

Situational Learning

Prevention of Neglect

RHRA

Retirement Homes Regulatory Authority

RHRA Retirement Homes Regulatory Authority

Contents

Introduction 2

About this Situational Learning Module 3

Prevention of Neglect 3

- Neglect – Definition 3
- Scenario One 4
  - Knowledge Check 1 4
  - Knowledge Check 2 5
- Scenario Two 5
  - Knowledge Check 1 6
  - Knowledge Check 2 6
- Scenario Three 7
  - Knowledge Check 1 7
  - Knowledge Check 2 8

Reflections 8

Conclusion 9

Still Have Questions? 9

Glossary 10

Resources 11

Introduction

Retirement homes that take the prevention of neglect seriously foster a culture of care.

Some steps that homes may take include monitoring actions essential to the prevention of neglect, such as meal census, wellness checks and in-person follow-up when a resident cannot be contacted.

Residents must be assessed appropriately to ensure care planning is thorough, and staff understand a resident's specific needs and preferences. Processes must be in place to ensure care services are being provided in accordance with the residents' plans of care.

Retirement homes that effectively prevent neglect:

- Put the care of retirement home residents first.
- Take time to understand each resident's needs, expectations and perspective.
- Ensure the comfort, respect, well-being and safety of each resident.

In other words, the retirement home effectively and continuously fosters a culture of care and promotes zero tolerance of abuse and neglect.

When staff and management are trained on their responsibilities, including how to recognize, report and respond to suspected, alleged or witnessed incidents of abuse or neglect, there is a **direct and positive impact on resident safety** in the home.

To help build this essential knowledge, the RHRA offers:

- A Guidance Document for Abuse and Neglect
- A set of four online situational learning modules, including this module

These RHRA learning resources are designed to assist operators in understanding the requirements of select portions of the Retirement Homes Act (the Act) and Ontario Regulation 166/11 (the Regulation). They are not, and do not replace, the home-specific training that is required by the Act and the Regulation.

If anything in this guidance conflicts with requirements in applicable legislation regulations or any other provincial requirements, those requirements prevail and retirement homes must follow them.

About this Situational Learning Module

This module, Prevention of Neglect, is designed to build your understanding of:

- How to recognize neglect in a retirement home setting
- When and how to report and respond to suspected, alleged or witnessed incidents or patterns of neglect
- Responsibilities in relation to the protection of residents from harm, including any form of abuse and neglect
- Available information resources

Prevention of Neglect

Neglect – Definition

Neglect is defined as the failure to provide a resident with the care and assistance required for their health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

- This definition is broad, and it should be interpreted liberally with a focus on resident protection.
- If staff suspect that a resident may be being neglected by an external caregiver and fail to intervene or take reasonable steps to protect the resident and prevent neglect, the staff's failure to act may itself constitute "neglect".
- This provision does not apply if a resident is absent from the retirement home, unless the resident continues to receive care services from the staff of the home (e.g., a resident who receives assistance with ambulation goes on an outing with staff from the home. The staff are responsible to continue providing assistance with ambulation even though the resident is outside of the home).

Source: *The Guidance Document for Abuse and Neglect*

Under the Retirement Homes Act (the Act) and Ontario Regulation 166/11 (the Regulation), licensees must ensure that the licensee and the retirement home staff do not neglect residents of the home. Additionally if staff suspect or become aware that a resident is being neglected by an external care provider, the home must take action to protect the resident and immediately investigate the incident. This may include notifying responsible parties, such as the manager for the external care provider.

Scenario One

Shortly after Christmas, John was moved to the assisted living floor of his retirement home after his dementia progressed, further impacting his short-term memory.

For two weeks, progress notes indicated that John was experiencing increased incidents of wandering and exit-seeking behaviour, especially during the afternoon and at night. Staff were instructed to re-direct him if he was found wandering or trying to leave the building.

The home did not contact John's family about his behavioral changes or to participate in updating his plan of care as required.

In addition, the home did not inform John's physician or contact any relevant experts to assist with effective interventions.

The next week, after lunch, John left the home through a side door. Throughout the afternoon, staff at the home were unaware that John was not in the building. Then, despite documenting that he was missing during the dinner meal census, no one checked to see if he was in his room.

John was found several hours later by the police who took him to the hospital to be assessed for symptoms of hypothermia.

Knowledge Check 1

Why does this scenario meet the definition of neglect?

- ☐ The side door should have been locked.
- ☐ The home demonstrated a pattern of inaction resulting in harm to the resident.
- ☐ John's family was not informed about his behaviour change.
- ☐ All of the above

→ **Correct Answer:** The home demonstrated a pattern of inaction resulting in harm to the resident.

Rationale/Reasoning

This scenario meets the definition of neglect because the home demonstrated a pattern of inaction resulting in harm to the resident.

In this scenario, the home was aware that John was experiencing increased episodes of exit seeking and wandering during the afternoon and at night. However, the home did not inform John's family or update his behaviour management strategy to include extra measures to keep him safe, such as increased monitoring.

The home's failure to take action to address John's exit seeking behaviour made it easier for John to leave the building and remain missing for several hours, jeopardizing his health and safety.

In addition, the home failed to take action to locate John as soon as the meal census revealed he did not attend dinner.

Knowledge Check 2

How does an annual evaluation of a home's zero tolerance of abuse and neglect policy assist in preventing incidents like John's from happening in the future?

- ☐ An annual evaluation can help identify trends or root causes pertaining to specific residents and/or staff.
- ☐ An annual evaluation exercise can help identify areas where re-training is needed.
- ☐ The insight gained from an annual evaluation provides opportunities for the home to make meaningful changes that help create a safer environment for residents.
- ☐ All of the above.

→ **Correct Answer:** All of the above

Rationale/Reasoning

All of the answer options apply.

Retirement homes must evaluate their abuse policies and the policy's effectiveness at least once every calendar year.

The evaluation must consider each incident of abuse or neglect that occurred during the year to determine what changes and/or improvements are required to prevent similar incidents from happening again.

Completing an annual evaluation can help the home identify: trends and root causes pertaining to specific residents and/or staff. It can also help the home identify where re-training is needed (such as, in this scenario, behavior management planning) and if the home's abuse policy itself needs to be updated.

Insights gained from an annual evaluation provide opportunities for the home to make meaningful changes that help create a safer environment for residents.

Scenario Two

For over a year, Irene has lived at a retirement home on an independent-living floor for residents with minimal care needs. Meals are optional for residents on this floor, as many choose to go out or eat in their rooms.

Also on this floor, the home completes daily wellness checks, either by phone or by checking the resident's room.

One Wednesday afternoon, a wellness staff member called Irene's room for her daily wellness check. Irene answered, said hello, and then the call abruptly ended. The staff member phoned back and received a busy signal. Irene was known to talk on the phone with family throughout the day, so the staff member didn't phone back again that day.

The next day, another wellness staff member phoned Irene and received a busy signal. Then, the same thing happened on Friday. During Friday lunch when Irene did not appear, dining staff

asked Irene's neighbor, John, if he had seen her. John said he remembered seeing Irene walking near the activity room earlier in the week.

On Friday evening, Irene's daughter came to pick her up for a family outing. She found her mother lying on the floor near the night table where the telephone receiver was located off the hook. Irene was unconscious and had dried blood on her head.

Knowledge Check 1

Does this scenario indicate neglect of a resident by the home?

Yes or No

→ **Correct Answer:** Yes

Rationale/Reasoning

Yes, this scenario indicates neglect of a resident by the home.

Neglect is defined as the failure to provide a resident with the care and assistance required for their health, safety or well-being.

While the home attempted to contact Irene, they failed to take adequate steps to verify her health and well-being as required in their wellness check policy.

If prompt in-person follow-up had been done and Irene was provided with immediate medical attention, she would have been protected from neglect.

Knowledge Check 2

In this scenario, when did the retirement home's pattern of inaction begin?

- ☐ After the Wednesday phone call abruptly ended
- ☐ After the wellness check phone calls that went unanswered on Thursday and Friday
- ☐ During Friday lunch when Irene did not appear
- ☐ All of the above

→ **Correct Answer:** After the Wednesday phone call abruptly ended

Rationale/Reasoning

The retirement home's neglect of Irene began after the Wednesday phone call abruptly ended.

In this question, while all of the answer options address the home's pattern of inaction, the retirement home's inaction started when the staff member who made the daily wellness check on Wednesday did not follow-up in accordance with their policy to ensure Irene's safety and well-being that day.

The purpose of wellness checks is to verify the health and well-being of residents and ensure they are accounted for. The implementation of meal census or daily wellness checks are ways that this can be accomplished.

When a resident does not appear for a meal or cannot be contacted or located, the retirement home should take immediate action to confirm the resident's safety and well-being.

If a home advises residents that it will conduct wellness checks, those wellness checks must be completed appropriately.

Scenario Three

While administering medication, a staff member discovered that medication to be dispensed daily at lunch to a diabetic resident, Don, had not been administered for a week. The week's supply of Don's medication was still in the blister pack in the medication cart. However, the staff member working that week had signed Don's medication administration record to indicate they'd properly dispensed all of Don's medication.

Progress notes on Don's health record indicated that Don's blood sugar levels were elevated, causing him to experience nausea, vomiting, shortness of breath and loss of consciousness that resulted in a hospital visit.

It was determined that one staff member was routinely signing medication administration records at the end of their shift instead of signing each record immediately after administering a resident's medication.

Knowledge Check 1

Can a failure to properly administer medication count as neglect?

Yes or No

→ **Correct Answer:** Yes

Rationale/Reasoning

Yes, a failure to properly administer medication can count as neglect.

Neglect means the failure to provide a resident with the care and assistance required for his or her health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

In this scenario, although it may have been accidental, the failure to provide the care service of medication administration, which was required for Don's health, and the pattern of inaction related to inaccurately documenting medication administration resulted in the resident's health deteriorating and the need for hospitalization.

The staff member routinely demonstrated improper care by signing off for medications that were not provided to the resident. And also demonstrated inaction by routinely failing to

administer the medication as per the physician's order, jeopardizing the health and well-being of the resident.

Knowledge Check 2

In this scenario, what step should the home take to help prevent a similar situation from reoccurring?

- ☐ Retrain staff on policies and procedures and conduct internal audits to verify staff are complying.
- ☐ Put the staff member on a temporary leave.
- ☐ Ask the residents to document when they've received their medications.
- ☐ All of the above

→ **Correct Answer:** Retrain staff on policies and procedures and conduct internal audits to verify staff are complying.

Rationale/Reasoning

To help prevent a similar situation from reoccurring, the home should retrain staff on policies and procedures and conduct internal audits to verify staff are complying.

This scenario presents an opportunity for the home to provide retraining on policies and procedures.

The legislation offers the minimal requirements for staff training, which is annually for medication administration.

Homes are encouraged to retrain staff as often as needed, so that staff are empowered to carry out their duties with a high level of competence.

Reviewing policies provides an opportunity to identify possible gaps in existing policies/procedures and allows for the implementation of meaningful changes.

Conducting internal audits helps management confirm that staff re-training has been effective.

Reflections

Reflecting on the scenarios in this module and what you've learned, consider the following additional questions.

1. How can the retirement home meet the level of care needed when a resident declines additional care services?
2. What makes Scenario Three an example of neglect?

Please refer to the ***Scenario Reflections - Prevention of Neglect*** document to view some answers and considerations.

Conclusion

We hope this module helps reinforce a culture of care in your retirement home.

1. Given the information learned, what more can you do in your home to build and support a culture of care?
2. How can you ensure the well-being, safety and protection of residents in the retirement home where you work?
3. Is there an opportunity to work through and discuss this module with the management team and staff?

Follow-up, as needed, to ensure that you fully understand your responsibilities and obligations regarding **the prevention of neglect of residents.**

Still Have Questions?

If you have any questions or would like to discuss education opportunities, please contact the **Retirement Homes Regulatory Authority** by calling 1-855-275-7472 or visiting the website at www.RHRA.ca.

Please complete this short survey. Thank you for your feedback.

Glossary

Abuse
The Act and Regulation outlines and defines five different types of abuse: Emotional abuse, verbal abuse, physical abuse, sexual abuse and financial abuse.

Incident
Alleged, suspected or witnessed abuse or neglect of a resident(s), and/or other behaviour that results in harm or risk of harm to the resident(s).

Investigation
An investigation may require interviewing multiple people (including the alleged victim), taking photographs of evidence, reviewing records, documents and video footage and keeping copies.

Mandatory Reporting
One of the ways the law protects retirement home residents is by requiring people to immediately report to the RHRA if they have reasonable grounds to suspect harm or risk of harm to a resident has occurred or may occur. This requirement is called mandatory reporting.

Mandatory reporting must happen immediately and should not wait until an investigation has been completed.

Neglect
Neglect is defined as the failure to provide a resident with the care and assistance required for their health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.

Protection
When there is a report of suspected abuse or neglect, the Licensee must take immediate steps to ensure the resident is protected. These steps may include immediate separation of the resident from the alleged abuser, physical and mental assessment, medical attention, counseling and increased monitoring.

Reasonable grounds to suspect
A person has "reasonable grounds to suspect" when they have information that would lead an average person, using normal and honest judgment, to believe that abuse or neglect occurred or may occur.

Resident
A person who lives in a licensed retirement home.

Retirement Home
A residential complex or part of a residential complex which has been licensed to operate as a retirement home by RHRA.

Substitute Decision Maker (SDM)
A person who is legally authorized to make a decision or to give or refuse consent on behalf of another person when required. This could, for example, include a Power of Attorney (POA).

Whistle-blowing Protection
It is a contravention of the Act to retaliate or threaten to retaliate against another person, whether by action or omission, because that person has disclosed anything to the Registrar or an inspector or has provided evidence.

Zero Tolerance
T

Resources

RHRA Guidance Document for Abuse and Neglect

Scenario Reflections - Prevention of Neglect

Retirement Homes Act (the Act)

Ontario Regulation 166/11 (the Regulation)

Elder Abuse Prevention (ON)

Behavioural Supports Ontario (BSO)

The Advocacy Centre for the Elderly (ACE)

Alzheimer's Society of Ontario


RHRA
Retirement
Homes
Regulatory
Authority

Scenario Reflections

Prevention of Neglect



How can the home meet the level of care needed when a resident or the resident's SDM declines additional care services?

- Homes are encouraged to have systems in place that can assist in identifying when a resident may need assistance.
- Residents have varying care needs. Depending on the home, it can be more challenging to account for residents who do not utilize care services.
- Difficult situations may arise when residents or families refuse to accept or pay for services that may be necessary to protect resident wellbeing. In these situations, the home should document:
  - Details and dates of related conversations that occurred with the resident, their family or power of attorney and the physician
  - The steps recommended to protect the resident and options that may be considered
- In situations where all options have been exhausted and the required care cannot be arranged or provided by the home, the home must provide a list of alternate accommodations.

What makes Scenario Three an example of neglect?

- Neglect is defined as the failure to provide a resident with the care and assistance required for their health, safety or well-being and includes inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents.
- In this scenario, the staff member failed to administer a drug required for the resident to maintain their health and wellbeing. The staff also demonstrated a pattern of inaction by routinely signing the medication administration record without verifying if the medications had been given, as per the physician's orders, resulting in a hospital visit.