Mapping the Policy Context of Violence in Long-Term Care in Manitoba and Nova Scotia

Knowledge User Advisory Committee Report

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The authors of the report are:

THE SAFE PLACES FOR AGING AND CARE PROJECT TEAM

SHEILA NOVEK, Postdoctoral Fellow[1], KEVIN BALKARAN, Research Assistant[2], YAZHI (ISABELLE) LUO, Research Assistant[2], RACHEL HERRON, Principal Investigator[1], MADELEINE KRUTH, Project Coordinator[1], KATIE AUBRECHT, Co-Investigator[3], DOUGLAS BROWNRIDGE, Co-Investigator[2], LAURA FUNK, Co-Investigator[2], CHRISTINE KELLY, Co-Investigator[2], DALE SPENCER, Co-Investigator[4], & LORI WEEKS, Co-Investigator[5]

1. Brandon University, Brandon, MB, Canada
2. University of Manitoba, Winnipeg, MB, Canada
3. Saint Francis Xavier University, Antigonish, NS, Canada
4. Carleton University, Ottawa, ON, Canada
5. Dalhousie University, Halifax, NS, Canada

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THE SAFE PLACES KNOWLEDGE USER ADVISORY COMMITTEE

Manitoba: SUZANNE DYCK, PAM GULAY, VIRGINIA MARTIN, LIZ MCLEOD, NANCY MCPHERSON, & LUANA WHITBREAD

Nova Scotia: CYNDI CORBETT, PAUL FIELDHOUSE, JUSTIN HILTZ, & MICHELE LOWE

EXECUTIVE SUMMARY

Introduction

Violence is pervasive within home and residential long-term care, affecting older adults, family carers and paid care workers. The aim of this knowledge user report is to identify and examine provincial and regional strategies for limiting violence and promoting safety within **residential** long-term care and home care in Manitoba and Nova Scotia. Based on a document analysis of violence prevention approaches in both provinces, we outline how violence and violence prevention is defined and conceptualized within continuing care legislation, policies and document materials, and identify best practices, gaps, and recommendations to prevent violence in home and residential care settings.

Key Findings

A fragmented policy context

- In both provinces, violence in long-term care (residential care and home care) is addressed through piecemeal legislation, regulations, and policies. In the absence of a comprehensive and integrated approach, legal and policy responses focus on either the abuse of care recipients or violence toward health care workers.
- Long-term care settings are places where people both live and work. Focusing exclusively on care recipients or paid providers overlooks the relational and multidirectional dimensions of violence and the prevalence of violence towards family carers.
- Mandatory reporting of abuse is the predominant legislative approach to addressing violence toward care recipients in both provinces. This legislation informs policies at the provincial and regional level. However, this approach lacks a preventative focus and does not include provisions to support or empower residents or clients who experience violence.
- Protection for Persons in Care legislation does not cover home care recipients in either province.
- There are provincial differences in terms of public reporting of abuse. Nova Scotia's Protection for Persons in Care Office publishes quarterly statistics; Manitoba's Protection for Persons in Care Office has not released any reports since 2016. Statistical reports from both provinces do not report sex or gender variations in abuse.

Policies addressing violence toward health care workers are not long-term care specific

- We identified two policy responses that address violence towards health care workers: violence prevention policies and respectful workplace policies.
- Both provinces had violence prevention policies for health services, which stem from occupational health and safety legislation, and emphasize risk management, clinical practice, and training. These policies were not devised for long-term care contexts and do not address resident-to-resident violence, which represents the most prevalent form of violence in residential care. In addition, these policies are largely geared toward regulated health professions, and thus do not fully represent the composition of the long-term care workforce. Given that unregulated care providers (i.e., continuing care assistants/health care aides) make up the majority of care providers in home care and residential care settings, the emphasis on clinical practice and expertise raises questions about how these policies apply across the long-term care workforce. This group of workers is also highly feminized and racialized, and may face multiple, intersecting forms of violence (e.g. racism and gender-based violence).
- In both provinces, respectful workplace policies for health care workers address a range of behaviours including harassment and discrimination. These regional-level policies emphasize health care workers' rights, diversity, and various forms of mistreatment. However, these policies only apply to situations involving employees, and do not cover mistreatment from care recipients toward providers.

Legislation and policies addressing violence in home care are lacking

- Unlike residential long-term care, home care standards are not legislated, and we found fewer policy documents addressing violence in home care. There is currently no mandatory reporting legislation for home care clients in either province.
- Three policy documents in Nova Scotia address violence or responsive behaviours within home care settings. These documents, however, do not address some of the unique risks associated with home care work, such as working alone. At the time of this report, Manitoba's home care policy was not publicly available, and we did not identify any publicly available policy documents that specifically address violence in home care in Manitoba.

Conclusions

The current policy response to violence in long-term care is fragmented and does not address the scope and context of violence across different long-term care settings. To address this, we recommend the development of comprehensive, sector-specific violence prevention policies that address multidirectional forms of violence, including resident-to-resident violence and violence toward family carers.

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Introduction

Violence is pervasive within home and residential long-term care, affecting older adults, family carers and paid care workers. Care workers and family caregivers can experience physical and psychological harm, emotional exhaustion, and burnout because of their experiences of violence. Moreover, older adults' quality of care and care relationships can be compromised if they are labelled as violent and difficult to care for. Home care and residential care settings are places where people both live and work. In these environments, violence takes different forms and can be directed toward different people. It includes violence toward care workers and family carers, violence toward care recipients, and violent incidents between residents in long-term care. In addition, there has been a growing interest in responsive behaviours--actions, words or gestures that a person living with dementia and/or other conditions that may include communication challenges, makes as a way of responding to their social and physical environment—that are sometimes experienced as violence by care workers and family carers (Alzheimer Society, 2019).

Research and policy tend to consider these forms of violence separately, focusing on either protecting care workers or care recipients. Violence is rarely examined from a system perspective: that is, by looking at existing policies and practices and how they influence

different operational 'actors'.**The focus of this knowledge user report is to identify and examine legislative and policy approaches** to limiting violence and promoting safety within long-term residential care and home care[1] in Manitoba and Nova Scotia[2]. Specifically, we outline how violence and violence prevention are defined and conceptualized within continuing care legislation, policies and document materials, and identify best practices, gaps, and recommendations to prevent violence in home and residential care settings.

How the research was conducted

The documents analyzed in this report were collected through a collaborative process involving a multi-university research team and provincial knowledge user advisory committees composed of older adults, family carers, health care workers, unions, long-term care organizations and other relevant stakeholder groups from Manitoba and Nova Scotia. Knowledge users helped to identify and facilitate access to key legislation, policies, protocols, training materials and reports within their field of practice and jurisdiction. Additional documents were identified through internet searches and reviewing the reference lists of retrieved documents. In total, 51 documents from both provinces were included in our analysis. These included legal documents (acts and regulations)**; provincial policy and implementation documents; regional policy and implementation documents; and reports from government and non-government organizations.** First, we examined each document and noted the type of document, the purpose of the document, the target audience, and key policy responses contained within the document. Next, using a data analysis method called qualitative content analysis, we carefully read each document and developed a list of codes that represented key themes and categories within the documents. We paid particular attention to how violence is defined and described within each document. Then we examined the documents more analytically, looking for embedded meanings and values and considering how these influence responses to violence. Once we finalized a list of codes, we read through and coded each document using a data organization software called NVivo. We used team meetings to help confirm or verify our interpretations.

[1] Although we did not review assisted living policies, home care policies may apply to individuals living and working in these settings.

[2] These jurisdictions were selected because of their balance of commonalities and differences. Both provinces are experiencing increasing demand for home and residential care services, and both have a mix of publicly funded non-profit and for-profit residential care facilities. A key difference is that Nova Scotia exclusively contracts private (for-profit or not-for-profit) agencies to deliver home care services, whereas Manitoba primarily employs government employees to manage and deliver services.

Key Legislative and Policy Responses

Mandatory Reporting of Abuse towards Care Recipients

Mandatory reporting is a key legislative and policy response to violence within health care and residential care settings. *Protection for Persons in Care Acts* in both Manitoba and Nova Scotia attribute responsibility to organizations, staff and members of the public to report suspected abuse in health care and residential care facilities. This legislation also assigns responsibility to each province for monitoring, investigating, and addressing occurrences of abuse within health and long-term residential care facilities. This legislation is further implemented through provincial, regional, and organizational policies that establish reporting requirements and training procedures.

We did not identify any mandatory reporting legislation for home care clients. Mandatory reporting requirements may apply to some home care clients under the Nova Scotia's *Adult Protection Act* (2014). Manitoba's *The Vulnerable Persons Living with a Mental Disability Act* (2014) has much more narrow eligibility criteria: '"mental disability" means significantly impaired intellectual functioning existing concurrently with impaired adaptive behaviour and manifested prior to the age of 18 years.' As such, mandatory reporting requirements in Manitoba do not apply to most home care clients.

Definitions of abuse vary:

Manitoba's Protection for Persons in Care Act (2013) defines abuse as: "an act or omission that (a) is mistreatment, whether physical, sexual, mental, emotional, financial or a combination of any of them, and (b) causes or is reasonably likely to cause (i) death of a patient, (ii) serious physical or psychological harm to a patient, or (iii) significant loss to a patient's property."

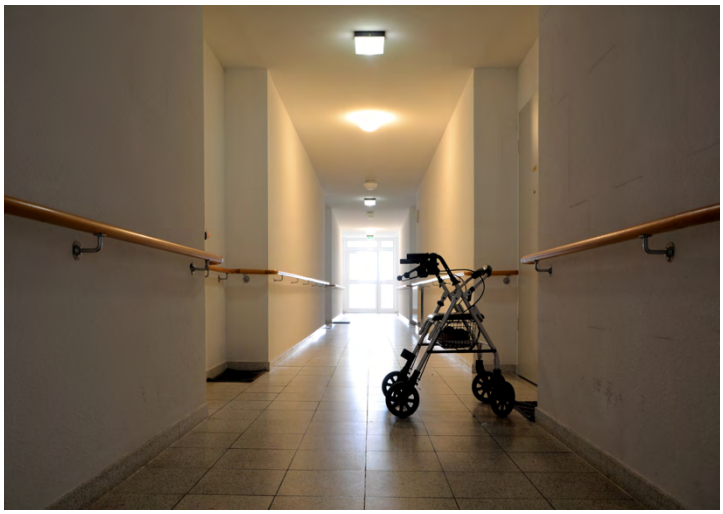
Nova Scotia's Protection for Persons in Care Regulations (2004) defines abuse as:
Any of the following:
a) the use of physical force resulting in pain, discomfort or injury, including slapping, hitting, beating, burning, rough handling, tying up or binding;
b) mistreatment causing emotional harm, including threatening, intimidating, humiliating, harassing, coercing or restricting from appropriate social contact;
c) the administration, withholding or prescribing of medication for inappropriate purposes;
d) sexual contact, activity or behaviour between a service provider and a patient or resident;
e) non-consensual sexual contact, activity or behaviour between patients or residents;
f) the misappropriation or improper or illegal conversion of money or other valuable possessions;
g) failure to provide adequate nutrition, care, medical attention or necessities of life without valid consent.

Mandating reporting of abuse toward individuals in care establishes a mechanism of accountability, ensuring that incidents of abuse are systematically reported, investigated, and monitored. Based on our review, however, we noted some limitations of these approaches:

- Definitions of abuse vary and include different thresholds of harm. Manitoba's *Protection for Persons in Care Act* (2013) sets a threshold of serious physical or psychological harm to constitute abuse. By contrast, Nova Scotia's *Protection for Persons in Care Regulations* (2004) sets a lower threshold of pain, discomfort or injury, or emotional harm. For sexual abuse, Nova Scotia's definition focuses on consent rather than harm, whereas Manitoba's focuses on the outcome of abuse. This variation raises questions about the comprehensiveness and comparability of these reporting systems. In addition, it unclear whether these definitions actually reflect residents' experiences of abuse, and whether or how residents, families and staff can pursue complaints for incidents that do not reach the threshold of abuse.
- Definitions of abuse group together very different types of violence (e.g., physical, verbal, emotional, sexual) along with financial misconduct and neglect. Using a single definition and policy response for very different and complex problems raises questions about how organizations can respond effectively to different types of violence. For example, these definitions do not distinguish between abuse involving residents or abuse committed by staff. In addition, the issue of sexual abuse in long-term care is an ethically and legally complex problem that involves determining consent among adults with impaired cognition and balancing the need for protection with the right to sexual expression (Grigorovich & Kontos, 2018). Without a dedicated policy to guide how facilities approach sexual abuse and sexual rights, it is unclear how this issue is dealt with.
- The rights of care recipients are defined in limited terms as the negative right to freedom from abuse. Legislation and related policies do not include provisions for assistance and supports for care recipients who have experienced or been accused of abuse, such as access to information about their rights, advocacy services or supports for victims. This legislation and related policies define care recipients as a vulnerable group in need of state protection. As such, it overlooks the diversity of these care recipients, and the possibility for self-advocacy.
- We found differences in terms of public reporting of investigations of abuse. Nova Scotia's Protection for Persons in Care Office publishes quarterly statistics. Manitoba's Protection for Persons in Care Office has not released any reports since 2016. The absence of comprehensive and reliable data on abuse in residential care significantly constrains our ability to understand and address issues of violence and abuse.
- Statistical reports from both provinces do not include sex or gender as a variable. A report from British Columbia's Office of the Seniors Advocate (2016) examining resident-to-resident aggression found that men were aggressors in 60 percent of reported incidents, even though they made up only 35 percent of care home residents. Including gender as a variable in reports and conducting more comprehensive analyses could enable examination of gender-based risks and other patterns of violence.

Mandatory Reporting of Violence towards Care Providers

Legislation and policies addressing violence toward health care workers also establish mandatory reporting of violence in the workplace. Policies governing violence in health care such as Nova Scotia Health Authority's *Violence in the Workplace* (2017) and Manitoba's *Violence Prevention Program for Health Care Worker*s (2013) establish requirements and protocols for reporting, investigating, and monitoring violence in the workplace. Although these policies recognize different types of violence in the workplace, the policy responses focus primarily on violence from patients/residents to staff. In addition, these policies are designed for all of health services, and were not designed specifically for long-term residential care or home care contexts[3].



We also reviewed regional health authorities' respectful workplace policies, that address a range of behaviours in the workplace including harassment, sexual harassment and discrimination [e.g. *Respectful Workplace* policies from the Nova Scotia Health Authority (2017), the Winnipeg Regional Health Authority (2019) and Prairie Mountain Health (2018)][4]

- Respectful workplace policies emphasize health care workers' rights and responsibilities, and address various forms of mistreatment. However, they only apply to situations involving employees, so it is not clear whether and how they apply to disrespectful behaviour from patients/residents to staff. This suggests a gap in terms of how long-term care organizations deal with disrespectful behavior, harassment, sexual harassment and discrimination from residents toward staff.

[3] Though they are not designed for long-term care settings, provincial and regional violence prevention policies apply to home care and residential care settings and may be tailored to these settings at the organizational level. However, we did not have access to organizational-level policies for this study.
[4] We collected documents from two out of five regional health authorities in Manitoba (Winnipeg Regional Health Authority and Prairie Mountain Health). These two regions, which represent rural and urban areas, were selected because members of our Knowledge User Advisory Committee were able to facilitate access to document materials from these regions.

Responsive Behaviours

The term 'responsive behaviours' is used in policy documents in both provinces but is defined and addressed differently. In Manitoba, the term is used in violence prevention policies governing health care workers and is often inserted into definitions of violence. For example, Manitoba's *Provincial Health Care Violence Prevention Operational Procedure* (2013) defines violence as: "Violence includes acts of aggression and/or responsive behaviours. This behaviour may be intentional, or unintentional and/or arising out of the medical condition for which a person seeks care." In some instances, the term is associated with unpredictable behaviours. For instance, Prairie Mountain Health's *Workplace Violence Prevention Program (2015)* includes the following definition of responsive behaviours: "actions that represents [sic] how people may respond unpredictably to something negative, frustrating, or confusing in their environment."

By contrast, in Nova Scotia, the term is not included in definitions of violence with health care policies. Instead, it is applied in long-term residential care specific policies and associated with a particular policy response. For example, the concept is used in the *Challenging Behavior Program Policy Manual (2013)*, which outlines a provincial program aimed at addressing challenging behaviours in long-term residential care through clinical consultation, capacity building and education. In this document, the terms "challenging behaviour" and "responsive behaviours" are used as alternatives to the language and concept of violence. The program's policy manual defines responsive behaviours – or challenging behaviours – as "behavioural responses that are potential evidence that a client's needs, in terms of care or assessment, have not been fully met" (p. 18).

The concept of responsive behaviours also appears in Nova Scotia's *Long Term Care Program Requirements: Nursing Homes & Residential Care Facilities* (2019). In this document, responsive behaviours are defined as: "actions, words or gestures of people with dementia utilized as a means of communicating unmet need(s) and/or something important in their personal, social or physical environment (e.g. wandering, restlessness, agitation, physical resistance) which may cause distress and/or risk for the person, other residents, family members, visitors and/or staff." For residents expressing responsive behaviour, the policy requires that an interdisciplinary team "asses[s] the residents to determine the underlying causes of the behaviour, identifies the type and level of risk, and develops, communicates and evaluates the plan of care and outcomes."

The definition and use of the term responsive behaviours in Nova Scotia's long-term residential care policies avoids labeling individuals as violent and suggests that these behaviours indicate unmet needs that require assessment and attention. In fact, there were no references in these policy documents to violence, perpetrators of violence, or victims. This framework emphasizes behaviour management and clinical best practices but overlooks supports for individuals affected by violence (residents, staff or family carers). In addition, this approach differs from the use of the term in Manitoba documents, which categorizes responsive behaviours as a type of workplace violence with no distinct practice or policy implications. Documents in both provinces link responsive behaviours primarily to an individual's impaired cognition.

Training and Education

Staff training and education are a major component of violence prevention policies in both provinces. Nova Scotia's *Violence in the Workplace Regulations* (1996) requires training for all employees who are "exposed to a significant risk of violence." The regulations stipulate training in the areas of employee rights and responsibilities, workplace violence prevention policies, recognizing and responding to violent situations, and reporting and documenting violent occurrences. These training requirements are reiterated in Nova Scotia Health Authority's *Violence in the Workplace* policy (2017). The *Manitoba Workplace Safety and Health Act and Regulations (2006)* includes the more limited training requirement that employees receive training in the organization's violence prevention policy. Training requirements, however, are expanded in other provincial and regional policies. For example, the *Violence Prevention Program for Health Care Workers in Manitoba (2013)* states: "workers are trained in and follow the safety procedures to prevent and respond to violence-related incidents." This training includes a general orientation for all employees as well workplace-specific training. The document notes that additional training may include "managing clients with cognitive impairments and/or self defence techniques." However, the policy document does not provide any details about the type of training offered, or who is eligible to receive it.

Within the long-term residential care sector, Manitoba's *Personal Care Homes Standards Regulations* (2017) requires operators to provide an orientation and in-service education program to all staff. The regulations do not mention training related to violence. Similarly, Nova Scotia's *Long Term Care Program Requirements (2019)* includes mandatory continuing education. However, there are no specific details regarding training in terms of violence prevention or responsive behaviors. We did not identify any provincial policy documents that stipulate training or continuing education requirements for home care workers in either province.

We also identified some differences in terms of training and education policies between both provinces. One key difference is the presence of Nova Scotia's Challenging Behaviour Program. As noted above, the program aims to address challenging behaviours within long-term residential care and home care settings through clinical consultation, capacity building and education. The policy manual describes P.I.E.C.E.S.™ education as a core component of the program and a method for promoting best practice and enhancing understanding of responsive behaviours. Notably, eligibility for P.I.E.C.E.S.™ education is limited to regulated health professionals in target organizations (e.g., nursing homes, homes for the aged, and home support agencies) as well as senior leaders in supervisory roles. As such, the program manual does not directly address the training of unregulated providers who provide the bulk of care work (i.e. continuing care assistants/health care aides).

In comparison, although Manitoba's regional long-term care programs and the Alzheimer Society of Manitoba provide P.I.E.C.E.S.™ education, the province does not have a publicly-available formalized policy focused on enhancing the care of older adults exhibiting responsive behaviours.

A second difference between the provinces relates to curriculum requirements for continuing care assistants in Nova Scotia and health care aides in Manitoba. These workers perform care work in residential care, home care, and other health and social care settings. In both provinces, these workers are unregulated (i.e., there is no governing body or legislation regulating this group of workers). In Nova Scotia, the Nova Scotia Department of Health and Wellness (DHW) provides oversight for the Continuing Care Assistant Program including the development of curriculum standards, the certification process, and a registry (Nova Scotia Health and Wellness, 2019). The curriculum standards include education about responsive behaviours, and techniques for identifying, preventing and responding to behaviours. By contrast, we did not identify any minimum standards or oversight for health care aide training programs in Manitoba. In addition, there is no provincial certification exam or registry for health care aides in Manitoba.

Risk assessment and management

Risk assessment and risk management are prominent features of legislation and policies aimed at preventing violence within health care in both provinces. These policies are designed for health services in general. So, they apply to residential care facilities and home care but are not specifically designed for these settings[5]. Occupational health and safety legislation in Manitoba and Nova Scotia require employers to conduct risk assessments to determine the risk of workplace violence. Provincial and regional policies from both provinces provide guidelines for conducting environmental risk assessments (to determine the risk of violence in a given workspace), as well as individual-level risk assessments (to determine the risk of violence posed by care recipients). This means that health care workers are responsible for identifying and mitigating "risks" through screening, risk assessment, care planning, risk communication, and medical or behavioural interventions. For example, the Violence Prevention Program for Health Care Workers in Manitoba (2013) states: "Resulting from the Patient Risk Screening, the care providers responsible for the patient shall initiate the Alert System as outlined in Section 3.6, and develop and implement a patient care plan/safety plan that eliminates and/or mitigates the patient's aggressive behaviour potential that is appropriate for the risks identified. This may include medical, behavioural and/or administrative procedures."

In both provinces, policies are in place to label patients deemed at-risk of violence using standardized symbols. For example, the Nova Scotia Health Authority mandates the wearing of purple wristbands and placing purple signs to identify individuals who have been assessed as a risk (Nova Scotia Health Authority, 2019). Similar policies in Manitoba require placing a sign containing two purple rings on a patient's door or in their room. These policies are described as a method for communicating the risk of potential or actual violence.

By emphasizing screening and managing "at risk" patients, these policies reflect a medicalized view of violence as an individual-level trait that can be predicted and mitigated through clinical intervention. To prevent occurrences of violence, patients categorized as "at risk" are subject to clinical assessment and interventions such as screening, surveillance, labeling practices, and medical and behaviour interventions. This language and orientation places responsibility on staff to prevent and mitigate violence. It also draws attention away from relational, organizational and structural factors that may contribute to violent interactions.

We noted that most of the policy documents focused on assessing risk among patients within health services with the goal of protecting health care workers. Indeed, care providers face significant risks of violence, but care recipients and family carers can also experience aggressive treatment. Policy documents rarely mention protecting patients and clients from risk. In addition, most of these policies are designed for health services in general; we found very few references to risk assessment within long-term residential care or home care contexts.

[5] Regional health authorities and care facilities may adapt these policies to accommodate long-term care contexts. This analysis did not look at organizational-level policies.

How do violence policies portray different groups of people?

Vulnerable care recipients: Policies addressing violence toward care recipients use the term “abuse” and frame care recipients as vulnerable and dependent. The emphasis on vulnerability overlooks the diversity of care recipients, and draws attention away from the possibility of empowerment, self-advocacy, as well as other factors that contribute to violence such as perpetrator characteristics, organizational conditions and social inequities.

Challenging care recipients: The concept of responsive behaviours was used to refer to care recipients with cognitive impairment or dementia who are framed as ‘challenging’ and at-risk of harming others. Although understandings of responsive behaviours differ between jurisdictions and documents, most references to this concept imply that the behaviour is part of a disease and care workers are responsible for mitigating and managing the behaviour.

Clinical risk managers: Violence prevention policies aimed at reducing violence in health care emphasize risk assessment and management strategies, and characterize staff as responsible for preventing and mitigating the risk of violence in the workplace. This medicalized view of violence focuses on individual-level risk factors and clinical management, overlooking relational, organizational and structural factors that contribute to violence.

Diverse workers with rights and responsibilities: Policies addressing disrespectful behaviour in the workplace recognized the diversity of the workforce, different forms of violence and mistreatment, and emphasized a range of employee rights and responsibilities. These policies, however, only apply to relations between employees, leaving a significant policy gap in terms of disrespectful behaviour from care recipients.

Policy Recommendations and Provincial Reports

We reviewed reports from both provinces that examined violence in long-term care. These included reports commission by the provincial government, reports published by public institutions such as the Office of the Auditor General of Nova Scotia and Manitoba, as well as reports published by unions and organizations representing long-term care institutions. Below is a list of recommendations identified from previous reports that address violence in long-term care:

- Develop and implement comprehensive, sector-specific violence prevention strategies for long-term care (Curry, 2015)
- Develop a comprehensive response to sexual aggression in long-term care. (Curry, 2015)
- Review and modernize long-term care legislation. (Keefe et al., 2018)
- Develop organization-wide culture of safety that addresses both client and staff safety together (Research Power Inc., 2017)
- Implement evidence-based staffing standards to support the health and well-being of long-term care residents, and the providers who care for them (Curry, 2015; Keefe et al., 2018; MNU, 2018; Research Power Inc., 2017)
- Increase funding for nurse practitioners in residential care facilities (Curry, 2015)
- Increase the number of specialized units to care for people with responsive behaviours. Improve access to specialized behavioural units in rural areas. (CGO, 2015; The Provincial Court of Manitoba, 2015)
- Review the layout of existing long-term care facilities and increase the number of private rooms (CGO, 2015)
- Review and enhance curriculum standards for direct care workers. Expand access to/mandate ongoing training on the subjects of violence and responsive behaviours (Curry, 2015; The Provincial Court of Manitoba, 2015)
- Make home care standards and policies in Manitoba public, in line with other provinces. (Office of the Auditor General Manitoba, 2015)
- Develop a provincial policy for dealing with suspected client abuse or neglect in Manitoba's home care program. (Office of the Auditor General Manitoba, 2015)

Conclusion

- The current policy response to violence in long-term care is fragmented, and does not address the scope and context of violence across care settings. As such, we recommend the development of comprehensive, sector-specific violence prevention policies that address multidirectional forms of violence, including resident-to-resident violence and violence toward family carers.
- Nova Scotia's Challenging Behaviour Program stands out as a key point of difference between long-term care policies in the two provinces. Other provinces have also implemented programs to address responsive behaviours (e.g., Behavioural Supports Ontario). This is a clear policy gap in Manitoba, and we recommend developing more targeted policies for responsive behaviours in long term care in Manitoba.
- Legislation and policies addressing violence in home care are lacking compared to long-term residential care. Home care brings unique risks and relational contexts that require a dedicated policy response.

- Definitions of abuse toward care recipients group together various types of violence and misconduct under a single definition and policy response. This approach differs from the range of policies directed at addressing different forms of violence towards health care providers. Elder abuse researchers have questioned the effectiveness of using a single definition and response to address problems as diverse and complex as sexual abuse and financial exploitation (Harbison et al., 2012). Accordingly, we recommend that violence prevention policies integrate dedicated responses to different forms of violence, including their gender-based aspects.
- With a few exceptions, the rights of care recipients are limited to the negative right to freedom from abuse. Policies should recognize care recipients as diverse citizens and affirm their full range of rights. To ensure the rights of care recipients and family carers are upheld, policies should include provisions for information, support and advocacy for care recipients who experience violence.
- Policies in both provinces emphasize care recipients' vulnerability to violence and risk of behaving violently due to cognitive impairments. This emphasis overlooks other intersectional risk factors such as gender and ability, as well as relational and institutional factors that create the conditions for violent interactions. Reports in both provinces identify a range of organizational and structural factors that contribute to violence in care such as staffing levels and curriculum requirements. We therefore recommend policy frameworks that address the organizational and structural conditions that contribute to violence.
- Public reporting of violent occurrences can contribute to institutional accountability and support a better understanding of the scope of the problem. We recommend policies prescribe public reporting of violent occurrences within residential care and home care. To capture the gendered dynamics of violence, reporting should include gender as a variable along with other intersecting risk factors such as age and race.

Limitations and future directions

It is important to consider the limitations of this analysis. First, not all policy documents are publicly available, so the data set was incomplete. In addition, documents do not provide detailed information about how these policies are implemented in practice. There is a need for further research to examine the impact of violence policies on practices and experiences across long-term care settings.

References

Adult Protection Act. R.S., c. 2, s. 1 (2014). https://nslegislature.ca/sites/default/files/legc/statutes/adult%20protection.pdf

Alzheimer Society. (2019). *Conversations about dementia and responsive behaviours*. https://alzheimer.ca/sites/default/files/documents/conversations_dementia-and-responsive-behaviours.pdf

Community Governed Organizations (CGO). (2015). *CGO task force on heightened aggression in LTC homes*. https://nhnsa.ca/wp-content/uploads/2017/03/CGO-Task-Force-on-Heightened-Aggression-in-LTC-Homes-Recommendations-Report.pdf

Curry, P. (2015). *Broken homes: Nurses speak out on the state of long-term care in Nova Scotia and chart a course for a sustainable future.* Nova Scotia Nurses Union. https://www.nsnu.ca/sites/default/files/Broken%20Homes%20Report%20Full.pdf

Grigorovich, A., & Kontos, P. (2018). Advancing an ethic of embodied relational sexuality to guide decision-making in dementia care. *The Gerontologist*, *58*(2), 219-225.

Keefe, J., Smith, C. A., & Archibald, G. (December 21, 2018). *Minister's expert advisory panel on long term care*. Government of Nova Scotia. https://novascotia.ca/dhw/publications/Minister-Expert-Advisory-Panel-on-Long-Term-Care.pdf

Manitoba Health, Seniors and Active Living. (2013). *Violence prevention programs for health care workers in Manitoba* (HCS 215.5).

Manitoba Nurses Union (MNU). (2018). *The future of long-term care is now: addressing nursing care needs in Manitoba's personal care homes.* https://manitobanurses.ca/system/files/MNU-Long%20Term%20Care%20Report%202018.pdf

Manitoba Workplace Safety and Health Act and Regulation; the Workplace Safety and Health Act (Chapter W210 10/02). (2020). https://www.gov.mb.ca/labour/safety/pdf/whs_workplace_safety_act_and_regs.pdf

Nova Scotia Health and Wellness. (2013). *Challenging Behaviour Program Manual.*

Nova Scotia Health and Wellness. (2019). *Long Term Care Program Requirements: Nursing Homes & Residential Care Facilities*. https://novascotia.ca/dhw/ccs/policies/Long-Term-Care-Facility-Program-Requirements.pdf

Nova Scotia Health and Wellness. (2019). *Continuing Care Assistant (CCA) Scope of Practice & Competency Framework*. Retrieved from: https://novascotia.ca/dhw/ccs/documents/Scope_of_Practice_CCA.pdf

Nova Scotia Health Authority (2017). *Respectful Workplace*. Administrative Manual Policy (AD-HR-020).

Nova Scotia Health Authority. (2017). *Violence in the Workplace*. Administrative Manual Policy and Procedure AD-OHS-010).

Nova Scotia Health Authority. (2019). *Potential for Violent or Aggressive Behaviour*. http://www.nshealth.ca/sites/nshealth.ca/files/patientinformation/2041.pdf

Office of the Auditor General Manitoba (2015). *Manitoba Home Care Program*. https://www.oag.mb.ca/audit-reports/report/manitoba-home-care-program/

Office of the Seniors Advocate British Columbia (2016). *Resident to Resident Aggression in B.C. Care Homes*. https://www.seniorsadvocatebc.ca/app/uploads/sites/4/2016/06/SA-ResidentToResidentAggressionReview-2016.pdf

Prairie Mountain Health.(2018). *Respectful Workplace.* (PPG-00066). https://www.prairiemountainhealth.ca/images/PPG/PPG-00066.pdf.

Prairie Mountain Health. (2015). *Workplace Violence Prevention Program*. (Regional Policy & Procedure Manual R.HR.WSH.930).

Protection for Persons in Care Regulations, N.S. Reg. 364/2007. https://novascotia.ca/just/regulations/regs/protperscare.htm#TOC3_1

Protection for Persons in Care Act, S.N.S. c. 33. (2004). https://nslegislature.ca/sites/default/files/legc/statutes/protection%20for%20persons%20in%20care.pdf

Research Power Inc. (2017). W*orkplace health and safety in the health and community services sectors: evidence-based best practices and assessment of current state in Nova Scotia.*

The Health Services Insurance Act, C.C.S.M. c. H35: Personal Care Homes Standards Regulation (2005). https://web2.gov.mb.ca/laws/regs/current/_pdf-regs.php?reg=30/2005

The Protection for Persons in Care Act, C.C.S.M., c. P144 (2013). https://web2.gov.mb.ca/laws/statutes/ccsm/p144e.php

The Provincial Court of Manitoba. (2015). R*eport on Inquest and Recommendations of Judge Michel Chartier*. http://www.manitobacourts.mb.ca/site/assets/files/1051/frank_alexander_inquest_final.pdf

The Vulnerable Persons Living with a Mental Disability Act, C.C.S.M. c. V90. (2014). https://web2.gov.mb.ca/laws/statutes/ccsm/v090e.php

Violence in the Workplace Regulations made, N.S. Reg. 209. (2007). https://novascotia.ca/just/regulations/regs/ohsviolence.htm

Winnipeg Regional Health Authority. (2019). *Respectful Workplace*. Regional Program (20.10.040).