THE PREVENTION OF ABUSE AND NEGLECT IN ONTARIO LONG-TERM CARE HOMES

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Mandatory Reporting of Elder Abuse in Canada

Canadian criminal law does not mandate the reporting of elder abuse on a national basis. The *Criminal Code*[1] does not explicitly define "elder abuse" as a discrete crime, nor does it provide any legal mechanism or requirement for the reporting of abuse. Elder abuse, when it forms the substance of a criminal offence, may be reported to a law enforcement agency at the discretion of the reporter, as with any other crime.

Despite the absence of any federal mandatory reporting of elder abuse, some Canadian provinces have adopted provincial mandatory reporting laws. Some provinces, such as Nova Scotia, have adopted forms of adult protection legislation that call for the mandatory reporting of the abuse of elderly and other vulnerable adults.[2] Most other provinces and territories, with some exceptions, require by law or government policy the mandatory reporting of the abuse of residents of nursing homes and other similar care facilities.[3] In each case, the nature of the mandatory report is not to the police or any other law enforcement agency, but to a bureaucrat somewhere within the community-services or health-care system.

Therefore, in Ontario, mandatory reporting of elder abuse does not exist outside of long-term care homes. Recent changes to the law that governs long-term care homes in Ontario have strengthened measures designed to prevent the abuse and neglect of long-term care residents, and have expanded the mandatory reporting of abuse in long-term care homes in a way that now includes mandatory police reports. The changes in the law have caused some transitional issues that are problematic for all stakeholders and have not yet been resolved. While the theme of the prevention of abuse is desirable, there are

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[1] *Criminal Code*, R.S.C., 1985, c. C-46.

[2] See e.g.: (Nova Scotia) *Adult Protection Act*, R.S., c. 2.

[3] See e.g.: (Ontario) *Long-Term Care Homes Act* , *infra* note 11.

some rather bumpy transitional issues that will require the time, attention and training of long-term care staff, police and other service providers.

Adult Guardianship Law in Ontario and the Prevention of Abuse

Even though Ontario does not have a general mandatory reporting obligation of elder abuse, it does have strong community-based measures for the prevention of abuse of mentally incapable adults of all ages. As with all other Canadian provinces and territories, Ontario has a publicly appointed Public Guardian and Trustee that performs adult guardianship functions. The Office of the Public Guardian and Trustee [the "OPGT"] has the legal duty to initiate a guardianship investigation where it receives information alleging that a person is not mentally capable of managing property or making personal-care decisions, and as a result of that incapacity serious adverse effects are occurring or are likely to occur.[4] It is therefore permissible, but not mandatory, for individuals to make reports to the OPGT to initiate the guardianship investigation of an allegedly mentally incapable adult. This law applies to all adults physically present in Ontario, including long-term care home residents.

The OPGT has very wide-ranging investigative powers in the course of a guardianship investigation. It may obtain an order for the assessment of an allegedly incapable person, including the right of entry to the person's home and requiring the person to attend any place for the purpose of the assessment.[5] It may obtain an order authorizing the apprehension and detention of the allegedly incapable person, with the assistance of the police, for the purposes of an assessment,[6] and an order restraining anyone else from restraining or hindering the assessment.[7]

The OPGT has other investigative powers in the course of a guardianship investigation that resemble and exceed those of the police in the course of a criminal investigation. It has a statutory right of access to certain forms of

[4] *Substitute Decisions Act* ["SDA"], S.O. 1992, c. 30, ss. 27 and 62.
[5] *Ibid.,* s. 79.
[6] *Ibid.,* s. 81.
[7] *Ibid.,* s. 80

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premises without a warrant, and can obtain a warrant for entry for all other premises.[8] It has a statutory right of access to documents, including health, banking and other financial documents without a warrant, and it can also obtain a warrant for access to any other documents required for a guardianship investigation.[9]

If necessary, as a result of a guardianship investigation, the OPGT may take other actions, including court proceedings, to become the person's temporary or permanent court-appointed guardian of property and of the person.[10]

These are very intrusive and wide-ranging powers designed to prevent the abuse and neglect of mentally incapable adults of all ages and in all living situations.

Ontario's New *Long-Term Care Homes Act, 2007*

Long-term care homes in Ontario consist of private nursing homes and non-profit homes for the aged that are mainly operated by municipalities and charitable institutions. All long-term care homes are publicly-funded health-care facilities in respect of which eligibility for admission is determined according to health-care criteria. Basic long-term care rates are geared to income (without encroachment on assets) such that anyone who qualifies for admission to long-term care can afford to live there without disposing of their assets. Importantly, a long-term care home is a health-care facility that is legally required to provide for all of the long-term care needs of its residents.

Ontario is Canada's largest province, with over ten million residents. It has more than 500 long-term care homes, and more than 70,000 long-term care residents. The demand for long-term care has dramatically increased with our ageing population, even more so than the supply of long-term care beds. As a result, long-term care residents are generally older and with higher care needs than ever before. A very high proportion of long-term care residents have some

[8] *Ibid.,* s. 82.
[9] *Ibid.,* s. 83.
[10] *Ibid.*, ss. 22, 27(3.1), 55 and 62 (3.1).

form of cognitive impairment, and with few exceptions all have care needs that can't be met in the community. Long-term care residents are among the most vulnerable members of Ontario society.

With the heightened vulnerability of long-term care residents prominently covered by the media and very much in the public eye, the Government of Ontario enacted a new *Long-Term Care Homes Act* that took effect on July 1, 2010.[11] The new *Act* carries over some important protections that have long been in effect for long-term care residents, and creates some new protections against abuse and neglect that in some ways change the ground rules for the operation of long-term care homes. Among these long-standing and new measures are strong statements of principles that denounce abuse and neglect; the screening, orientation and training of long-term care home staff and volunteers; zero-tolerance of abuse and neglect; measures addressing responsive behaviours; the provision of specialized units; the mandatory reporting of abuse and neglect; and whistle-blowing protection. The implementation of some of these measures have caused predictable spill-over effects for long-term care residents, their families and loved ones, and for the administration of justice including the courts and the police.

Statements of Principle

As with previous legislation, the *Long-Term Care Homes Act* contains very strong statements of principle that support residents' rights and denounce all forms of abuse and neglect. These consist of a "fundamental principle", the continuation of a statutory *Residents' Bill of Rights,* and the new requirement of a mission statement that must be developed and operationally implemented in each home.

The fundamental principle of the *Long-Term Care Homes Act* is that a long-term care home "is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs

[11] *Long-Term Care Homes Act* [*"LTCHA*"], S.O. 2007, c. 8.

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adequately met."[12] This statement of principle is carried over from previous legislation, and is a very instructive command.

Not long ago, "long-term care *homes*" were in Ontario called "long-term care *facilities"*, and this concept of institutional care was itself incongruous with the fundamental principle (which then existed) that the place is primarily "the *home* of its residents". The concept of "*home*" is indeed fundamentally important where the same physical space is at once the intersection of a home, a work place, and a place of business. The displacement of the concept of home to the busy work and business interests of a nursing home or home for the aged can be overwhelmingly disempowering to older adults who live there.

The new *Act* continues a *Residents' Bill of Rights* that has existed by law or by government policy for nearly twenty years.[13] The *Residents' Bill of Rights* is a list of 27 rights that are prominently posted in every long-term care home, and are deemed to form part of every long-term care home admission agreement. Among the more basic rights that are pertinent to the prevention of abuse and neglect are:

- the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity;
- the right to be protected from abuse; and,
- the right not to be neglected by the licensee or staff.

Other rights such as the right to be properly sheltered, fed, clothed, groomed and cared for; to live in a safe and clean environment; to be afforded privacy in treatment; to have one's participation in decision-making respected, and the like are equally important in the recognition and prevention of abuse.

A new requirement of the *Long-Term Care Homes Act* is that each long-term care home have a mission statement that is consistent with the fundamental principle and the *Residents' Bill of Rights*, and that the mission statement is "put into practice in the day-to-day operation of the long-term care home".[14]

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[12] *Ibid.*, s. 1.
[13] *Ibid.*, s. 3.
[14] *Ibid.*, s. 4.

Screening, Orientation and Training of Staff and Volunteers

Although many long-term care homes have already been screening staff and volunteers as a risk management measure, this was not an industry-wide practice because they were not legally required to do so. The new *Long-Term Care Homes Act* requires that all staff and volunteers must be screened with a criminal reference check, including a "vulnerable sector screen", conducted within six-months before the staff member is hired or the volunteer accepted by the home.[15]

There is no periodic renewal of the screening process, but instead there is a self-reporting mechanism. The *Act* requires every staff member or volunteer to provide the home with a signed declaration disclosing every criminal offence with which the person has been charged and the outcome of the charge; and every peace bond, probation order, fire-arms prohibition order, warrant or restraining order made under the criminal or family law promptly after the person has been charged or an order or conviction has been made.[16]

The screening requirements do not apply to the medical director of the home, or any physician or registered nurse who acts as an attending health-care professional on call to provide around-the-clock medical coverage. Occasional maintenance workers who do not have direct contact with residents and work on-site under the supervision of a screened employee are also exempt.[17]

Before starting work, all staff must receive training in areas that include the *Resident's Bill of Rights*, the home's mission statement, zero tolerance of abuse and neglect, mandatory reporting of abuse, whistle-blower protection, and the minimization of restraints.[18] Volunteers are not required to undergo any training, but the home is required to offer orientation sessions to volunteers on the same topics.[19] In addition, all staff who provide direct care to residents must receive training on an annual basis on abuse recognition and prevention; mental

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[15] *Ibid.*, s. 75 and O.Reg. 79/10, s. 215(1)-(3).
[16] O.Reg. 79/10, s. 215(4) and (5).
[17] *Ibid.*, s. 215(6) and (7).
[18] *LTCHA*, *supra* note 11, s. 76 (1) and (2).
[19] *Ibid.*, s. 77.

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health issues, including caring for persons with dementia; behavioural management; and the minimization of restraints.[20]

Zero Tolerance of Abuse and Neglect

The *Long-Term Care Homes Act* requires every home to develop a written policy to promote zero tolerance of abuse and neglect of its residents, and to ensure that the policy is complied with. At minimum, the policy must clearly state what constitutes abuse and neglect and that it will not be tolerated. It must provide a program for preventing abuse and neglect. It must explain the duty of mandatory reporting and procedures for investigating and responding to specific incidents, along with the consequences for those who abuse or neglect residents. The home must ensure that the zero-tolerance policy is communicated to all staff, residents and residents' substitute decision-makers.[21]

The *Act* now requires that the home promptly notify the abused resident's substitute decision-maker, if there is one, and any other person designated by the resident of any alleged, suspected or witnessed incident of abuse or neglect. If the incident causes a physical injury, pain or distress that could potentially be detrimental to the resident's health or well-being, notification must be made immediately. In any other case, notification must be made within 12 hours of the time the home became aware of the incident.[22]

The home must also notify the resident (without regard to mental capacity) and the resident's substitute decision-maker of the results of the investigation immediately upon its completion.[23]

The home is also permitted, at its discretion, to notify a person the home reasonably believes is responsible for the suspected abuse or neglect of a resident.[24]

If any alleged, suspected or witnessed incident of abuse or neglect may constitute a criminal offence, the home is now required to notify the police

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[20] *Ibid.*, s. 76(7).
[21] *Ibid.*, ss. 19 and 20.
[22] O.Reg. 79/10, s. 97.
[23] *Ibid.*
[24] *Ibid.*

immediately. [25] This is a new provision that has wide support because of historical reluctance to make police reports in these matters. However, zero-tolerance policies of any type are very difficult to implement, and it has been very problematic for long-term care homes and police forces to come to a common understanding of which incidents may constitute a criminal offence and therefore must be reported to the police.

Responsive Behaviours

Under the new *Long-Term Care Homes Act*, a "responsive behaviour" means a resident's behaviour that may indicate an unmet need in the person or a response to circumstances that may be frustrating, frightening or confusing to the resident.[26] The *Act* now requires every long-term care home to develop screening protocols and means to assess and identify behavioural triggers that may result in responsive behaviours, and techniques and interventions to prevent, minimize or respond to responsive behaviours. These materials are to be developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. They are to be evaluated and updated at least annually, with a written record supporting the evaluation process. Most importantly, the home must ensure that for each resident demonstrating responsive behaviours, the behavioural triggers for the resident are identified where possible; strategies are developed and implemented to respond to the behaviours, where possible; and action is taken to respond to the resident's needs.[27]

The home must also develop procedures and interventions to help residents and staff who are at risk of harm because of a resident's behaviours and to minimize the risk of altercations between and among residents. The *Act* requires that all direct-care staff must be advised at the beginning of every shift

[25] LTCHA, *supra* note 11, s. 98.
[26] O.Reg. 79/10., s. 1.
[27] *Ibid.*, s. 53.

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of each resident whose behaviours require heightened monitoring because they pose a risk to the resident or others.[28]

Specialized Units

The development of specialized long-term care units that provide the care and supervision that is needed for violent or aggressive cognitively impaired residents has a place of particular importance in Ontario health-care policy. In June 2001, a violent and cognitively impaired man was admitted to a Toronto, Ontario nursing home. He did not speak English or any other language in which care services were offered and might not have recognized his surroundings. Before nightfall on the day of his admission, be bludgeoned two of his roommates to death and attempted to kill a third resident of the home. The assailant was charged with two counts of murder, but later died in hospital while undergoing a psychiatric assessment.

The repercussions of this tragic incident continue to resound throughout the long-term care system. It has highlighted the much overlooked fact of resident-on-resident violence that so often results from housing demented and other cognitively impaired residents in congregate living situations. The resulting coroner's inquest recommended the development of specialized behavioural units that are now mandated as a response to responsive behaviours and other factors that place long-term care residents at risk of abuse from other residents.

The new *Act* provides for a separate waiting list for admission to a specialized unit, and allows crisis admissions to be made in advance of earlier non-crisis applications for admission.

Mandatory Reporting of Abuse and Neglect

While Ontario does not have laws requiring the mandatory reporting of elder abuse in most situations, a specific mandatory reporting requirement applies to long-term care homes. Any person, save and except for a long-term care resident, who "has reasonable grounds to suspect" that specified acts of

[28] *Ibid*., ss. 54 and 55.

abuse or neglect have occurred or may occur is required by law to immediately report the suspicion and the information upon which it is based to the Director of long-term care. The reportable acts of abuse and neglect are:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident;
2. Abuse of a resident by anyone or neglect of a resident by the home or its staff that resulted in harm or a risk of harm to the resident;
3. Unlawful conduct that resulted in harm or a risk of harm to the resident;
4. Misuse or misappropriation of a resident's money; and,
5. Misuse of misappropriation of government funding provided to the home.[29]

The provision of a mandatory report to the Director of long-term care can form a quandary for the reporter because it is an offence to include in the report information the reporter knows to be false.[30] Undoubtedly, the prohibition against false statements is a necessary measure. However, in the world of long-term care in Ontario the creation of this offence can have a very chilling effect. In the past, whistle-blowers have felt extremely frightened and intimidated by the pressures brought to bear on them after publicly voicing complaints over documented and recorded abuse and neglect.

While residents are not required to make reports, they may do so and the prohibition against false reporting explicitly does not apply to incapable residents.[31]

The obligation to report does extend to physicians, social workers and other health care practitioners, even if the information upon which a report may be based is privileged and confidential.[32] However, the mandatory reporting obligation does not affect any solicitor/client privilege.[33]

While the obligation to report applies to everyone, a *quasi*-criminal offence of failing to report applies only to the following categories of persons:

[29] *LTCHA*, *supra* note 11, s. 24(1).
[30] *Ibid.*, s. 24(2).
[31] *Ibid.*, s. 24(3).
[32] *Ibid.*, s. 24(4).
[33] *Ibid.*, s. 24(7)

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1. The long-term care home licensee or manager, its officers, directors and members of a management board or committee;
2. A staff member of the long-term care home;
3. Any person who provides professional services to a resident or to the long-term care home in the areas of health, social work or social services work.[34]

It is also an offence for any of the same group of persons to coerce or intimidate a person not to make a report; to discourage a person from making a report; or to authorize, permit or concur in a contravention of the duty to report.[35]

However, outside of the specified group of persons, there is no penalty under the *Act* for failing to make a mandatory report of resident abuse and neglect. It seems odd that the *Act* imposes a very broad legal obligation to report long-term care resident abuse or neglect on everyone but long-term care residents, and then creates an offence of failing to report only for limited categories of individuals. Despite this, the duty to report is helpful to family, friends and other visitors to long-term care homes who wish to report abuse and are able to point to a legal duty to do so, even if there is no corresponding penalty for failing to report. One of the many functions of law is to instruct the public on what forms proper conduct, and in this case mandatory reporting law is of assistance to those individuals.

Whistle-Blower Protection

The *Long-Term Care Act* provides that no person shall retaliate against another person, whether by action or omission, or threaten to do so because of the disclosure of information to an inspector or to the Director of long-term care, or for giving evidence in any proceeding in connection with the enforcement of the *Act*. Retaliation includes dismissing, disciplining or suspending a staff

[34] *Ibid.*, s. 24(5).
[35] *Ibid.*, s. 24(6).

member; imposing a penalty upon any person; and intimidating, coercing or harassing any person.[36]

The *Act* also addresses the technique of long-term care home management making problematic residents feel unwelcome to the point that they fear discharge or may in fact seek their own discharge from the home. The *Act* provides that “a resident shall not be discharged from a long-term care home, threatened with discharge, or in any way be subjected to discriminatory treatment” because of any disclosure or report, “even if the resident or another person acted maliciously or in bad faith, and no family member of a resident, substitute decision-maker of a resident or a person of importance to a resident shall be threatened with the possibility of any of those being done to the resident.” Discriminatory treatment includes “any change or discontinuation of any service or care of a resident or the threat of any such change or discontinuation”.[37]

The *Act* also provides that the long-term care home must have written procedures for handling complaints, and that every alleged, suspected or witnessed incident of abuse or neglect is investigated, reported to the Director of long-term care, and that appropriate action is taken.[38]

Police Response

Police forces throughout Ontario have had mixed responses to the zero-tolerance policies that are now combined with the mandatory reporting of elder abuse in Ontario long-term care homes. Police forces have described the implementation of these policies as a “steep learning curve”. Police forces want to be notified of reportable incidents of abuse and neglect in long-term care homes. However, the investigation of these reports can severely affect the staffing requirement of smaller police forces and detachments. In some quarters, the additional resources required for investigations of this type are difficult to

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[36] *Ibid.*, s. 26.
[37] *Ibid.*
[38] *Ibid.*, ss. 21-23.

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accommodate while operational aspects of police budgets are, at the same time, being reduced.

The crux of the problem for some homes and police detachments is the absence of guidelines and protocols, and the lack of a clear understanding as to what forms a reportable offence under a zero-tolerance policy. One of the most problematic areas is resident-on-resident violence, where the cognitive ability of the assailant, and perhaps the victim(s) of violence as well, is so severely compromised that it would be difficult if not impossible to form the intention to commit a criminal offence. Another difficult area is the fact of sexual relations involving cognitively impaired long-term care residents. It is difficult to know when behaviours that involve a cognitive impairment cross the line of criminality.

In some cases, an overburdened home may respond issues of resident-on-resident violence by simply turning the matter over to the police in hopes that the arrest and removal of an aggressive, cognitively impaired resident from the premises will relieve the home from taking other steps that might be needed to cope with the resident's responsive behaviours. In some sense, the arrest and criminal detention of a cognitively impaired older adult potentially forms an unsatisfactory substitute for a workable care plan in a long-term care home. In most cases, if an arrest were made, the older adult would eventually re-enter the long-term care system at a different home with much higher care needs due to the upset caused by intervening events. This merely transfers the managerial problems from one home to another. This dynamic creates an uneasy tension between the roles of the health-care and criminal-justice systems, with the police, the courts and long-term care homes on the front lines of the conflict.

Police forces throughout Ontario are presently developing training materials on the basis of case scenarios and previous examples of incidents that police have dealt with in the field. For example, the Ontario Provincial Police, the Durham Regional Police and partners including the University of Ontario Institute of Technology are presently developing e-learning materials on elder abuse that will include a segment on long-term care homes, with appropriate attention to the new zero-tolerance policies. These materials are intended to provide a means of

delivering consistent training to police throughout the province. Police working in the area are acutely aware that similar training is also needed for long-term care staff to make the zero-tolerance policies more effective.

From a practical point of view, it will also take time to gather statistics on how many incidents are being reported, how many charges are being laid, the time and resources taken to process charges and to measure the outcomes of the charges laid.

Conclusions

The new *Long-term Care Homes Act* is intended to transform the model of service delivery in Ontario in a way that prevents elder abuse and neglect. It contains a very strong statements of principles that support the right of long-term care residents to safe and secure surroundings free of abuse and neglect. It offers a progression of operational measures that starts with the screening, orientation and training of staff and volunteers; the development of zero-tolerance policies for abuse and neglect; the identification of responsive behaviours that may lead to resident-on-resident violence; and appropriate responses including the use of specialized behavioural units. It continues with a scheme of mandatory reporting of abuse and neglect in long-term care homes and provides whistle-blower protection, including protection from retaliation against any long-term care residents and their families, friends and substitute decision-makers. These measures are already causing necessary tension by adjusting the boundaries between the health-care and criminal-justice systems. The cumulative effect of these efforts is to signal a heightened sense of public importance and urgency to the prevention of the abuse and neglect of Ontario long-term care home residents. However, a full evaluation of the success of these measures can only be known in years to come.

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