

Situational Learning

Protection from Physical Abuse and Sexual Abuse

RHRA
Retirement Homes Regulatory Authority

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Introduction

Retirement home residents thrive when management and staff prioritize and proactively support a culture of care.

A culture of care means that you:

- 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.
- Are knowledgeable about how to protect residents from harm, including any form of abuse or neglect.
- Follow the requirements in the abuse policy to help identify root causes and possible risk factors.
- Immediately investigate concerns about potential abuse and neglect.
- Implement strategies to prevent any abuse from happening again, ultimately protecting residents.
- Create an environment where everyone has the confidence to speak up about resident safety concerns and trust that these concerns will be addressed.

When residents know that homes are committed to taking incidents of abuse and neglect seriously, it helps create a culture where residents feel safe and comfortable in the environment they live in.

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, Protection from Physical Abuse and Sexual Abuse, is designed to build your understanding of:

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

Protection from Physical Abuse

Physical Abuse - Definition

Physical Abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain, administering or withholding a drug for an inappropriate purpose, or the use of physical force by a resident that causes physical injury to another resident.

- It is important to note that physical abuse does not include incidents where the use of force is appropriate to the provision of care or assisting a resident with activities of daily living, unless the force used is excessive in the circumstances.
- Incidents of abuse where a drug is withheld includes intentionally withholding the drug without a physician's order.
- Incidents of physical abuse between residents are to be treated the same no matter the cognitive ability of the residents involved. A resident's cognitive impairment does not alleviate the licensee's responsibility to investigate alleged, suspected or witnessed incidents of abuse and follow all requirements in the abuse policy.
- Even if an incident of abuse appears to be unintentional, the home still needs to fully implement their abuse and neglect policy.
- Failure to take appropriate action, including taking appropriate steps to protect residents from further abuse may result in findings of non-compliance and enforcement action.

Source: *The Guidance Document for Abuse and Neglect*

Under the Retirement Homes Act (the Act) and Ontario Regulation 166/11 (the Regulation), licensees must protect residents from abuse by anyone and prevent neglect by the home's staff.

Scenario One

Scenario One: Betty, a resident at a retirement home, has dementia and often resists receiving care from staff.

One afternoon, a staff member was assisting Betty with bathing. Betty struck the staff member on the nose. When struck, the staff member instinctively tried to distance herself, and, in doing so, pushed Betty, causing her to fall.

The fall caused stiffness and soreness in Betty's lower back.

Knowledge Check 1

Since there was no visible bruising or physical injury observed during this incident, does the retirement home need to investigate this interaction between Betty and the staff member as an incident of alleged, suspected, or witnessed abuse?

Yes or No

→ **Correct answer:** Yes

Rationale/Reasoning

Yes, the retirement home does need to investigate this interaction between Betty and the staff member as an incident of abuse.

Physical abuse is defined as the use of physical force by anyone other than a resident that causes physical injury or pain.

Even though the staff member's actions may have been an instinctive response to being struck and not intended to cause harm to the resident, the staff member's use of force resulted in stiffness and soreness (pain) in Betty's lower back.

Therefore, a thorough and immediate investigation is required to determine whether this scenario meets the definition of physical abuse.

In this scenario a thorough investigation could reveal that there is a history of resident complaints relating to this staff member being "rough" during care.

It could result in the home implementing additional support for this resident, such as a two person assist during bathing or including personal bathing preferences of the resident during baths to reduce agitation.

A thorough investigation could provide an opportunity to evaluate behaviour management strategies. If interventions are not effective, the home should reassess the resident and update their behaviour management strategy.

Identify that additional training is needed, to help the staff member respond more effectively to Betty's aggression.

A thorough approach helps to identify root causes and positively impacts resident care and well-being.

- ❖ Please refer to page 13 in the ***Guidance Document for Abuse and Neglect*** for information on how to conduct a thorough investigation.

Knowledge Check 2

During its investigation, the Home determines that the staff member has had multiple incidents of being rough with residents. Would this incident need to be reported to the RHRA?

Yes or No

→ **Correct answer:** Yes

Rationale/Reasoning

Yes, this incident would need to be reported to the RHRA.

The staff member's use of force made in response to Betty's act of aggression resulted in the resident falling and sustaining harm.

If you see or suspect that any of the following has occurred or may occur, you must immediately report the suspicion and the information on which it is based to the RHRA:

Mandatory Reporting obligations

If you see or suspect that any of the follow has occurred or may occur, you must immediately report the suspicion and information on which it is based to the RHRA:

1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident
2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or risk of harm to the resident
3. Unlawful conduct that resulted in harm or risk of harm to the resident
4. Misuse or misappropriation of a resident's money

You must report it to the Registrar of the **Retirement Homes Regulatory Authority** (by calling 1-855-275-7472 or on the website www.RHRA.ca) along with any other relevant information which may include:

- names of involved persons, and dates/times of incidents;
- the nature of any injuries or other harm sustained;
- actions taken or planned by the home to investigate, address and reduce any risk of harm (if available);
- any relevant historical information relating to the persons involved.

Scenario Two

Two married residents, David and Judy, live in the same suite at their retirement home.

Following the onset of dementia, Judy began having episodes of aggression towards David. Though her behaviour caused multiple injuries to David that required medical attention, David advised the home's staff that he did not want to report the incidents or take any action against his wife.

The home advised that they would monitor the situation by listening at the door when Judy and David were heard arguing. No further action was taken.

The situation continued over several months. Then one day, David was injured with a knife used by Judy and had to be hospitalized.

Knowledge Check 1

Given that Judy has dementia, answer the following two questions.

Do Judy's actions that caused injury to David meet the definition of physical abuse? What other concern relating to abuse does this scenario present for the retirement home?

- ☐ Yes, her actions are physical abuse. Another concern is the home failing to document David's wishes to keep the matter private.
- ☐ Yes, her actions are physical abuse and the home failed to protect David from abuse.
- ☐ No, given Judy's dementia, her actions are not physical abuse. Another concern is the home's failure to separate the residents after the first incident.

→ **Correct answer:** Yes, her actions are physical abuse and the home failed to protect David from abuse.

Rationale/Reasoning

Yes, her actions are physical abuse and the home failed to protect David from abuse.

Incidents of physical abuse between residents are to be treated the same no matter the cognitive ability of the residents involved. A resident's inability to remember details of an incident or understand the consequences of their actions due to cognitive impairment does not impact a finding of abuse or the follow-up action required when incidents of abuse occur.

In this example, the retirement home was required to report and investigate the first incident to allow for the implementation of meaningful changes to prevent further incidents of abuse from occurring.

By failing to investigate and implement any changes, the home failed to protect David from abuse.

A comprehensive investigation and follow-up may have helped to ensure that David was protected from further harm, and that Judy's needs related to dementia were being met.

Examples of actions that could have been taken for each resident:

Actions – Judy

The home could have taken several courses of action for Judy including: contacting Judy's substitute decision maker, if it is not David, to make them aware of the situation and to discuss support strategies, having an assessment completed, implementing a behaviour management strategy, referring to a physician and/or requesting a medication review.

A comprehensive investigation and follow-up approach could have ensured that Judy's needs related to dementia were being met.

Actions – David

For David, the home could consider referrals to external organizations, such as those with expertise in intimate partner violence and dementia, to support him in coping and understanding the challenges around living with a person with dementia.

A comprehensive investigation and follow-up approach could have protected David from further harm.

Knowledge Check 2

The home did not report the altercations resulting in harm to the RHRA because the altercations occurred between two married residents, one of whom had dementia and the other requested to keep the matter private. Was the home compliant with its zero tolerance of abuse policy?

Yes or No

→ **Correct answer:** No, the home was not compliant.

Rationale/Reasoning

Even if a resident does not want involvement from outside parties, retirement homes are required to adhere to the abuse policy and the Act, including the duty to immediately report to the RHRA.

When the abuse policy is followed after each incident, it provides an opportunity for the home to keep residents safe by implementing measures to prevent further incidents of abuse from occurring.

Protection from Sexual Abuse

Sexual Abuse - Definition

Sexual Abuse is defined as any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

- Touching, behaviour or remarks of a clinical nature that are appropriate to the provision of care or assisting a resident with activities of daily living do not meet the definition of sexual abuse.
- Incidents of sexual abuse between residents are to be treated the same no matter the cognitive ability of the residents involved.
- A resident's cognitive impairment does **not** alleviate the licensee's responsibility to investigate and follow all requirements in the abuse policy.
- Even if an incident of abuse appears to be unintentional, the home still needs to fully implement their abuse and neglect policy.
- Failure to take appropriate action may result in findings of non-compliance and enforcement action.

Source: *The Abuse and Neglect Guidance Document*

Under the Retirement Homes Act (the Act) and Ontario Regulation 166/11 (the Regulation), licensees must protect residents from abuse by anyone and prevent neglect by the home's staff.

Scenario One

Scenario One: Sarah, a resident at a retirement home, reported to the General Manager that another resident, Richard, had kissed her without her consent. Sarah described feeling uncomfortable and fearful.

The General Manager spoke with Richard who was apologetic. Richard said he was struggling to cope with the recent loss of his wife. He understood that his actions were inappropriate and promised that it would not happen again.

The General Manager then met with Sarah and explained that Richard had just lost his wife, feels badly and did not mean to cause her any harm. Sarah expressed empathy for Richard's situation.

Given these conversations, the General Manager considered the incident closed.

Knowledge Check 1

Did the General Manager appropriately follow the abuse policy in the case of an alleged incident of sexual abuse?

Yes or No

→ **Correct Answer:** No

Rationale/Reasoning

No, the General Manager did not appropriately follow the abuse policy in this scenario.

While the home spoke with both residents, the home failed to follow all requirements in the abuse policy, such as: reporting to required parties, providing support to Sarah, implementing measures to manage Richard's behaviour, identifying root causes and possible risk factors, or taking action to address and prevent the abuse from recurring.

Knowledge Check 2

Should the home have implemented strategies to address and prevent abuse in this scenario?

- ☐ Yes, for both residents
- ☐ Yes, for Richard
- ☐ No, because the General Manager believes a resolution was achieved.

→ **Correct Answer:** Yes, for both residents

Rationale/Reasoning

Yes, the home should have implemented strategies to address and prevent abuse for both residents.

The home should further assess Sarah's feelings and concerns to determine interventions that may be needed for her to feel safe in her home.

The home should also consider steps to assess Richard's mental state and explore support options, such as grief counselling to help Richard process the loss of his wife and address the potential causes of his behaviour.

The home should also implement heightened monitoring given the situation.

Scenario 2

Two residents, Liz and Matthew, were found to be engaging in a sexual relationship.

Before starting the relationship, Liz had been diagnosed with moderate dementia. Matthew has no history of cognitive impairment.

After becoming aware of the relationship, the home interviewed both residents and met with their families to discuss the situation.

Matthew's family was supportive of the relationship. Liz's family, on the other hand, did not approve of the relationship and advised the home that they did not want the residents to be alone together. Liz's family also voiced concerns that due to Liz's dementia diagnosis, she was being sexually abused by Matthew.

The home asked Liz about the relationship and, while she cannot recall details due to her dementia, she does speak fondly of Matthew and expresses her desire for his companionship.

Knowledge Check 1

Does this situation need to be investigated as alleged sexual abuse?

A. Yes, because Liz has dementia and Matthew does not.
B. No, because Liz's dementia diagnosis does not mean she is unable to provide consent.
C. Yes, because Liz may lack capacity and Liz's family has alleged sexual abuse.
D. Both A and C

→ **Correct Answer:** C: Yes, because Liz may lack capacity and Liz's family has alleged sexual abuse.

Rationale/Reasoning

Yes, this situation requires an investigation for possible sexual abuse because Liz may lack capacity and Liz's family has alleged sexual abuse.

Homes are required to follow up on all reports of alleged and witnessed abuse.

Just because a resident has cognitive impairment doesn't mean the resident is incapable of consenting to an intimate relationship.

Adhering to measures outlined in the abuse policy, such as completing an investigation, allows for information to be gathered to determine if the allegation is substantiated, and take any further action to protect the resident.

If the Home suspects that sexual abuse took place, it must report it to the RHRA immediately.

Knowledge Check 2

Should Liz's family's wishes to keep them separated override Liz's desire to continue her relationship with Matthew?

Yes or No

→ **Correct Answer:** No

Rationale/Reasoning

No, Liz's family's wishes to keep them separated does not override Liz's desire to continue her relationship with Matthew.

Residents are entitled to personal autonomy. The Resident Bill of Rights acknowledges that residents have the right to live in a way that fully respects residents' dignity, to have their lifestyle and choices respected and to freely pursue their social interests.

Even though Liz has dementia, it is still her right to decide to engage in relationships, including intimate ones. This choice should be respected by the home.

Just because a resident may lack capacity at times to make certain types of decisions, for example with respect to financial matters or health care decisions, does not mean the person lacks capacity to make other decisions about their life.

The home should remain vigilant and monitor for any cognitive changes that may put Liz at risk of abuse.

Since these situations are often challenging, connecting with external organizations for support may be required and helpful to ensure residents are protected from potential abuse.

Reflections

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

1. Why is it important to report incidents of abuse to the RHRA?
2. Would any of the incidents described in these scenarios need to be reported to the police?
3. Are all sexual relationships between two residents, where one resident has dementia, a form of sexual abuse?

Please refer to the ***Scenario Reflections - Protection from Physical Abuse and Sexual Abuse*** document to view some answers and considerations.

Conclusion

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

Given the information learned, what more can you do in your home to build and support a culture of care?

How can you ensure the well-being, safety and protection of residents in the retirement home where you work?

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 protection of residents from all forms of abuse by anyone.

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
To never tolerate, allow or ignore abuse or neglect of a resident.

Resources

RHRA Guidance Document for Abuse and Neglect

Scenario Reflections - Protection from Physical Abuse and Sexual Abuse

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


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Scenario Reflections

Protection from Verbal Abuse and Emotional Abuse



Who is required to report abuse to the RHRA?

With the exception of residents, **all persons are obligated to immediately report situations of resident harm or risk of harm to the RHRA**. These are called mandatory reports. All persons include:

- Family members
- Substitute decision makers (SDMs)
- Volunteers
- Visitors
- Retirement home staff
- Retirement home operators and licensees
- Regulated Health Professionals such as doctors, nurses and social workers must also report incidents of harm or risk of harm to the RHRA, even if the information is confidential.

The failure of certain persons to make a report is an offence under the Act. If you witness or suspect that any of the following has occurred or may occur to a resident of a retirement home, you must report it to the **Registrar of the Retirement Homes Regulatory Authority**:

- Improper or incompetent treatment or care
- Abuse of a resident by anyone
- Neglect of a resident by staff of the retirement home
- Unlawful conduct
- Misuse or misappropriation of a resident's money

In cases where there is uncertainty, homes are encouraged to err on the side of caution.

Relevant information when reporting may include:

- names of involved persons, and dates/times of incidents;
- the nature of any injuries or other harm sustained;
- actions taken or planned by the home to address and reduce any risk of harm (if available);
- any relevant historical information relating to the persons involved.

Can people be penalized for making a report to the RHRA or the police?

While a mandatory report may be made anonymously, the *Retirement Homes Act, 2010* protects people who report or provide information to the Registrar from any retaliation.

For more detail see *Fact sheet: Whistle-Blowing Protection* on the RHRA website.

Scenario Reflections

Protection from Verbal Abuse and Emotional Abuse
(Continued)



What other steps can retirement homes take to support residents harmed by verbal or emotional abuse and ensure care needs are met?

- Homes must follow their abuse policy for addressing the person who has committed the abuse.
- In situations where a resident may not be able to recall the details of an incident, increased monitoring following the incident can help to identify possible behavioural changes such as aggression, wandering, fearfulness and sadness. If behavioural changes are identified, written strategies must be developed and implemented to monitor and respond to the behaviours.
- When behavioral changes are noted, residents should be reassessed, and their plan of care should be updated.
- In instances where emotional or verbal abuse has occurred between two residents, an assessment of the resident who committed the abuse is required. The assessment can help determine if there are underlying causes for the behaviour, such as cognitive impairment or medical issues such as a urinary tract infection. The findings from the assessment should be updated in the resident's plan of care.
- There is a potential for power imbalances to exist between staff and residents since residents rely on staff to provide care, food and social activities. It is important to be mindful of how words can negatively impact a resident even in instances when they might not be intentional.
- To use an example from this module relating to Joan, who experienced emotional abuse from a Dietary Aide due to her shaking that resulted in spilled food, the home should ensure that an assessment is completed to determine what changes in care services Joan requires. Further, Joan's plan of care should be updated with clear directions to staff on how to assist her during meals and include details of what that assistance involves. Joan and/or any other person that she designates, such as an SDM, should be offered an opportunity to participate in the development of her plan of care to ensure Joan is provided with the level of care that she wants and needs and is satisfied with the measures put in place.

Scenario Reflections

Protection from Verbal Abuse and Emotional Abuse

(Continued)



In Scenario Two: Protection from Emotional Abuse involving a stranger entering the retirement home, what other reasonable steps could the home have taken to address resident safety concerns, after the individual was apprehended?

- It is reasonable for the home to learn lessons from the incident, including implementing a visitor sign-in log, video surveillance or other safety processes.