatives. # of new partnerships developed or strengthened.
Provider	Mandatory and continuing education programs developed and provided for staff. Release time provided for staff to attend education programs. Policies, procedures and	Mandatory and continuing education are attended by nurses, other health-care providers, supervisors and other staff throughout the organization/institution. Nurses and other health-care providers receive supports needed to adhere to best practices, including ■ access to collaborative team and ■ resources and referral sources.	% of staff receiving basic education to prevent and address abuse and neglect of older adults. % of nurses, other health-care providers and supervisors trained on core content to prevent and address abuse and neglect of older adults. % of nurses, other health-care providers, supervisors and other staff satisfied with education programs.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
	supports established that align with best practices for preventing and addressing abuse and neglect of older adults.		% of nurses, other health-care providers, supervisors and other staff who have improved knowledge, attitudes and skills post training. # of nurses and other health-care providers with positive performance appraisals with regards to preventing and addressing abuse and neglect of older adults. # of nurses and other health-care providers reporting improved ability (self assessment) to: ■ assess and respond to abuse and neglect according to best practices and legal and professional responsibilities, ■ develop positive approaches to working with older adults (and families), ■ apply appropriate strategies for responsive behaviours, and ■ foster a safe and healthy work environment and maintain personal well-being.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Client	Policies and procedures established. Nurses and other health-care providers have received mandatory and continuing education on abuse and neglect of older adults. Education resources available for older adults and families. Availability of accurate information for staff regarding resources and referral sources available to prevent and address abuse and neglect. Appropriate staffing levels and skill mix secured.	Nurses and other health-care providers assess older adults for risk factors and signs of abuse and neglect. Nurses and other health-care providers collaborate with older adults (and families, as appropriate) when assessing planning and evaluating plan of care regarding abuse and neglect. Nurses and other health-care providers offer individualized education, support, and referrals to older adults (and families, as appropriate). Nurses and other health-care providers establish therapeutic relationships and maintain privacy and confidentiality when interacting with older adults (and families, as appropriate). Nurses and other health-care providers inform older adults (and families, as appropriate) of ■ their rights, ■ resources available to prevent or address abuse and neglect, ■ information about where to report abuse and neglect, ■ complaints procedures.	% of older adults (and families, as appropriate) who report ■ therapeutic relationships; ■ information kept private and confidential (legal exceptions); ■ rights respected; ■ feeling their priorities, needs and preferences are incorporated into care planning; and receipt of ■ education, resources, referral, supports, and safety planning that matches particular needs. % of older adults (and families, as appropriate) satisfied with plans of care.

LEVEL OF INDICATOR	STRUCTURE	PROCESS	OUTCOME
Financial costs	Mechanism in place to assess and monitor costs of implementing and sustaining best practices for preventing and addressing abuse and neglect of older adults.	Yearly budget costs for: ■ committee meetings and training; ■ developing educational programs; ■ developing information and education resources; ■ delivering education programs, including relief time for staff; and ■ human resource costs: (e.g., adequate staffing to meet care needs of older adults).	Measures of cost efficiency and effectiveness of interventions. Measures of overall resource utilization.

Other RNAO Resources for Evaluation and Monitoring of Best Practice Guidelines:

- Nursing Quality Indicators for Reporting and Evaluation (NQuIRE®) were designed for RNAO's Best Practice Spotlight Organizations® (BPSO®) to systematically monitor the progress and evaluate the outcomes of implementing RNAO best practice guidelines in their organizations. NQuIRE® is the first international quality improvement initiative of its kind consisting of a database of quality indicators derived from recommendations of selected RNAO's clinical best practice guidelines. More information is available at www.RNAO.ca/bpg/initiatives/nquire
- Objective evaluation can be done through regular review of nursing order sets and their effect on the client's health outcomes. Nursing order sets embedded in clinical information systems simplify this process through electronic data capture. More information is available at www.RNAO.ca/bpg/initiatives/nursing-order-sets

Process for Update and Review of the Guideline

The Registered Nurses Association of Ontario (RNAO) commits to updating its best practice guidelines (BPGs) as follows:

1. Each BPG will be reviewed by a team of specialists in the topic area every five years following publication of the previous edition.
2. RNAO International Affairs and Best Practice Guidelines (iaBPG) Centre staff regularly monitor for new systematic reviews, randomized controlled trials, and other relevant literature in the field.
3. Based on that monitoring, iaBPG Centre staff may recommend an earlier revision period. Appropriate consultation with members of the original Expert Panel and other specialists and experts in the field will help inform the decision to review and revise the guidelines earlier than the targeted milestone.
4. Three months prior to the review milestone, the iaBPG Centre staff commences planning of the review by:
   a) Inviting specialists in the field to participate on the Expert Panel. It will be comprised of members from the original panel as well as other recommended specialists and experts.
   b) Compiling feedback received and questions encountered during the implementation, including comments and experiences of BPSOs® and other implementation sites regarding their experience.
   c) Compiling new clinical practice guidelines[G] in the field and conducting a systematic review of the evidence.
   d) Developing a detailed work plan with target dates and deliverables for developing a new edition of the guideline.
5. New editions of guidelines developed will undergo dissemination based on established structures and processes.

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Appendix A: Glossary of Terms

Aboriginal: "Aboriginal Peoples" is a collective name for all of the original peoples of Canada and their descendants. Section 35 of the Constitution Act of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups – Indian (First Nations), Inuit and Métis. It should not be used to describe only one or two of the groups (National Aboriginal Health Organization, 2012).

Ageism: Two definitions provided:

Discrimination on the basis of age that: makes negative assumptions about capacity, removes decision-making powers, ignores an older person's known wishes, and treats an older adult like a child (Butler, as cited in ESDC, 2011).

Ageism refers to a socially constructed way of thinking about older persons based on negative stereotypes about aging as well as a tendency to structure society as though everyone is young. (Ontario Human Rights Commission, 2009, p.6).

Analytical studies: Analytical studies test hypotheses about exposure-outcome relationships. The investigators do not assign an intervention, exposure, or treatment but do measure the association between exposure and outcome over time, using a comparison group (Centers for Disease Control, 2013). Analytical study designs include case-control studies and cohort studies.

Case-control study: A study that compares people with a specific disease or outcome of interest (cases) to people from the same population without that disease or outcome (controls) (The Cochrane Collaboration, 2005).

Cohort study: An observational study in which a defined group of people (the cohort) is followed over time either prospectively or retrospectively (The Cochrane Collaboration, 2005).

Best practice guideline (BPG): Systematically developed statements to assist practitioner and client decisions about appropriate health care for specific clinical (practice) circumstances (Field & Lohr, 1990).

Client-centred (person-centred) care: An approach in which clients are viewed as whole; it is not merely about delivering services where the client is located. Client-centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making (RNAO, 2006a, p.12).

Clinical practice guidelines: See definition of best practice guidelines.

Collaborative practice: A joint venture or cooperative endeavour that ensures a willingness to participate. This relationship involves shared planning and decision making, based on knowledge and expertise rather than on role and title (RNAO, 2013b, p.63).

Competencies: Statements about the knowledge, abilities, skills, attitudes and judgments required to perform safely within the scope of an individual's nursing practice or in a designated role or setting (RNAO, 2013b, p.63).

Consent: Consent means giving someone permission to do something that impacts you (Canadian Centre for Elder Law, 2011a, p.12). Older adults should provide consent or refusal for treatment or services. Depending on the situation, written or verbal consent must be provided but in some cases, implied consent is sufficient (for example, pulling up a sleeve for the nurse to take blood pressure). In some situations (such as emergencies), consent may not be required. If an older adult lacks mental capacity to consent to or refuse treatment or services, a Substitute Decision Maker (SDM) should do so on their behalf (Canadian Centre for Elder Law, 2011a).

For more detailed information, see provincial or territorial professional practice standards.

Controlled study: A clinical trial in which the investigator assigns an intervention, exposure, or treatment to participants who are not randomly allocated to the experimental and comparison or control group (The Cochrane Collaboration, 2005).

Culture: Culture refers to the shared and learned values, beliefs, norms and ways of life of an individual or a group. It influences thinking, decisions and actions (RNAO, 2012b, p.84).

Descriptive studies: Descriptive studies generate hypotheses and describe characteristics of a sample of individuals at one point in time. The investigators do not assign an intervention, exposure, or treatment to test a hypothesis, but merely describe the who, where, or when in relation to an outcome (Centers for Disease Control, 2013; The Cochrane Collaboration, 2005). Descriptive study designs include cross-sectional studies.

Cross-sectional study: A study measuring the distribution of some characteristic(s) in a population at a particular point in time (also called survey) (The Cochrane Collaboration, 2005).

Education recommendation: Statement of educational requirements and educational approaches or strategies for the introduction, implementation and sustainability of the best practice guideline.

Empathy: Empathy is the ability of the care provider to enter into the client's relational world, to see and feel the world as the client sees and feels it, and to explore the meaning it has for the client. Empathy involves the nurse being able to attend to the subjective experience of the client and validate that his/her understanding is an accurate reflection of the client's experience (RNAO, 2002, p.21).

Evidence: Evidence is information that comes closest to the facts of a matter. The form it takes depends on context. The findings of high-quality, methodologically appropriate research provide the most accurate evidence. Because research is often incomplete and sometimes contradictory or unavailable, other kinds of information are necessary supplements to, or stand-ins for research. The evidence-base for a decision is the multiple forms of evidence combined to balance rigor with expedience while privileging the former over the latter (RNAO, 2014b, p.66).

Family: Whomever the person defines as being family. Family members may include spouse, parents, children, siblings, partners, neighbours, and significant people in the community (RNAO, 2010b, p.57).

Family council: A family council is an organized, self-led, self-determining, democratic group composed of family and friends of the residents of long-term care homes (Spencer, 2006).

Forensic nurse: A nurse who applies the forensic aspects of health care combined with the biopsychosocial education of the registered nurse in the scientific investigation and treatment of trauma, and or death of victims and perpetrators of violence, criminal activity, and traumatic accidents within the clinical or community institution (Lynch, as cited in Forensic Nurses' Society of Canada, 2014).

Grey literature: In this document, grey literature refers to documents produced by government, academic groups and organizations that are not published in academic journals.

Health promotion: Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO, 2014).

Healthy work environment: A practice setting that maximizes the health and well being of nurses (and other health-care providers), quality patient outcomes and organizational performance (RNAO, 2013b, p.64).

Health-care provider: In this document, health-care provider refer to the regulated and unregulated health-care providers[G] who provide care for older adults and their families.

Institution (institutional setting): The term 'institution' typically refers to a wide range of regulated and unregulated settings that provide assistance and care to older adults, including hospitals, long-term care facilities, retirement homes, nursing homes and [care] homes for older adults (ESDC, 2011).

Interprofessional: Teams made up of different professions working together to reach a common goal and share decision making to achieve the goal. The goal in health care is to work in a common effort with individuals and their families to enhance their goals and values. An interprofessional team typically includes one or more physicians, nurses, social workers, spiritual advisors, personal support workers and volunteers. Other disciplines may be part of the team, as resources permit and as appropriate (Ferris et al., 2002).

Long-term care facility (in Ontario, the term long-term care homes is used): A facility that provides care on a sustained and prolonged basis to meet the physical, social, and personal needs of individuals whose functional capacities are chronically impaired or at risk (Ontario Hospital Association, as cited in Hirst, 2002, p. 270).

Mental capacity: Mental capacity generally refers to one's ability to make decisions, but definitions of mental capacity vary between jurisdictions.

In Ontario, the legal definition of mental capacity involves the ability to understand information relevant to making a decision and appreciate the consequences of a decision or lack of a decision (Health Care Consent Act, 1996).

Meta-analysis: A systematic review of randomized controlled trials that uses statistical methods to analyze and summarize the results of the included studies (The Cochrane Collaboration, 2005).

Nurse: Refers to registered nurses, licensed practical nurses (referred to as registered practical nurses, in Ontario), registered psychiatric nurses, and nurses in advanced practice roles such as nurse practitioners and clinical nurse specialists (RNAO, 2013b, p.64).

Nursing order set: A nursing order set is a group of evidence-based interventions that are specific to the domain of nursing; it is ordered independently by nurses (i.e., without a physician's signature) to standardize the care provided for a specific clinical condition (RNAO, 2013a, p.68).

Older adult: In this document, an older adult includes people who are 55 years and older to include individuals who may have aged prematurely or have shortened life expectancies such as some Aboriginal persons (Dumont-Smith, 2002).

Power of attorney: A power of attorney is a legal document that gives someone else the power to act on your behalf (ACE, 2013).

Practice recommendations: Statements of best practice directed at the practice of health-care professionals; ideally, they are based on evidence.

Public Guardian and Trustee: The role of the Public Guardian and Trustee varies from one jurisdiction to another. Examples:

Act to make personal, healthcare, legal, or financial decisions for someone who is mentally incapable and cannot make those decisions if there is no one willing and able to act on behalf of the individual (New Brunswick Legal Aid Services Commission, 2012).

When an eligible person is not available, or there is a dispute in choosing between equally ranked decisions makers, the Public Guardian and Trustee (PGT) is called upon to authorize a suitable decision maker or to make substitute treatment decisions (Public Guardian and Trustee of British Columbia, 2014).

Qualitative research: Research that uses an interactive and subjective approach to investigate and describe phenomena (e.g., lived experience) and to give them meaning. The nature of this type of research is exploratory and open-ended. Analysis involves the organization and interpretation of non-numerical data (e.g., Phenomenology, Ethnography, Grounded Theory, Case Study, etc) (Speziale & Carpenter, 2007).

Quasi-experimental study: A study that lacks randomization and a control group and therefore is not considered a 'true' experimental design (e.g., randomized controlled trial). The investigator controls the assignment to the intervention, exposure, or treatment by using some criterion other than random assignment (e.g., pre-post design) (Polit, Beck, & Hungler, 2001).

Racialization: Race is a socially constructed way of judging, classifying and creating difference among people on the basis on physical features such as skin colour (Ontario Human Rights Commission, as cited in Toronto Public Health, 2013, p.6).

Racialization is the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life (Ontario Human Rights Commission, as cited in Toronto Public Health, 2013).

Randomized controlled trial (RCT): An experiment in which the investigator assigns an intervention, exposure, or treatment to participants who are randomly allocated to either the experimental group (receives intervention) and the comparison (conventional treatment) or control group (no intervention or placebo) (The Cochrane Collaboration, 2005). The participants are followed and assessed to determine the efficacy of the intervention. Includes double-blind, single-blind and non-blind trials.

Reflective practice: Reflective practice (sometimes referred to as self awareness) is an important component of a therapeutic relationship and can be defined as the ability to reflect on one's practice, thoughts, feelings, needs, fears, strengths and weaknesses and to understand how these might affect one's actions and the nurse-client relationship (RNAO, 2002, p.13).

Relationship of trust (trusting relationship): In this guideline a relationship of trust refers to a relationship between the older adult and a family member, caregiver, health-care provider (or institution/organization providing care or service to the older adult) whether or not there is actually a feeling of trust in that relationship.

Resident council: The purpose of the resident council is to provide a forum where issues that concern residents can be discussed, including the services provided to residents in the care facility. The discussion is to facilitate any needed changes in the facility. Resident councils are considered as a means to achieving quality improvement (Spencer, 2006, p.44).

Resident-to-resident aggressive behaviour: Negative and aggressive physical, sexual or verbal interactions between long-term care residents that, in a community setting that would be likely be construed as unwelcome and have high potential to cause physical or psychological distress in the recipient (Rosen, Pillemer, & Lachs, 2008, p.77).

Responsive behaviours: The Ministry of Health and Long-term Care define responsive behaviours as behaviours that often indicate: (a) An unmet need in a person, whether cognitive, physical, emotional, social, environmental or other, or (b) a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person (as cited in RNAO, 2012b, p.86).

Restraints: The CNO defines restraints as physical, chemical or environmental measures used to control the physical or behavioural activity of a person or a portion of his/her body. Physical restraints limit a client's movement. Physical restraints include a table fixed to a chair or a bed rail that cannot be opened by the client. Environmental restraints control a client's mobility. Examples include a secure unit or garden, seclusion or a time-out room. Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behaviour or movement. Least restraint means all possible alternative interventions are exhausted before deciding to use a restraint and the least restrictive form of restraint to meet the client's needs should be used (as cited in RNAO, 2012b, p.86).

Sexual Assault Nurse Examiner (SANE): Sexual Assault Nurse Examiners provide specialized health and forensic care to adult and adolescent patients who have experienced sexual violence (International Association of Forensic Nurses, n.d).

Social determinants of health: The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries (WHO, 2013).

Stakeholder: An individual, group, or organization with a vested interest in the decisions and actions of organizations that may attempt to influence decisions and actions (Baker et al., 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem.

Staff mix: The combination of different categories of health-care personnel employed for the provision of direct client care in the context of a nursing care delivery model (CNA, 2012).

Substitute decision maker (SDM): A substitute decision maker is a person who makes decisions for another who is not mentally capable. This may include making certain decisions about their property or personal care (Wahl, 2009).

Systematic review: A review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyze data from the studies that are included in the review (The Cochrane Collaboration, 2005).

Unregulated health-care provider: According to the College of Registered Nurses of British Columbia (CRNBC) unregulated care providers are paid providers who are neither licensed nor registered by a regulatory (as cited in CNA, 2008).

Appendix B: Guideline Development Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure this BPG is based on the best available evidence. To meet this commitment, a monitoring and revision process has been established for each guideline every five years.

For this new guideline, the RNAO assembled a pan-Canadian panel of experts who represent a range of sectors and practice areas (refer to RNAO Expert Panel). A systematic review of the evidence was based on the purpose and scope of the guideline and supported by five questions. The systematic review captured relevant literature published between 2000 and 2013. The following research questions were established to guide the systematic review:

1. What are the most effective ways for nurses (and other health-care providers) to identify and assess for abuse and neglect of older adults?
2. What are the most effective ways for nurses (and other health-care providers) to respond to the abuse and neglect of older adults?
3. What education do nurses (and other health-care providers) need to effectively address abuse and neglect of older adults?
4. What prevention and health promotion strategies are recommended regarding elder abuse and neglect?
5. What organizational policies and system level supports are required to effectively prevent and address abuse and neglect of older adults (living in facilities and community settings)?

Appendix C: Process for Systematic Review and Search Strategy

Guideline Review

The Registered Nurses' Association of Ontario (RNAO) guideline development team's project coordinator searched an established list of websites for guidelines and other relevant content published between 2002 and 2012. This list was compiled based on knowledge of evidence-based practice websites, recommendations from the literature and key websites related to abuse and neglect of older adults. Furthermore, Expert Panel members were asked to provide guidelines from their own personal libraries. Detailed information about the search strategy for existing guidelines, including the list of websites searched and inclusion criteria, is available online at www.RNAO.ca

Members of the Expert Panel critically appraised six international guidelines using the *Appraisal of Guidelines for Research and Evaluation Instrument II* (Brouwers et al., 2010). The following three guidelines were used to inform the recommendations and discussions of evidence:

Curran, V., Barrett, J., Hollet, A., & Barrett, L. (2009). *Identification of best practices to educate and train health professionals in the recognition, intervention and prevention of violence against older persons.* Retrieved from: http://www.gov.nf.ca/vpi/publications/vaop_final_report.pdf

Public Health Research Education and Development Program (2003). *Interventions to prevent the recurrence of elder abuse.* Retrieved from: http://www.ephpp.ca/PDF/2003_Prevent%20Elder%20Abuse_Summ.pdf

U.S. Preventive Services Task Force. (2013). *Screening for intimate partner violence and abuse of elderly and vulnerable adults*: Recommendation statement. Retrieved from: http://www.uspreventiveservicestaskforce.org/uspstf/uspsipv.htm

Systematic review

A comprehensive search strategy was developed by RNAO's research team and a health sciences librarian, based on inclusion and exclusion criteria created with the Expert Panel. A search for relevant articles in English and French, published between 2000 and 2013, was applied to the following databases: Cumulative Index to Nursing and Allied Health (CINAHL), Cochrane Controlled Trials (CT), Cochrane Systematic Reviews (SR), Database of Abstracts of Reviews of Effectiveness (DARE), Embase, Joanna Briggs Institute, MEDLINE, MEDLINE In Progress, Ovid Healthstar, and PsycINFO. In addition to this systematic search, panel members were asked to review personal libraries for key articles not found through the above search strategies.

Detailed information about the search strategy for the systematic review, including the inclusion and exclusion criteria as well as search terms, is available online at www.RNAO.ca

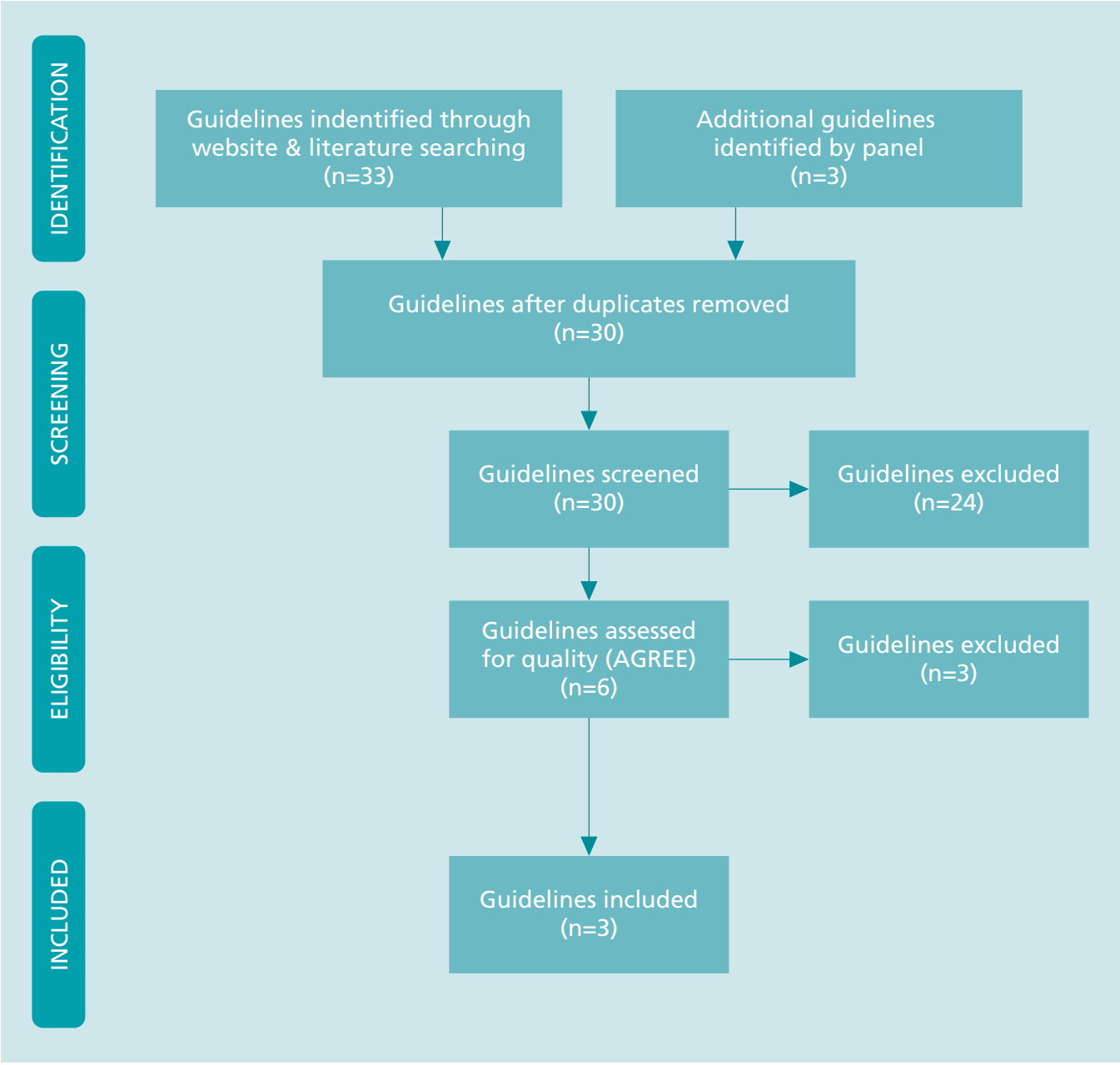
Once articles were retrieved, two Nursing Research Associates (Master's prepared nurses) independently assessed the eligibility of studies according to established inclusion/exclusion criteria. The RNAO BPG Program Manager involved in supporting the RNAO Expert Panel, resolved disagreements.

Quality appraisal scores for 20 articles (a random sample of ten percent of articles eligible for data extraction and quality appraisal) were independently assessed by the RNAO BPG program research associates. Acceptable inter-rater agreement (kappa statistic, K=0.76) justified proceeding with quality appraisal and data extraction by dividing the

remaining studies between four RNAO BPG program research associates (Fleiss, 2003). A final summary of literature findings was completed. The comprehensive data tables and summary were provided to all panel members in September 2013 for review and discussion.

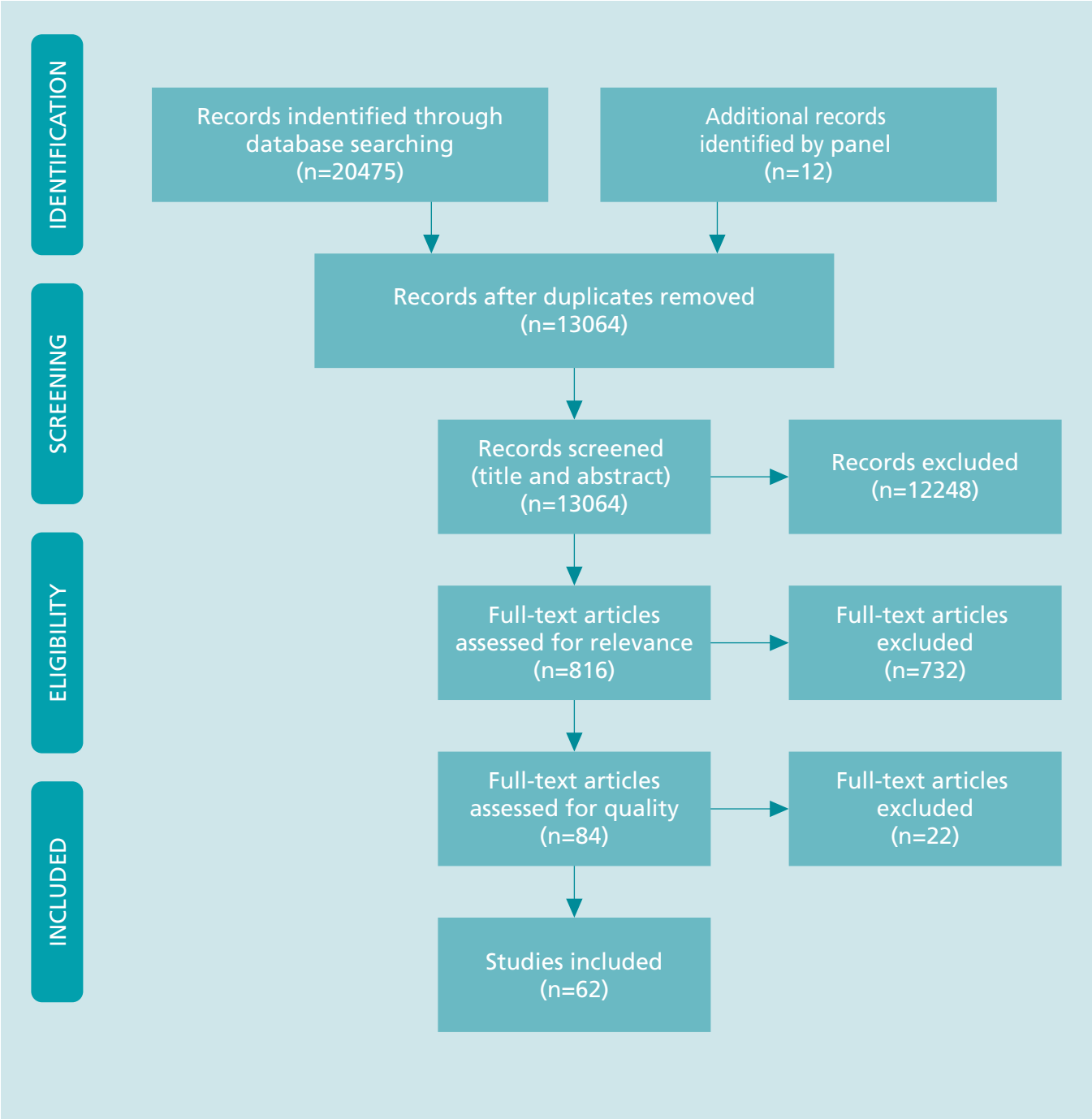
A complete bibliography of all full text articles screened for inclusion is available at www.RNAO.ca

Guideline Review Process Flow Diagram



Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, & The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: the PRISMA Statement. BMJ 339, b2535, doi: 10.1136/bmj.b2535

Article Review Process Flow Diagram



Flow diagram adapted from D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, & The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: the PRISMA Statement. BMJ 339, b2535, doi: 10.1136/bmj.b2535

Appendix D: Definitions of Abuse and Neglect of Older Adults

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).
- "Elder abuse is a term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult" (Department of Health & Human Services, n.d).

Note: some people may experience several types of abuse and neglect simultaneously or at different points in their lives.

Types of abuse and neglect discussed in the literature

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).

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 non-verbal, 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).

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 behavior 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).

Spiritual abuse

According to Marshall Freeman and Asselin Vaillancourt (1993) and The Aboriginal Family Healing Joint Steering Committee (1993), spiritual abuse refers to "the erosion or breaking down of one's cultural or religious belief systems." Spiritual abuse has particular significance for Aboriginal peoples with regards to historical trauma (e.g., colonization, forced assimilation, and cultural genocide) (as cited in Public Health Agency of Canada, 2012b, p.11).

Polyvictimization

Polyvictimization in late life is an emerging definition/area of study that generally refers to older adults who have experienced multiple forms of victimization.

For more information about polyvictimization related to older adults, refer to the National Committee for the Prevention of Elder Abuse (NCPEA). This resource is available at http://www.preventelderabuse.org/

Self neglect

"A self-neglector is a person who exhibits *one or more* of the following:

- persistent inattention to personal hygiene and/or environment,
- repeated refusal of some/all indicated services which can reasonably be expected to improve quality of life, and/or
- self-endangerment through the manifestation of unsafe behaviors (e.g., persistent refusal to care for a wound, creating fire-hazards in the home)"

(Pavlou & Lachs, 2008, p.1842).

Appendix E: Theories of Abuse and Neglect

THEORY	OVERVIEW	SOURCES
Caregiver stress	Views elder abuse as a consequence of a caregiver not being able to manage his or her caregiving responsibilities for a dependent older adult. The older adult is viewed as dependent on the caregiver who becomes abusive due to the difficulty of caregiving, the perceived burden of the caregiver role, and the duration of caregiving.	Burnight, K., & Mosqueda, L. *Theoretical model development in elder mistreatment*. (Report No. 234488). Retrieved from: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=256445
Ecological theory	Attempts to identify potential causes of elder abuse by considering cultural and societal variables such as: the macrosystem (age and gender inequality, societal aggression norms); the exosystem (economic environment, integration into the community); the microsystem (individual and family characteristics); and ontogenetic (physiology, affect, and behavior).	Burnight, K., & Mosqueda, L. *Theoretical model development in elder mistreatment*. (Report No. 234488). Retrieved from: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=256445
Feminist model	Views spousal abuse of older women as a consequence of family patriarchy and can be seen as spousal abuse that has developed into elder abuse. Theory suggests that the power imbalance between men and women in society result in women being more vulnerable and open to abuse.	Employment and Social Development Canada. (2011). *Elder Abuse Modules*. Retrieved from http://www.esdc.gc.ca/eng/seniors/funding/pancanadian/elder_abuse.shtml

THEORY	OVERVIEW	SOURCES
Lifecourse theory	A theory which views life as marked by sequential stages, in which an individual is considered a unique being but is also linked to the lives of friends, family and other close individuals. The theory links life events and social conditions that have occurred over the older adult's lifetime; experiences that create accumulated advantages or disadvantages. The hallmark of this theory is its proposition that early life experiences are related to abuse later in life.	McDonald, L. & Thomas, C. (2013). Elder abuse through a life course lens. *International Psychogeriatrics*, 25(8), 1235–1243.
Power and control wheel	A visual aide that demonstrates the dynamics of power and control in abusive relationships. Explains common traits of abusive behaviour that enables the abuser to maintain power and control. These include: coercion and threats; intimidation; emotional abuse; isolation; minimizing, denying and blaming; using children; economic abuse; and male privilege. These traits are further reinforced by one or more acts of physical violence.	National Center on Domestic and Sexual Abuse. (n.d.). *Power and Control Wheel*. Retrieved from: http://www.ncdsv.org/images/powercontrolwheelnoshading.pdf
Situational model	Mistreatment of older adults is an irrational response to stressful situations caused by the physical or cognitive impairment of the older adult. The situational variables associated with abuse include individual, social, and financial factors related to the caregiver and the dependent older adult.	Employment and Social Development Canada. (2011). *Elder Abuse Modules*. Retrieved from http://www.esdc.gc.ca/eng/seniors/funding/pancanadian/elder_abuse.shtml

THEORY	OVERVIEW	SOURCES
Social exchange theory	Views the relationship between a caregiver and an older adult as an exchange of rewards and punishments. Theory suggests that older adults may remain in an abusive relationship only as long as the rewards (e.g., physical care) exceeds the punishments (e.g., financial abuse).	Employment and Social Development Canada. (2011). *Elder Abuse Modules*. Retrieved from http://www.esdc.gc.ca/eng/seniors/funding/pancanadian/elder_abuse.shtml
Social learning theory	A theory developed by Bandura (1978) that views violence as a learned behavior passed on through the generations (e.g., if children witness incidents of parent-to-grandparent mistreatment, they learn that abuse is a component of adult relationships). This theory has been applied to the etiology of elder abuse.	Burnight, K., & Mosqueda, L. *Theoretical model development in elder mistreatment*. (Report No. 234488). Retrieved from website: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=256445 Bandura, A. (1978). Social learning theory of aggression. *Journal of communication*, 28(3), 12-29.
Sociocultural context	The model portrays a transactional process occurring over time among the older adult, the caregiver, and other involved parties. The model considers the social network of both the older adult and the caregiver, and individual factors such as demographic characteristics, physical health, personality, mental health, and caregiving attitudes. This model looks at inequality within the relationship and power and exchange dynamics that may perpetuate elder abuse.	Burnight, K., & Mosqueda, L. *Theoretical model development in elder mistreatment*. (Report No. 234488). Retrieved from: https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=256445

Appendix F: Communication Strategies

This appendix outlines considerations, tips and resources to support effective communication when addressing issues of abuse and neglect of older adults.

The three A's

The *Core Curriculum and Resource Guide* from the Ontario Network for the Prevention of Elder Abuse (2008) outlines three A's to consider when interacting with older adults.

The three A's include

- active listening and reassurance,
- ask the older person what he or she wants, and
- action according to wishes and follow-up.

Caution: Nurses and other health-care providers might need to override the wishes of an older adult if mandatory reporting exists (e.g., abuse by a staff member).

This resource is available at http://www.onpea.org/english/trainingtools/corecurriculum.html

Tips for conducting caring communications

The document *Looking Beyond the Hurt: A Service Provider's Guide to Elder Abuse* outlines tips for caring communications that help make it easier to talk about abuse and neglect. Caring communication includes the following:

- "I" messages (e.g., I am concerned about you…),
- is specific (e.g., because you missed your last appointment and today I see a bruise on your arm),
- is sensitive to others' feelings (e.g., I understand that it's hard to talk about personal concerns),
- is non-judgmental and non-threatening (e.g., would you like to talk to me about it?),
- empowers rather than "rescues" (e.g., do you want to talk about some of the resources you might want to use?),
- helps to remove any perceived stigma about being abused (e.g., I have often seen people who are not receiving the care that they deserve),
- is respectful of an older person's right to make his/her own decision in his/her own time, and
- is prepared to assist the older person to find the supports and services he/she needs.

(Siegel, 2013)

This resource is available from the Newfoundland and Labrador Network for the Prevention of Elder Abuse at http://www.nlnpea.ca/LBH

Other communication tips-when talking about abuse and neglect

The *Elder Abuse Modules* from Employment and Social Development Canada (2011) outline communication tips to assist with having a preliminary conversation with an older adult regarding abuse and neglect. These tips include the following:

- choose an environment where the older adult is comfortable and at ease;
- do everything possible to ensure that the conversation will not be overheard or interrupted;
- be mindful of hearing difficulties, language barriers, cultural and religious values;
- maintain a relaxed, non-judgmental, supportive demeanor;
- talk less and listen more; allow them to talk at their own pace;
- notice inconsistencies and discrepancies;
- take time to allow them to respond;
- avoid comments that may seem like putting down the alleged or suspected abuser; and
- offer support, discuss options but do not give advice.

This resource is available at http://www.esdc.gc.ca/eng/seniors/funding/pancanadian/elder_abuse.shtml

Responding to disclosure of abuse

The RNAO guideline, *Woman Abuse: Screening, Identification and Initial Response* (2012), provides suggestions for responding to disclosures of abuse including suggested dialogue that may be appropriate for discussing issues of abuse and neglect with older adults. Refer to **Appendix M** of the supplement in the guideline.

This resource is available at www.RNAO.ca/bpg/guidelines/woman-abuse-screening-identification-and-initial-response

Therapeutic communication

In the Practice Standard titled *Therapeutic Nurse-Client Relationship*, the CNO (2006) outlines elements of therapeutic communication including communication strategies and interpersonal skills.

This resources is available at http://www.cno.org/Global/docs/prac/41033_Therapeutic.pdf

Strategies for working effectively with interpreters

In the Practice Guideline titled *Culturally Sensitive Care*, the CNO (2009a) outlines considerations and strategies for working with interpreters.

This resource is available at http://www.cno.org/Global/docs/prac/41040_CulturallySens.pdf

Communication with people who have dementia

The Alzheimer's Society of Canada (2012) offers tips to enhance communication with people who have dementia.

This information is available at http://www.alzheimer.ca/en/Living-with-dementia/Helping-with-communication

Appendix G: Assessment and Screening Tools

Tools included in the list below are used in practice and have undergone some form of psychometric testing, with published results. Psychometric testing generally refers to tests of validity or reliability and sometimes includes measures of sensitivity and specificity. Sensitivity refers to how good a test is at detecting who may have a condition or disease. Specificity is defined as how good a test is at identifying who does not have the condition or disease (RNAO, 2012b, p. 82). References listed in the footnote outline psychometric testing results or considerations for using the tool in practice. For more detailed information on psychometric testing with regards to screening and assessment tools for abuse and neglect of older adults, refer to Spencer (2010).

Notes: Inclusion in this list is not an endorsement. Please refer to discussion in Recommendation 1.3 about considerations for using tools. Permissions may be required for use.

NAME OF TOOL	PURPOSE	COMMENTS	REFERRAL SOURCE OR LINK TO TOOL
American Medical Association (AMA) Screen for Various Types of Abuse or Neglect[1, 2, 3, 4, 5]	To screen for whether a particular harm has ever happened to the older adult.	**General Description:** Comprised of nine yes/no questions and screens for neglect, coercion, and physical, psychological, and financial abuse.	Refer to p.67 in Spencer, C. (2010). *Environmental scan and critical analysis of elder abuse screening and assessment and intervention tools for Canadian health-care providers*. Ottawa, ON: Public Health Agency of Canada.
Brief Abuse Screen (BASE)[1, 5]	A decision-making tool to help asses or evaluate the likelihood of abuse by a caregiver towards an older adult.	**General Description:** Five questions are asked to gauge the suspicion of neglect and physical, psychosocial, and financial abuse. There are five categories used to determine how soon an intervention or follow up would be required.	Available online at http://www.nicenet.ca/tools-elder-abuse

NAME OF TOOL	PURPOSE	COMMENTS	REFERRAL SOURCE OR LINK TO TOOL
Caregiver Abuse Screen (CASE)[1, 5, 6]	To screen caregivers of cognitively impaired older adults for current abuse and possible tendencies to harm (potential future abuse).	**General Description:** Asks eight yes/no screening questions in a non-blaming way. Screens for physical abuse, psychological abuse, control, and neglect. **Languages:** French and English versions available.	Available online at http://www.nicenet.ca/tools-elder-abuse
Caregiver Risk Screen[1]	A high risk screening tool designed to be used at intake by home care staff to assess caregivers' physical and/or emotional health and to determine whether the care being provided is adequate.	**General Description:** Two sections 1) socio-demographic information, 2) 12 statements related to caregiver risk (Likert scale). A score greater than 23 indicates high risk and further assessment needed. Available in French and English.	Available online for reference only at www.msvu.ca/family&gerontology/project

NAME OF TOOL	PURPOSE	COMMENTS	REFERRAL SOURCE OR LINK TO TOOL
Elder Abuse Suspicion Index (EASI)[1, 5, 6, 7, 8]	Intended to help physicians determine if there is a reasonable level of suspicion of abuse to justify referring an older adult for in-depth assessment.	**General Description:** A short screening tool that includes five questions conducted with an older adult and one observation item to be completed by the physician. Screens for: physical, sexual, psychological, verbal and financial abuse, and material and emotional deprivation. In the future, the tool may be expanded for use by social workers and nurses. The World Health Organization has adapted the EASI. It has been piloted in several different countries.	Available in English and French online at http://www.mcgill.ca/files/familymed/EASI_Web.pdf
Elder Assessment Instrument (EAI)[1, 2, 5, 6, 7, 9,10]	To be used as a comprehensive approach for screening suspected elder abuse victims in all clinical settings, and to identify individuals at high risk of mistreatment who should be referred for in-depth assessment.	**General Description:** Several versions have been produced over time. An assessment/screening tool using a Likert scale. Includes a general, physical, social, medical and independence assessment, and a summary section. Assesses for neglect, exploitation, abandonment, and physical, financial, and sexual abuse. No scoring for this tool. Health-care provider uses clinical judgment to determine the likelihood of abuse from assessment.	2003 version available for review online at http://www.medicine.uiowa.edu/uploadedFiles/Departments/FamilyMedicine/Content/Research/Research_Projects/elder.pdf

NAME OF TOOL	PURPOSE	COMMENTS	REFERRAL SOURCE OR LINK TO TOOL
Elders' Psychological Abuse Scale (EPAS)[7, 23]	To screen for psychological abuse.	**General Description:** A 32-item scale with a yes/no format. Health-care provider administers the tool with the older adult through direct observations and interviews. A sum of the total is used for scoring with a cutoff point of 10, indicating potential of psychological abuse.	Refer to Wang, J. J., Tseng, H. F., & Chen, K. M. (2007). Development and testing of screening indicators for psychological abuse of older people. *Archives of Psychiatric Nursing*, 21(1), 40-47.
Expanded Indicators of Abuse Inventory (E-IOA)[1, 6, 7, 16, 17,18]	To identify high risk situations for older adults that warrant clinical intervention.	**General Description:** Builds on the 27-item Indicators of Abuse (IOA) tool. Uses 11 indicators of risk regarding the caregiver and 14 indicators of risk regarding the older adult. Responses are indicated on a Likert scale and focuses on physical and psychological abuse, neglect, and economic exploitation.	Refer to Cohen, M., Halevi-Levin, S., Gagin, R., & Friedman, G. (2006). Development of a screening tool for identifying elderly people at risk of abuse by their caregivers. *Journal of aging and health*.
Hwalek Sengstock Elder Abuse Screening Test-Revised (H-S/EAST or EAST)[1, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14]	To help service providers identify situations that may be, or have the potential to become abusive or neglectful.	**General Description:** Tool has been refined and revised over the years. The original 15-item version was completed by health-care providers and the current 6-item version is a self-report measure completed by older adults themselves. The 15-item version focused on physical, psychological and financial abuse. The 6-item version assesses for physical harm, control and psychological/emotional abuse.	15-item version (1991) available for review online at http://www.medicine.uiowa.edu/familymedicine/emscreeninginstruments/

NAME OF TOOL	PURPOSE	COMMENTS	REFERRAL SOURCE OR LINK TO TOOL
Indicators of Abuse (IOA)[1, 5, 6, 9, 10, 15]	To screen for cases of abuse among health-care and social service clients.	**General Description:** Screening/assessment tool that is administered by a trained professional after a comprehensive home assessment is completed. A 27-item and 22-item version available. The practitioner rates each indentified abuse indicator (for the caregiver and the care receiver) using a scale, and sums up the total to estimate the extent of the problem. A cut-off score of 16 is used to indicate abuse. Available in French and English.	Available online at http://www.nicenet.ca/tools-elder-abuse
Modified Conflict Tactics Scale (MCTS)[1, 5, 7, 19, 20]	To identify a caregiver's risk of causing emotional or physiological harm to an older adult (care recipient).	**General Description:** Adapted from the Conflict Tactics Scale. There are five psychological abuse questions and five physical abuse questions answered using a Likert scale. The scale has been modified to include a new weighted scoring system.	Refer to Cooper, C., Manela, M., Katona, C., & Livingston, G. (2008). Screening for elder abuse in dementia in the LASER-AD study: Prevalence, correlates and validation of instruments. *International journal of geriatric psychiatry*, 23: 283-288.
Older Adult Financial Exploitation Measure (OAFEM)[7, 24]	To aid in the assessment of financial exploitation of older adults.	**General Description:** An 82-item, self-report measure. Yes/no question format. Screens for financial exploitation of older adults.	Refer to Conrad, K. J., Iris, M., Ridings, J. W., Langley, K., & Wilber, K. H. (2010). Self-report measure of financial exploitation of older adults. Gerontologist, 50(6), 758-773.

NAME OF TOOL	PURPOSE	COMMENTS	REFERRAL SOURCE OR LINK TO TOOL
Older Adult Psychological Abuse Measure (OAPAM)[7, 22]	To screen for psychological abuse of older adults and to identify severity of abuse.	**General Description:** A 31-item, self-report measure screening for psychological abuse.	Refer to Conrad, K. J., Iris, M., Ridings, J. W., Langley, K., & Anetzberger, G. J. (2011). Self-report measure of psychological abuse of older adults. *Gerontologist, 51*(3), 354-366.
QUALCARE[1]	To evaluate the quality of care given by a caregiver to an older adult.	**General Description:** The assessment is completed by a health-care provider after visiting the older adult at home. Involves observations and semi-structured interviews with the older adult and caregiver. A 52 or 53-item scale with 6 subscales (environmental, physical, medical maintenance, psychosocial, human rights, and financial) which are rated on a Likert scale.	Refer to p.105 in Spencer, C. (2010). *Environmental scan and critical analysis of elder abuse screening and assessment and intervention tools for Canadian health-care providers*. Ottawa, ON: Public Health Agency of Canada.
Vulnerability to Abuse Screening Scale (VASS)[1, 3, 4, 5, 6, 7, 15, 21]	To assess the risk of abuse.	**General Description:** A 12- item, self-report measure. Adapted from the H-S/EAST. Screens for physical, psychological and financial abuse, and control.	Refer to Schofield, M. J., & Mishra, G. D. (2003). Validity of self-report screening scale for elder abuse: Women's Health Australia Study. *Gerontologist, 43(1)*, 110-20.

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Appendix H: Resource List

This resource list can be completed with details specific to your region. Information on this list should be validated and kept up-to-date.

RESOURCE	NAME OF RESOURCE/ CONTACT DETAILS	COMMENTS
Emergency, hotlines, helplines (e.g., seniors abuse line, crisis line, 911)		
Safe houses, safe accommodation, shelters, transitions houses		
Victim services (e.g., police-based services; sexual assault centre; fraud detection)		
Response team or resource team for cases of abuse and neglect		
Information and resource centres		
Provincial or territorial networks (refer to **Appendix J**)		
Associations (e.g., Alzheimer's Society)		
Seniors organizations for recreation, education, peer support, advocacy		
Community centre/seniors' centres: social activities, wellness, education		

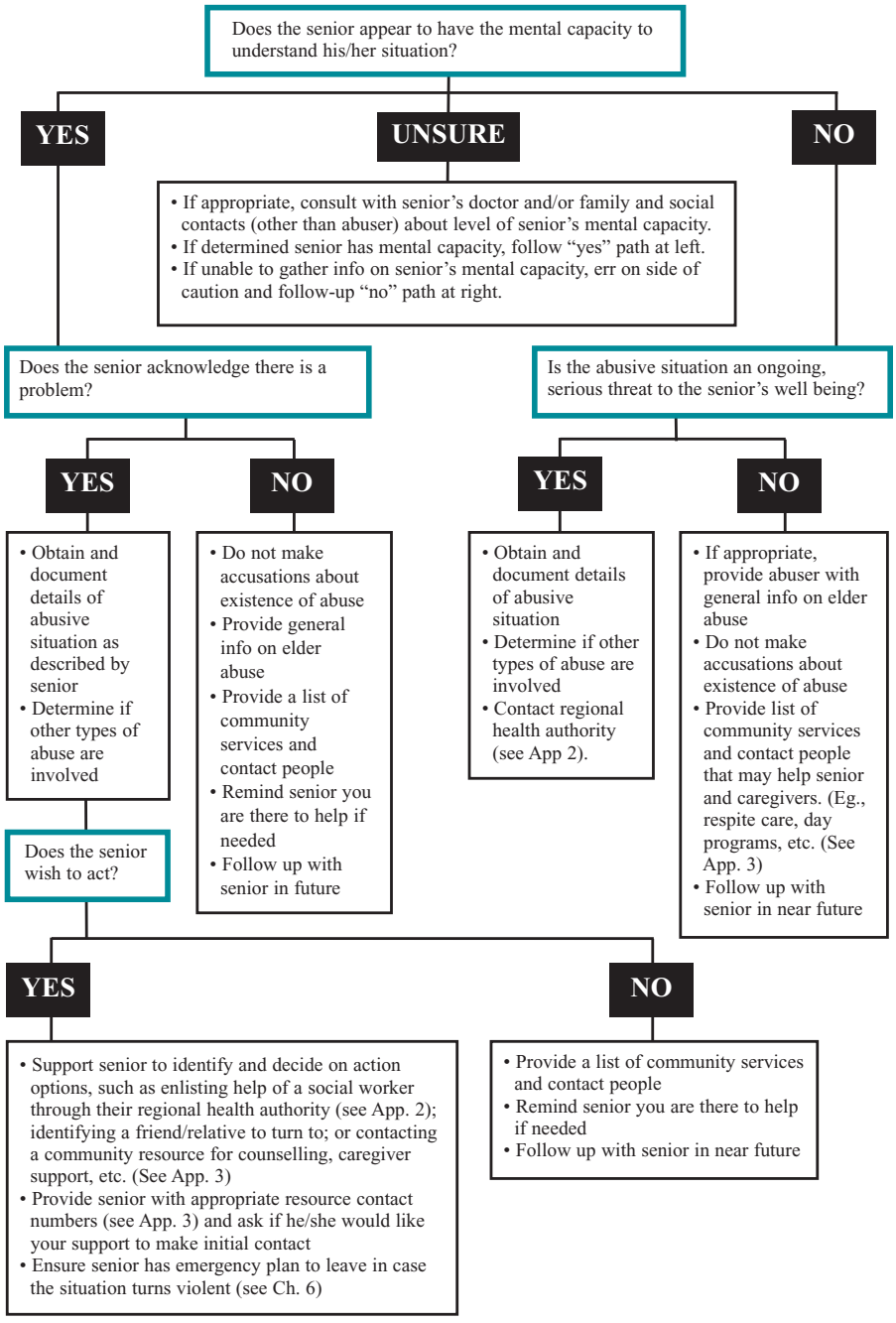
RESOURCE	NAME OF RESOURCE/ CONTACT DETAILS	COMMENTS
Pension information: sources to find information or assistance with Canada Pension Plan, Old Age Security and Guaranteed Income Supplement		
Health services: home care, home visiting for house-bound seniors, nursing station (for remote communities)		
Community health centres: health promotion, primary health care		
Home services: housekeeping, home meal delivery		
Respite care		
Language services (i.e., translation/interpretation services)		
Immigrant or refugee services		
Ethonocultural organizations that address abuse issues		
Counseling and mental health services: support groups (for older adults or for caregivers), addictions counselors, healing circles		
Programs for people who abuse or neglect		

RESOURCE	NAME OF RESOURCE/ CONTACT DETAILS	COMMENTS
Community Leadership (Chief and Council)		
Community police		
Clergy/faith healer		
Legal aid/legal services for low income people		
Public Guardian/Trustee/Curator services: if older adult is mentally incapable of financial and/or personal care decision-making. May act as a financial and/or personal decision maker if no one else is appropriate and available.		
Ombudsman: investigates complaints of public services; advises government; recommends changes to practices, policies and legislation.		
Other		

Appendix I: Sample Decision Tree

Caution: decision trees need to be tailored to the type of abuse, the sector, the scope of practice of the care provider and relevant laws. The nurse or health-care provider must use critical thinking when using decision trees and collaborate with the older adult, and family, as appropriate, when making decisions.

Decision Tree: Helping a Senior Who May be Psychologically Abused. Available from http://www.nlnpea.ca/LBH, Chapter 6, p. 60.



Decision Tree: Helping a Senior Who May Be Psychologically Abused. Reprinted from *Looking Beyond the Hurt: A Service Providers Guide to Elder Abuse* from the Seniors Resource Centre of Newfoundland and Labrador, 2013, p. 60. Reprinted with permission.

Appendix J: Resources and Links for Abuse and Neglect of Older Adults

The following list, compiled together with members of the Expert Panel and with input from external stakeholder reviewers, includes some of the main organizations that provide information or resources on abuse and neglect of older adults.

Links to websites are provided for information purposes only. The RNAO is not responsible for the quality, accuracy, reliability, or currency of the information provided through these sources. Further, the RNAO has not determined the extent to which these resources have been evaluated. Questions related to these resources should be directed to the source.

ORGANIZATION	DESCRIPTION	LINK
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
British Columbia Law Institute & Canadian Centre for Elder Law	The British Columbia Law Institute (BCLI) carries out scholarly research, writing and analysis for law reform, collaborating with government and other entities, and providing materials and support for outreach and public information. The Canadian Centre for Elder Law (CCEL) carries out similar work focused on issues of interest to older adults.	http://www.bcli.org/ccel
CANE: Clearinghouse on Abuse and Neglect of the Elderly	The Clearinghouse on Abuse and Neglect of the Elderly (CANE) is a US based computerized catalog of literature pertaining to many aspects of abuse and neglect of older adults.	http://www.cane.udel.edu/index.asp
Canadian information hub	Information hub in the process of development, expected completion in 2015.	

ORGANIZATION	DESCRIPTION	LINK
Canadian Nurses' Association (CNA) NurseONE	The CNA's NurseONE has a section specific to abuse and neglect of older adults which includes general information, a list of Canadian web resources, a webliography and more.	http://www.nurseone.ca/Default.aspx?portlet=StaticHtmlViewerPortlet&stmd=False&plang=1&ptdi=672
Employment and Social Development Canada (ESDC) – Elder Abuse Modules	ESDC has created three modules which contain general information about elder abuse, resources, theories of abuse and neglect, risk factors, interventions and more.	http://www.esdc.gc.ca/eng/seniors/funding/pancanadian/elder_abuse.shtml
Government of Canada Information for Seniors and Caregivers	Click on your province or territory to access federal and provincial or territorial resources available in your region.	http://www.seniors.gc.ca/eng/index.shtml
National Center on Elder Abuse NCEA (United States)	The NCEA is a U.S. based resource for policy makers, professionals in the elder justice field, and the public that provides up-to-date information regarding research, training, best practices, news and resources abuse and neglect of older adults.	http://www.ncea.aoa.gov/
National Initiative for the Care of the Elderly (NICE)	NICE is an international network of researchers, practitioners and students dedicated to improving the care of older adults, both in Canada and abroad. Information about projects, resources and events can be found on the NICE website.	http://www.nicenet.ca/
The Hartford Institute for Geriatric Nursing (HIGN), New York University, College of Nursing (United States)	The website provides access to programs and resources that are designed to help healthcare practitioners improve the quality of care for older adults (U.S. based information).	www.hartfordign.org Clinical Nursing Website www.ConsultGeriRN.org

ELDER ABUSE NETWORKS		
PROVINCE	**NETWORK NAME**	**LINK**
Alberta	Alberta Elder Abuse Awareness Network	http://www.albertaelderabuse.ca/
British Columbia	BC Centre for Elder Advocacy and Support	http://bcceas.ca/
	BC Association for Community Response Networks	http://www.bccrns.ca/generated/homepage.php
Manitoba	Manitoba Network for the Prevention of Abuse of Older Adults	http://www.olderadultabuse.mb.ca/
Newfoundland and Labrador	Newfoundland and Labrador Network for the Prevention of Elder Abuse	http://www.nlnpea.ca/
Nunavut/North West Territories/Yukon	NWT Seniors Society	http://www.nwtseniorssociety.ca/
Ontario	Elder Abuse Ontario (formerly Ontario Network for the Prevention of Elder Abuse)	http://www.onpea.org/
Québec	Services Québec	http://maltraitanceaines.gouv.qc.ca/en/
Canada	Canadian Network for the Prevention of Elder Abuse	http://www.cnpea.ca/
International	International Network for the Prevention of Elder Abuse (INPEA)	http://www.inpea.net/home.html

Appendix K: Description of the Toolkit

Best Practice Guidelines (BPGs) can only be successfully implemented if planning, resources, organization and administrative supports are adequate and there is appropriate facilitation. In this light the Registered Nurses Association of Ontario (RNAO), through an Expert Panel of nurses, researchers and administrators, has developed the *Toolkit: Implementation of Best Practice Guidelines (2nd ed.)* (2012c). The *Toolkit* is based on available evidence, theoretical perspectives and consensus. We recommend the Toolkit for guiding the implementation of any clinical practice guideline in a health-care organization.

The *Toolkit* provides step-by-step directions to individuals and groups involved in planning, coordinating and facilitating the guideline implementation. These steps reflect a process that is dynamic and iterative rather than linear. Therefore, at each phase preparation for the next phases and reflection on the previous phase is essential. Specifically, the *Toolkit* addresses the following key steps, as illustrated in the "Knowledge to Action" framework (Straus et al., 2009) in implementing a guideline:

- identify problem: identify, review, select knowledge/BPG;
- adapt knowledge to local context by
  - assessing barriers and facilitators to knowledge use and
  - identifying resources;
- select, tailor and implement interventions;
- monitor knowledge use;
- evaluate outcomes; and
- sustain knowledge use.

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The *Toolkit* is one key resource for managing this process. The *Toolkit* can be downloaded at www.RNAO.ca/bpg.

Endorsements

Canadian Association on Gerontology / Association canadienne de gérontologie

July 22, 2014

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON
M5H 1L3

Dear Dr. Grinspun,

On behalf of the Canadian Association on Gerontology (CAG), I am delighted to provide CAG's endorsement of RNAO's evidence-based clinical best practice guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*.

As you know, CAG is Canada's premier multidisciplinary scientific and educational association established to provide leadership for those who practice, conduct research, and have an interest in the field of aging. In the past we participated on the pan-Canadian Advisory Committee for the project, *Promoting the Awareness of Elder Abuse in Long-Term Care*, an important project for long-term care settings in Canada, led by the Canadian Nurses Association and the RNAO.

This new best practice guideline builds on that important work in long-term care. It takes a comprehensive approach to preventing and addressing abuse and neglect of older adults across the continuum of care in Canada. The guideline outlines solid recommendations that will have value for the members we serve, namely, health care professionals, researchers, academics, administrators, government representatives, national organization executives, students and seniors.

We are pleased to see the emphasis on collaborative approaches to addressing this complex and difficult issue. We look forward to and are prepared to contribute to widespread dissemination of the guideline to nurses, other health care professionals and individuals and organizations providing care and services to older adults.

Thank you for this excellent resource!

With warm regards,

Maggie Gibson, PhD, CPsych
President, Canadian Association on Gerontology

Mailing Address: 263 McCaul Street, Suite 328, Toronto, ON M5T 1W7, Canada
Toll-Free Telephone & Fax: 1-855-CAG-ACG0 (224-2240)
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Canadian Geriatrics Society
20 Crown Steel Drive, Unit 6
Markham, Ontario, Canada. L3R 9X9
Tel: 1-905-415-9161, Toll Free: 1-866-247-0086
Fax: 1-905-415-0071
Website: www.cgs-sgc.ca

Office of the President
Dr. José A. Morais
Email: jose.morais@mcgill.ca

August 28, 2014

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.

Chief Executive Officer

Registered Nurses' Association of Ontario (RNAO)

158 Pearl Street

Toronto, ON

M5H 1L3

RE: Endorsement of RNAO's clinical guidelines on elder abuse and neglect

Dear Dr. Grinspun,

On behalf of the Canadian Geriatrics Society (CGS), I am pleased to provide CGS's endorsement of RNAO's evidence-based clinical best practice guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centered, Collaborative, System-Wide Approaches.*

As you know, CGS promotes excellence in the medical care of older Canadians. We promote a high standard of research in the field of geriatrics/ gerontology and aim to improve the education provided to Canadian physicians on aging and its clinical challenges. Furthermore, we disseminate Canadian research and knowledge on clinical care of older patients to physicians with an interest in Gerontology, medical students, residents, fellows and other practitioners and researchers in the field of aging.

This new best practice guideline aligns with our mandate to promote excellence and share best practices among the medical community. It provides direction for clinical practice, as well as recommendations for education, policy and for system level changes. Furthermore, the guideline emphasizes the importance of interprofessional collaboration and education throughout health-care organizations.

Thank you for developing this valuable resource. This comprehensive guideline will be useful, not only for nurses, but for all practitioners and organizations who are invested in excellence in care for older Canadians.

Sincerely,

José A. Morais, M.D., F.R.C.P.C.

President
Canadian Geriatrics Society

CNPEA ~ RCPMTA

Canadian Network for the Prevention of Elder Abuse
Réseau canadien pour la prévention des mauvais traitements envers les aînés

August 5, 2014

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON
M5H 1L3

Dear Dr. Grinspun,

On behalf of the *Canadian Network for the Prevention of Elder Abuse ~ Réseau canadien pour la prévention des mauvais traitements envers les aînés (CNPEA~RCPMTA)* I am pleased to convey *CNPEA's~RCMPTA's* endorsement of RNAO's evidence-based clinical best practice guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches.*

As you know, *CNPEA~RCPMTA* is the national organization focused on elder abuse prevention and response that works at local, regional, provincial/territorial, and national levels. CNPEA~*RCPMTA* fosters networks and knowledge exchange in Canada and shares best practices in program and policy development for the prevention of elder abuse.

The RNAO guideline outlines best practices for front-line providers, essential education, for every staff member in the organization, and important policy and system-level recommendations targeted to prevent abuse and neglect of older adults. It also addresses the importance of collaborative work in the community to prevent abuse and neglect, and provides clear recommendations in this regard. Furthermore, we were impressed with the team of expert panel members and stakeholder reviewers who contributed their wealth of knowledge to inform the recommendations.

This evidence-based best practice guideline will be a useful resource for our networks across the country. The free accessibility of this guideline in both French and English is much appreciated.

Congratulations and many thanks for leading this critically important work!

Sincerely,

Raeann Rideout
Co-Chair
Canadian Network for the Prevention of Elder Abuse
Réseau canadien pour la prévention des mauvais traitements envers les aînés

The national voice of registered nurses | Porte-parole national des infirmières et infirmiers

CANADIAN NURSES ASSOCIATION | ASSOCIATION DES INFIRMIÈRES ET INFIRMIERS DU CANADA

July 28, 2014

Doris Grinspun, RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario
158 Pearl Street
Toronto, ON M5H 1L3

Dear Ms. Grinspun,

On behalf of the Canadian Nurses Association (CNA), I am pleased to endorse RNAO's evidence-based clinical best practice guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches*.

As you know, CNA is the national professional voice of registered nurses with a mandate that includes promoting nursing excellence, advocating for healthy public policy and a quality health system, and serving the public interest. Having collaborated with RNAO on the pan-Canadian project, *Promoting the Awareness of Elder Abuse in Long-Term Care*, we are delighted to see that this most recent best practice guideline builds on our work and expands into various institutional and community settings across the continuum of care in Canada.

CNA supports this guideline, with recommendations at the three levels of practice, education, and policy/organization/systems, which will provide a resource for nurses and other team members to reduce abuse and neglect of older adults and promote quality care.

Kind regards,

Anne Sutherland Boal

Anne Sutherland Boal, RN, BA, MHSA
Chief Executive Officer

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cpsi icsp
Canadian Patient Safety Institute
Institut canadien pour la sécurité des patients

July 25, 2014

Dr. Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON M5H 1L3

Dear Dr. Grinspun,

On behalf of the Canadian Patient Safety Institute (CPSI), I am pleased to convey CPSI's endorsement of RNAO's evidence-based clinical best practice guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches.*

As you are aware, CPSI is a not-for-profit organization that exists to raise awareness and facilitate implementation of ideas and best practices to achieve a transformation in patient safety. We envision safe health care for all Canadians and are driven to inspire extraordinary improvement in patient safety and quality. Furthermore we recognize that evidence-informed resources together with knowledge exchange activities will lead to practice change.

We are confident that this RNAO best practice guideline will help improve safety and quality of care for older adults. The practice recommendations highlight a collaborative, person-centred approach to prevent and address abuse and neglect. The education recommendations describe important mandatory education that will support behavior change. The policy/organization/system recommendations outline the fundamental roles of organizations, governments, and nursing regulatory bodies to ensure that the structures are in place to prevent and address abuse and neglect.

This evidence-based best practice guideline can influence safe care and services provided to older persons in all types of health-care and social service settings across Canada. We appreciate that the guideline will be freely accessible and available in French and English.

Many thanks and congratulations on your outstanding work!

Sincerely,

Hugh MacLeod
Chief Executive Officer

Safe care…accepting no less
Soins sécuritaires…n'acceptons rien de moins

www.patientsafetyinstitute.ca
www.securitedespatients.ca

INTERNATIONAL NETWORK FOR THE PREVENTION OF ELDER ABUSE

July 19, 2014

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON, M5H 1L3

Dear Dr. Grinspun,

On behalf of the International Network for the Prevention of Elder Abuse (INPEA), I am pleased to convey our organization's endorsement of RNAO's evidence-based clinical best practice guideline, *"Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches"*.

INPEA is an independent, non-profit, non-governmental organization that, together with the World Health Organization's Ageing and Life Course department and other divisions and of the United Nations, the International Association of Gerontology and Geriatrics, and partners around the world, are working to protect the rights of older persons through advocacy, education and research.

The RNAO guideline has been developed according to a rigorous process and outlines a comprehensive approach to preventing and addressing abuse and neglect of older adults. The practice recommendations highlight the rights of older persons, education recommendations describe essential content for all staff in health-care settings, and the organization and system level recommendations outline the structures that need to be in place to enable best practices. We are particularly pleased to see that the guideline addresses advocacy roles and areas that require further research.

This evidence-based best practice guideline is an excellent resource for health-care settings in Canada and throughout the world. We are pleased to see that the guideline will be freely accessible and available in both English and French.

Congratulations on a comprehensive, forward-looking and useful piece of work.

Best regards,

Gloria M. Gutman, PhD, FCAHS, OBC, LLD (hon. UWO)
President, International Network for the Prevention of Elder Abuse
Past-President, International Association of Gerontology & Geriatrics
Professor/Director Emerita, Gerontology, Simon Fraser University

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NICE
National Initiative for the Care of the Elderly
Initiative nationale pour le soin des personnes âgées

July 15, 2014

Doris Grinspun RN, MSN, PhD, LLD(hon), O.ONT.
Chief Executive Officer
Registered Nurses' Association of Ontario (RNAO)
158 Pearl Street
Toronto, ON
M5H 1L3

Dear Dr. Grinspun,

On behalf of the National Initiative for Care of the Elderly (NICE) I would like to offer a letter of endorsement of RNAO's evidence-based clinical best practice guideline, *Preventing and Addressing Abuse and Neglect of Older Adults: Person-Centred, Collaborative, System-Wide Approaches.*

NICE is an international network dedicated to improving the care of older adults, both in Canada and abroad. NICE provides a variety of resources and education for a broad spectrum of disciplines and professions in the field of ageing, including geriatric medicine, gerontological nursing, gerontological social work, gerontology, rehabilitation science, sociology, psychology, policy and law.

This new best practice guideline is a strong addition to the field of elder abuse. We are pleased that RNAO selected a diverse panel of experts across Canada to work with the research team to develop best practice guideline recommendations. The guideline is applicable for nurses and will also be of value to various disciplines and professionals within the NICE network.

We support this guideline in the strongest possible terms and look forward to its widespread use by practitioners, educators, policy makers, researchers, regulatory bodies and governments.

Thank you for your leadership in developing this comprehensive resource!

Sincerely yours,

Lynn McDonald, PhD
Scientific Director, National Initiative for Care of the Elderly

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INTERNATIONAL
AFFAIRS & BEST PRACTICE
GUIDELINES

TRANSFORMING
NURSING THROUGH
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Clinical Best
Practice Guidelines

JULY 2014

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