HE DESERVED BETTER

ONE MAN'S FINAL DAYS IN LONG-TERM CARE

New Brunswick **Seniors'** Advocate

Défenseur des **aînés** du Nouveau-Brunswick

New Brunswick
Seniors'
Advocate

Défenseur des
aînés
du Nouveau-Brunswick

P.O. Box 6000
Fredericton, NB
E3B 5H1

Toll Free: 1.888.465.1100
Local: 1.506.453.2789
Fax: 1.506.453.5599

www.nbseniorsadvocate.ca

How to cite this document:

Office of the NB Seniors' Advocate, He Deserved Better-One Man's Final Days in Long-Term Care, January 2022.

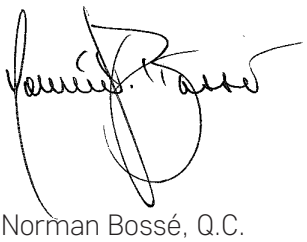
English PDF # 978-1-4605-2993-5

TABLE OF CONTENTS

FOREWORD

Pursuant to my authority, as set out in the *Child, Youth and Senior Advocate Act*, I am providing this report following an investigation into the death of a 91-year-old nursing home resident due to complications arising from a broken hip caused by assault from another resident. Both residents suffered from dementia; however, I want to make it abundantly clear that this is not a report about dementia and the challenges posed by this diagnosis. We are aware that dementia is extremely complex, manifesting itself differently in each individual diagnosed. Throughout the report we examine assaults inflicted by one nursing home resident against others. We must stress that because of his dementia, this person was not in control of his actions and so cannot be blamed for the injuries he caused. Rather, this report is about ability to protect vulnerable nursing home residents from harm, regardless of its origin.

It should be stressed that while this is a public report, it does contain detailed information about these people and those who cared for them. Although we have taken great care to protect the privacy of these individuals, we cannot guarantee that interested parties will not be able to identify them or others charged to care for them. The identities of everyone involved have been anonymized. Nevertheless, I would request that readers and interested parties, including the media, respect their privacy and not focus on identifying individuals and locations involved in the matter. This report was not prepared in an attempt to find fault or to assign blame, but rather it is written to identify failings or gaps in a very complex system serving our province's older adult population. Many hours have been dedicated to this effort by my staff in an effort to examine the details of how such a tragedy occurred and what process was followed by officials to ensure it would not happen again. In this report, recommendations are offered seeking to move the system in a positive direction, to bring about changes for the benefit of all older persons in New Brunswick. When loved ones move into nursing homes, there is an expectation that they will be protected from harm. This report does not question the intentions of staff and management at any nursing home or the Department of Social Development. This report is concerned with institutional capacity, processes, and monitoring to ensure the safety of residents. All recommendations are directed to government. I trust that this report will be welcomed by nursing home operators and government officials concerned with constantly improving the system, and that the recommendations which emerge from this report will be implemented to improve the safety of all vulnerable seniors in the care of nursing homes.



Norman Bossé, Q.C.
NB Child, Youth and Seniors' Advocate

EXECUTIVE SUMMARY

George was a loving husband, father and grandfather. He was also an avid curler, a dedicated employee, an active volunteer, and a man with a true passion for gardening. George led a very dynamic lifestyle with a vivacity that would rival many who were decades younger. Until his eighties, very little slowed him down. However, after the death of his wife his family began noticing a change where he no longer seemed quite himself. The patience they had always known was at times replaced with agitation, and soon after, George began forgetting to do basic things like feeding himself. George's children's worst fears and suspicions were confirmed when he received a diagnosis of Alzheimer's Disease.

Independent, caring and proud, George did not want to burden his children with his care and therefore refused to move in with any of them. So, in an effort to keep him at home they hired home-care workers. What should have been a convenient solution quickly turned into an ongoing headache, as frequently, these workers did not show up for their scheduled shifts, leaving George unfed and without his medication.

George's family then realized that they were pressed to make the extremely difficult decision to place him in a nursing home. As he was no longer safe on his own and they could not rely on home-care workers to meet his needs, they felt this was the only option. In the spring of his 91st year, George was admitted to the local nursing home. His children believed that he would receive optimal care and thrive once he settled in. They assumed that they would be informed about any issues relating to their father's care and well-being.

One week after George moved in, George's daughter phoned and was told that he had fallen the day before. The following month, George's daughter was contacted by management and informed that he had fallen again and needed to go to the hospital, as he required stitches in his elbow. Five days after that, George was hospitalized once more, as he had fractured his hip. Yet again, George's family was told that he had fallen. They found it unusual that their father was falling so often, as prior to his admission to the nursing home, George was able-bodied and walking independently. He was even snowshoeing earlier that year. For this reason, they insisted on viewing the surveillance videos of his falls. The footage from the first fall was never viewed nor saved by the nursing home staff, but they were able to watch the second and third incidents. What they saw that day left them shocked and traumatized. Until that point, they were led to believe that their father had fallen on each occasion. However, the videos from these two incidents clearly depicted George collapsing to the floor due to assaults by a resident named Tom. During our investigation, we also discovered that, although no staff witnessed the first incident, George told the employee who discovered him on the floor with Tom standing in close proximity that "he pushed me to the ground".

Two weeks after his hip replacement surgery, George passed away while in hospital. Just three days prior to his death, two members of the nursing home's senior management team phoned George's daughter to say that he was being discharged from the nursing home, effective immediately. This call caught George's daughter off-guard as she had not received any indication this would happen.

Following George's passing, the Department of Social Development conducted an Adult Protection investigation at the nursing home and concluded that allegations of neglect and abuse were unsubstantiated and did not contribute to George's injury and subsequent death. What is troubling, however, is that the Adult Protection social worker only examined the final assault on George and did not factor in any of the other concerning incidents between his attacker and other residents. By the start of the Adult Protection investigation, Tom had been involved in a total of nine episodes with several residents, including George, yet Adult Protection neglected to review any of these other incidents. Moreover, the only people at the nursing home interviewed during that investigation were two members of the senior management team. None of the care staff or residents were spoken to.

In February of last year, the Office of the Seniors' Advocate gave notice to the Department of Social Development of an investigative review of the Department's involvement with George through both Nursing Home Services and Adult Protection. Through this investigation, the following questions arose regarding the services provided to George:

- Could George's death have been prevented?
- Were there warning signs that his safety was at risk?
- What was done to protect George?
- Was his family kept informed and invited to collaborate on ways to keep him safe?
- Did the Adult Protection investigation fulsomely examine all pertinent issues surrounding the nursing home's ability to protect residents?
- Was George's family treated with compassion and dignity in the wake of the unexpected and exceptionally disturbing loss of their father?

What we found was a wide array of failings ranging from the nursing home's inability to protect residents from harm and under-reporting of major incidents, to an Adult Protection investigation that did not take measures to ensure that all relevant and pertinent information was obtained and reviewed. To address these issues and several others that were identified during the course of the investigation, and to improve upon the level of care and support provided to New Brunswick's seniors, the Office of the Seniors' Advocate makes recommendations in key areas including:

- Protection of nursing home residents
- Major incident reporting
- Complaint process
- Staff training
- Communication with family members of nursing home residents
- Adult Protection investigations in nursing homes
- Independence and oversight of reviews of geriatric deaths and critical injuries

HE DESERVED BETTER: ONE MAN'S FINAL DAYS IN LONG-TERM CARE

George was born and raised in a rural community where he lived a very full and rewarding life, a life not so very different from other New Brunswickers. Family was central to George and his commitment to his loved ones was evident in his roles as son, brother, husband, father and grandfather. Raised in a family with twelve children, George was constantly surrounded by his many siblings whom he adored. When only two out of his four brothers who served in WWII returned, George vowed to one day visit the graves of the brothers he lost overseas, and eventually made this trip with his daughter on the 60th anniversary of D-Day. In adulthood, George was a devoted husband to the love of his life and alongside his wife of 54 years, raised a family of four children. According to his children, their mother was the outgoing one while their father was more soft-spoken and "behind the scenes". Later in life, George became a doting grandfather to ten grandchildren and five great-grandchildren.

George's children all have fond memories of their father. One commonality among these recollections is in the description of his character as being gentle and calm, and as a father who never raised his voice nor seemed to get angry. One daughter described him as, "more of a solver than a fighter" and recalls how, according to her dad, a bowl of ice cream would solve everything. George was a loving father who offered his children his time, patience and kindness. For that reason, they can each remember unique experiences shared with him, from skating on the backyard rink, to fishing trips and reassuring snuggles on the couch.

George led a very dynamic lifestyle and was active into his nineties. Growing up in a large family with meagre means, he learned early on the value of discipline and hard work and brought dedication to all facets of life. George was a strong supporter of community and was generous with his time volunteering for many local organizations. After retirement, George continued to work seasonally for the Emergency Measures Organization doing River Watch into his eighties. For recreation, George enjoyed keeping physically active, and snowshoed right up until his final winter. When he wasn't snowshoeing, George could often be found at the local curling club as he was an avid fan of the sport, enjoying the game past the age of eighty. In the summer, gardening was a true passion for George and he relished keeping his flower gardens and lawns meticulous. His green thumb even extended to several of the community gardens where he took pride in their maintenance as though they were his own. He was a nurturer, a caretaker, a man with a warm heart.

Something Changed

A few years after the death of his wife, when George was in his mid-eighties, his children began to notice a change in their father wherein "he wasn't quite himself." His concentration faltered and he began forgetting to do important things like feeding himself, although he tried to hide this from his loved ones by saying he had already eaten. Also troubling was that the patience they had always known in him was now replaced with agitation and annoyance. For his son-in-law, the event that was most alarming took place on a fishing trip when George arose in the middle of the night and insisted on returning home. George's daughter recalls visiting him on a frigid winter day and discovering that his front door had been left open for hours. Soon after, his family's most dreaded fears and suspicions were confirmed when George received a diagnosis of Alzheimer's Disease.

A Difficult Choice

Like many families, George's children tried for as long as possible to accommodate their father living in his own home. With none of his children living near, one who was battling cancer, another who for health reasons could not drive, and the remaining two working full-time, they decided to hire home-care workers. What should have been a convenient solution to keep their father at home, quickly turned into an ongoing headache with workers who frequently did not show up for their scheduled shifts, thus resulting in George not being fed nor taking his medication. As his Alzheimer's progressed, George became paranoid about having different people enter his home. He got along well with his main worker who was reliable; however, when she told the family that she was planning on taking an extended summer vacation, they realized that they were now pressed to make an incredibly difficult choice. Their father's safety was the primary concern and, ultimately, the determining factor for their decision to start the application process for his admission to a nursing home." This decision was "heart-wrenching" but was what his family felt was best for him based on the circumstances. George wasn't willing to move in with any of his children, not wanting to burden them with his care. They felt they had no other options.

George's family felt reassured in the belief that he would thrive at the nursing home once he settled in. They thought he would enjoy the socialization and activities and that he might gain back some of the weight he had recently lost. They believed it was a good facility and placed absolute trust in leaving their father in its care. Their main expectation of the nursing home was to keep their father safe, as he was no longer safe on his own at home. They also assumed that they would be informed immediately of any issues or problems. In late spring of his 91st year, George was admitted to the local nursing home.

A Victim of Assaults

One week after George moved into the home, an employee discovered him lying on the floor with another resident, Tom, standing nearby. George told the employee, "He pushed me to the ground." The following day, one of George's daughters phoned the nursing home for an update and was told that he had fallen the day before. Upon visiting him, she found that his hand was swollen and had a cut that appeared infected, which did not heal properly even after several weeks. The video record of this incident was never saved and was automatically erased before anyone could view it.

The following month, a second concerning incident happened to George at the home. Since his admission, George could regularly be found wandering the hallways, often following Tom, the same resident George had said pushed him to the ground. Both residents had been diagnosed with dementia. One day while George was following Tom, Tom became aggressive and pushed him away. In what appears to be an effort to keep his balance, George reached for Tom's arm but was shaken off, causing him to fall to the floor and hit his head. George's daughter was phoned and told that her father had fallen again and needed to go to the hospital. George was transported to the local hospital by ambulance where he received eight stitches for a cut on his elbow.

Less than one week later, George encountered his third and most critical incident while under the care of the nursing home. Once more, he was following Tom down a hallway when Tom seemingly became annoyed and violently shoved George to the floor. This assault caused George severe pain and injury, again necessitating transport to the hospital by ambulance. George was kept overnight at the local hospital where he awaited transferral to a larger hospital to undergo hip replacement surgery. His left hip had been fractured from the impact of the fall. The surgery was performed without immediate complications; however, 48 hours later, George's oxygen level dropped, he developed apnea and his level of consciousness decreased. He soon became confined to his bed and was unable to feed himself.

Prior to suffering this final assault at the nursing home, George was able-bodied, never requiring any mobility aids such as a cane or walker, and the last time he required hospitalization was nearly forty years prior. Earlier that day, George had enjoyed a pleasant outing for ice cream with his daughter and was walking independently.

While recovering from surgery, George's health continued to decline dramatically as he developed bedsores and pneumonia and was given oxygen and intravenous fluids. Less than one week following his hospital admission, George's condition worsened with the collapse of the bottom of his lungs. Two weeks post-surgery, George passed away while in hospital.

The regional coroner declared George's death a homicide. This finding was due to the assault by Tom, which the coroner found had led to George's death. This classification of death by the coroner is separate from any criminal process and does not relate to any potential criminal culpability. A coroner may classify a matter as a homicide (as one of five categorizations of death) when the actions of one person (or several) directly cause the death of another. This is separate from any criminal finding of homicide, which requires criminal intent on the part of the perpetrator. No criminal investigation was undertaken in this case, and the Adult Protection review noted that "Due to the dementia diagnosis, there is not a means to measure intent to harm." Coroner Services is mandated to investigate all suspicious or questionable deaths in New Brunswick. In order to determine the means of death, the regional coroner reviews applicable evidence including the pathology report, conducts interviews and carries out other activities necessary to arrive at their conclusion. In George's case, the regional coroner made his final determination after consultation with the deputy chief coroner.

ANALYSIS AND RECOMMENDATIONS

The physical agony and emotional distress George endured during his final days should never be an ending to anyone's story. Although 91 years of age, George was admitted to the nursing home in excellent physical condition. Two months later, George left the home on a stretcher, never to walk again. The primary reason George's family placed their father in a nursing home was to keep him safe, affording him the opportunity to live the remainder of his life in comfort and good health. What they did not, and could not, have foreseen was that this decision would ultimately result in their father's unexpected death shortly after his admission to the nursing home. Every day in New Brunswick, families are faced with the difficult reality of how to meet the intensive care needs of their elder loved ones. Few have the time or resources to care for or accommodate aging parents in their homes. More than ever, long-term care has developed into a resource that we have become reliant on for our aging population. Presently, there are seventy-one facilities in the province and plans to add an additional 1026 nursing home beds by 2023.[1] Current waitlist numbers for nursing home placements exceed 800[2] - a testament to how vast of a demand exists. With specialized healthcare staff, meals customized to meet individual dietary requirements, planned recreational activities and compassionate attendants offering care around the clock, the decision to place a loved one in a nursing home seems evident. It is not unreasonable to expect nursing homes to provide optimal care for those who devoted countless years into looking after us when we were most vulnerable. No one would presume that placing loved ones in these facilities would risk putting them in harm's way. In a nursing home, we would never fathom that our mothers or fathers would be subjected to repeated harm. While we accept the inevitability that end of life is nearer for those who have reached a certain age, death is never acceptable when it is preventable. With this in mind, we ask the following difficult questions. Could George's death have been prevented? Were there warning signs that his safety was at risk? What was done to protect George? Was his family kept informed of what was happening and invited to collaborate on ways to keep him safe? Did the Department of Social Development's Adult Protection investigation fulsomely examine all pertinent issues surrounding the nursing home's ability to protect residents? And finally, was George's family treated with compassion and dignity in the wake of the unexpected and exceptionally disturbing loss of their father?

A known risk, left unreported and unaddressed

Issue: Failure to protect residents from harm

During Tom's first month at the nursing home, five concerning events were documented, including the first one involving George. According to a member of the senior management team, this is not considered unusual in someone with dementia as it takes several months for staff to become familiar with a new resident and for the resident to adjust to the nursing home. She referred to this time as the *Learning Phase* - a period of observation for staff to identify the new resident's triggers.

The nursing home's employees soon realized that George was not safe in Tom's presence. Some would encourage George to sit with them in the Nursing Station, and several voiced concerns to management over allowing George and Tom to continue to dine together at the same table, especially following the first two incidents between them. Likewise, some staff suggested that the two residents should be separated into different wings of the nursing home. Many employees interviewed felt that their concerns and suggestions to management "fell on deaf ears." A member of the senior management team explained that her facility is considered "home" to each resident and as such, they are permitted to do whatever they wish, including dine with whomever they wish. This approach led to a failure to recognize risks of allowing a violent resident to interact with others. Consequently, there was a failure to proactively address Tom's dangerous behaviours.

No effective safeguards were instituted to prevent this violence. When we asked the nursing home's management why interventions were not put in place early on to protect residents from Tom's assaultive behaviour, they claimed that during the Learning Phase, staff were still getting accustomed to him. It took two and a half months following Tom's admission before management posted notices around the facility, providing staff guidelines on how to redirect certain residents away from Tom who were known to trigger his aggression. This was after seven documented concerning incidents including the second one with George and three other violent assaults on other residents [See Appendix D for a Timeline of Concerning Incidents]. At the same time, the nursing home assigned a "Project Worker" to Tom for one-on-one supervision. Unfortunately, these interventions did not prevent Tom's third assault on George. After this third and final incident between Tom and George, based on a recommendation by the New Brunswick Association of Nursing Homes, the nursing home applied for funding for more Project Workers to supervise Tom.

It is important to note that the confrontation with Tom that led to George's death transpired within two months of George's admission to the nursing home, and just over two months following Tom's admission, i.e., within the time parameters of what management refers to as the Learning Phase. Actively implementing safety measures during this time period and not simply passively observing may have averted several of Tom's assaults on residents including those on George.

Due to the series of assaults that were inflicted upon George during his time at the home, it appeared as though he no longer felt safe and lost trust in allowing others to care for him. In interviews with various nursing home employees, we learned that George would often sit in a corner, always on guard in case of attack. Hospital staff told his family that he would cower in their presence and plead with them not to hurt him.

The Nursing Home Services Standards[3] require that the "nursing home must ensure residents are receiving adequate care," and that the "rights of residents are met." As the Standards state: "These rights include their entitlement to feel safe, and to live in an environment where they are protected from assault, neglect." More specifically, the Standards obligate that "The interactions between clients are managed to avoid incidents of abuse" and that "The behaviour management plans include the triggers that may cause one client to harm another." There is no 'waiting period' or 'learning phase' attached to these obligations. On the contrary, the Standards require that "The nursing home must continually assess, plan, design and implement programs and services to meet the current and future needs of the residents in order to achieve the best possible outcome." And furthermore, the programs and services must have "a written description which include: goals, directives, methods to reduce risks, methods to monitor outcomes." These standards were not adhered to in this case.

Moreover, according to the Department of Social Development's Adult Victims of Abuse Protocols, "efforts must be made to avoid secondary victimization of the abused which occurs when the system fails to identify abuse or neglect and follow-up effectively, with negative effects on the quality of care provided to the victim."[4]

The multiple attacks by Tom on multiple victims, including George, reveal the potentially fatal consequences when incidents are not identified and followed up on.

Recommendation 1

It is recommended that the Department of Social Development develop evidence-based best safety practices for all nursing homes to implement. Nursing homes should be obligated to incorporate these practices as a minimum requirement to comply with the adequate care standards. Inspectors must review each nursing home's services description for compliance, and must interview random staff to determine if adequate care standards for safety are being followed in practice.

Not just a New Brunswick issue: How other provinces are addressing aggressive behaviours in long-term care residents

A jurisdictional scan of practices in long-term care facilities across Canada highlighted diverse methods for minimizing the risk of violence and aggression against residents. Several jurisdictions have demonstrated that the use of a variety of interventions and strategies prior to resorting to physical restraints and/or pharmaceutical therapy has proven effective in preventing and managing agitation and aggression in residents with dementia. In the Atlantic region, a paper written by the Newfoundland & Labrador Centre for Applied Health Research in 2014[5] noted that long-term care residents often lack stimulation, leading to anxiety, depression and subsequently, agitation and aggression. The authors also raise the point that oftentimes personal attention can relieve some of the anxiety that causes aggressive behaviour in residents. The paper makes several recommendations that have proven helpful in reducing aggressive behaviour, including: using a person-centred approach by offering attention to individual residents to help relieve anxiety; playing relaxing music at mealtimes and having group and personal music sessions; and using structured and informal animal intervention sessions such as canine therapy.

The Community Governed Nursing Home Society of Nova Scotia (commonly referred to as CGO for 'Community Governed Organizations') published recommendations in 2014[6] to improve the lives of those in long-term care facilities, specifically those who demonstrate heightened aggression. The paper made several recommendations common to other studies, but also included the following two: establish an electronic database of resources for long-term care facilities and staff across the country to share information and de-escalation techniques; and create specialized units used to stabilize aggressive behaviours in the small number of residents that will continue to exhibit aggression regardless of supports and prevention.

Although many papers have been published nationwide offering recommendations to address this serious issue, we note one final study, titled "Resident to Resident Aggression in B.C. Care Homes".[7] Released in 2016 by the British Columbia Seniors Advocate, the report includes a recommendation for standardized reporting using a province-wide system to track resident data to ensure that incident reporting and tracking is consistent.

Recommendation 2

It is recommended that the Department of Social Development undertake a thorough review of best practices in violence mitigation, and develop a comprehensive policy and practice structure, in collaboration with the Seniors' Advocate and representation from: nursing homes, the Nurses Association of New Brunswick, the New Brunswick Council of Nursing Home Unions, the Association of New Brunswick Licensed Practical Nurses, the New Brunswick Association of Nursing Homes and academic experts from New Brunswick post-secondary institutions.

Unreported Violence

Tom was admitted to the nursing home just two weeks prior to George, but during that short time period, staff noted four concerning incidents involving Tom with other residents, including one where he shoved a wheelchair-bound woman into a wall. There were numerous notes in Tom's chart about his incessant wandering and several people complained of being intruded upon in their own rooms as he would regularly barge in, uninvited. According to the nursing home's management, this wandering behaviour is very common in people with dementia and is not generally a concern.

Issue: Incidents of violence were not recorded in the resident's chart and were not reported to authorities

George experienced his first adverse interaction with Tom just one week after moving into the nursing home. Even though staff discovered George on the floor with Tom standing over him and with George verbalizing that Tom had pushed him to the floor, the surveillance video was never saved nor viewed. A member of the nursing home's senior management team classified the incident as "unwitnessed" and referred to it as a "fall". All major incidents must be reported by the nursing home to two officials at the Department of Social Development: (1) A regional Liaison Officer, responsible for inspecting the province's nursing homes for compliance with the Nursing Homes Act to protect the health, safety and well-being of residents; and (2) an Adult Protection officer, responsible for investigating allegations of neglect or abuse. Nursing home management did not report this incident between George and Tom to either the regional Liaison Officer or Adult Protection. The rationale for this decision was that it was, notwithstanding George's statement, in their view an unwitnessed fall. They stated that they believed the fall was not due to an assault and required no reporting. The deletion of video footage leaves the question of the actual facts of the incident unanswered. No details of this event were recorded in Tom's chart despite the Nursing Home Services Standards requirement that, "An operator shall keep a complete and up-to-date record for each resident from time of admission to the time of discharge."[8] This is a problem of due diligence, as necessary steps were not taken to ascertain the cause of the fall. Whether this first incident was one requiring reporting could only be established if measures were taken to determine the cause.

The following month, George experienced his second harmful altercation with Tom and required stitches in his elbow. This time, the video footage was viewed and saved. On the video, it is apparent that Tom pushed George and then shook him onto the floor when George clung to Tom's arm for balance. Despite this clear evidence, the nursing home again told George's family that he had fallen, and again did not report the incident to the regional Liaison Officer nor to Adult Protection. As well, no documentation about this incident was recorded in Tom's chart. What is alarming is that by this point Tom had been involved in six disturbing episodes with several residents, including one where he punched a resident in the face. According to the Nursing Home Services Standards, major incidents include: "Suspected abuse or neglect of the resident" and "Accident causing admission to hospital".[9] Therefore, this second incident that sent George to the hospital for stitches should have been reported as *suspected abuse* and *accident causing admission to hospital*. Management at the nursing home is of the opinion that the second incident did not require reporting because George wasn't technically 'admitted' to the hospital as he returned to the nursing home after receiving his stitches. This illustrates a case of management seeking to find an interpretation that limits their reporting obligations, when they should be instead seeking to give their reporting obligations a large interpretation. A reasonable and purposive interpretation of the standard would find that George was admitted to hospital, since he was admitted as an outpatient, and this should therefore have triggered a reporting obligation. It is never wrong to report, the error will always be found on the side of not reporting.

Issue: Reporting of violent incidents was not completed in a timely manner

Three days after sending George to the hospital for stitches in his elbow, Tom struck another resident in the face and pushed her backwards causing her to strike her head on a chair and land on her back with her feet in the air. Two days after that, Tom assaulted George for the third and final time, breaking his hip and again sending him to the hospital. This was the only time the nursing home reported Tom's behaviour to the Department of Social Development. Even then, since it occurred on a Saturday it was not reported to the Liaison Officer until the following Monday, and then to Adult Protection on Wednesday. The Nursing Home Services Standards require that major incidents be reported to the Liaison Officer within 24 hours and to Adult Protection "as soon as possible".[10] When a manager at the Department of Social Development was asked during this review about this Standard, she informed us that in practise the 24-hour time constraint does not apply over weekends, as Liaison Officers' work hours are from Monday to Friday - business hours.

Recommendation 3

It is recommended that

A. **The Department of Social Development amend practice standards to obligate reporting of major incidents to both the Liaison Officer and Adult Protection within 24 hours, and ensure that there is staff available to respond.**

B. **As part of the annual inspection, the Department of Social Development require Liaison Officers to review with nursing home management their duty to report major incidents to Nursing Home Services and Adult Protection.**

C. **The Department of Social Development develop a universal incident report form to be used by all nursing homes in the province, with Liaison Officers delivering training to nursing home management on how to use the form. This incident report form must be completed by nursing home staff for all incidents that cause harm to residents, and each completed form must be signed by a resident's family member. The incident report form must not include any identifying information about other residents.**

D. **The Department of Social Development's Nursing Home Services practice standards be amended to require mandatory inclusion of all major incidents in a resident's record whether they are the victim or aggressor, as part of the comprehensive care plan. This requirement should also be explicitly stated in the *Nursing Homes Act*.**

A family "left in the dark"

Issue: the nursing home's communication with George's family was inadequate

In the nursing home's handbook, it states that upon admission, each resident is assigned a registered nurse as their case manager and point of contact for concerns from the resident or family. According to George's daughter, no one was ever appointed.

Furthermore, due to an administrative error, George's family was never given the opportunity to participate in an initial care conference for newly admitted residents, as they did not receive the relevant paperwork from the nursing clerk in advance of the meeting. This paperwork, termed the *Family Audit*, allows the family to identify any issues and/or concerns regarding the resident's care. The Nursing Home Service Standards require that "Every nursing home shall ensure an initial care conference with the multidisciplinary team providing a resident's care is held within 6 weeks following the resident's admission, to allow for the resident's family to discuss the plan of care and any other matters of importance."[11] Two days before the scheduled date of this care conference with George's family, George was sent to the hospital for stitches after his second altercation with Tom. This would have been an opportune time for his family to discuss their concerns and collaborate on a plan with the nursing home to keep their father safe, but management rescheduled the meeting with the family for a later date.

By that point, George had been admitted to hospital for his fractured hip from the final assault. Even so, the family insisted that this meeting be kept, to allow them to view the video footage of their father's falls.

For all three episodes with Tom, George's family was told by management at the nursing home that their father had fallen. They were unaware that their father had been assaulted by Tom until they viewed the surveillance video. Understandably, they were shocked by what they saw. In separate interviews with our Office, George's children each told us that if the nursing home had been upfront and had given them accurate accounts of what really happened, they would have seriously considered hiring a sitter or re-arranged their schedules to spend more time visiting to keep their father safe. One daughter revealed that she will carry with her forever a paralyzing feeling of guilt.

Recommendation 4

It is recommended that beyond the transparency and accountability aspects of publishing individual annual nursing home inspections, the Department of Social Development report publicly, annually, on aggregate data resulting from inspections. Such reporting must identify nursing homes with multiple and persistent non-compliance with the law and practice standards.

Inadequate recourse for a grieving family

Issue: Absence of a standardized and effective complaint process

During our interview with a member of the nursing home's senior management team, we asked her to describe the process for handling complaints by residents and/or family. She explained that during her initial meeting with the family she tells them to bring their complaints to the relevant manager first, and not to her. She gave the example of a resident not liking peas and how this complaint should be brought to the Kitchen Manager. All complaints are then forwarded to the director of nursing who "problem-solves". When we asked a manager of Social Development's Nursing Home Services about Standards for nursing home complaint processes, she replied that each nursing home should have a committee to hear these complaints and that the composition of the committees is decided upon by the individual nursing homes. George's family was not made aware of any such committee.

George's family requested but were denied a meeting with the nursing home's Board of Directors to address their concerns regarding their father's treatment. In an interview with a past member of the Board of Directors who served on the Board while George lived at the nursing home, we learned that Board members were "not kept in the loop regarding this case."

The process at George's nursing home of directing complaints to managers who then relay these to the director of nursing to "problem solve" is wholly inadequate and does not meet the precise criteria as laid out in the Standard, including: "Policy and procedures are in place for the submission of a complaint or concern and follow-up is carried out and documented within 30 days of receipts of the complaint/concern" and, "A resident/family committee is in place, meetings are held at least on a quarterly basis and minutes are kept."[12]

Recommendation 5

It is recommended that:

A. The Department of Social Development create a standardized complaint process, in consultation with the Seniors' Advocate, to ensure a consistent province-wide system for nursing home complaint, response and appeal processes with fidelity to administrative fairness and rights-respecting practices. The Department also ensure effective monitoring of this complaint process system by establishing a Provincial Nursing Home Complaints Committee.

B. The Department of Social Development ensure that each nursing home appoints its own Complaints Committee to hear complaints that have not been satisfactorily addressed by the nursing home, and that these committees are comprised of individuals from the Board of Directors, family members, and residents. Each nursing home Complaints Committee must report regularly to the Provincial Complaints Committee on issues raised within the nursing home.

C. The Department of Social Development confirm that Resident/Family Committees are in place in each nursing home as per the Standards. The role of these Resident/Family Committees must be clearly defined in the Standards. In addition to providing orientation and communication to new residents and their families, the Resident/Family Committees should offer a platform for members to share concerns regarding resident care, with a responsibility to forward issues to the nursing home Complaints Committee as needed. If a resident/family is still not satisfied and is seeking further recourse even after speaking with the nursing home's Liaison Officer, they should be advised to contact the Office of the Seniors' Advocate. All nursing homes must prominently display posters with information about how to reach the Seniors Advocate's Office and include the Seniors' Advocate brochure in all resident registration packages.

Staff feel unprepared

Issue: Training on violence-reducing interventions is required in nursing homes.

The Nursing Home Services Standards require "in-service training for staff which includes but is not limited to: safe resident handling, behavior management, pain management, prevention of abuse, dementia care".[13]

Some of the training programs offered to the nursing home staff include: Gentle Persuasive Technique[14] and the U-First Approach[15]. However, not all staff interviewed could recall receiving this training. One employee divulged, as there is insufficient guidance provided to staff on how to deal with violent behaviours in residents, "you just have to wing it." A member of the senior management team stated that she values training and education, but she revealed that the $6000/year that is allotted for her ninety-five staff simply isn't adequate.

Recommendation 6

It is recommended that the Department of Social Development guarantee comprehensive training for all nursing home staff on violence-reduction interventions, with mandatory reporting to the Department to ensure that all staff have received training.

A superficial investigation

Issue: The Adult Protection investigation did not take measures to ensure that all relevant and pertinent information was obtained and reviewed.

It was, as noted above, only the third violent interaction between Tom and George that was reported by the nursing home to the Department of Social Development. The referral made by the nursing home to the Department's Adult Protection Services screened in as a Priority 3,[16] meaning that George's case was damaging but not life-threatening or dangerous (because by this point, he was receiving appropriate healthcare intervention at the hospital). Upon assignment to this case, the Adult Protection social worker consulted with a Clinical Specialist social worker on an investigation plan and they agreed that the investigation should determine whether this was an isolated issue between Tom and George, or a nursing home issue that affected other residents.

When interviewed, the Adult Protection social worker said that she became aware of the incidents by Tom against other residents but focused her investigation only on the final incident against George, i.e., the only one that was reported to Adult Protection by the nursing home. From the date of Tom's admission to the nursing home, to the start of the Adult Protection investigation, he was involved in a total of nine documented disturbing events. Some of these incidents were physical attacks while others were verbal in nature. Solely focusing the investigation on George, and only on one incident, was, in our opinion, too narrow a focus that did not consider the safety of, and risk to, all of the home's residents. It also fails to situate that narrow incident in an appropriate context to inform the home's duty of care and make a credible finding as to whether due diligence was exercised, or the applicable standards were met.

A further problem with the investigative process was that the only nursing home employees who were interviewed as part of the Adult Protection investigation were two members of the senior management team. One of these employees told the Adult Protection social worker that the first incident between George and Tom was not alarming as it was an isolated incident, and that Tom never exhibited any aggression until his second assault against George. These statements significantly contradicted what was noted in Tom's chart – specifically that he had been involved in seven violent or otherwise concerning incidents by that point in time.

None of the many staff who provided direct care to the residents were interviewed for the Adult Protection investigation. These are the people who work with the nursing home residents on a daily basis and so could have offered much valuable information relevant to the social worker's investigation. Moreover, none of the residents were interviewed.

The Adult Protection Practice Standards related to an investigation of a facility specifically state that "Depending on the details of the situation, it may be appropriate to assess/interview all of the residents to determine abuse/neglect."[17] In this case, the details of the situation were unknown due to the limited focus of the investigation, but the extreme nature of even the one violent incident being investigated should have provided cause to interview and assess other residents.

Part of the Adult Protection investigation involved ensuring that nursing home's staffing ratios were adequate on the day of the incident that broke George's hip. To do so, the social worker obtained the staffing timesheet from the regional Liaison Officer who had requested it from the nursing home. The nursing home provided a staffing timesheet to the Liaison Officer who then verified that staffing levels were adequate and forwarded this timesheet to the Adult Protection social worker who used this information to conclude that the home was fully staffed on the date of Tom's third assault on George. What is problematic, however, is that Tom assaulted George on the day *before* the date on the timesheet that was provided. Therefore, the staffing timesheet that the Liaison Officer gave to the Adult Protection social worker for her investigation was entirely irrelevant. Neither employee realized this error until questioned about it during interviews with our Office. Furthermore, the Adult Protection investigation failed to check staffing levels on the dates of the other two incidents between George and Tom, nor for any of the dates of the attacks by Tom on other residents. These omissions and errors further call into question the efficacy of the Adult Protection investigation.

Given the limited focus of the Adult Protection investigation, the lack of comprehensive interviewing of relevant people, and the lack of due diligence in documentary examination, we must conclude that the Adult Protection investigation was inadequate in the determination of level of risk to all of the nursing home's residents.

Recommendation 7

It is recommended that the Department of Social Development's Adult Protection investigations in nursing homes take measures to ensure a comprehensive harm prevention approach informs all investigations, in order to assess and address the risk to all residents, even if the Adult Protection referral relates to only one or a few residents. The Adult Protection investigator must ensure comprehensive documentary disclosure is obtained to make certain that all relevant information (e.g., charts and incident reports) for all affected residents is considered. Formal interviews must also be conducted with affected residents, their family members, as well as staff who provide direct care, rather than addressing all questions to management staff. Adult Protection investigations should follow a template to ensure that comprehensive harm prevention approaches are enforced and that the scope of review is not unreasonably limited. Staff training should be offered to guarantee that more robust investigation techniques are adopted consistently in accordance with the practice standards.

Issue: The Adult Protection investigation was inconsistent in whether it was investigating physical abuse or physical neglect, and did not thoroughly address either.

In her investigation conclusion summary, the Adult Protection social worker noted that the allegation of physical abuse toward George was unsubstantiated. However, the conclusion letter sent to the nursing home's Board of Directors stated that the allegation of physical *neglect* was unsubstantiated. When questioned about this discrepancy during an interview with our Office, the social worker didn't realize that she had written "abuse" in one document and "neglect" in another, and replied that she was likely investigating both.

The regional coroner's conclusion into the manner of George's death as homicide did not factor into the Adult Protection investigation. The Adult Protection supervisor advised the social worker to close the investigation without waiting for the coroner's report, as they still had not received it 8 ½ months after George's death. During our interview with the Adult Protection social worker, when questioned why she did not wait for the coroner's report before closing her investigation, she clarified that the cause of death as homicide would not have changed her conclusion because, due to Tom's dementia, there was no way of proving his intent to harm.

In our view, the Adult Protection investigation was flawed insofar as it did not appropriately identify the issues for investigation at the outset, nor indeed throughout the investigation, nor in its reporting process. The investigation needs to make necessary distinctions between allegations of resident-to-resident abuse, abusive behaviour by staff and neglect of residents by staff. In the current matter the nursing home may have been neglectful in failing to appropriately supervise George, or in failing to properly supervise Tom or follow up effectively to curb his harmful behaviour towards other residents.

The Adult Protection social worker justified her conclusion of unsubstantiated abuse/neglect by stating that the nursing home was meeting George's care needs and staff were appropriate in immediately responding to the third violent incident and getting him medical attention. She stated that the staff followed all protocols and reported to Adult Protection. She stated that the nursing home was not neglectful or abusive as they responded appropriately. In our view, this conclusion stems from a very narrow focus of only considering reactive measures taken by the nursing home while completely overlooking the preventative measures that should have been in place to protect an extremely vulnerable population. The Adult Protection review completely misses the mark by failing to address the hard question as to whether Tom's continued presence on the floor posed an unreasonable foreseeable risk to other residents and whether his propensity to violence towards other residents might have justified more restrictive measures, or whether it could have been effectively addressed with more sustained programming interventions.

Our review of judicial and academic authorities makes it clear that nursing homes are generally subject to the same duties of care as hospitals. In the law of tort, a duty of care is not owed to the entire world, but only to those who are in sufficient proximity to the defendant. The scope of the duty of care is the avoidance of reasonably foreseeable harm.[18]

In what seems to be the first Canadian nursing home case on the subject, a resident in a nursing home fell and was injured after being struck by another resident into whose room she had wandered uninvited. The victim resident was suffering from Alzheimer's disease yet was allowed to wander around the home, since this was a more humane alternative to having her confined to a room. The assailant resident was known to be aggressive, yet the nursing home had to keep caring for him since no other facility in the province of Saskatchewan could have accommodated his medical conditions. The judge ruled that although allowing the victim to roam freely was standard medical practice, the nursing home had to "exercise reasonable caution and diligence" to protect her from injuries, and the nursing home was not sufficiently diligent in keeping the victim and the assailant away from each other.

This case established the proposition that nursing homes are liable when a resident is attacked and injured by another resident,[20] but has been primarily used to support the proposition that "a hospital ... owes a duty to other patients in the hospital to exercise such control and supervision over mentally ill patients that because of his or her conduct or behaviour, fellow patients do not come to harm.[21]

The extensive case law in relation to hospitals duty of care in this context is instructive. They can be vicariously liable for their staff's wrongdoing – although the question of whether a medical staff member is an "employee" such that can trigger the employer's vicarious liability is often fact-specific, rather than clear-cut and automatic[22]. In particular, doctors who merely use the hospital premises, but otherwise operate independently, are usually not deemed to be employees.[23] They have a duty "to ensure proper co-ordination by the medical staff using the Hospital's facilities,"[24] as well as to ensure that whenever it implements new policies designed to improve quality of care all the staff follows those policies, so that the hospital is operated "as a unified and cohesive whole[25]." Some of the other duties of care are the duties "to select competent staff and to monitor their continued competence, to provide proper instruction and supervision, to provide proper facilities and equipment, [and] to establish systems necessary for the safe operation of the hospital."[26]

They must make certain that "premises are as safe as reasonable care and skill on the part of anyone can make them,"[27] and owe this duty of care to patients as well as their next of kin.[28] They have a duty of care to train their staff, to force compliance with adopted policies, ensure there is enough staff on duty to adequately attend to residents. And they owe a duty of care to prevent disturbed patients from injuring themselves and other patients.

Succinctly stated: preventing abuse and neglect require a broad focus on ensuring that staff competencies can meet the needs of the residents, and that the nursing home is safe.[29] An investigation into potential abuse or neglect at a nursing home must thoroughly examine the individual situations but also comprehensively address potential systemic problems.

Remedying the problems uncovered by this review will require not only the adoption of more thorough investigation processes as recommended above, but also new practice standards to identify the several forms of abuse and neglect that can arise in nursing home operations and guidance as to how to effectively prevent these harms, while respecting patient autonomy and liberty interests.

The literature that we have reviewed suggests that patient wandering and aggressive resident behaviour, which are two compounding and common risky behaviours in nursing homes, can be most effectively addressed with intensive monitoring and programming supports. As long as residents are actively engaged in program activities they enjoy, and that they have adequate staff supervision, the risk of resident-to-resident abuse can be significantly abated and addressed. However, in the absence of such protective measures, other short term and more restrictive measures, curtailing an aggressive resident's freedom of movement, may need to be considered. What should not be allowed to happen is for an aggressive resident to aggress multiple residents in a repeated fashion, over a course of weeks without adequate supervision, program supports or intervention being attempted. Our review confirms that this is what happened in the instant case, but that the Adult Protection review failed to make any such finding because of its flawed investigation. According to a director in Adult Protection, "Assault is something we would expect to see in a nursing home." While this may be true, it is simply not acceptable.

In the Ashley Smith Report, our Office looked into a broken system of correctional services where youth would enter the correctional services system for minor misdemeanours, but then spend all their childhoods in detention because of the accumulation of multiple institutional charges. In Ashley's case she was subjected to multiple indignities including lengthy periods of segregation in isolation, strip searches, use of multiple restraints and pepper stray. Following recommendations from the Advocate, the youth services Branch established a Behavioural Management Review Board (BMRB) at the New Brunswick Youth Centre. Initially the Advocate met quarterly with the BMRB to review all behavioural incidents involving youth on the units and to monitor all uses of segregation. In recent years the Advocate has been attending BMRB meetings on a monthly basis. Following the institution of the BMRB process, the use of segregation dropped off remarkably and other behavioural incidents are addressed more effectively within the units. We believe that a similar system of regular reporting and auditing of critical incidents, injuries and abusive behavioural incidents in long-term care, with the participation of the Advocate's office would be very beneficial.

Recommendation 8

It is recommended that:

A. **The Department of Social Development create new, detailed Adult Protection practice standards for nursing homes, that adequately address the particular situations of abuse and neglect that can occur in these facilities, and provide guidance as to how to curb and address resident to resident violence so as to minimize all risks of harm.**

B. **The Department of Social Development establish a behavioural incident review process wherein monthly reports of all critical injuries and behavioural management incidents in long-term care are produced and reviewed at the provincial level through monthly meetings of Adult Protection officials with the participation of the Seniors' Advocate's Office.**

A call for greater independence and oversight

The above analysis underscores important limitations in the Department of Social Development's current ability to effectively monitor its own Adult Protection and Nursing Home Services programs to protect the rights of vulnerable older persons. The above recommendations propose improvements to these current systems, and in the Advocate's view, these improvements are necessary to restore faith in the safety of our Nursing Home and Long-term Care system and in the Department's oversight function. However, we are also of the view that these recommendations by themselves will not be sufficient. Indeed, when working with a vulnerable population like older persons in long-term care, it is simply unwise and not credible to have the Department and Minister responsible for this service delivery also assume full responsibility for the system's quality assurance and oversight. It invites comparison with the adage of the fox watching the henhouse. There is too much self-interest at stake, for the public to give full faith and credit to such self-policing measures.

In the Advocate's report Broken Promises, we looked at the system in place for child death reviews in New Brunswick and found that it was impossible for the child death review committee to do credible work while operating from within the department of Family and Community Services and reporting to the minister responsible for child protection. We recommended a more independent mechanism such as existed for child death and critical injury reviews in many other Canadian provinces and territories, placing the mandate with the Advocate's Office or with an independent arm's length office such as the Coroner's office. We indicated also that in either case, additional resources would be required to carry out the task adequately. Ultimately the Coroner's Office was tasked by government with this new mandate, but no additional resources were advanced.

The Advocate concludes from our review of this case that a similar mandate should be added to the Seniors' Advocate's Office to carry out reviews of all critical injuries and geriatric deaths that arise from suspected abuse or neglect in New Brunswick nursing homes and long-term care facilities. This new mandate will require additional resources and cannot be carried out within existing resources, but is a function which fits best with the Advocate's mandate rather than the Coroner's Office as it should encompass critical injuries as well as suspicious deaths, and as it is a specialized review function within the Advocate's expertise in defending and enforcing the human rights and interests of older persons in the Province.

Recommendation 9

It is recommended that the Province enact amendments to the Child, Youth and Senior Advocate Act to give a clear legislative mandate to the Advocate to carry out geriatric death and critical injury reviews arising from reported cases of abuse or neglect in nursing home and long-term care in New Brunswick and that additional resources be allocated to the Seniors Advocate to allow for the hire of additional staff to effectively carry out this new mandate.

Issue: Disclosure of information to George's family was limited and it was difficult for them to obtain information.

When asked about their experience with Adult Protection, George's children described it as "cold" and, in their opinion, inefficient. Despite repeated efforts, they were unsuccessful in their attempts to speak with the Adult Protection social worker or supervisor. When one of his daughters phoned the Adult Protection supervisor to inform her that some of the dates in the file were inaccurate, she never received a call back. The social worker would only speak with George's Power of Attorney – his eldest daughter, but even she found communication very limited. This is in contradiction with the 2019 Adult Protection Investigation Guide that states how important it is to make every effort to work with the Power of Attorney to ensure the safety of the alleged victim.[30] In addition, the Adult Protection Practice Standards state, "Where possible, the social worker should develop a case plan in consultation with the client and his family/support system."[31] It is also troubling that the Adult Protection social worker did not conduct interviews with any of the nursing home care staff, only with two members of senior management. According to the Adult Protection Practice Standards, "When concluding an investigation, the social worker should consider all components to the investigation including interviews with the alleged victim, alleged perpetrator, offender, family members, care providers, referral sources, witnesses, police, etc."[32]

George's eldest daughter said it was extremely difficult to obtain information on the results of the Adult Protection investigation and was required by the social worker to provide documentation proving that she was her father's Power of Attorney. She ended up sending the social worker her father's will – an extremely private document - and even then, the only information the social worker would disclose was the conclusion of the investigation that allegations of physical abuse and/or neglect by the nursing home were unsubstantiated. No details of the investigation were provided. Again, this is in opposition to the guidance provided in several Adult Protection Practice Standards, namely, "When closing a case, the social worker should: advise the adult and/or family accordingly and tell them the reason(s) for closure" and, "If appropriate, feedback should be provided to referral source within 2 weeks of completing the investigation."[34] In addition to being George's Power of Attorney, his eldest daughter was also a referral source. Clearly, the Adult Protection investigation was in violation of Practice Standards promoting collaboration and information exchange with the victim's family, referral source and care providers.

Considering how onerous and intrusive the process was to gain access to her father's Adult Protection file, George's daughter was very surprised that she was never asked to present photo identification when picking up the documentation from the Social Development office. She believed anyone could have picked it up. Given the delays (the Adult Protection investigation took 10 months to complete; the Adult Protection Practice Standards state the investigation should be completed within 45 working days[35]), the grieving period and the circumstances of George's death, his family felt they were not treated with consideration and sensitivity at every stage of the investigation. In fact, they felt the opposite – they felt victimized by an upsetting process with little empathy. A nursing home incident leading to death is a tragic and traumatic process for all involved. The rights affected call for a high degree of administrative fairness and due diligence in the investigative work and reporting process. The Province's Adult Protection response in this case failed repeatedly by providing little in the way of answers, accountability, compassion or comfort.

Recommendation 10

It is recommended that the Department of Social Development ensure Adult Protection social workers undergo mandatory initial and annual training on the Practice Standards, and in all investigations they should complete a checklist document to ensure the Standards have been followed.

An unjust discharge

Issue: While George was in hospital, the nursing home gave notice to his family of his discharge, effective immediately.

One week after George's hip surgery, a member of the nursing home's senior management team phoned the hospital for an update on his status and was told that his health was declining as the bottom of his lungs had collapsed. Four days later, nursing home management again called the hospital and learned that George was no longer receiving supplementary oxygen. The following day, during an interview with the Adult Protection social worker, management disclosed that they would not be taking George back when he was discharged from the hospital, and that they believed that his family would blame the nursing home if George died. Two days later, two members of the management team phoned George's eldest daughter to inform her of her father's discharge from the nursing home, effective immediately.

This call caught George's daughter off-guard, as she had not been given any prior indication, verbal or written, that this would happen. She was also dealing with the news of her father being transferred to palliative care just hours before. George's daughter was not given an opportunity to discuss this decision, but was told that she would receive a registered letter and that the Board of Directors voted to discharge her father. The letter addressed to George's daughter claimed that her accusatory actions were disrespectful and that her father's continued stay at the nursing home "unduly endangers the safety of himself, other residents and staff." According to the nursing home, the reason for discharging George while he was hospitalized was to allow his family time to make alternate arrangements for his release from the hospital. However, as noted earlier, a member of the nursing home's senior management team had already learned that George's health status had significantly declined. From our interviews, we have learned that Board members were told by management that George would be released from the hospital any day. George died three days after his family was informed of his immediate discharge.

This discharge was in direct violation of Nursing Home Services Standards.[36] Those standards require the following:

1. The nursing home must ensure that alternatives to discharge have been considered and, where appropriate, tried.
2. The nursing home must ensure that the resident/his next of kin or legal representative is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration.
3. The nursing home must provide a written notice, at least fifteen days, to the resident and to his next of kin or legal representative except where the operator believes, on reasonable grounds, that the immediate discharge of the resident to the custody of another person is necessary for the safety of the resident or of other residents or staff.
4. The written notice must set out a detailed explanation of the supporting facts, justifying the nursing home's decision to discharge the resident.

None of the above requirements were met.

The regional Liaison Officer's review of the incident resulted in the nursing home receiving an infraction for non-compliance under section 17(1) of the *Nursing Homes Act*. That section provides a legal obligation that "If for any reason an operator intends to discharge a resident, the operator shall give at least 15 days' notice of that intention to the resident and to his or her next of kin or legal representative unless the operator believes, on reasonable grounds, that the immediate discharge of the resident to the custody of another person is necessary for the safety of the resident or of other residents or staff".[37] This was the only infraction the nursing home was given in the Liaison Officer's inspection of the situation and required only that an action plan be provided to the Liaison Officer within a month on how to address the issue.

The discharge was illegal. It was also uncaring. The decision by management at the nursing home to inform George's family of his immediate discharge, and the manner of this communication while he was still hospitalized, but being transferred to palliative care, clearly demonstrates a lack of respect and empathy for his loved ones.

The Office of the Seniors' Advocate makes the following recommendation in relation to this investigation, however, is also presently reviewing discharge processes for nursing home residents and will make further recommendations on this matter at a later date. Recent amendments have been made to the legislation after public consultation on proposed changes to regulations.

Recommendation 11

It is recommended that the Department of Social Development ensure that prior to notice of discharge of any resident of a nursing home, the nursing home must be required to notify both the Department and the Seniors' Advocate, with contact information for the resident and/or the resident's substitute decision-maker. The Department should then be required to institute a rapid response procedure to assess the validity of the discharge. When there is no irremediable safety concern, a process of mandatory mediation should be instituted between family and nursing home. The Department should also engage in a consultation with the Seniors' Advocate and other relevant stakeholders in regard to a review of protections in the *Nursing Homes Act* to guard against unfair discharge practices.

A denial of compassion

During interviews with employees of the nursing home, we were told that while George was in hospital post-surgery, some staff were directed by management to pack up his belongings and remove his name from the door. We were also informed that after George died, management told staff to supervise while his youngest daughter and his son-in-law cleared out his room. Employees said that they were not made aware that George had passed away and so no one offered the family their condolences. Probably the most troubling disclosure was that nursing home employees were instructed by management not to attend George's funeral or have contact with any of his family members. This came as a surprise as many of them regularly attend residents' funerals. These findings were corroborated during interviews with George's family members, however, senior management at the nursing home have disputed these claims entirely. They also assert that compassion was provided to the family as George was visited in hospital and a memorial ornament was gifted to his family as is the custom with all residents who pass. After hearing from both staff and management, we find on balance that the directions reportedly given to staff to not attend the funeral services are less-self serving and more credible than management's denial. In any case, the reduced staff presence in a community where these grieving processes normally offer families the support of community and a chance to heal by coming together did contribute to the sorry outcome of this matter. In the Advocate's view the Nursing home's concerns with risk mitigation prevented it from responding to George's passing with all of the solemnity and human dignity that the occasion required.

Recommendation 12

It is recommended that the Department of Social Development amend Nursing Home Services practice standards to ensure supportive interactions with family and insist upon the compassionate care needed to uphold human dignity, including throughout the grieving process and in relation to funeral rites.

A system that fails to protect the rights of the most vulnerable

The Advocate's review of this matter has found significant flaws with the nursing home's provision of care, by failing to take adequate measures to protect George and other residents when Tom's repeated aggressive behaviour required it. We have also found significant flaws in the Department of Social Development's investigation and review of the matter through its Adult Protection and Liaison Officer functions. The scope of the review was too narrow, the issues for investigation were not properly defined, there was no consideration given to the broader context of prior incidents of repeated aggressions by the same resident and the hard issue of how best to address resident-to-resident violence while balancing all the rights of all residents was studiously avoided. Most troubling in our view was the limited compassion offered to George's family after his passing.

It is for this reason that the Advocate is formulating a final recommendation calling upon Government to do more to support the human rights of older persons and to protect these rights in nursing homes and long-term care settings.

In 2007, Ontario reformed the governing nursing homes regime with the passage of the *Long-Term Care Homes Act*[38] to replace Ontario's *Nursing Homes Act*,[39] which largely resembled the New Brunswick statute presently in force. Unlike the New Brunswick legislation, Ontario's new *Act* contains an aspirational preamble. The preamble provides, among other statements, that the people of Ontario and its government:

- "Strongly support collaboration and mutual respect amongst residents, their families and friends, long-term care home providers, service providers, caregivers, volunteers, the community and governments to ensure that the care and services provided meet the needs of the resident and the safety needs of all residents";
- Firmly believe in public accountability and transparency to demonstrate that long-term care homes are governed and operated in a way that reflects the interest of the public, and promotes effective and efficient delivery of high-quality services to all residents;
- Firmly believe in clear and consistent standards of care and services, supported by a strong compliance, inspection and enforcement system; and
- Recognize the responsibility to take action where standards or requirements under this Act are not being met, or where the care, safety, security and rights of residents might be compromised...[40]

The Ontario *Act* in fact establishes a 27-point nursing home *Resident Bill of Rights*[41] that, again unlike the New Brunswick legislation, not only seeks to ensure residents are protected against abuse (Right 2) and neglect (Right 3) and are provided with adequate physical care (Rights 4-5), but more broadly insists that "every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity (Right 1)".

For instance, residents have a right to be informed who is responsible for their care (Right 7), participate in development and review of their care plan and consent to or refuse treatment (Right 11), have an explicit right not to be restrained except for limited circumstances provided for in the Act (Right 13), a right to form friendships (Right 18), to meet "privately" with a "spouse or another person in a room that assures privacy" (Right 21), to have their lifestyles respected by the nursing home staff (Right 19), a right to form and participate in nursing home residents' councils (Right 20), and the right to exercise citizenship rights (Right 6).

To promote a culture of compliance with this *Bill of Rights*, nursing homes licensees are legally obligated to create for their establishments mission statements consistent with the *Act* and the *Bill of Rights*,[42] and provide to new residents and residents' relatives information packages which, among other things, must include the *Bill of Rights* and the nursing home's mission statement consistent with it.[43]

These legal rights found in Ontario's legislation are directed to the specific situations of older persons in long-term care homes, but these rights also reflect the broader human rights residents have.

The concept of human rights is founded on the idea that each human, regardless of our differences, is entitled to certain fundamental rights. These rights, enshrined in international human rights law, include the right to life and its protection, freedom from cruel or degrading treatment, freedom from discrimination, security of one's body (one's "person"), liberty, privacy, adequate food and housing, and the right to the highest attainable standard of health. Many of these rights are protected in our Constitutional law, the supreme law of Canada, under the Charter of Rights and Freedoms, which applies to all governments – federal, provincial and territorial.[44] Many are not, including the right to the highest attainable standard of health, which is a matter of provincial authority.

Canada is founded upon principles that recognize the rule of law.[45] In turn, it is a principle of the rule of law that the law must provide adequate protection of fundamental human rights.[46] The Charter of Rights and Freedoms protects life and security of the person, but these rights require specific application in the provincial legislative and regulatory regime governing nursing homes. This regime must also ensure protections of the highest attainable standard of health and other fundamental human rights found in the core international human rights law instruments including the International Covenant on Civil and Political Rights,[47] the International Covenant on Economic, Social and Cultural Rights,[48] and the Convention on the Rights of Persons with Disabilities.[49] These are legal obligations. There are also moral obligations to ensure that the United Nations Principles for Older Persons are reflected in New Brunswick's legal protections.

Recommendation 13

It is recommended that a Committee comprised of senior management from the Department of Social Development and the Department of Health should lead a comprehensive consultation with all relevant stakeholders, with the goal of thoroughly amending the *Nursing Homes Act*, Regulations, and Practice Standards, to ensure protection of human rights.

CONCLUSION

Throughout his entire life, George worked hard, was actively involved in his community, loved and was loved by his family. He played a significant role in many lives and his passing is a tragedy that will never fade for those closest to him. George was a caring man who lived his life with dignity but was denied the right to end his days in peace. George's final days were marked by pain and suffering. He deserved better.

While troubling to read, we felt that George's story needed to be told. He didn't deserve the ending that he was given, but his death should not be in vain. By providing this report, we are hoping to change the ending for the rest of our loved ones who have reached the point in their lives when living independently has become a distant memory. Because of varying circumstances, some will depend on long-term care to live out the remainder of their days. They are our mothers, our fathers and our grandparents...our veterans and kind-hearted souls in the community and they all deserve better.

ENDNOTES

[1] Government of New Brunswick. *2018-2023 Nursing Home Plan.* Online: https://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/NursingHomes/2018-23NursingHomePlan.pdf

[2] M. Urquhart. (2021, February 23). Auditor general says N.B. hasn't done nearly enough to meet need for nursing home beds. CBC News. Retrieved from https://www.cbc.ca/news/canada/new-brunswick/province-fails-to-keep-up-with-nursing-home-needs-1.5924623

[3]Department of Social Development, *Standards Manual: Nursing Home Services*, 2020. Online: https://www2.gnb.ca/content/dam/gnb/Departments/sd-ds/pdf/Standards/NursingHomesStandardsManual.pdf

[4] Government of New Brunswick. *Adult Victims of Abuse Protocols.* Fredericton, September 2005.

[5] N. Chappell, S. Bornstein, and R. Kean, *Agitation and Aggression in Long-term Care Residents with Dementia in Newfoundland and Labrador.* Online: https://www.nlcahr.mun.ca/CHRSP/CHRSP_Dementia_LTC_2014.pdf

[6] Community Governed Organizations, *Task Force on Heightened Aggression in LTC Homes,* 2015. Online: https://nhnsa.ca/wp-content/uploads/2017/03/CGO-Task-Force-on-Heightened-Aggression-in-LTC-Homes-Recommendations-Report.pdf

[7] Office of the Seniors Advocate British Columbia, *Resident to Resident Aggression in B.C. Care Homes*, 2016.

[8] *Nursing Home Services Standards*, ibid, at pg. 84.

[9] *Ibid*, at pg. 89.

[10] *Ibid*, at pg. 88.

[11] *Ibid*, at pg. 98.

[12] *Nursing Home Services Standards*, ibid, at pg. 81.

[13] *Nursing Home Services Standards*, ibid, at pg. 140.

[14] Advanced Gerontological Education. (n.d.). *Gentle Persuasive Approaches.* https://ageinc.ca/about-gpa-2/

[15] Alzheimer Society. (n.d.). *U-First! Training for professional caregivers of people with Alzheimer's Disease and other dementias.* http://u-first.ca/

[16] Department of Social Development. *Adult Protection Services Practice Standards and Guidelines.* Pg.13. September 2007

[17] *Adult Protection Services Practice Standards and Guidelines*, ibid, at pg. 29.

[18] *Cooper v Hobart* 2001 SCC 79.

[19] *Stewart v Extendicare Ltd,* [1986] 4 WWR 559, 48 SaskR 86 (QB).

[20] Lewis Klar, "Recent Developments in Canadian Law: Tort Law" (1991) 23 Ottawa L Rev 177.

[21] *Wenden v Trikha,* [1991] AJ No 612, 28 ACWS (3d) 135 (QB).

[22] *Comeau v Saint John Regional Hospital,* 2001 NBCA 113, at para 29-36.

[23] Ibid.

[24] *Comeau v Saint John Regional Hospital,* 2001 NBCA 113, at para 55.

[25] Ibid, at para 53.

[26] Ibid, at para 56.

[27] *Prosko v Regina Qu'Applle Regional Health Authority*, 2008 SKQB 144, at para 26.

[28] Ibid.

[29] Phelan, Amanda. "Protecting care home residents from mistreatment and abuse: on the need for policy," *Risk Management and Healthcare Policy.* 2015; 8: 215–223. Published online 2015 Nov. 19. doi: 10.2147/RMHP.S70191 Protecting care home residents from mistreatment and abuse: on the need for policy (nih.gov)

[30] Department of Social Development. *Adult Protection Investigations Guide.* July 2019.

[31] *Adult Protection Services Practice Standards and Guidelines*, ibid, at pg. 26.

[32] *Ibid*, at pg. 20.

[33] *Ibid*, at pg. 27.

[34] *Ibid*, at pg. 22.

[35] *Ibid*, at pg. 22.

[36] *Nursing Home Services Standards*, ibid, at pg. 87.

[37] *Nursing Homes Act*, RSNB 2014, c 125, <https://canlii.ca/t/54c8n>. Section 17(1) If for any reason an operator intends to discharge a resident, the operator shall give at least 15 days' notice of that intention to the resident and to his or her next of kin or legal representative unless the operator believes, on reasonable grounds, that the immediate discharge of the resident to the custody of another person is necessary for the safety of the resident or of other residents or staff.

[38] Ibid.

[39] RSO 1990, c N7.

[40] Ibid.

[41] Ibid, s. 3(1).

[42] Ibid, s. 4.

[43] Ibid, s. 78.

[44] *The Constitution Act*, 1982, Schedule B to the Canada Act 1982 (UK), 1982, c 11, <https://canlii.ca/t/ldsx>

[45] Ibid. Preamble.

[46] Lord Bingham, Tom. The Rule of Law. Penguin Books, 2011.

[47] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171

[48] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3

[49] UN General Assembly, *Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly*, 24 January 2007, A/RES/61/106

APPENDICES

Appendix A: The Office of the Seniors' Advocate

The New Brunswick Senior's Advocate has a mandate to:

- Ensure the rights and interests of seniors (aged 65 and over) are protected;
- Ensure the views of seniors are heard and considered where those views might not otherwise be advanced;
- Ensure seniors have access to approved services and that the complaints about these services receive appropriate attention;
- Provide information and advice to government, government agencies and communities about the availability, effectiveness, responsiveness, and relevance of services to seniors; and
- Act as an advocate for the rights and interests of seniors in general

Appendix B: Investigative Team

New Brunswick Child, Youth and Seniors' Advocate

- Norman J. Bossé, QC

Lead Investigator

- Wendy Cartwright

Contributors

- Christian Whalen
- Gavin Kotze
- Robert Savoie
- Brigid Martin
- Rajvir Gill
- Clara Bataller

Legal Counsel

- Gavin Kotze

Communications

- Heidi Cyr

Appendix C: Review Process

The investigation began in February 2021. Pursuant to section 19 of the Child, Youth and Senior Advocate Act, notices of investigation were sent to the Departments of Social Development, Justice and Public Safety, Office of the Chief Coroner, Horizon Health, and copied to the Department of Health and President of the nursing home's Board of Directors. The file disclosure by government comprised of documentation including nursing home chart information for residents George and Tom, surveillance video footage, incident reports, nursing home inspection reports, hospital records, case notes documented by the Adult Protection social worker, assessments completed, referrals made, medical documentation, autopsy report, email correspondence and other information. The extensive file was reviewed, and a timeline of events created detailing what transpired in the weeks leading to George's death and ensuing Adult Protection investigation. Both case-specific and systemic processes were identified for further study along with relevant legislation, policy and practice standards. Finally, valuable information and insight was gained through a total of 20 key informant interviews. Those interviewed included members of George's family, individuals on the nursing home staff and Board of Directors, the Adult Protection social worker, liaison officer, regional coroner, and management in both Nursing Home Services and Adult Protection. The final report and recommendations were further informed by an internal literature review and research.

Appendix D: Timeline of Concerning Incidents/Notable Events

Week 1

- Tom admitted to nursing home.
- First documentation in Tom's nursing home chart about a concern with Tom's interactions with resident Shirley, "especially when said resident is wheeling about" (taken from Tom's chart).
- Tom is constantly in and out of other residents' rooms and had an altercation with those in room 13 (taken from Tom's chart).

Week 2

- Tom is "nasty" with other residents (Shirley and Ruth). Tom tells Shirley that he will "smash her" (taken from Tom's chart).
- Tom is "nasty" with resident Shirley again, swearing at her and shoving her wheelchair into a wall (taken from Tom's chart).
- George admitted to nursing home.

Week 3

- First incident between Tom and George. Night-shift LPN discovers George on the floor with Tom standing nearby. George tells LPN, "He pushed me to the ground." This was not reported to Nursing Home Services or Adult Protection (taken from incident report; it was not documented in Tom's chart).

Week 4

- Tom punches resident Shirley in the face, knocking her glasses to the floor (taken from Tom's chart).

Week 12

- Second incident between Tom and George. George is following Tom who then pushes George and causes him to grab onto Tom's arm. Tom shakes George off, causing him to fall on the floor and hit his head. George is sent by ambulance to hospital for stitches. This is not documented in Tom's chart nor reported to Nursing Home Services or Adult Protection (taken from incident report and hospital records).
- Nursing home posts notices with:
  - *guidelines for staff on redirecting George and Shirley away from Tom*
  - *how to identify Tom's triggers for aggression including foot pain*
- Nursing home assigns a Project Worker to Tom for one-on-one supervision
- Tom hits resident Ruth in the face, then grabs her arm and pushes her causing her to fall backwards, striking her head on the back of a chair and landing on her back with her feet in the air (taken from Tom's chart and incident report).
- Third (and final) incident between Tom and George. George is following Tom who then pushes George to the floor and breaks his hip. This is not documented in Tom's chart but is reported to Nursing Home Services and Adult Protection (taken from incident report).

Week 15

- George passes away in hospital

Appendix E: Table of Recommendations

Recommendation 1

It is recommended that the Department of Social Development develop evidence-based best safety practices for all nursing homes to implement. Nursing homes should be obligated to incorporate these practices as a minimum requirement to comply with the adequate care standards. Inspectors must review each nursing home's services description for compliance, and must interview random staff to determine if adequate care standards for safety are being followed in practice.

Recommendation 2

It is recommended that the Department of Social Development undertake a thorough review of best practices in violence mitigation, and develop a comprehensive policy and practice structure, in collaboration with the Seniors' Advocate and representation from: nursing homes, the Nurses Association of New Brunswick, the New Brunswick Council of Nursing Home Unions, the Association of New Brunswick Licensed Practical Nurses, the New Brunswick Association of Nursing Homes and academic experts from New Brunswick post-secondary institutions.

Recommendation 3

It is recommended that:

A. The Department of Social Development amend practice standards to obligate reporting of major incidents to both the Liaison Officer and Adult Protection within 24 hours, and ensure that there is staff available to respond.

B. As part of the annual inspection, the Department of Social Development require Liaison Officers to review with nursing home management their duty to report major incidents to Nursing Home Services and Adult Protection.

C. The Department of Social Development develop a universal incident report form to be used by all nursing homes in the province, with Liaison Officers delivering training to nursing home management on how to use the form. This incident report form must be completed by nursing home staff for all incidents that cause harm to residents, and each completed form must be signed by a resident's family member. The incident report form must not include any identifying information about other residents.

D. The Department of Social Development's Nursing Home Services practice standards be amended to require mandatory inclusion of all major incidents in a resident's record whether they are the victim or aggressor, as part of the comprehensive care plan. This requirement should also be explicitly stated in the *Nursing Homes Act*.

Recommendation 4

It is recommended that beyond the transparency and accountability aspects of publishing individual annual nursing home inspections, the Department of Social Development report publicly, annually, on aggregate data resulting from inspections. Such reporting must identify nursing homes with multiple and persistent non-compliance with the law and practice standards.

Recommendation 5

It is recommended that:

A. The Department of Social Development create a standardized complaint process, in consultation with the Seniors' Advocate, to ensure a consistent province-wide system for nursing home complaint, response and appeal processes with fidelity to administrative fairness and rights-respecting practices. The Department also ensure effective monitoring of this complaint process system by establishing a Provincial Nursing Home Complaints Committee

B. The Department of Social Development ensure that each nursing home appoints its own Complaints Committee to hear complaints that have not been satisfactorily addressed by the nursing home, and that these committees are comprised of individuals from the Board of Directors, family members, and residents. Each nursing home Complaints Committee must report regularly to the Provincial Complaints Committee on issues raised within the nursing home.

C. The Department of Social Development confirm that Resident/Family Committees are in place in each nursing home as per the Standards. The role of these Resident/Family Committees must be clearly defined in the Standards. In addition to providing orientation and communication to new residents and their families, the Resident/Family Committees should offer a platform for members to share concerns regarding resident care, with a responsibility to forward issues to the nursing home Complaints Committee as needed. If a resident/family is still not satisfied and is seeking further recourse even after speaking with the nursing home's Liaison Officer, they should be advised to contact the Office of the Seniors' Advocate. All nursing homes must prominently display posters with information about how to reach the Seniors Advocate's Office and include the Seniors' Advocate brochure in all resident registration packages.

Recommendation 6

It is recommended that the Department of Social Development guarantee comprehensive training for all nursing home staff on violence-reduction interventions, with mandatory reporting to the Department to ensure that all staff have received training.

Recommendation 7

It is recommended that the Department of Social Development's Adult Protection investigations in nursing homes take measures to ensure a comprehensive harm prevention approach informs all investigations to assess and address the risk to all residents, even if the Adult Protection referral relates to only one or a few residents. The Adult Protection investigator must ensure comprehensive documentary disclosure is obtained to ensure that all relevant information (e.g., charts and incident reports) for all affected residents is considered. Formal interviews must also be conducted with affected residents, their family members, as well as staff who provide direct care, rather than addressing all questions to management staff. Adult Protection investigations should follow a template to ensure that comprehensive harm prevention approaches are enforced and that the scope of review is not unreasonably limited. Staff training should be offered to ensure that more robust investigation techniques are adopted consistently in accordance with the practice standards.

Recommendation 8

It is recommended that:

A. The Department of Social Development should create new, detailed Adult Protection practice standards for nursing homes, that adequately address the particular situations of abuse and neglect that can occur in these facilities, and provide guidance as to how to curb and address resident to resident violence so as to minimize all risks of harm.

B. The Department of Social Development establish a behavioural incident review process wherein monthly reports of all critical injuries and behavioural management incidents in long term care are produced and reviewed at the provincial level through monthly meetings of Adult Protection officials with the participation of the Seniors' Advocate's Office.

Recommendation 9

It is recommended that the Province enact amendments to the Child, *Youth and Senior Advocate Act* to give a clear legislative mandate to the Advocate to carry out geriatric death and critical injury reviews arising from reported cases of abuse or neglect in nursing home and long-term care in New Brunswick and that additional resources be allocated to the Seniors Advocate to allow for the hire of additional staff to effectively carry out this new mandate.

Recommendation 10

It is recommended that the Department of Social Development ensure Adult Protection social workers undergo mandatory initial and annual training on the Practice Standards, and in all investigations, they should complete a checklist document to ensure the Standards have been followed.

Recommendation 11

It is recommended that the Department of Social Development ensure that prior to notice of discharge of any resident of a nursing home, the nursing home must be required to notify both the Department and the Seniors' Advocate, with contact information for the resident and/or the resident's substitute decision-maker. The Department should then be required to institute a rapid response procedure to assess the validity of the discharge. When there is no irremediable safety concern, a process of mandatory mediation should be instituted between family and nursing home. The Department should also engage in a consultation with the Seniors' Advocate and other relevant stakeholders in regard to a review of protections in the *Nursing Homes Act* to guard against unfair discharge practices.

Recommendation 12

It is recommended that the Department of Social Development amend Nursing Home Services practice standards to ensure supportive interactions with family and insist upon the compassionate care needed to uphold human dignity, including throughout the grieving process and in relation to funeral rites.

Recommendation 13

It is recommended that a Committee comprised of senior management from the Department of Social Development and the Department of Health should lead a comprehensive consultation with all relevant stakeholders, with the goal of thoroughly amending the *Nursing Homes Act*, Regulations, and Practice Standards, to ensure protection of human rights.