

Seniors Neglect and Abuse Response Line – A Systems and Services Review of Regina Qu’Appelle Health Region



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Executive Summary

Canadians are increasingly aware of the issue of senior neglect and abuse, according to a 2011 EKOS survey. While it is difficult to determine the exact percentage of affected seniors, it is certain that the issue is significant in our communities. Many service agencies in Saskatchewan receive reports of senior abuse and neglect. However, there is uncertainty regarding what community resources exist for older adult victims and whether those resources are meeting current community needs.

The Saskatchewan Seniors Mechanism reached out to the Community Research Unit (CRU) at the University of Regina to assist with a piece of this puzzle. The provincial health regions were identified as key players who interact with senior victims of abuse and neglect. This project investigates policies and procedures relating to senior abuse and neglect in the Regina Qu'Appelle Health Region (RQHR), in order to identify existing services and any gaps or challenges that may exist. The CRU provided funding for a student researcher and Drs. Tom McIntosh and Nuelle Novik joined the project advisory committee to contribute their expertise in the area of seniors' health. Researchers interviewed senior managers with the Regina Qu'Appelle Health Region and reviewed the region's grey literature including policy and written information provided to clients, as well as scanning the relevant academic literature. This report is the result.

Our research data shows that while RQHR does not have specific policies relating to senior neglect and abuse, it has policies around abuse and neglect in situations that senior clients are often in. Managers interviewed were quite aware of policies and processes and recent health region changes to improve them. They expressed confidence in the ability of health region staff to respond to situations of abuse and neglect, but also suggested that further supports could make their responses more thorough and timely. In particular, study participants recommended the creation of a provincial Guardian and Trustee for Seniors and more connections between the health region and community organizations for assistance with education and service provision.

This is a small study that only involved a certain segment of health worker – management rather than front-line workers – and did not access data on the issue from intersectoral partners. As such, it forms one small part of a larger project, the Senior Neglect and Abuse Response Line. This report can help identify gaps or challenges in the Regina Qu'Appelle Health Region in providing senior victims of abuse and neglect the supports that they require.

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Purpose of the study

The Saskatchewan Seniors Mechanism (SSM), a non-profit volunteer organization concerned with seniors' quality of life, has been working with stakeholders since 2013 on establishing a crisis response service for victims of senior abuse and neglect. Identified as the Seniors Neglect and Abuse Response Line (SNARL), part of this project involves the examination of community resources for older adult victims and assessing whether those resources are meeting current community needs. The provincial health regions are specifically identified as community resources as part of this examination.

For this particular piece of the larger project, the Saskatchewan Seniors Mechanism reached out to the Community Research Unit for research assistance. The Community Research Unit (CRU) is based in the Faculty of Arts, University of Regina, and connects community groups and University of Regina faculty and students through research, service-learning, and other collaborative activities. The mandate of the Unit is to provide independent, participatory research support in response to needs identified by communities with a view toward building capacity and enhancing quality of life. "Seniors Neglect and Abuse Response Line – A Systems and Services Review of Regina Qu'Appelle Health Region" was approved as a CRU project in June 2015 and faculty members Dr. Tom McIntosh and Dr. Nuelle Novik joined the project steering committee. SSM obtained a small grant from the CRU's Community Research and Action Fund that went towards hiring a graduate student researcher who conducted a literature review and interviews, and assisted with the final report.

A key goal for the SNARL project, as stated in the CRU project application, is "to work collaboratively and in partnership with all CBOs, police, and health institutions to provide continuity of care through seamless service delivery." As part of this, the SNARL project members need to understand the roles and responsibilities of health regions in responding to senior neglect and abuse in order to help establish seamless services regardless of responding sector. Determining the state of current practice, policy and education regarding senior neglect and abuse in the Regina Qu'Appelle Health Region was identified as a first step. A further goal was to do similar research in all Saskatchewan health regions, focusing on services and any gaps or challenges that may exist.

Thus, this report was completed as part of a larger project report that will form the basis of identifying the needed services in the community based sector in order to support Health and

Police in enhancing and improving services to older adults. This report can be used by community-based seniors' services, Mobile Crisis Services and the Regina Qu'Appelle Health Region to inform them of what is available so that recommendations to address any gaps in the sector can be formed.

What is Senior Neglect and Abuse?

Following a three-year federal government awareness campaign, a 2011 EKOS survey showed that more Canadians were aware of the term “elder abuse” than in 2009, with nine in ten Canadians saying they had heard the term (EKOS, 2011). However, as Lynn McDonald, Director of the Institute for Life Course and Aging at the University of Toronto, shows in her 2011 article, there is no agreement among researchers about the definition of senior neglect and abuse (also referred to as, “elder abuse” or “elder mistreatment”). Most agree that it encompasses abuse in the community and in institutions and includes neglect; and that the major types are physical, psychological, sexual, and financial abuse. However, there is little agreement beyond this. For example, there is some disagreement about whether non-intentional and self-inflicted neglect should be included in the definition. Various studies may use different definitions, or understand those definitions differently, and can exclude certain types of abuse or include others. An example of a type of identified abuse that seems to defy categorization is spiritual abuse (McDonald, 2011).

This research study employed the definition of senior neglect and abuse used by the World Health Organization:

[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.’ Elder abuse can take various forms such as physical, psychological or emotional, sexual and financial abuse. (WHO, 2016).

It is difficult to determine the extent of senior abuse and neglect in Canada, and not primarily because definitions differ. The Public Health Agency of Canada (PHAC) estimates that 4-10% of the population aged 65 and over is directly impacted, but says “the data are extremely limited, outdated and, due to the nature of the issue, most likely under-reported” (PHAC, 2010, p. 40). Seven per cent of seniors surveyed in the 1999 Canadian General Social Survey reported having experienced some sort of emotional, physical, or financial abuse in the past 5 years (Dauvergne, 2003). McDonald (2011) calls for prevalence studies in institutions and in the community, pointing out that the last extensive national study was completed in 1989. There is

currently a study underway led by the National Initiative for the Care of the Elderly which is focused on prevalence, risk factors, and causes of elder mistreatment. However, this study only focuses on older adults living in private dwellings (National Initiative for the Care of the Elderly, n.d.). The extent of abuse in institutional settings in Canada is still unknown (Registered Nurses' Association of Ontario, 2014).

As life expectancy and the population of seniors increase, so does the challenge of addressing the problem of abuse and neglect. In Saskatchewan in 2011, 14.87% of the population was 65 and older (153,705 individuals), down 0.55% from 2006 but still representing an increase in absolute numbers (Government of Saskatchewan, 2011). The growth rate of the senior demographic in the province has been increasing for years.

Why focus on the Regina Qu'Appelle Health Region?

The health regions have emerged as a key point of entry for identifying senior neglect and abuse because they often serve a vulnerable population of seniors. Not only is the population of older adults in Canada increasing, but the number of seniors living in health care institutions continues to steadily rise as well. The proportion of seniors in health care institutions has remained at 7% for more than two decades, but absolute numbers have increased as more of Canada's population ages and life expectancy increases (McDonald, 2011). Furthermore, 20-30% of them will likely spend the last years of their lives in a care setting (McDonald et al., 2012). Health care workers may be the best positioned to spot abuse. Fulmer et al. (2004) argue that older adults rarely self-report abuse and neglect, so people who work in health care, social services, or law enforcement often are responsible for identification and reporting. In a study that surveyed adult protective service workers in the United States, health care workers were rated the most likely occupational group to detect elder abuse (Blakely & Dolon, 2003). In fact, nurses and hospital social workers topped the list, and five of the next ten occupations that are rated as being more than *somewhat helpful* in discovering abuse are also employed in healthcare, including nursing home personnel and health aides (Blakely & Dolon, 2003).

The Registered Nurses' Association of Ontario (2014) dates the emergence of senior abuse and neglect as a research and policy concern in Canada to the 1980s. It applauds the efforts taken since to address and prevent it, while acknowledging that more must be done. Charpentier and Soulières (2007), researchers in a Quebec portion of a national study, argue that not enough

discussion of senior abuse and neglect takes place in long term care situations “for fear of being considered ‘an undesirable institution’, making the problem difficult to assess” (p. 2). Given all of this, it is fair to assert that health regions in Saskatchewan have a key role to play in detecting and responding to the issue of neglect and abuse of older adults.

How Was the Information Gathered?

In order to gather information on the big picture of programs and policies in the health region that addresses senior neglect and abuse, the Saskatchewan Seniors Mechanism directed the research team to focus on higher-level management in the health region. A literature review of health region grey literature was completed, and interviews with senior management were conducted. These interviews included representatives from Regina Qu’Appelle Health Region (RQHR) in Palliative Care, Primary Health Care Services, Facility-Based Continuing Care, Rural Long Term Care, and Home Care. Ethics approval for the project was obtained from the University of Regina and RQHR Research Ethics Boards. Snowball sampling was utilized for participant recruitment and allowed researchers to identify key management players who would have knowledge of how the Health Region addresses senior neglect and abuse. Interview topics and questions were designed based on feedback from the project advisory team. Six interviews were conducted via telephone or in person at a time convenient for each participant during the months of April and May 2016, at which point saturation was reached. Interviews were recorded with permission, and were then transcribed by the interviewer. Transcripts were coded according to theme, and analyzed by two independent team members. The grey literature supplemented and filled out some of the interview data.

The interviews were semi-structured to allow the interviewer to explore responses, and were guided by the following questions (see Appendix A for the full script):

- 1) What specific services does the Regina Qu’Appelle Health Region provide to older adult victims of abuse and neglect?
- 2) What other services are offered to a general population of victims of abuse and neglect that includes older adult victims?
- 3) Does the RQHR have policy and procedures relating to the treatment, victim support and reporting of senior abuse?
- 4) Are there supports from intersectoral partners that you would like to make use of

to help senior victims of neglect and abuse?

- 5) What does the RQHR do when they encounter senior abuse and do not have the capacity to respond effectively?
- 6) What specific services and follow-up does RQHR provide upon discharge of a senior victim of abuse?
- 7) How are services for senior victims of abuse and neglect advertised or communicated to the public?

To maintain confidentiality, all participants are identified by letters (e.g. “Participant A”) in this report.

What Have We Learned?

Participants are familiar with the concept of senior abuse and neglect. They identified, and have experience with, the same types of abuse discussed in the literature. They recognized the complexity of issues of autonomy when dealing with seniors. Most of their responses related to long term care, as this is the situation in which abuse and neglect appears to be most clearly detected in the health region. In situations specific to their respective departments, participants appeared to be clear on how to deal with these reports according to established policies and processes.

The Regina QuAppelle Health Region does not do public outreach on the issue of senior neglect and abuse; nor does it have a process for active intake of cases. Participants largely did not see that as their role, nor was there evidence that they believed that the currently have the capacity to undertake that sort of programming. Those interviewed expressed some need for legislative support and the participation of intersectoral partners to assist with some situations of senior abuse and neglect. However, participants appeared to be confident overall in RQHR’s ability to deal with client cases.

Types of Abuse Identified

In their discussion of RQHR’s services, processes and policies, participants distinguished between different situations and types of abuse. In particular, participants distinguished between abuse and neglect in care settings and in the community. They also mentioned physical abuse, financial abuse, neglect, and other less-easily categorized facets of abuse. Many respondents talked most about abuse of home care residents by health region staff (indeed, some assumed staff-on-resident abuse is the only situation the research was asking about). Abuse by staff is the

type of abuse for which the most formalized policies and procedures have been established, so it also seems a natural focus for responses to the questions. However, participants also mentioned resident abuse of other residents, family abuse of residents, and resident abuse of staff; as indicated in the following direct quotes:

There are situations, like, maybe a family member is getting involved that creates a lot of angst for a resident and we've had to deal with it. (Participant E)

Staff are entitled to a harassment free environment and we're very clear on that, that harassment of any type will not be tolerated. (Participant D)

Yeah, there's a zero tolerance for any of that - staff to staff, staff to resident, resident to resident has to be dealt with too. Often times there's clinical issues involved. (Participant E)

While participants generally understood a definition of abuse consonant with that of the World Health Organization, one individual, who works in the area of long term care, pointed out that identification of abuse can still be difficult:

It's easier when we're dealing with something tangible like financial abuse where someone's bills aren't being paid [...]. It is harder when we're dealing with both internal to the organization between staff and our patients, and external between the client and their family members, to identify when there are potential issues of abuse or bullying, harassment. [...] If someone gets hit or there's some sort of physical sign it's much easier and more tangible to deal with. (Participant F)

This respondent also pointed to the possibility of nuanced perceptions of power relationships:

I call them power issues. Residents coming into long term care are placed in a very vulnerable position. We make all the decisions about what happens in their day, and if we don't actively facilitate a process where we get to hear their voice and they get to participate in that; many would feel I think somewhat bullied, somewhat intimidated, somewhat like the control of what happens in their day is out of their hands. That's the front level of abuse that I think we don't necessarily identify very clearly.

This statement reflects what Charpentier and Soulières (2007) note in their documentation of a provincial forum that was held with stakeholders concerned about elder abuse and neglect in institutional and care settings. They propose that the serious cases of physical abuse and neglect that end up in the news are rare, and that the majority of abuse is more subtle and almost routinized, taking the form of “psychological neglect, infantilizing language, failure to respect freedom, rigid regulations and institutional practices, excessive use of physical or chemical

restraints” (Charpentier & Soulières, 2007, p. 2). They stress that this abuse is primarily not intentional, but due to a lack of knowledge, training and support of staff. Management from Long Term Care Services in RQHR seem to acknowledge this issue and address it:

We do a lot of training with our staff. We have a program, *Dignity for All*, which is really about respectful care and prevention of abuse and we go through resident rights and we have their purposeful interactions and we talk about that respectful communication. (Participant F)

Working with older adults often brings up the issue of competency and capacity and the fine line between allowing an older adult to have autonomy and deciding whether to intervene. Participant F’s reflections on power relationships, above, reflects sensitivity to this issue. For example, self-neglect can be a grey area when it comes to dealing with a situation that comes to the notice of a health care worker. This is particularly relevant in Home Care, as Participant A suggests:

I think we always struggle with the competency/capacity issue and the right to live at risk. We have clients who live at risk all over, you know, we think they'd probably be better off in a long term care facility, and they want to stay at home. And we have to respect that and support them to stay at home. So not even inside the realm of neglect or abuse, but more around just for safety reasons. But people have a right to live at home, and they have a right to live in the environment they've lived in for a long time too. So I think it must be very difficult. (Participant A)

Processes and Procedures related to Abuse and Neglect

How is Abuse and Neglect Identified?

Participants brought up several ways that abuse could be detected or come to the attention of a health care worker in a care setting or at intake. Two participants from Primary Health Care explained that on the psychosocial part of the intake assessment, which is part of the intake process, there is a question that leaves room to bring up possible abuse or neglect.

This new assessment that we do which is called the RAI-HC, it's an MDS tool that's an international tool, and there is a component in there - I don't know if it's specifically asked, but the question is worded such that it does talk more about, are you getting the support you need, is there anything coming out. I do know when I did do it [...] because it's so pointed, it really did open up that conversation. (Participant B)

Participant B went on to point out that circumstances could make it difficult for a patient to directly speak about abuse.

Of course you know that it's very hard to say, 'I'm being abused.' I mean, we have lots of situations where there's maybe a family member or son or a daughter living with the family, and you kind of don't know what's going on, because it's very important for the parents to stay there, or the parent to stay there, because that other son or daughter is living there. So whose house is it, those kinds of things, you know. We do have some red flags for sure that we would see. (Participant B)

In situations where the health care worker can get a sense of family dynamics or living situation as part of an assessment, as with Home Care, these “red flags” or intuitive feelings may come into play:

It would be the person who would initially go and do an assessment in the home and have the conversation with the person and determine whether or not we really think something is happening and would launch that process [...] We look at the client in the context in their environment and their family and their care needs and it's a fairly robust assessment tool. And, I think, we look at the outputs of that tool too and sometimes it will flag us to be paying attention and so an observation, going into the person's home, observing, observing them interacting with other people sometimes can provide a clue as well. If we suspect then we would go to our social worker and say, 'I think something might be going on' [...] Sometimes there's just an intuition that something might be happening and we have lots of experience, so I trust that my staff will come to me and say, 'I think something is going on.' (Participant C)

There are also situations where a patient or their family may come forward about a situation of neglect or abuse. Participants stated that information about the role of the Patient Advocate and contact information are available in brochures and posters displayed in health care facilities, as well as in the handbook that's given to residents and their families in care facilities. The brochure recommends that people with concerns resolve them “at the point of care” and “speak first with the staff and doctors involved in your care” before proceeding up the line of command (Regina Qu'Appelle Health Region, 2015). The brochure directs people to the Unit Manager and then to the Patient Advocate, “who is the flow through when someone has a concern but where we would refer a resident or their family member or someone to” (Participant F). As Participant D explains the process:

First you try to settle that with the facility because things are always easier to resolve if you resolve it at the lowest level where people who are often correcting things can be activated. Then if not, the pamphlet would say contact the client rep, Patient Safety or contact us or contact the Ministry.

When asked how information about senior neglect and abuse is communicated to the public, most participants indicated that providing information about programs and policies is done internally with clients rather than the broader public. “Because we don’t generally serve clients in the community, or ask people in the community to come to us to deal with the issue on their behalf, we don’t advertise publically in long term care” (Participant F). However, there are still some possible points where the public might encounter the information. “We probably wouldn't say, ‘If you're being abused and neglected, call this number,’ no. But we have the health line, we have our intake numbers that are out there, we have our mental health colleagues, so I think do we formally say it? No, but we do have access points” (Participant A). Participant A and Participant B were uncertain about whether Public Health had any initiatives regarding senior neglect and abuse, but Participant B felt that “those are things that we should be promoting, and maybe some prevention stuff.”

Financial Abuse

Financial abuse was brought up by participants in most of the interviews. This may partly be because this type of abuse is more easily identified in long term care or primary health care work situations, and partly because of its prevalence. A Manitoba study found that, in one year, approximately 20% of the cases brought to the provincial Office of the Public Trustee involved financial abuse of mentally incompetent older adults (Bond et al., 2000). Many of the referred clients lived in personal care homes, reinforcing that workers in homes are well-placed to identify financial abuse (Bond et al., 2000). Participant D, interviewed for this study, supports that assertion:

The facility will recognize very quickly if some relative or someone who’s managing the resident’s finances isn’t managing them for the resident’s benefit because the long term care fee is not being paid, there’s no money available for the resident to buy a new pair of slippers, have their hair done, any of those things.

In the United States, Acierno et al. (2010) found that 5.2% of seniors in a randomly selected national sample of 5,777 reported current financial abuse by a family member – more than reported neglect, emotional, physical, and sexual abuse. Participant F from Long Term Care stated that “many of our clients come in in difficult financial situations, so looking after financial propriety or potential [im]propriety is probably one of the biggest things that we deal with.”

It was not clear from interviews what the typical initial steps were included in the process for dealing with financial abuse. Participant B said, “We work on it on an individual, case by case basis. We probably start with working with the family to see if we can find some agreement. If not then we would start initially probably referring them to the public trustee who would get the financial competency piece of it.” Once there was more certainty about the situation of financial abuse, the process was clear. All of our participants mentioned using the Public Trustee. It is part of the mandate of the Public Guardian and Trustee in Saskatchewan to “[administer] the property and finances of adults who are incapable of managing their financial affairs, monitors other property guardians and investigates allegations of financial abuse” (Government of Saskatchewan, n.d.). This matter was discussed by those interviewed for this study:

There is a process for getting that person’s finances managed by the public trustee. It’s a fairly lengthy process but it really is the only recourse that we have in order to ensure that the individual person is benefiting from the Old Age Security and supplements. (Participant D)

We would make the referral to the public trustee’s office. [...] Then they do an investigation themselves and gather all that information, and we don't really have the expertise to do that, we can just start that, and then they do that investigation. (Participant B)

Several participants, however, expressed some frustration with the referral and investigation process. Participant E stated, “It takes years for them”. Other respondents indicated:

Those wheels turn sometimes very slowly. Meanwhile the person is still being abused, they don’t have access to their old age cheques and stuff like that and their bills are piling up and it takes months sometimes. (Participant D)

That can be a little bit of a longer process, so one of the things that our system does allow us to do is to work with our affiliates. So if we're trying to work out some of that financial stuff, we will keep them within our system until that gets sorted out, because they're affiliated with RQHR, but they're in the right spot for them. But the Public Trustees office has quite a few people, and we can't jump the queue, although we've tried to do that. You have to take them as they come. (Participant B)

How is Abuse and Neglect Addressed in Specific Settings?

Long Term Care

The Regina Qu'Appelle Health Region offers long term care services for individuals who can no longer live independently in the community. Clients are adults, 18 years of age and older, who require on-going support due to age, disability, injury, or long-term illness. SWADD (System Wide Admissions and Discharge Department) manages admission to long term care facilities within the health region, and there are approximately 1983 long term care beds located at 23 facilities. There are 9 facilities located within Regina, and 14 facilities located in rural areas. The area in Saskatchewan that is covered by RQHR also has many small private care homes. RQHR does not provide services at these homes, but does have an obligation, through legislation, to assess these homes once every two years.

Participant F was able to clearly outline the process for dealing with a situation in long term care where staff may be perpetuating abuse or neglect:

If there was neglect or there was allegation of physical abuse or sexual abuse or poor care, we have an internal process where we investigate that, working with the family. So when we identify a situation we talk to the individual, if they have capacity to participate, or we involve their family member and let them know what the circumstance is and what step we will be taking to do that investigation, follow through. (Participant F)

At this point in the above process, the Patient Advocate is involved as a resource to the family, separate from the investigation.

The labour relations human resources team typically conducts the investigation. "We actually go in and do a hands-on, in the site, investigation of all of the information that's available in the chart. You know, interviewing staff if that's required in order to complete the investigation" (Participant D). Sometimes, an external investigator is brought in.

We've hired external investigators when there's a concern that we as a facility that we would really be in a position of conflict to actually conduct that investigation or wouldn't be perceived as being able to do so fairly. (Participant F)

It initiates a whole string of actions and investigations and depending on whether we involve an outside investigator if it looks like it's something that could be bordering on charges. (Participant D)

It's usually kind of a steering committee that includes the home in question, so the CEO leadership, the executive directors that are responsible for that home, perhaps Security Services depending on the investigator. So there are a number of parties that come together, it's kind of a 'stop the line' approach in a way. (Participant E).

At the outcome, actions taken may include discipline according to the collective agreement (RQHR staff are unionized) or other correction. "So sometimes, that means we provide resources to pay for something that might have been [unclear] or damaged, so we provide counselling or other support services. Or we might move an individual from one place to another unit if they feel that would be best for them or they feel less vulnerable in those surroundings" (Participant F). The process ends with a follow-up meeting with the resident and/or family to tell them the outcomes of the investigation, to see if they are satisfied, and to offer any more needed supports.

Participant F did indicate that there may be a lack of follow-up supports in the health region for older adult victims of abuse or neglect:

But in terms of other victim services [other than the Patient Advocate], I would say no. We do tend to deal with those on an informal basis and to use the social workers within the long term care homes that have them, so the larger sites have them. We tend to use them in that counseling support role and they will often be the support to someone who feels that they have been victimized. And the social worker will assist them through the process of connecting with the right people but really that's our resource, that support side. (Participant F)

However, other participants did not comment on a lack of follow-up support for victims.

Although participants focused mainly on abuse perpetuated by staff when explaining procedures, Participant F did bring up some actions that might be taken in situations of abuse by other perpetrators. "In certain circumstances we would involve our security team or make a referral to RPS [Regina Police Service] and then we would provide support through our social work team and potentially a referral to other supports for that individual, based on what they require."

Primary Health Care

The Primary Health Care portfolio in RQHR covers everyday supports for individuals and communities to better manage their own health, by providing coordinated health services that are community designed and team delivered. It includes a wide range of coordinated services including prevention, health promotion, treatment and rehabilitation and involves

linking with agencies and organizations to work together to address other social factors that influence health. Relevant to this report, Primary Health Care encompasses Home Care Services, Seniors House Call Program, SWADD, and Palliative Care, all of which have significant senior client populations.

In primary health care situations of abuse or neglect may come to the attention of case managers (primarily social workers) who are assigned to work with clients and families, or emerge during an assessment, on a case by case basis. Participant B explains that “through that work, many of our social workers would have had situations where we're concerned about family members, about clients, about neglect, abuse, all that kind of stuff. We try to work it out with the family, I would say.”

Participant B referred previously to the RAI-HC assessment done with clients and expanded on the process of arriving at a course of action:

We would start that initial consultation case consult, with probably both players, because more than likely we're involved in other areas, it could be nursing involvement, we're gathering that information from more than one source. So, we would meet and then we would develop an action plan, and typically what happens there is that you do have a conversation with the particular client, and say, ‘We have some concerns, we've noticed this, and you would document that, and then you escalate it up accordingly. The best case scenario, and this probably comes from some of the advice I've been given from Patient Safety, that your intention is to do due diligence and gathering the information, and working towards that. (Participant B)

Participant B then spoke about connecting the client “with the appropriate services” and gave an example of working with a personal care home to improve their care in a situation of neglect. “In this case, the power of attorney was very clear, to say no, I want her to go back in that home because that's where her husband is, and so we worked within that to say, ‘Okay, we know that the care wasn't up to say our best practice so how do we help that, and allow them to stay together as long as possible?’” (Participant B). In the case of care homes, there is a provincial body to turn to: “there is a mechanism that we can report to the ministry that is a licensing body of that personal care homes, for example. So we would follow that process, and then they would do the investigation” (Participant B).

Home Care is under the Primary Health Care portfolio. It provides health and support services for people who wish to remain in their homes, in order to assist people to live independently as possible. Clients can be any age, and services are need-based. Services include

nursing, palliative care, and meal service. According to Participant C, the majority of regular clients are over the age of 65. In the regular program, RQHR averages about 5500 active clients a month and does approximately 1500 home visits a day.

Participants indicated that detection of neglect or abuse would primarily be done by the person conducting the initial assessment in the prospective client's home, in conversation with the client. However, not all those interviewed seemed fully aware of the process for dealing with neglect and abuse from detection to resolution. Regardless, there was clear identification of where to report issues and whom to contact for further assistance.

Policies and Legislation

Interviewees referred to internal health region policies that guide care and act as preventative in the area of senior neglect and abuse.

We have policies in place that says we will treat people respectfully and we will not be abusive. It doesn't say it quite that clear but it's pretty clear. [...]So we have that, and we have policies on resident rights and we talk about being client centered. (Participant F)

We do have what's called challenging cases protocol, which is part of our core care guidelines that we do have to, we would, again, it needs to be updated because we're on a different structure now, but we do have that in place, which is related to community safety programming. (Participant B)

As well, the collective agreement was referred to in the context of staff discipline. These policies are not specific to senior neglect and abuse, but do encompass it within a general philosophy of care.

Recently, an Ombudsman's investigation into a situation at a long term care facility in Regina prompted changes to policy and procedures in RHQR. The Ombudsman, Mary McFadyen, investigated the care provided to Margaret Warholm, who resided at the Santa Maria Senior Citizens Home which is owned by the Archdiocese of Regina and is affiliated with, and funded by, RQHR. A letter of response from Vice President of Integrated Health Services, Michael Redenbach, on Nov. 9, 2015, is available on the RQHR website and outlines improvement measures made in response to the Ombudsman's recommendations (Redenbach, 2015). RQHR, with other health regions and the Ministry of Health, "developed a process to collect policies/procedures [for special care homes] from across the province" for regions

without these to adopt or other regions to adapt (Redenbach, 2015, para. 4). Participants referred to these changes in the interviews:

We are just now going through the process with the Ministry of Health related to turning the [provincial] program guidelines [from May 2016] into policies, long term care policies and that's applicable to every region across Saskatchewan. So this will become our long term care policy binder [...] And then the procedure is being developed. That will identify all the steps that we currently take operationally as standard practice but have not necessarily been identified formally in one document before. They are in a number of different areas - they're in our HR processes and in some other areas - but it hasn't been pulled into one document, so that will be coming. (Participant F)

As a region we are working together collaboratively with all of our homes and our affiliates to have one approach, one policy. (Participant E)

Subsequently, the provincial *Program Guidelines for Special-care Homes* was updated in May 2016 (Government of Saskatchewan, 2016). Of special interest is the revised *Section 2.3 Resident Abuse*. This policy states, "All reasonable steps shall be taken to ensure residents of special-care homes are provided with an environment that is free of all forms of abuse" (Government of Saskatchewan, 2016, p. 22) including taking measures such as staff orientation, documentation, and eliminating risk of resident abuse. As well as outlining procedures for reporting and investigation of abuse claims, the policy promotes prevention of abuse. For example, *Section 1.2* states that special-care homes will "Function within a resident and family centred approach where [...] All are treated with respect and dignity" (Government of Saskatchewan, 2016). Likewise, the *Care Standards* in the same document range from respecting individuality, privacy and dignity to enabling that through specific guidelines for maintaining good hygiene in clients and using restraining devices as a last resort. *Resident Rights and Responsibilities* include "to be protected from any form of abuse, neglect or exploitation while residing in the special care home" (Government of Saskatchewan, 2016).

Stemming from the Ombudsman's recommendations, RQHR has also developed a new process for Confidential Occurrence/Critical Incident reporting so that less serious, as well as more serious, incidents are reported to the Health Region. As a result, they have also updated the *Long Term Care Resident Handbook*. Significantly, RQHR created Geriatric Services for southern Saskatchewan in consultation with the five regions that will be served by the program. The program provides "support, advice, coaching and leadership to all services that provide care

to seniors” (Redenbach, 2015, para. 14). Participants were familiar with these recent changes and mentioned them in interviews, specifically identifying many of the changes as positive:

We’re updating the handbook that’s given out to residents and families in any of the facilities that they’re living in [...] All of that was laid out but I think it’ll just be easier for people to follow and keep track of if it’s in the handbook. (Participant D)

We also have a new service that’s called Geriatric Services, so that service is attached to a different service line than us, it’s under the facility-based continuing care which is a lot of the long term care programming, but we can access a resource team there now that will include - it’s not completely developed, but the behaviour consultants are part of that. (Participant B)

[Except for critical incidents] we at this point don’t track our number of residents that come forth with concerns. So if something comes up and is dealt with at the facility level it doesn’t get up through those other areas, we have no way of tracking that process. Through this new process at the Ministry being introduced, we will actually have to track every one of those interactions and the outcomes of those. (Participant F)

There is a new appeal process where, through an investigation of a situation where a resident thought they were inappropriately treated or other situations, if they are unhappy with that there is actually an appeal process that’s being developed that will have an external party to that process. So, right now, if the resident has a concern they bring it to us, we investigate it then we send it to *our* Patient Advocate to be a support to them so it’s a pretty one sided process, there isn’t an independent or objective party. (Participant F)

Participants mentioned health region resources outside of their areas that they accessed when needed, whether to support a client or assist with the process of dealing with senior neglect and abuse. These include the security services in institutions, mental health services, Patient Safety, physicians, the ethics committee, and the Privacy Officer.

In certain circumstances we would involve our security team or make a referral to RPS [Regina Police Services] and then we would provide support through our social work team and potentially a referral to other supports for that individual, based on what they require. (Participant F)

For me, I would always say, ‘Have we called over mental health, what do they know about this situation, can we work together, can we get this person to safety, a safe place for them to be assessed appropriately?’ Because we always want a medical assessment, that’s the other part of it, so any of these beds we’re accessing, we want to make sure that they’re stable medically, so we would always involve the physician as well. (Participant B)

We also know that we could refer to internal stakeholders as well as external. So say for example, we might be collaborating with our mental health colleagues, mobile crisis, or the crisis response team within mental health. (Participant B)

I often link our privacy officer in to something that I'm doing follow up on or investigating [...] to make sure that we're not stepping over any boundaries or breaching anybody's confidentiality. (Participant C)

One of the go-to's is our Patient Safety for sure. Within our health systems, we also have an ethics committee that meets regularly, and one of the managers that works with us, she's part of that, so we often consult with her. Sometimes it's an ethical question as we've said. Person wants to live at risk, so. We've also worked closely with security. (Participant B)

Intersectoral Partners

During the interviews for this project, participants mentioned several intersectoral partners with whom RQHR regularly collaborates, or from whom they might seek support on cases of senior neglect and abuse. Some of these partners provide resources for staff training and education on seniors' capacity and competency, linking to the topic of abuse, according to Participant B. Interview participants mentioned other topics that external agencies supplied education on, depending on their particular area of expertise:

We've had people involved from the Seniors Mechanism, involved in providing us with information and particularly with our housing clients. So they've provided some in-servicing and some information for us on housing clients. (Participant F)

[The Ministry of] Justice has come and talked to us on several occasions [about legislation]. (Participant A)

When I was working with the social worker, she had information, brochures and literature that was available and that she gave out [...] Specifically from RQHR, I don't know how much of it is ours or how much we've received from other agencies to be able to distribute. We don't always create everything that we distribute to clients. We don't always recreate the wheel. (Participant C)

Participants also identified victim support services that RQHR might connect to outside of the health region, but did not identify specific organizations in the community:

When we have a meeting where we think we need to look to outside resources, the [RQHR] Patient Advocate office has a really good contact structure and then they will reach out. So if there's a victim service, or other resource that they think would be appropriate, they will often be our touch point [...] with other partners in

the community. We can't direct those partners but we can facilitate communication with them and identify the patient's issues and needs so it works both ways [...] or they will find somebody for us if we say look this person needs this kind of support, who out there in your network can provide that. (Participant F)

If you're talking at a very local level, we have good cooperation and collaboration with even the police force if we need it. Because on occasion, we have had to restrict access within the facility. (Participant D)

A participant from Long Term Care went on to say,

I think it's an area where we have not necessarily spent as much time as we might have. We tend to do internally. I'm not even sure what other resources are out there that might be available for our clients coming into long term care where we've identified a circumstance outside of what we've already talked about. [...] Yes, it would be very valuable to have additional information and to be able to work a little bit more collaboratively. There's so much we already have internally to RQHR that we don't even really use, as fully as we might I think, that we sort of forget that there might be other resources as well that are available and often they are either volunteer resources or other low-cost or no-cost resources that could be helpful for our residents. (Participant F)

Identified Gaps

There were several suggestions for legislative actions that could increase the efficacy of RQHR in dealing with situations of senior abuse and neglect that emerged during the interviews. Two suggestions involved legislation on a provincial level. This suggested action is supported by McDonald (2011) who points out that unlike the United States, Canada "pursues different aspects of elder abuse within separate legislative responses to domestic violence, to institutional abuse, and to adults who are incapable or otherwise unable to access assistance on their own" (p. 457). Those interviewed for this study pointed to a lack of senior-specific legislation or governmental bodies in Saskatchewan compared to other provinces. Three participants spoke about other models utilized in other parts of the country that they believed should be considered for implementation in Saskatchewan:

I don't have detailed information but my understanding is that that has been raised several times and our province has never chosen to pursue it. If you look at other provinces, yes, there's a very strong guardianship, or public guardianship for seniors. In fact in Alberta, I've had a recent experience with a family situation and that office oversees any of the goals of care and arrangements that are being made on behalf of an older person. Like if somebody has proxy or quite a bit of control over this person there's a real oversight which I think would be preventive as

opposed to reactive. We are more reactive in this province and if there's anything that we believe is necessary, that's it. (Participant D)

Yeah, every health region mentioned has the Patient Advocate piece and you know that works well, but what you're talking about is a whole provincial infrastructure that takes the whole notion of seniors and seniors' care and abuse and so on is at a real profile and those cases that you're talking about like financial abuse or even emotional would probably get dealt with way quicker having that kind of an office oversee it. (Participant E)

The thing about having that office of the public guardianship for the elderly - it puts it into a whole different realm. Now you are in a situation where it's a legal situation so there's far more clout than there is when you're negotiating and recommending and all of those more soft approaches. (Participant D)

Some participants expressed dissatisfaction with existing legislation, or confusion about what legal routes could be followed in certain cases of abuse and neglect:

There's no legislation as I understand it in this province to actually act upon abuse, specific, as we would a child abuse case. We don't have the authority, necessarily, to go in and investigate in that regard. (Participant A)

It's so tough because we don't have authority, so I've still myself been unclear, even after talking to [government contact in Ministry of Justice]. Like I would call [contact] right away, and say, "How do I process through this?", but it's quite unclear, because unless they're actually charging the person, that's kind of a grey area for me, and I haven't been involved in any specific case where we've gone that route. (Participant B)

Despite these gaps, none of the participants who were directly asked felt that there are situations of senior abuse and neglect to which the health region does not have the capacity to respond:

We mobilize, we get the resources we need to get to get the job done. I'm not sure we've come across a situation where we just say, well you know we don't have the capacity to do that so we're not doing it. It just doesn't happen. (Participant E)

We always deal with it. I don't think that there's an instance where we go, 'We're too busy to deal with someone who we feel is in a neglectful situation.' (Participant A)

I would be confident that we would report it and would take some kind of action, we would try and ensure the safety of the client. (Participant C)

What We Don't Know

It is important to keep limitations of this study in mind when considering results and coming to any conclusions. First, the participant pool was limited. It did not include representatives from Patient Safety, Public Health, or physicians. Interviews with these groups might have offered further insight into situations of senior neglect and abuse, how they deal with the issues, and whether they perceive that any additional supports are needed. As well, we did not look at individual long term care institutions' policies, just those policies that apply throughout the region.

Second, because this study focused on senior management, we cannot make any claims about front line workers. These workers are more likely to interact with seniors in situations of neglect and abuse that may not necessarily come to the attention of senior management participants in this study. We do not know front line workers' understanding of the policies and processes that our participants explained.

Focusing on RQHR limited our scope, and did not allow access to data from other organizations that deal with senior neglect and abuse, such as the Regina Police Service. This data would help us to fill in unknowns such as the extent or change in rates of reported abuse.

Recommendations and Directions for Further Research

In RQHR, policies exist for situations of neglect and abuse of other populations but not specifically for seniors, who often find themselves in different and complex situations of abuse due to health issues and finances. Senior abuse and neglect is also not addressed specifically in legislation that affects the health region, and no provincial senior-specific bodies have been established, as they have in other provinces, to address the issue. Interview participants suggested that a senior's advocate office, which could oversee and act on behalf of seniors in situations of abuse and neglect, is something that Saskatchewan should implement based on those in other provinces. As well, some participant responses indicated that community victim supports are not well-known or well-used by the health region; this is an area that intersectoral partnerships could investigate.

In January 2017 the Saskatchewan government announced a plan to combine the province's twelve health regions into one provincial health authority by fall 2017. While it dates this research report, in this situation, a provincial response line for senior abuse and neglect, as

SNARL proposes, could provide continuity of awareness and coordination around the issue. Such a response line could also help generate data needed to assess the extent of the problem. Coordination of services among different providers is essential for accurate assessment of and response to the problem. Partnerships between the health region and local organizations could offer needed resources to individuals within the health region who have been victimized. These organizations would necessarily need to be included in a full discussion of senior neglect and abuse within the health region. Further research is needed to help connect the systems that intersect with the issue and the population under study.

Conclusion

As the number of seniors in Saskatchewan continues to increase, dealing with senior abuse and neglect increases in importance. Healthcare workers play an important role in identifying and responding to senior neglect and abuse. Interviews with senior managers in the Regina Qu'Appelle Health Region show that they are aware of the issue of senior abuse and neglect, can identify types of it, and have personal experience of situations where senior abuse and neglect has been dealt with in their workplaces. While there are no health region policies that specifically address senior neglect and abuse, this study's participants clearly identified policy and processes used to deal with these situations. However, they also identified supports needed in order to provide services to victims in a timely, comprehensive manner

With the pending amalgamation of health regions in Saskatchewan, it is important that effective policies and procedures be applied across the system. At the same time, it is important that local community supports are known and accessed by health care workers for support in cases of senior abuse and neglect. A coordinating body such as SNARL could assist with continuity of education and care, and assist with data collection so that a picture of senior neglect and abuse in the entire province can be formed.

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Appendix A

Interview Questions

The definition of ‘senior neglect and abuse’ used in this study is that of the World Health Organization: “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust that causes harm or distress to an older person” (http://www.who.int/ageing/projects/elder_abuse/en/). This can take the form of physical/sexual abuse; psychological, emotional, and verbal; financial; neglect; and denial of entitlements protected by law.

1. What specific services does the Regina Qu’Appelle Health Region (RQHR) provide to older adult victims of abuse and neglect?

- How are they organized?
- How are they delivered?

2. [If the respondent indicates there are no, or only a few, senior-specific services:]

What [other] services are offered to a general population of victims of abuse and neglect that includes older adult victims?

- Can you comment on how well these services work for seniors? How might the services be improved for the specific needs of seniors?

3. Does the RQHR have policy and procedures relating to the treatment, victim support and reporting of Senior Abuse?

- What are the policies and procedures related to abuse and neglect regarding what is done when abuse is identified or the patient discloses abuse?
- What are the policy & procedures regarding the treatment, the support of the victim and the reporting of the abuse to the appropriate authorities?
- Who tells who? Who has what mandate?
- Are the policy and procedures current?
- Are they consistent with what happens in other Health Regions?
- Where did they come from? Who was involved in developing them?
- How are they updated? By whom?

4. Are there supports from intersectoral partners that you would like to make use of to help senior victims of neglect and abuse?

5. What does the RQHR do when they encounter senior abuse and do not have the capacity to respond effectively?

6. What specific services and follow-up does RQHR provide upon discharge of a senior victim of abuse?

- How are they organized?
- How are they delivered?

- How long are these services provided?

7. How are services for senior victims of abuse and neglect advertised or communicated to the public? How does the public know who to contact and how to get assistance in a situation of abuse and neglect?

8. Who is the go-to person in the Health Region to speak to issues of violence, abuse and neglect of seniors (the person who can walk staff through the process)?