

Seeking Action for Safety in Long Term Care Facilities

Response to the

W5 Documentary, *Crisis in Care* aired on CTV February 9, 2013

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Action for Safety is being sought in response to the February 9 2013 W5 documentary, **Crisis in Care** reported by Sandi Rinaldo and the CTV team of investigators. This investigation uncovered horrific statistics and stories of abuse taking place in Long Term Care facilities in Canada. The focus was on residents with dementia assaulting and killing other residents.

Incidents where residents with dementia in Canadian Long Term Care Facilities harm or kill other residents are unfortunately not new stories. For instance, there was a 2011 CBC report in Manitoba and a report of a Quebec resident to resident assault leading to death in Lisa Priest's 2004 Globe and Mail report (See References to read more on these stories).

Another W5 staff member Melissa Martin, in a CTV news investigation reported a 2007 killing in Sudbury, Ontario. The resident was killed by his 55 year old roommate who was a chronic schizophrenic with a history of not complying with his medication.

After analyzing the data in 2012, Martin reported that experts declare that "residents with aggressive behaviors should not be placed in care facilities alongside the frail elderly. However, with the closure of psychiatric hospitals and group homes, there really is nowhere else for these patients to go."

There was widespread media press back in 2001 about a resident killing another resident at Casa Verde, a Long Term Care facility in Toronto, Ontario. Following up from the 2001 Casa Verde incident, there were 85 recommendations made in 2005 at a Coroner's Inquest to assure that the vulnerable residents in Long Term Care are in a safe environment. The recommendations included increased staffing, education, funding, and specialized units in Long Term Care. It is wonderful to make recommendations but how well are they being implemented to assure a safe environment for our most vulnerable?

The Casa Verde incident occurred in 2001, the recommendations from the Coroner's Inquest came out in 2005 and here it is 12 years later-same story in the 2013 W5 documentary. Does this mean that we will see and hear this story again in 2025 or sooner?

Individuals who provide care to family members with dementia in the community have a difficult enough time as it is providing unpaid care and when there is no other option, they then make the choice to move their family members into Long Term Care. This process alone is extremely emotional and requires many discussions before a final choice is made, leaving them grief ridden, weak, often burned out and questioning their decision.

Hearing such horrific stories is harmful for the caregivers since it raises their own fears, guilt and concerns, acting on behalf of their family members with dementia. The idea of putting their vulnerable family member's safety at risk can also potentially put their own overall health at risk.

Dramatized documentaries such as W5, Crisis in Care gives family members a false sense of what the Long Term Care environment is predominantly like, discounting that there are hardworking, caring and overworked staff in these facilities and that administrators make every effort to assure a safe and comfortable environment. From professional experience, it has been observed that many people with dementia are safer and better cared for in the Long Term Care Facilities than they would be if they were in the community with their families.

Susan Lambert is a nurse and a family care provider for her father who was interviewed by Dr. Brian Goldman on his radio program *White Coat, Black Art* after her father was beaten in a Long Term Care Facility. After the assault there was more of a family presence in the residence. Family member involvement as part of the team, although not the optimum remedy for staff shortage, can be helpful.

In order to avoid future acts of violence, we seek solutions. Bringing this old story of violence in Long Term Care back to light is an opportunity to implement solutions, such as increased staffing, in a timely manner to assure safety for our most vulnerable. (See References: thestar.com Ending Violence in Seniors Homes, Readers Letters). Some other suggestions to *assist* in obtaining effective solutions are:

1. Those participating in making needed changes must be educated and have or receive insight into the nature of the disease – dementia. In her 2004 article, Priest quoted David Sedran, the Casa Verde coroner:

"It is scary, but unfortunately aggressive behaviour and dementia go hand in hand.

It's part and parcel of the disease."

In their 2005 position paper, the Alzheimer Society of Ontario made a valid point that not all people with dementia are aggressive. Aggression may be more likely to occur, though, in a unit where there are so many people with dementia and there is a low staff to resident ratio. A helpful strategy to alert staff may be having the aggressive residents wear a bracelet signaling staff if they have left their room at night & their whereabouts.

2. Those participating in making change must understand the culture in Long Term Care, what is “normal” in Long Term Care is not the “norm” in the community. For many it is like entering into a foreign country where they cannot speak the language. For instance, it is common for individuals in the late stage of dementia to be sleeping for over 75% of their day. It would not be unusual for people visiting a Long Term Care residence for the first time to think that those with dementia sleeping have been highly medicated.

3. *Acknowledge* and *assess* the initiatives that have been made to date to assure safety since the 2001 Casa Verde incident. For instance, in Ontario, there has been extra staff training and crisis support on responsive behaviors implemented through the Behavior Supports Ontario Program. How is this program working and does it need to be improved, expanded, or modified?

4. Those participating in making change are working together, *assisting* one another towards a common goal. Rather than finger pointing and blaming others, focus on action towards solutions. As the famous quote states,

“If you are not part of the solution, you are part of the problem!”

For the cause of assuring safety in Long Term Care, it means the coming together of expertise including the appropriate government officials, community agency workers, Long Term Care administration, frontline staff, family caregivers, researchers.....and the media.

In conclusion, here is a passage from the Alzheimer Society of Ontario’s 2005 paper supporting the Casa Verde inquest recommendation, on groups coming together which they call an Inter-Association Task Force coming out from the coroner’s report as a

.... call for a plan (or” framework”) to assure proper standards, funding tracking and accountability in Long Term Care. We support this recommendation because we believe a framework is needed to be in place in order to support resulting changes that will develop. We are asking that an Inter-Association Task Force be convened at the earliest possible moment with representatives from the Ministry of Health and Long Term Care and all relevant provincial agencies.....

...We believe that the Inter-Association Task Force will establish a partnership with common goals which will ultimately strengthen the government’s commitment to effect change in long term care and would ensure the safety of one of the most vulnerable groups in our society....

Do you think it is time for Canada to work on a National Strategy on resident-to-resident abuse in Long Term Care Facilities? A framework would provide each province with some direction in terms of prevention and management of this devastating and growing problem.

Perhaps Sandi Rinaldo and her team at W5 would be willing to follow-up from their story **Crisis in Care** to assure **Action for Safety in Long Term Care Facilities** to protect our most vulnerable.

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