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A snapshot violence in home and residential long-term care in Manitoba

RACHEL HERRON, PRINCIPAL INVESTIGATOR
SHELBY DOELL, RESEARCH ASSISTANT

Acknowledgements

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The Safe Places for Aging and Care Team includes:
Katie Aubrecht, Co-Investigator
Douglas Brownridge, Co-investigator
Laura Funk, Co-investigator
Christine Kelly, Co-investigator
Dale Spencer, Co-investigator
Lori Weeks, Co-investigator

For More Information

Please Visit our Website:
https://www.safeplacesproject.com/

Contact:
Dr. Rachel Herron at
herronr@brandonu.ca

EXECUTIVE SUMMARY

Why this research is important?

Long term care should be a safe place to work and a safe place to receive care. Yet, violent situations happen in long-term care facilities and home care. Violence can cause physical, psychological and emotional harm to staff. At the same time, being labelled as violent or difficult can impact older adults' sense of self, care relationships, and quality of care. There is an urgent need to address different forms of violence and strengthen violence prevention strategies for the wellbeing of staff and older adults. To do this, it is important to understand the conditions surrounding violence. The Safe Places for Aging and Care Project, is a four year project based out of Brandon University that focuses on understanding how and why features of care environments influence violent situations.

How the research was conducted?

The Safe Places project involves multiple methods and phases (e.g., document analysis, surveys, interviews, diaries, and observations). This report summarizes the findings of an online survey that was conducted across Manitoba from July 2021 to April and 2022. Respondents were recruited through listservs (e.g., unions), long-term care and aging websites, and social media advertisements. Respondents were asked questions about their working conditions, training, and the frequency of different acts of violence in different relationships of care.

Who participated in the study?

A total of 103 long-term care staff in Manitoba participated in the online survey. Many respondents were nurses and some were health care aides or other support staff. Most respondents identified as women (90%) and the majority were white (70%). Forty-six percent of respondents were over the age of 50. The majority of respondents had either a college or trade certificate (45%) or Bachelor's degree (42%) as their highest level of education.

Most respondents (90%) worked with older adults in a personal care home, 6% worked in home care in clients' own homes, and 4% worked in both environments. Thirty-one percent worked over 40 hours, 27% worked 30-39 hours, 25% worked 20-29 hours, 10% worked 10-19 hours, and 7% worked less than 10 hours. In personal care homes, respondents would often interact with 30 or more residents (56%) or 20 to 29 residents (27%). Of the 10 staff working in home care, five respondents interacted with less than 10 clients/residents (50%), four respondents interacted with 10 to 19 clients/residents (40%), and 1 worked with more than 30 clients/residents daily (10%).

What the researchers found

Most respondents received some form of relevant training in relation to violence prevention. Crisis Prevention Institute Non-Violent Crisis Intervention (CPI NVPI, 75%), P.I.E.C.E.S. (67%), Manitoba Workplace Violence Prevention Program (60%), Dementia Care modules (52%), Teepa Snow videos (37%), Gentle Persuasive Approaches (11%), and DementiAbility (8%) were the types of training most respondents received. Respondents reported not having enough time (48%), experienced difficulty accessing appropriate training (31%), and found training to be expensive (12%). In addition, some participants also found the training was not relevant to their work context.

All staff had experienced some form of verbal aggression from residents or clients during their work in long-term care. For example, respondents who were insulted or sworn at experienced this violence several times a week (37%), monthly or less than monthly (44%), or all the time (13%). Staff also reported being insulted or sworn at (72%), shouted or yelled at (71%), and being called names (47%) by family members of residents/clients. Physical violence was also common; 88% of respondents reported being pushed, grabbed, or shoved, 78% had something thrown at them, 71% were slapped, 67% were punched or hit with something, 64% were kicked, and 22% were choked during their work in long-term care by a resident or client.

Punching or being hit with something occurred monthly or less than monthly (45%) or happened in previous year(s) (16%). Respondents experienced sexual comments (87%) and 64% were either touched or groped in a sexual manner during their career. Sexual comments occurred monthly or less than monthly (57%) or happened in previous year(s) (20%). Touching or groping in a sexual manner occurred monthly or less than monthly (37%) or happened in previous year(s) (22%).

In an open-ended question, 45 respondents provided recommendations for how to improve safety in long-term care and home care in Manitoba. Adequate staffing was the most frequently mentioned recommendation. Staff also identified the need for accountable and supportive management, more dementia-specific training, improved spaces or design of facilities, and more recreational activities.

How this research can be used?

Long-term care staff in Manitoba have endured significant verbal, physical, and sexual violence during their careers. The conditions of care work must be improved. Provincial inquiries and calls to reform the long-term care system in the wake of COVID-19 are resulting in some investment in parts of the system. This is a critical first step. Minimum adequate staffing levels must be developed to address issues of violence as well as enable paid training and recreation activities. All staff should complete provincial violence prevention training and receive training specific to caring for people living with dementia who exhibit responsive behaviours. In addition, reports of violence must be taken seriously by leadership and management in long-term care. This research provides a snapshot of the training, barriers to training, types and frequency of violence and recommendations for addressing violence. The information in this report can be used to inform investments and initiatives in long-term care as well as identify progress in reducing rates of violence in the future.

Introduction

Violence can have far-reaching impacts on the well-being of staff in long-term care and the older adults for which they provide care. The general public expects long-term care to be safe for everyone. Yet, violence is common in the long-term care sector. It occurs in different forms (e.g., verbal, physical, and sexual) and in different directions (e.g., from residents/clients toward staff and from staff toward residents/clients). Some violence is referred to as responsive behaviours, recognizing that the actions, words or gestures of person living with dementia have meaning and may reflect something wrong in their social and physical environment or an unmet need (Alzheimer Society, 2019). In this report, we focus on violence toward staff within long-term residential care (referred to as personal care homes in Manitoba) and home care settings. We review the findings of a provincial survey, which is part of a larger project called Safe Places for Aging and Care. We outline the types of training staff receive to prevent violence, types and prevalence of violence, and staff recommendations for preventing violence.

How was the research conducted?

From July 2021 to April 2022, researchers conducted an online survey of long-term care workers to explore violence in personal care homes and home care settings in Manitoba. Notably, Manitoba was ending the third wave of the COVID-19 pandemic. Several restrictions remained in place including masking, sanitization, and vaccination requirements. Respondents were recruited through listservs (e.g., unions), long-term care and aging websites, along with social media advertisements. The survey was administered online through the Qualtrics website. It consisted of 29 questions and the average respondent took 33 minutes to complete the survey.

Who participated in the study?

A total of 103 long-term care staff in Manitoba participated in the online survey. Respondents included registered nurses (45%), health care aides (20%), licensed practical nurses (16%), registered psychiatric nurses (6%), and various occupations (14%). Other occupations included recreational programmer or worker, kitchen staff, allied health professionals, case coordinator, nurse practitioner, manager, support worker, dietician, and nurse/clinical coordinator. Most respondents identified as women (90%); 7% of respondents identified as men and 3% preferred not to say. Approximately 70% of respondents identified as white. The remaining respondents identified as Black (4%), Indigenous/Aboriginal/First Nation (4%), Asian (3%), Metis (3%), Filipino (3%), and either Middle Eastern (2%) or mixed (2%); 12% preferred not to disclose their race. Forty-six percent of respondents were over the age of 50, 28% were 36-49 years old, and 26% were 18-35 years old. The majority of respondents had either a college or trade certificate (45%) or Bachelor's degree (42%) as their highest level of education. Additionally, 9% had a graduate degree, 2% other diplomas or certificates and only 2% had high school or high school equivalent.

The largest number of respondents worked in Prairie Mountain Health (36%) or Winnipeg Regional Health Authority/Shared Health (36%), the two largest health authorities in the province. Further, 13% of respondents worked in Interlake-Eastern Regional Health, 12% in Southern Health, and 3% in Northern Health. In particular, 90% of respondents worked with older adults in a personal care home, 6% worked in home care in clients' own homes, and 4% worked in both environments. Thirty-one percent worked over 40 hours, 27% worked 30-39 hours, 25% worked 20-29 hours, 10% worked 10-19 hours, and 7% worked less than 10 hours. Approximately 53% worked in a community of less than 10,000 people.

Table 1

Description of Manitoba Staff Participants (n = 103)

	Response	N	% (of X who responded to the question)
Health Authority (X = 100)	Interlake-Eastern	13	13%
	Northern	3	3%
	Prairie Mountain Health	36	36%
	Southern Health	12	12%
	Winnipeg/Shared Health	36	36%
Work setting (X = 101)	Home care in clients' own homes	6	6%
	Personal care home	90	90%
	Both	4	4%
Current profession (X = 103)	Health care aide	21	20%
	Licensed practical nurse	16	16%
	Registered nurse	46	45%
	Registered psychiatric nurse	6	6%
	Other	14	14%
Hours worked per week (X = 103)	Less than 10 hours	7	7%
	10-19 hours	10	10%
	20-29 hours	26	25%
	30-39 hours	28	27%
	40 or more hours	32	31%
Age (X = 65)	Early career (18-35 years old)	17	26%
	Mid-career (36-49 years old)	18	28%
	Late career (50+ years old)	30	46%
Gender (X = 102)	Man	7	7%
	Woman	92	90%
	Prefer not to say	3	3%
Racial identification (X = 102)	Black	4	4%
	Indigenous/Aboriginal/First Nation	4	4%
	Asian	3	3%
	Filipino	3	3%
	Metis	3	3%
	Middle Eastern	1	1%
	White	71	70%
	Other: Mixed	1	1%
	Prefer not to say	12	12%
Highest level of education (X = 102)	High school/high school equivalent	2	2%
	College or trade certification	46	45%
	Bachelor's degree	43	42%
	Graduate degree	9	9%
	Other: RN diploma and/or certificate in adult education	2	2%
Rurality (X = 101)	Yes	47	47%
	No	54	53%

What type of conditions do they work in?

Personal care homes and home care settings each differed in terms of how many residents or clients the long-term staff interacted with daily. In personal care homes, respondents would often interact with 30 or more residents (56%) or 20 to 29 residents (27%). It was less common to interact with 19 or less clients/residents (17%). Of the 10 staff working in home care, five respondents interacted with less than 10 clients/residents (50%), four respondents interacted with 10 to 19 clients/residents (40%), and 1 worked with more than 30 clients/residents daily (10%). Over half of respondents reported that a quarter of the clients/residents they interacted with had dementia or cognitive impairment and 28% said that between one half to three quarters of the clients/residents had dementia or cognitive impairment. In contrast, only 19% of respondents reported half of the clients/residents as having cognitive impairment.

Figure 2

Average Number of Clients/Residents Interact with in Personal Care Home (n = 94)

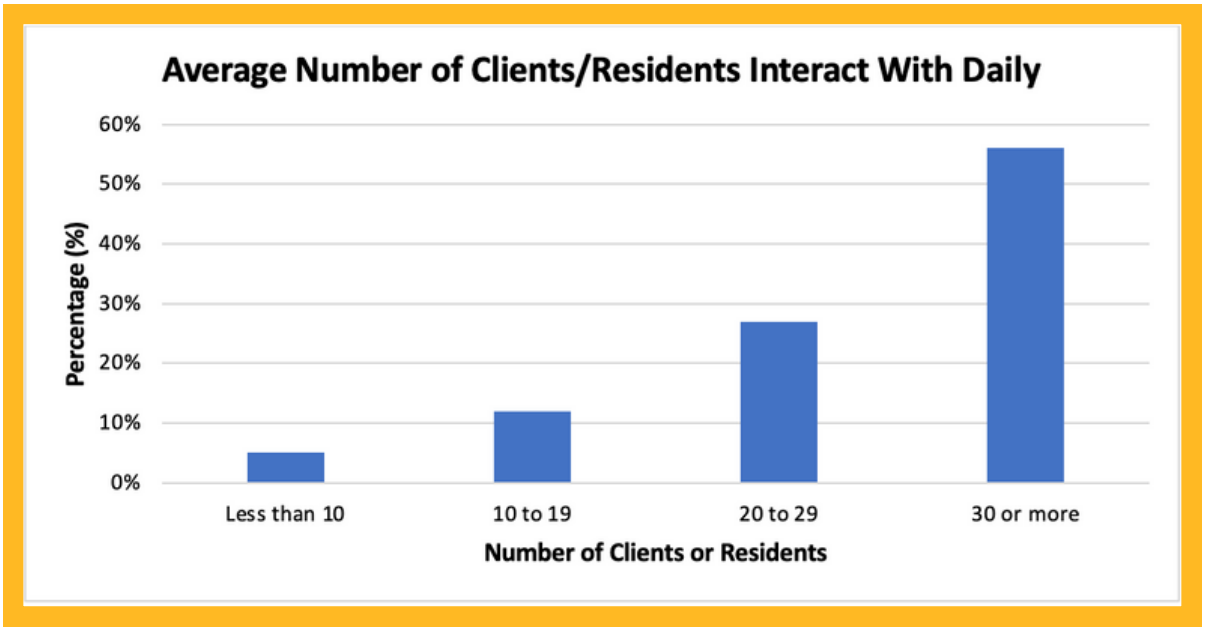


Figure 3

Average Number of Clients/Residents Interact with Receiving Home Care (n = 10)

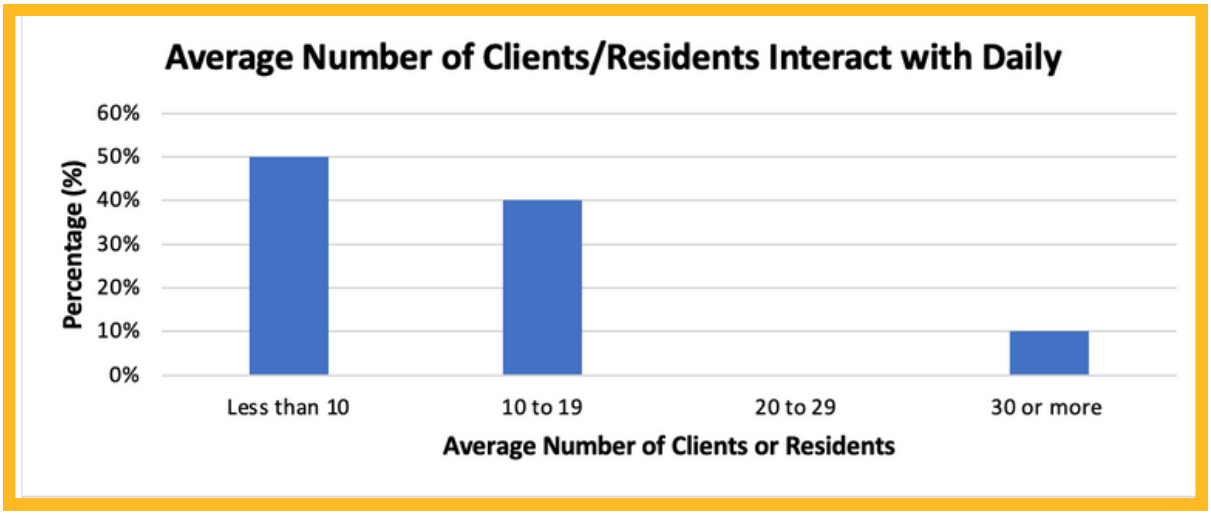
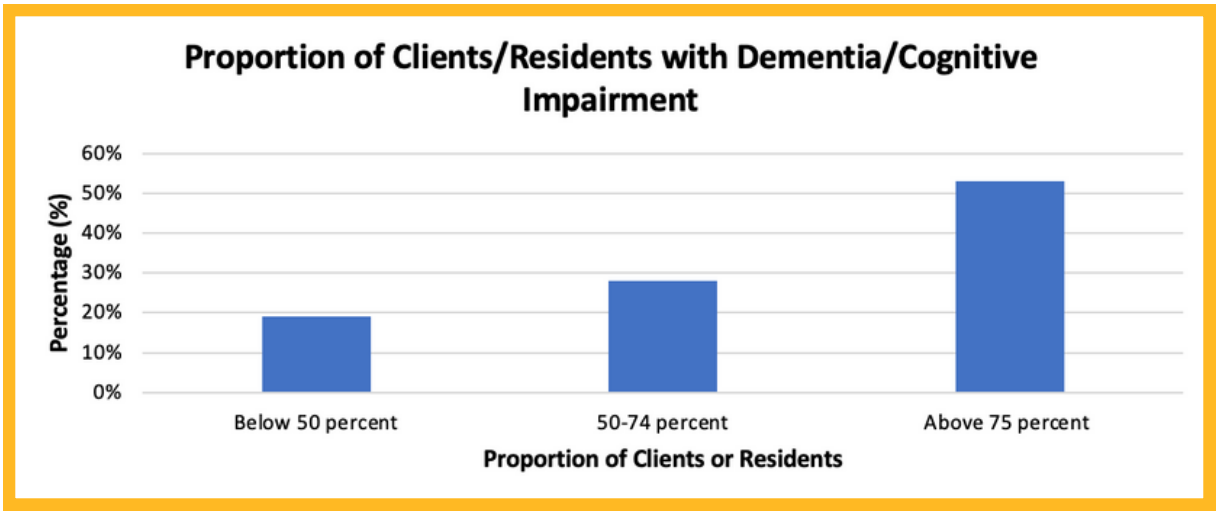


Figure 4

Proportion of Clients/Residents Interact With Who Have Dementia or Cognitive Impairment (n = 101)

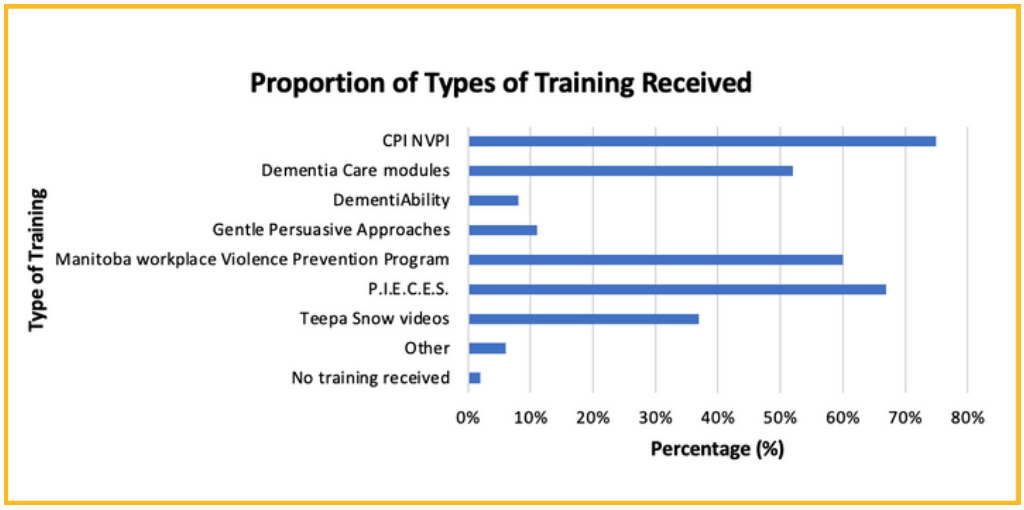


What kind of training workers receive?

Several types of violence prevention and responsive behaviour training were completed by respondents. Crisis Prevention Institute Non-Violent Crisis Intervention (CPI NVPI, 75%), P.I.E.C.E.S. (67%), Manitoba workplace Violence Prevention Program (60%), Dementia Care modules (52%), Teepa Snow videos (37%), Gentle Persuasive Approaches (11%), and DementiAbility (8%) were the types of training most respondents received. Additionally, 6% of respondents received training such as Ufirst, The Mandt System, Mental Health First Aid, dementia-specific training, and supplemental materials. Of the 102 respondents who completed this survey question, only 2 had not received any relevant training.

Figure 5

Proportion of Training Related to Violence Prevention and Responsive Behaviour Received (n = 102)



When accessing training, several barriers were identified. Most respondents reported not having enough time (48%), experienced difficulty accessing appropriate training (31%), and found training to be expensive (12%). Thirteen percent of respondents experienced barriers including irrelevancy of training to work context, no in-person option, travel expenses, and lack of available training.

What violence did workers experience (in all relationships)?

Respondents were asked about their experiences of violence in relation to clients or residents, co-worker(s), and/or the family and friends of clients or residents. The researchers used a modified version of the Conflict Tactics Scale (CTS; Straus et al., 1996) that asked respondents about the frequency of different acts of violence in different contexts and relationships of care (see Figure 6). The researchers calculated the prevalence of the violence as occurring at any time in the past year or previous years (ever) in comparison to never experiencing the type of violence. The researchers grouped the violence items into either verbal, physical, or sexual violence. Psychological (verbal) violence included being insulted/sworn at, shouted or yelled at, something belonging to the respondent was destroyed, and being called names. Physical violence included being threatened to be hit or have objects thrown at respondent, having objects thrown at respondent, being pushed/grabbed/shoved, being slapped, punched or hit with something, being choked, and being kicked. Sexual violence included sexual comments and being touched or groped in a sexual manner. All findings can be seen in the corresponding tables and figures for each relationship.

Figure 6

Sample Questions from Survey Asking About Violence Experience

The following is a list of things that may have happened to you when interacting with a client or resident. Please identify how many times each of these have happened in the past year.

- Insulted or swore at you
- Shouted or yelled at you
- Destroyed something belonging to you
- Threatened to hit or throw something at you
- Called you names
- Threw something at you that could hurt
- Pushed, grabbed, or shoved you
- Slapped you
- Punched or hit you with something that could hurt
- Choked you
- Kicked you
- Made sexual comments towards you
- Touched or groped you in a sexual manner

Relationships with Clients or Residents

SIn relation to a client or resident, 100% of respondents were insulted or sworn at, 99% had been shouted or yelled at, 93% were called names, and 39% had experienced their belongings being destroyed. On average, respondents who were insulted or sworn at experienced this violence several times a week (37%), monthly or less than monthly (44%), or all the time (13%). Experiences of being shouted or yelled at occurred monthly or less than monthly (47%), several times a week or close to every week (33%), or all the time (16%). Name calling occurred monthly or less than monthly (50%), several times a week or close to every week (23%), or all the time (12%). Personal belongings were destroyed monthly or less than monthly (26%) or happened in previous year(s) (13%). Name calling occurred monthly or less than monthly (50%), several times a week or close to every week (23%), or all the time (12%).

For physical violence, 89% had experienced the threat that something could be thrown at them, 88% of respondents were pushed/grabbed/shoved, 78% had something thrown at them, 71% were slapped, 67% were punched or hit with something, 64% were kicked, and 22% were choked. Respondents experienced the threat of being hit or having objects thrown at them monthly or less than monthly (47%) or several times a week or close to every week (25%). Pushing, grabbing, or shoving occurred monthly or less than monthly (51%), several times a week or close to every week (17%), or happened in previous year(s) (17%). Experiences of something being thrown at the respondent occurred monthly or less than monthly (46%) or happened in previous year(s) (23%). Slapping occurred monthly or less than monthly (40%) or happened in previous year(s) (21%). Punching or being hit with something occurred monthly or less than monthly (45%) or happened in previous year(s) (16%). Kicking occurred monthly or less than monthly (40%) or happened in previous year(s) (18%). Choking occurred monthly or less than monthly (17%).

For sexual violence, 87% of respondents had experienced sexual comments and 64% were either touched or groped in a sexual manner during their career. Sexual comments occurred monthly or less than monthly (57%) or happened in previous year(s) (20%). Touching or groping in a sexual manner occurred monthly or less than monthly (37%) or happened in previous year(s) (22%).

Figure 7

Type of Violence from a Client or Resident Experienced in Participants' Career

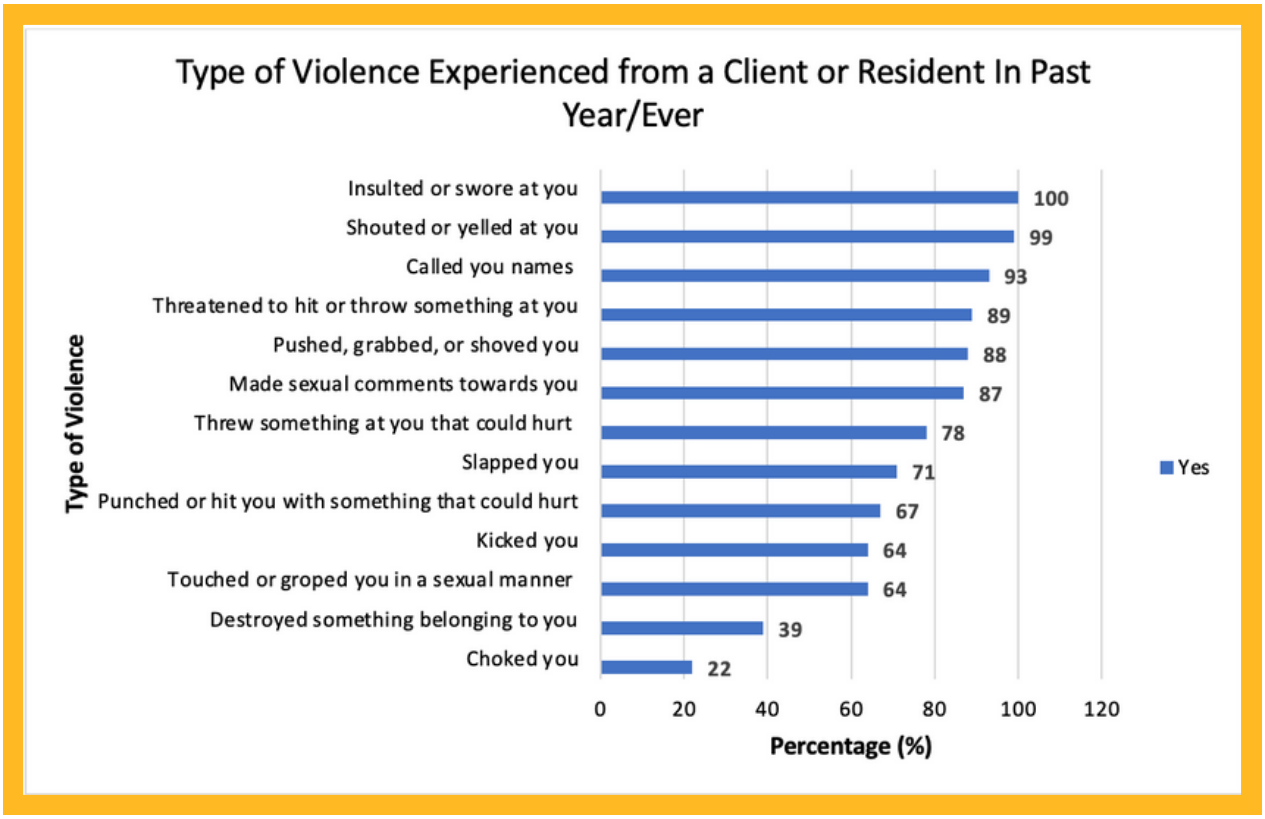


Table 2

Occurrence of Type of Violence from Client or Resident Experienced by Participants

Type of Violence Encountered	All the time (100 or more times per year)	Several times a week or close to every week (25-99 times per year)	Monthly or less than monthly (1-24 times per year)	Happened in previous year(s)	Never happened
Insulted or sworn at (X = 93)	13%	37%	44%	6%	0%
Shouted or yelled at (X = 91)	16%	33%	47%	2%	1%
Destroyed something belonging to participant (X = 92)	0%	0%	26%	13%	61%
Threatened to hit/throw something at participant (X = 92)	9%	25%	47%	9%	11%
Called names (X = 92)	12%	23%	50%	9%	7%
Threw something at participant that could hurt (X = 91)	4%	4%	46%	23%	22%
Pushed/grabbed/shoved (X = 92)	2%	17%	51%	17%	12%
Slapped (X = 89)	3%	6%	40%	21%	29%
Punched/hit with something that could hurt (X = 92)	4%	2%	45%	16%	33%
Choked (X = 89)	0%	0%	17%	6%	78%
Kicked (X = 92)	4%	1%	40%	18%	36%
Sexual comments (X = 91)	3%	7%	57%	20%	13%
Touched or groped in sexual manner (X = 91)	3%	1%	37%	22%	36%

The researchers asked respondents if there were other relevant experiences of violence from clients or residents not included in the closed questions. Nine respondents reported additional physical, verbal, and sexual violence. Respondents identified other forms of physical violence such as spitting, pinching, or biting. Respondents perceived verbal threats as a response to unreasonable demands from clients or residents. One respondent noted that "patients with dementia became fixated on me specifically with the intent to harm. I had to make a break away both times as I felt extremely threatened by aggression and the ability to cause bodily harm to myself." [P35] Some staff were verbally harassed by family members pressuring the staff to "initiate physical violence" while being video recorded [P65]. Respondents reported verbal insults were made based on racism. One respondent mentioned sexual encounters took place between residents or families. Lastly, lack of safety was emphasized both among staff and residents.

Relationships with Coworkers

In their relationships with co-workers, 59% of respondents were shouted or yelled at, 53% were insulted or sworn at, 42% were called names, and 10% had their belongings destroyed. Experiences of being shouted or yelled at occurred monthly or less than monthly (28%) or happened in previous year(s) (28%). Respondents who were insulted or sworn at experienced this abuse monthly or less than monthly (24%) or happened in previous year(s) (23%). Name calling occurred in previous year(s) (23%) or monthly or less than monthly (18%). Notably, 90% of respondents reported that personal belongings were never destroyed.

Physical violence was less prevalent with 90% of respondents reporting that they did not experience the threat of something being thrown at them, being pushed/grabbed/shoved, having an object thrown at them, being slapped, being punched or hit with something, being choked or being kicked.

Sexual violence was experienced in relation to co-workers; 27% received sexual comments and 13% were touched or groped in a sexual manner by a co-worker. Sexual comments occurred monthly or less than monthly (12%) or happened in previous year(s) (15%). Touching or groping in a sexual manner occurred monthly or less than monthly (7%) or happened in previous year(s) (7%).

Figure 8

Type of Violence from Co-worker(s) Experienced in Participants' Career

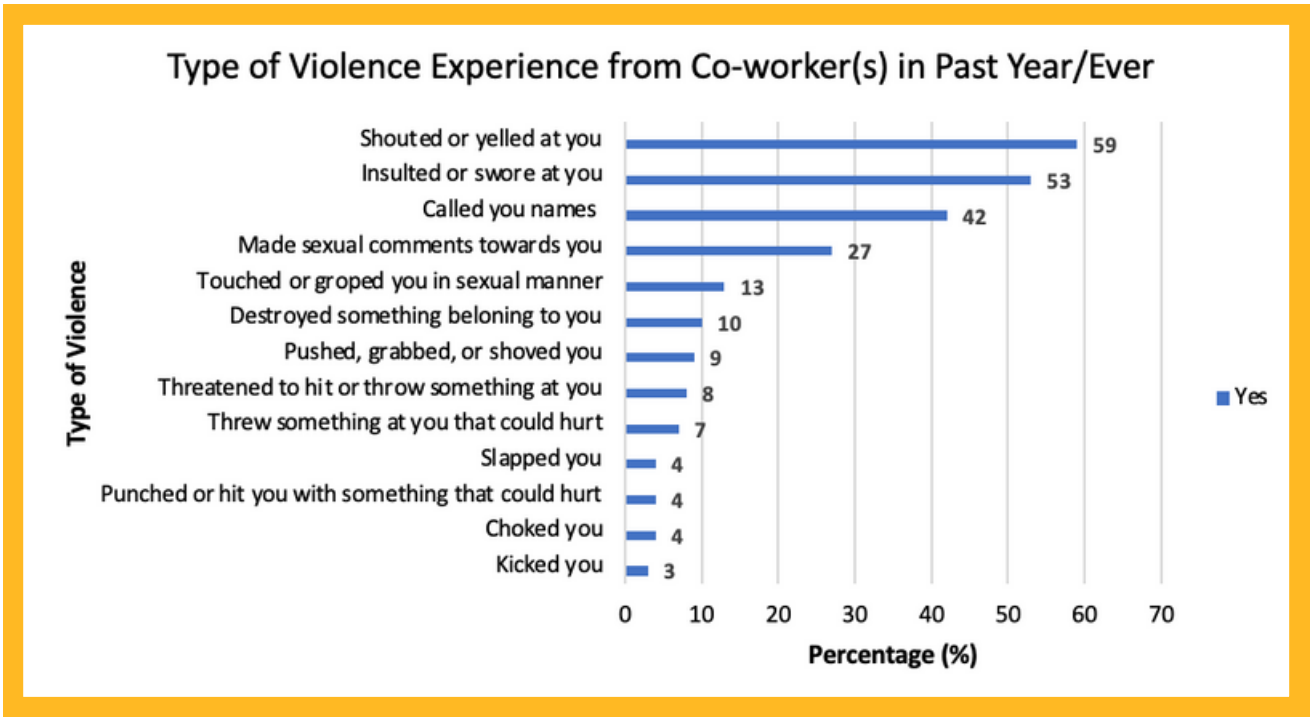


Table 3

Occurrence of Type of Violence from Co-worker(s) Experienced by Participants

Type of Violence Encountered	All the time (100 or more times per year)	Several times a week or close to every week (25-99 times per year)	Monthly or less than monthly (1-24 times per year)	Happened in previous year(s)	Never happened
Insulted or sworn at (X = 94)	1%	4%	24%	23%	47%
Shouted or yelled at (X = 93)	1%	2%	28%	28%	41%
Destroyed something belonging to participant (X = 93)	0%	0%	5%	4%	90%
Threatened to hit/throw something at participant (X = 92)	0%	1%	3%	3%	92%
Called names (X = 92)	0%	1%	18%	23%	58%
Threw something at participant that could hurt (X = 91)	0%	0%	4%	2%	93%
Pushed/grabbed/shoved (X = 93)	0%	2%	3%	3%	91%
Slapped (X = 91)	0%	0%	4%	0%	96%
Punched/hit with something that could hurt (X = 93)	0%	0%	3%	1%	96%
Choked (X = 92)	0%	0%	2%	2%	96%
Kicked (X = 91)	0%	0%	2%	1%	97%
Sexual comments (X = 92)	0%	0%	12%	15%	73%
Touched or groped in sexual manner (X = 92)	0%	0%	7%	7%	87%

Additional comments from eight respondents highlighted psychological violence that occurred in the workplace. Negative, verbal interactions between co-workers involved belittling, intimidation based on race, sarcastic comments, and a strong emphasis on gossiping. Such behaviours contributed to disrespectful workplace environments, where sometimes work ethics were scrutinized. As well, respondents indicated that violence was perpetrated by management or people with more power in the workplace toward people in entry level jobs. In addition, some respondents indicated that a perceived bias of management resulted in barriers to reporting and respondents feeling blamed.

Relationships with Clients' and Residents' Family or Friends

In relation to family and friends of residents or clients, psychological violence was prevalent with 72% of respondents reporting they were insulted or sworn at, 71% were shouted or yelled at, and 47% were called names. Insults or being sworn at occurred monthly or less than monthly (46%) or happened in previous year(s) (20%). Shouting or being yelled at occurred monthly or less than monthly (49%) or happened in previous year(s) (17%). Name calling occurred monthly or less than monthly (26%) or happened in previous year(s) (18%). In contrast, 98% had never experienced personal belongings destroyed.

Physical violence was less prevalent with over 90% of respondents not having experienced something thrown at them, being pushed grabbed or shoved, being slapped, being punched or hit with something, being choked or kicked. Similarly, 88% had never received a threat to be hit or have something thrown at them.

Sexual comments were experienced by 22% of staff from family and friends of residents or clients and 5% were touched or groped in a sexual manner. Sexual comments occurred monthly or less than monthly (11%) or happened in previous year(s) (11%). Touching or groping in a sexual manner occurred monthly or less than monthly (5%).

Figure 9

Type of Violence from Client's or Resident's Family and Friend Experienced in Participants' Career

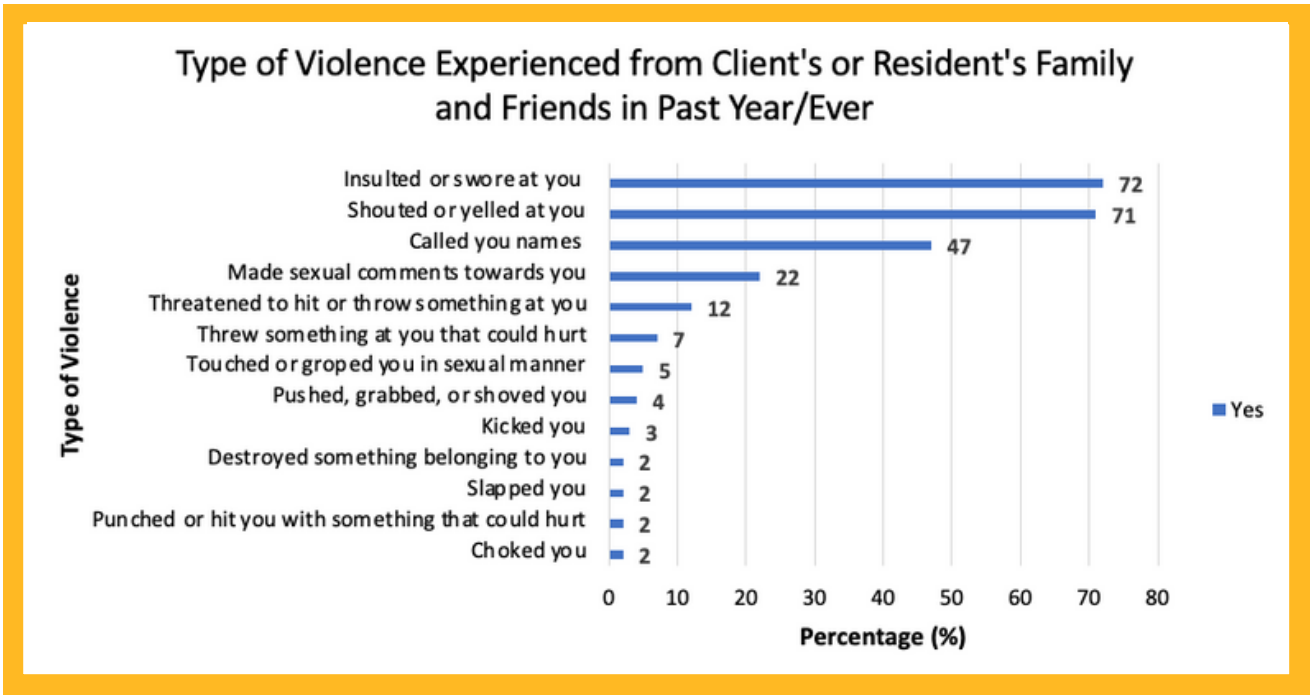


Table 4

Occurrence of Type of Violence from Client's or Resident's Family and Friends Experienced by Participants

Type of Violence Encountered	All the time (100 or more times per year)	Several times a week or close to every week (25-99 times per year)	Monthly or less than monthly (1-24 times per year)	Happened in previous year(s)	Never happened
Insulted or sworn at (X = 94)	1%	5%	46%	20%	28%
Shouted or yelled at (X = 92)	0%	4%	49%	17%	29%
Destroyed something belonging to participant (X = 91)	0%	0%	2%	0%	98%
Threatened to hit/throw something at participant (X = 92)	1%	0%	3%	8%	88%
Called names (X = 92)	0%	2%	26%	18%	53%
Threw something at participant that could hurt (X = 93)	0%	0%	2%	4%	94%
Pushed/grabbed/shoved (X = 93)	0%	0%	2%	2%	96%
Slapped (X = 93)	0%	0%	2%	0%	98%
Punched/hit with something that could hurt (X = 93)	0%	0%	2%	0%	98%
Choked (X = 92)	0%	0%	2%	0%	98%
Kicked (X = 92)	0%	0%	2%	1%	97%
Sexual comments (X = 93)	0%	0%	11%	11%	78%
Touched or groped in sexual manner (X = 91)	0%	0%	5%	0%	95%

Two respondents provided additional comments, noting that sometimes staff were blamed for aggressive residents or psychological violence occurred when COVID-19 visitation rules were enforced.

What participants said made a difference in safety in long-term care

Respondents agreed (35%) that workplace practices, or what staff do at work, prevented violence toward workers. Further, respondents agreed (48%) and strongly agreed (24%) that workplace practices prevented violence toward older adults. In terms of policies, 36% of respondents agreed that workplace policies prevented violence toward workers and 53% agreed that workplace policies prevented violence toward older adults. This suggests that policies and practices are more focused on protecting older adults than staff.

Table 5

Proportion of Participants that Agree with the Effectiveness of Workplace Practices/Policies

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
Workplace practices (what you do at work) prevent violence toward workers (X = 92)	11%	16%	23%	35%	15%
Workplace practices (what you do at work) prevent violence toward older adults (X = 93)	5%	11%	12%	48%	24%
Workplace policies prevent violence toward workers (X = 92)	13%	21%	23%	36%	8%
Workplace policies prevent violence toward older adults (X = 92)	3%	12%	17%	53%	14%

When asked if they chose to change workplaces, 20 respondents reported leaving their workplaces for various reasons. For example, daily verbal and/or physical "attacks" resulted in some respondents leaving. Psychological violence was a key reason whether it was from management, condescending attitudes from co-worker(s), intimidation tactics of co-worker(s), bullying, or harassment. Consequently, such relational problems with co-workers and/or management contributed to issues with reporting practices. For instance, respondents were concerned with the lack of reporting and lack of action following reported violent encounters as well as the lack of accountability of management. Safety concerns arose for some respondents where one respondent stated "I used to work more. The constant noise and aggression wears anyone down" [P93], suggesting that persistent aggression led to reduced work hours. Likewise, another respondent reported "I ended up retiring before the job hurt me anymore than it already has" [P118], demonstrating the impact the violence had on the respondent.

Feedback from Participants

Forty-five respondents provided recommendations for how to improve safety in personal care homes and home care in Manitoba. Below are the key themes that emerged:

·Adequate staffing was the most frequently mentioned recommendation (n = 17). Increasing staffing levels would allow for sufficient time to interact with and provide care as this allows for building trusting relationships with residents or clients. One respondent elaborated on the importance of flexibility of routines, saying: "we are constantly told we don't have the staff to allow one person to sleep in, or the smoking policy prevents you from allowing an agitated dementia resident from going out on the patio by himself and using a cigarette to calm down" [P92].

·More staff on the floor enables staff to assist residents to engage in meaningful and calming activities. This is tied to having proper reinforcement for emergency protocols such as Code Whites and reduces burnout for staff having to run from one task to another. There are consequences for short staffing as one respondent reported:

> **"ABUSE HAPPENS WHEN THERE AREN'T ENOUGH STAFF TO IMPLEMENT ALL THE GREAT DEMENTIA CARE PROGRAMS AND ACTIONS, RESIDENTS ARE LEFT TO BE ISOLATED AND BORED, NEEDS ARE NOT BEING MET, UNMENT NEEDS EQUAL BEHAVIOURS. ALSO, KACK OF STAFF RESULTS IN FRUSTRATION AND CREATES OPPORTUNITIES FOR STAFF TO ACT IN ABUSIVE WAYS BECAUSE NO ONE WILL SEE IT. WE DO NOT PUT ENOUGH VALUE INTO THE CARE OF OUR SENIORS." [P95]**

·Some respondents indicated the need for “Quality staff” who value integrity and have a good work ethic. These comments may reflect the particular challenges staff faced during the time of the survey. Due to staff shortages, staff may not have had positive or trusting relationships with the other staff they were working with during their shift as many full time staff had to be replaced with casual and agency workers.

·Accountable and supportive management was mentioned by numerous respondents in the recommendations and emerged in response to questions about other forms of violence. Management and leadership are crucial for ensuring the protection of employee rights to a safe and respectful workplace. Addressing concerns, recognizing employees’ hard work, and providing space for communication and debriefing after violent situations will help establish trusting relationships between staff and management.

Respondents identified adequate training as a recommendation such as minimum training requirements and access to dementia-specific training to prepare staff to work in long term care contexts. More specifically, respondents recommended learning about de-escalation methods, understanding reactive behaviours, and employing adaptive care plans based on situations that arise.

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When working with clients or residents who are aggressive, respondents recommended working in teams (e.g., specifically in home care) to ensure the safety of staff and accountability.

In long-term care, respondents recommended improved spaces or design of the facility. For example, this could include creating quiet places and loop-shaped hallways for safe wandering to reduce agitation of residents or clients.

Respondents recommended various recreational activities to promote engagement and reduce boredom of residents or clients, especially for those who do not have visitors often.

Respondents suggested clinical assessments should be conducted to ensure residents or clients who are aggressive are in an appropriate environment and receive medication to help reduce distress.

Finally, respondents recommended staff advocacy for the care of residents and clients to protect the dignity and liberty of those whom they care for.

Conclusion

Long-term care staff in Manitoba have endured significant verbal, physical, and sexual violence during their careers. The conditions of care work must be improved. Provincial inquiries and calls to reform the long-term care system in the wake of COVID-19 are resulting in some investment in parts of the system. This is a critical first step. Minimum adequate staffing levels must be developed to address violence as well as enable paid training and recreation activities. All staff should complete provincial violence prevention training and receive training specific to caring for people living with dementia who exhibit responsive behaviours. Some respondents indicate that training is not geared toward long-term care and the population in long-term care. In addition, reports of violence must be taken seriously by leadership and management in long-term care. This research provides a snapshot of the training, barriers to training, types and frequency of violence and recommendations for addressing violence. The information in this report can be used to inform investments and initiatives in long-term care as well as identify progress in reducing rates of violence in the future.