Continuing Care Safety Association

Protecting Workers' Safety in Managing the Risks of Violence, Harassment and Responsive Behaviors in Continuing Care Settings

September 2024

About CCSA

Established in 2005, the Continuing Care Safety Association (CCSA) is a not-for-profit organization that supports employees in long-term care (LTC) and senior supportive living (SSL) through:

- ✓ Health and Safety education and training
- ✓ Health and Safety consultation
- ✓ Health and Safety resources
- ✓ Certificate of Recognition (COR) audit supports and administration
- ✓ Advocacy on issues that impact Health and Safety

We are funded primarily through a levy administered by the Worker's Compensation Board (WCB) of Alberta. We help Alberta's Long Term Care (LTC; Industry code 82808) and Seniors' Supportive Living (SSL; Industry Code 82800) employers prevent illness and injury in the workforce.

226 EMPLOYERS 82800 (SSL) + **149** EMPLOYERS 82808 (LTC) = **375** EMPLOYERS IN TOTAL

Because we represent so many service providers across the province - large and small, rural and urban, private and not-for-profit - CCSA is in a unique position to provide insight into industry trends and issues, and the impact of change within this growing, dynamic sector.

Industry partners

Worker's Compensation Board - Alberta
Alberta Occupational Health and Safety

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Executive Summary

The delivery of care and support services across various continuing care home types, supportive living accommodations, and home and community care facility-based settings, is essential in Canada's healthcare system. This becomes even more significant as the population evolves and the demand grows. Maintaining the quality of care and services, along with ensuring the safety of residents and staff, are integral components of operational processes and management structures. However, the rising incidents of violence, harassment, and responsive behaviors in these environments present a persistent challenge that calls for an immediate reassessment of supportive processes and systems.

Workplace violence poses a significant threat to the psychological and physical health and safety of healthcare workers worldwide, including in Alberta's continuing care and supportive living care sector. Despite ongoing attention and research on this issue for the past decades, the full extent of its impact remains uncertain and underemphasized. Contributing factors include limited funding, inadequate surveillance and research, poorly aligned training programs, ineffective and fragmented policies, and a general lack of collaboration among stakeholders and governing bodies.

Managing the risk of violence is crucial in healthcare, with a focus on higher prevalence of incidents in continuing care settings, which cater to a senior population with underlying medical conditions. As a significant portion of incidents originates from residents and families, the emphasis is on handling violence, aggression, and responsive behaviors (VARB). The evolving landscape of healthcare has brought about systemic changes impacting how risks are managed by staff and employers. Furthermore, the changing population demographics in supportive living accommodations, which includes seniors housing and lodges, presents new challenges in resident behaviors. New best practices, research, and innovation for VARB are trying to adapt to these changes in care delivery. However, with expected systemic shifts in Alberta's healthcare and continuing care, new efforts might get misguided and new challenges could arise that could exacerbate the ongoing hardships that workers are already experiencing.

For decades, we have been lobbying that providing care should not entail accepting violence as an inherent aspect of the job or a 'normal' part of the working conditions within such environments. But how much have we accomplished?

Because of prolonged exposure, workers in continuing care have become accustomed to these incidents and are not reporting them. VARB incidents are “normalized” and underreported. VARB are mainly exhibited by the residents receiving care and services and their families, leading to a situation where workers may misinterpret their obligations to report and mistakenly prioritize the residents' safety over their own. The underreporting of such incidents poses a significant challenge in tackling this problem and contributes to unsafe workplace environments.

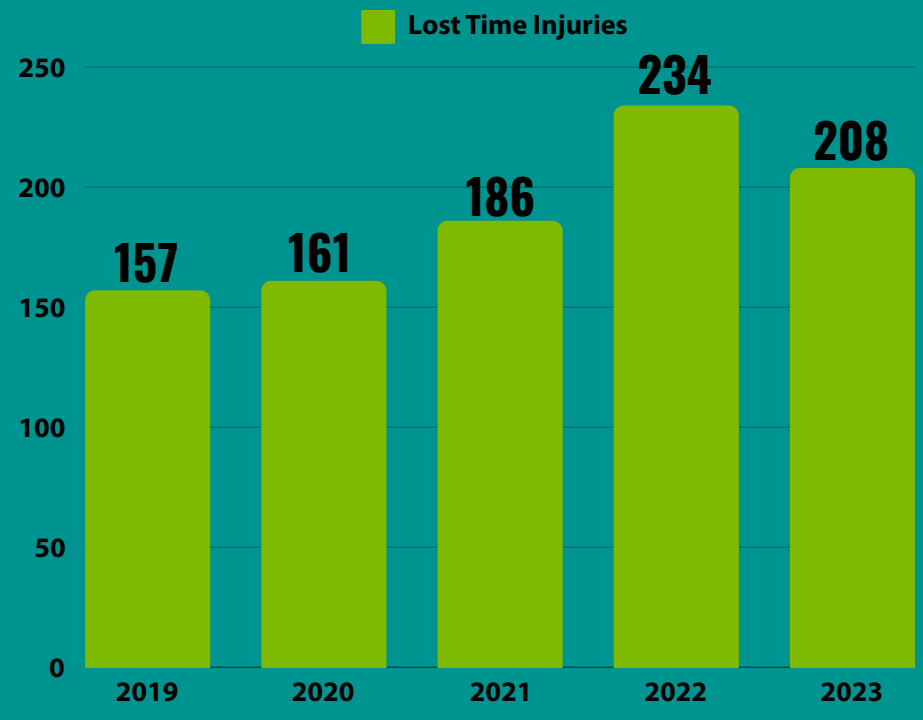
What is the root cause of this core issue, and how can we reduce the risks linked to caring for this vulnerable group? For decades, we have been lobbying that providing care should not entail accepting it as an inherent aspect of the job or a 'normal' part of the working conditions within such environments. But how much have we accomplished? While it poses a significant risk in continuing care and supportive living settings, various factors within the work environment complicate addressing these challenges.

Though this paper looks at these issues through an occupational health and safety lens, it recognizes that there needs to be a multifaceted approach to addressing these challenges. This whitepaper delves into various trends and strategies, evaluating their effectiveness and impact in different operational contexts. It highlights the importance of aligning workforce training and capabilities with the specific needs of the resident population, ensuring that care and services are delivered efficiently and safely. Key contributing factors such as employee training, workload distribution, and staffing ratios are reviewed. The paper also highlights psychosocial risk factors, including burnout, turnover rates, and the impact of regulatory compliance on staffing decisions. By understanding these elements, organizations can develop robust staffing models that not only enhance worker well-being but also minimize risks of violence and harassment and improve overall service quality. Ultimately stakeholders can work together to improve working conditions and care for those who care.

Workplace Violence and Harassment in Continuing Care Settings

Continuing care environments encompass various types of continuing care homes and supportive living accommodations (formerly supportive living and senior's housing). Continuing care homes are licensed facilities that receive public funding to offer residents nursing care, personal assistance, life enrichment activities, and additional support services. Continuing care Type A homes were formerly referred to as long-term care facilities, while Type B homes (including Type B-Secure) specifically provide designated supportive living (DSL) care and services. Although most violent incidents occur in continuing care home types A and B, the incidence of violence and harassment in supportive living accommodations have been also increasing over the years.[1]

WORKPLACE Violence related Lost time injuries have doubled since 2018. Source: CCSA Report - Workplace Violence in Alberta Continuing Care Sector (Continuing Care and Supportive Living and Senior's Lodges): 2019 to 2023



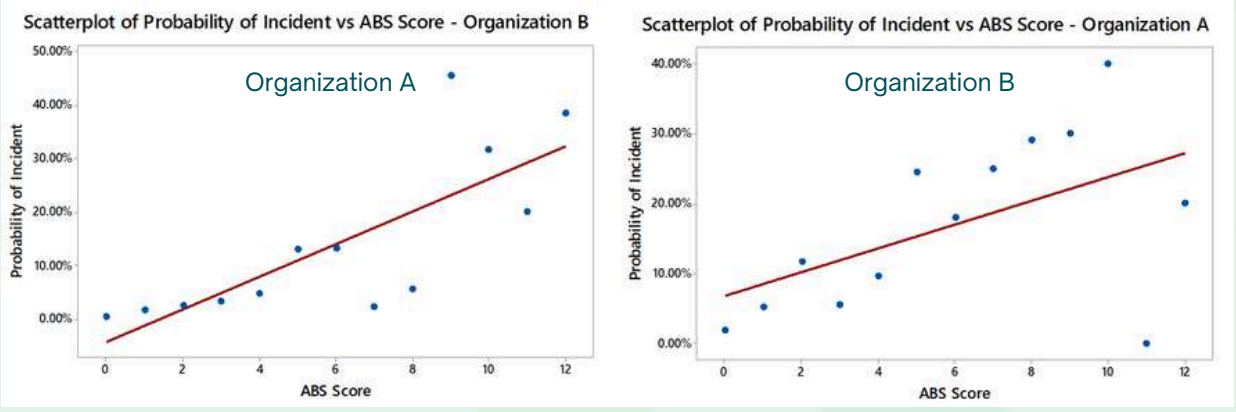
According to WCB data analyzed for the Alberta continuing care sector: from 2019 to 2023, Workplace Violence related Lost time injuries have doubled since 2019 with continuing care home type A reporting at three times the rate of reports in CC Type B, supportive living and senior's housing. Nevertheless, both continuing care and Supportive Living and Senior's Lodges show an increasing trend over the years. In fact, over the last 5 years, "assaults/violent acts/harassment' remains one of the top 5 types of injuries reported to WCB in Continuing Care Homes Type A, B, supportive living accommodations and senior's lodges.[2]

There are many sources and types of Violence and Harassment in Continuing Care. This whitepaper aims to explore the multifaceted nature of Type II violence providing insights into its prevalence, impact, and strategies for prevention and mitigation. Type II violence, characterized as "physical or verbal assault of an employee by a client, family member, or customer,"[3] is the most prevalent form of workplace violence found in healthcare environments.[4] This issue is so pervasive that it has been labeled an "epidemic public health problem."[5] It is essential to understand that in a care environment, the stressors on both residents and their families can lead to heightened emotions and, unfortunately, aggressive behaviors.

Workers in continuing care settings often face unique challenges as they strive to balance compassionate care with maintaining their own safety and well-being.

These behaviors, collectively known as Violence, Aggression, and Responsive Behaviors (VARB), are often seen in continuing care homes and supportive living settings. The terms “violence” and “aggression,” particularly in relation to individuals with dementia, can be complex to address within the continuing care sector.[6] Healthcare professionals understand that these behaviors frequently arise from unmet needs and not necessarily intentional. The term "responsive behaviour" has been used as a more person-centered approach.[7] It describes how their actions, words, and gestures serve as intentional responses that convey significant insights about their personal, social, or physical surroundings. However, employers must take steps to reduce potential risks to staff, regardless of the underlying motivations, as these behaviors can significantly impact both the residents exhibiting them and those around them.

Recognizing the root causes of VARB is crucial for developing effective strategies to manage and lessen these behaviors and prevent injuries to workers. A study conducted by the CCSA using RAI MDS Outcomes Scales and reported violent incidents in Continuing Care Type A Homes, aimed to find indicators to show if a resident has a higher chance for an aggressive incident towards healthcare workers. It was noted that there is a correlation between the Aggression Behavior Scale (ABS), Activities of Daily Living (ADL) and Depression Rating Scale (DRS) scores of residents and the probability of a violent incident. The findings show that if the ABS score, which are residents that had positive indicators for verbal and physical abuse, resistance to care and socially inappropriate or disruptive behaviors, is higher than 5, the higher the probability of a violent incident or injuries. The same findings were noted regarding the DRS scores indicating that the more the resident experiences depression symptoms, the higher the probability of violent incidents and worker injuries from aggression.[8]



The probability of a violent/aggressive incident increases as a resident’s ABS score increases. ABS includes resident’s positive indicator scores for physical and verbal aggression, physical aggression, resists care, socially inappropriate/disruptive behavior.

Dementia and the Prevalence of Violence, Aggression, and Responsive Behaviors

As the number of Canadians aged 65 and over rises, so does the prevalence of dementia. The number of people living with dementia in Alberta is rising rapidly. According to the Alzheimer Society of Alberta and Northwest Territories, it is projected that by 2050, over 200,900 individuals in Alberta will be living with dementia. This represents more than a threefold increase from the current figure of 59,000 people in the province.[9] The demographics of continuing care type A and B homes in Canada have changed rapidly, with a growing population experiencing moderate to severe dementia, making it increasingly challenging to provide adequate care in these facilities. In addition to severe cognitive impairment, 50% of continuing care home type A residents exhibit responsive behaviors, 31% show signs of depression, and 82% require extensive assistance with daily activities. This results in a higher incidence of responsive behaviors within these care environments.[10]

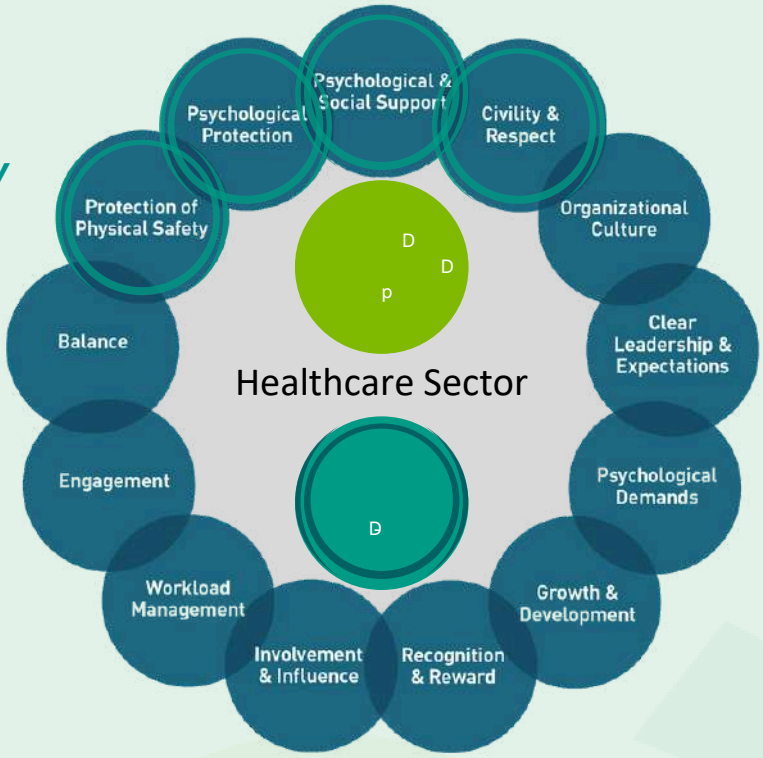
Individuals with dementia undergo considerable cognitive decline. As they may struggle to verbally convey their physical or emotional discomfort, they often communicate their needs and feelings through their behaviors. These responsive or reactive behaviors, a subset of behavioral and psychological symptoms of dementia (BPSD), are believed to impact up to 90% of those with dementia during their illness.[11] Such behaviors are associated with negative outcomes, causing distress for both residents and caregivers. The exact prevalence of violence among individuals with dementia remains unclear. This issue frequently complicates nursing care, as any activity that encroaches on personal space heightens the risk of aggression.[12]

Workplace Violence and Psychological Health and Safety are Interrelated

Every worker has the fundamental right to a healthy and safe workplace. Workplace violence is recognized as a significant threat to staff psychological wellness and physical safety in health care environments. Many individuals associate violence solely with physical attacks. However, workplace violence encompasses a much wider range of issues. It refers to any instance where an employee experiences abuse, threats, intimidation, or assault during their work. Psychological health and safety are just as important as physical health and safety in creating a holistic approach to employee well-being. Ultimately, a commitment to both psychological health and physical safety promotes a more resilient, motivated, and productive workforce, where individuals can thrive and contribute to a positive and supportive work environment.

The National Standard for Psychological Health and Safety in the Workplace, acknowledged as a best practice by the Health Standards Organization, outlines 13 factors that influence (either positively or negatively) psychological health and safety in Canadian workplaces. Two other factors are more recently developed specifically for the health-care sector: (1) support for psychological self-care and (2) protection from moral distress. The threat of workplace violence and harassment in continuing care directly affects at least 5 psychosocial factors in the workplace: civility and respect, psychological and social support, psychological protection, and protection of physical safety and protection from moral distress. This shows that managing workplace violence and harassment plays a huge role in creating a psychologically safe workplace in continuing care.[13]

Violence, Aggression and Responsive Behaviors can directly affect at least five psychosocial factors. Managing the risk of violence and harassment plays a huge role in creating a psychologically healthy and safe workplace.



The relationship between workplace violence and psychological health and safety is mutually influential, with each significantly affecting the other. For instance, a worker experiencing high levels of stress or emotional fatigue may struggle to provide high quality, person-centered care.[14] Workers who are emotionally drained are more susceptible to encountering hostile behavior from residents.[15] Moreover, the mental well-being of individual employees shapes the overall workplace dynamics. Those not feeling mentally well may display negative behaviors, resulting in heightened interpersonal conflicts.[14] Conversely, a higher incidence violence, aggression and responsive behaviors adversely impacts the mental health of everyone in the organization, creating a psychologically unsafe work environment characterized by fear and anxiety.[16]

Alberta Occupational Health and Safety Legislation and the Underreporting of Violent Incidents

In Alberta's Occupational Health and Safety (OHS) Act, violence and harassment are categorized as workplace hazards. Workplace violence, as per the Alberta OHS Act, refers to any threatened, attempted, or actual behavior by an individual that may cause physical or psychological injury. Workplace harassment, on the other hand, involves objectionable or unwelcome actions intended to intimidate or offend. The OHS Act mandates that employers must take reasonable steps to prevent and address these hazards, ensuring a safe and healthy environment for both employees and residents.[17]

The Alberta OHS Code mandates that employers establish and enforce both a harassment prevention plan and a violence prevention plan in the workplace. This encompasses the reporting and investigation of incidents involving violence and harassment, including Type II violence. While the Occupational Health and Safety legislation specifies provisions regarding workplace violence and harassment, including protective measures for those who report such incidents, violence and harassment in healthcare settings are significantly underreported. There seems to be a culture of acceptance or normalization of violence within the system. The culture of silence surrounding violence is a significant barrier to acknowledging and addressing the issue.[18]

78% **WORKPLACE VIOLENCE INCIDENTS IN ALBERTA CONTINUING CARE AND SENIOR SUPPORTIVE LIVING INVOLVE A HEALTH CARE PATIENT/RESIDENT**

Alberta WCB Data 2019- 2023

...But what if we REPORT ALL INCIDENTS Involving Violence, Aggression and Responsive Behaviors from RESIDENTS?

The underreporting of workplace violence presents a significant challenge that sets back efforts to enhance working conditions. Without a clear understanding of the actual scope of the issue, it becomes difficult to address the problem and allocate preventive resources in an effective manner.[21] There can be a notable gap between how healthcare professionals perceive incidents of violence or harassment at work compared to employees in other sectors, which may significantly contribute to the underreporting of such violent occurrences.[19] There are several key factors that can contribute to an environment where violence and harassment are tolerated. The most prevalent factor is the 'normalization' of such behaviors, which occurs when incidents of violence and harassment happen so often that they become perceived as a regular, unquestioned aspect of daily work life.[20] Aside from worker's perception, numerous and varied reasons have been identified in several literature regarding why healthcare workers fail to report incidents. These factors include: absence of visible injuries, lengthy reporting processes, insufficient support from peers and management, fear of retaliation or being held responsible for the incident, and the belief that reporting will not lead to any meaningful changes.[21,22]

The Chronic Crisis of Understaffing in Continuing Care

According to a recent survey by Parkland Institute regarding Staffing and Workload in Alberta's LTC (Continuing Care Home Type A) Facilities, the vast majority (62%), of those who worked short staffed daily, once a week or occasionally were direct care staff in HCA, LPN, RN or recreational therapy roles.[23] This was also confirmed by a study by Translating Research in Elder Care (TREC), which examined work-life quality experienced by health-care aides in Canada. It was found that one-half of the health care aides worked short staffed either daily or weekly. In the same study, walking and talking with residents were the most frequently missed elements of care due to rushing.[24]

The Parkland Institute survey indicated that 43% of participants experienced one or more incidents during periods of staff shortages. Additionally, 65% of respondents highlighted that boosting staff levels would reduce instances of violence among both employees and residents.[23] Workers are facing immense stress, which is worsened by their working conditions, the behavior of residents, and interactions with their families. Insufficient staffing heightens the risk of harm not only to residents but also to workers who are already at their limits. Consequently, burnout exacerbates and ultimately contributes to understaffing, making this a chronic crisis that needs to be urgently addressed. A study examining violence across various healthcare settings in Ontario identified factors such as understaffing, underfunding, inadequate legislative and institutional protections, and a lack of public awareness as contributors to workplace violence. [3]

Trends in Best Practice, Programs and Impact

Over the years, particularly during the COVID-19 pandemic, workplace violence in the continuing care sector has consistently increased due to heightened workloads, demanding work pressures, excessive stress, socio-economic uncertainties, and constraints.[26] According to data from WCB, in 2022, nurse aides, orderlies, and patient services associates accounted for the highest percentage of lost time claims, representing 17% of all violence and harassment claims. As a result, costs associated with WCB-accepted mental health claims surged by 230% in 2022 compared to 2017, affecting both supportive living accommodations as well as continuing care facilities.[27]

Reflecting on decades of systemic changes and practices in health care, several trends have emerged that have reshaped the approach to managing the risks of violence, aggression, and responsive behaviors, affecting workers and the industry overall. Over the past twenty years, there have been significant transformations in continuing care. Residents now require more complex care. Based on the most recent data published by Alberta Health in 2018 regarding the resident profile of residents in long-term care (now continuing care type A), There was an overall increasing trend in residents' needs in extensive assistance in activities of daily living from 2012 - 2017. And in 2017, 35.4% of Alberta's LTC residents worsened or remained completely dependent in transferring and locomotion, which is higher than the Canadian average of 33.1%. In the same year, 90% of residents in LTC have some form of cognitive impairment and has remained consistent over the past five years.[28]

Patient- Family Centered Care and the Appropriate Use of Antipsychotics

In 2012, Following the best practice guideline for accommodating and managing Behavioral and Psychological Symptoms of Dementia (BPSD) in residential care developed by the BC ministry of Health, Alberta Health adopted the patient family centered care (PFCC) approach by commissioning AHS to develop the Appropriate Use of Antipsychotics (AUA)[29] with the goal to reduce antipsychotic use in persons with dementia and help staff enhance care by focusing on person-centered care approaches.

A dementia-friendly approach requires families, physicians and staff to work together to investigate and trial approaches to reduce agitation and anxiety and to take time to consider each person's unique life story, look for underlying reasons for agitation and address unmet needs.[30] This entails frontline staff to take time out of their busy, task-laden schedules to ensure that they talk to their residents and hear out their stories and process every day interactions to determine their residents needs for the day, which is the ideal picture. More time spent to understand the residents' needs would mean there should be more staff to complete tasks or provide a better staff to resident ratio or improve professional staffing mix. Based on a recent 2020 study, it was noted that higher nurse staffing and more staff psychiatric training were associated with lower prevalence of severe aggressive behaviours.[31]

Unfortunately, the reality is quite different. Ongoing challenges such as inadequate staffing, insufficient funding, burnout, and compassion fatigue hinder continuing care homes and supportive living facilities from fostering a more person-centered environment. Inadequate staff means there's less time to care. In a survey for frontline workers by Parkland institute in Continuing Care Type A homes, nearly half of respondents stated that they lacked adequate time to complete their required tasks and expressed their desire for additional time to provide emotional and social connection for residents, which was the primary goal of PFCC. Based on responses, there was a clear link that additional staff will reduce and prevent the incidence of violence among staff and residents.[23]

Use of Resident Assessment Instrument (RAI-MDS 2.0) and Patient Care Based Funding (PCBF) for Continuing Care Type A Homes

The problem of understaffing and limited funding in continuing care homes may be attributed to the limited funding to support right staffing ratios. The Resident Assessment Instrument-Minimum Data Set (RAI-MDS) 2.0 is designed to collect the minimum amount of data to guide care planning and monitoring for residents in long-term care settings. It is also the clinical instrument used in Alberta for LTC funding when the province implemented the Patient Care Based Funding (PCBF) which is an output based allocation model, which "splits the pie" of total LTC funding based on weighted resident days.[32]

Inadequate staff means there's less time to care...

First rolled out in 2010, the PCBF relies on the RAI assessment data from LTC providers to allocate funding based on the intensity of care for each resident, including the scope of expected services. The funding is intended to represent staff, equipment and supply costs associated with resident care and is based on the case-mix index (CMI), which is the weighted average value. This value is adjusted based on the assessed Resource Utilization Group (RUG) generated from the RAI-MDS 2.0 assessment.[32]

Though widely adopted across Canada for the past 2 decades, the reliability and validity of the RAI-MDS 2.0 and its use for PCBF is now questionable. Care needs for residents in LTC experienced a substantial increase over ten years, and may have kept increasing since 1999.[32] The RUG III Grouping methodology that is being used in RAI-MDS 2.0 also assigns residents with behavioral problems with a lower resource utilization category[33] which means although workers are expected to spend more time to care for a resident with a higher risk of responsive behaviors, it is not reflected in the assessed funding value. Therefore, funding allocated for more staff to care for more aggressive and resistive clients is very limited and further exacerbates the challenges in managing the risk of violence and harassment in continuing care.

It was also reported in a review of the PCBF commissioned by AHS, that a weakness of the RAI-MDS 2.0 was measuring dementia and behavioral health, with a number of findings report that it poorly measures indicators of mood and behavioral problems, particularly delirium and dementia. Considering that the reports indicate that the nature of concern is that behavioral problems and aggressive behaviors are not measured for high needs;[32] it is not a reliable tool to reflect the ideal staff time spent caring for residents with aggressive behaviors.

Trauma Informed Care and the AHS Behavioral Safety Plan

Trauma-Informed Care (TIC) is recognized as an effective practice for engaging vulnerable populations, improving outcomes for clients and service providers. It enhances service delivery, efficiency, and results by considering clients' trauma histories, including Adverse Childhood Experiences (ACEs). TIC aims to meet needs and reduce re-traumatization. It serves as both an organizational and clinical practice, addressing the impacts of toxic stress, adversity, and trauma on clients and staff.[34] It promotes positive outcomes by emphasizing safety and offering a universal framework for organizations to cultivate a culture aware of the trauma residents and staff have faced.[35]

Although numerous research strongly recommends the use TIC practice in continuing care with its strong link to the management of responsive behaviors,[35,36] there is no current clear direction of implementation of training for the continuing care industry. Alberta Health Services (AHS) developed "Trauma Informed Care (TIC) education and training modules, which introduce learners to key concepts and practices of TIC.[37] This voluntary training is designed for anyone employed by AHS but is also accessible to external individuals with internet access. AHS may have been training their staff internally and the external link is provided and accessible through the AHS Addictions and Mental Health page, however, the majority of the contracted continuing care and supportive living care providers that would benefit extensively with this training have not completed it.

According to a 2023 jurisdictional review that highlight the varying standards of care that currently exist for LTC home services in comparison to the newly released HSO Standards for LTC in Canada, there specifically appears to be a lack of oversight in the following highlighted topics that were found in Alberta's documents: trauma-informed approach to care (Criterion 1.1.8).This means Alberta has missed an opportunity to enhance workforce training and capabilities to manage the risk of violence and aggression related to resident and staff trauma.[38]

Aligned with the Trauma-Informed Approach, the Behavioral Safety Program (BSP) is the newest update in practice that affects the management of VARB in continuing care. It was developed specifically as a workplace health and safety hazard identification, assessment and control program for patient to worker violence and harassment within AHS. It was started in acute care and AHS sites with the implementation of Connect Care and is currently being adopted by continuing care contracted service providers (CSP) until its full implementation in December 2024. Its goal is to have a coordinated alerting program, from acute care to continuing care, for individuals that have a potential risk for violent or aggressive behaviors based on a standardized assessment tool called Violence and Aggression Screening Tool (VAST).[39]

Though this implementation is in its early stages of implementation, the communication is that contracted service providers in continuing care is strongly recommended to align or adopt this process.[39] Considering the vast expertise and engagement that the Continuing Care Safety Association (CCSA) has with Alberta Occupational Health and Safety and most importantly, the continuing care industry members, there could be an opportunity to collaborate with external stakeholders such as the Continuing Care Safety Association and gather important feedback from members.

The CCSA Violence and Harassment Prevention Program for Continuing Care

The CCSA has adopted resources and tools from the evidenced based research that Public Services Health and Safety Association (PSHSA) has developed while leading a multi-stakeholder collaboration to address the pervasive and impactful issue of workplace violence in healthcare. Their initiative engaged partners from various levels and subsectors of the healthcare industry in Ontario and the goal of the project was to deliver a model and toolkit that provides workplaces with a consistent, scalable, and consensus-based approach for achieving sustainable outcomes and thereby reducing incidents and the impact of VARB.[40]

The CCSA is dedicated to assisting organizations and communities within Alberta's continuing care sector, including facility-based home and community care, supportive living arrangements, and continuing care residences, in safeguarding workers against the risks of VARB. This initiative features a thorough risk assessment tool that organizations can use to develop or improve their existing violence and harassment prevention strategies, as well as to identify key program elements that will help prevent incidents, protect employees, and ensure appropriate responses to occurrences of violence and harassment. The pilot phase of the CCSA Workplace Violence and Harassment Prevention Program Review has been actively conducted with several of our member organizations.

The CCSA recognizes that looking at violence and harassment as hazards is an occupational health and safety perspective that needs to be integrated into continuing care. As we advocate for our members, we continue to engage with other stakeholders such as the ministry, research organizations and government institutions and other non-profits to find coordinated solutions to address these challenges.

87% **have found the CCSA Workplace Violence & Harassment Prevention Program useful. This shows that CCSA's efforts in violence and harassment prevention among our members were successful.**

CCSA 2024 Member Engagement Survey

Case Study: The Butterfly Model of Care

For decades, the Butterfly Model has gained international recognition as it provides opportunities for meaningful engagement and purpose to persons with dementia, supporting not just their physical needs, but emotional needs as well. The Butterfly Model is a "feelings-based" approach that focuses on understanding, acknowledging and embracing human feelings of those with dementia. The Butterfly approach has demonstrated benefits to persons living with dementia by reducing their anxiety, distress and incidents of falls and providing improvement in their overall well being. The model is a proven methodology with outcome measures that have been shown to dramatically improve the overall quality of life for persons with dementia through purposeful human interactions.[41]

The Butterfly approach for caring for persons with dementia is to understand their feelings and life history; and to recognize the importance of spending time together 'with' the resident - not just 'doing' things for the resident. Caregivers and support staff are mentored and taught to shift away from 'task-focused' care to 'feeling-based' care. Developed by Dementia Care Matters (DCM) and led by Dr. David Sheard, it is recognized worldwide due to DCM's evidence-based findings from real-time observational audits, standardized baseline measures, and global tools assessing well-being and ill-being.[42]

Launched by Intercare, Alberta in February 2017 at its Southwood Care Centre, the pilot project's goal was to implement the butterfly model of care and, along with it, implement a culture shift that would see one entire dementia care unit at the site completely transformed from a "traditional" dementia care and treatment model into a fully recognized Butterfly Household Model of Care. In 2018, Willow Park unit at Southwood Care Center was officially accredited by Dementia Care Matters as two Butterfly Model of Care Homes - Serenity Cottage and Haven House. In April of 2019, both of the Homes we were re-audited and both achieved the highest possible accolade - Level 1 accreditation status, which is only achieved when accredited Homes exemplify 'exceptional person-centered dementia care'.[41, 43]

According to Intercare's Care Managers, Implementation was not an easy task. It required focusing on detailed observations of interactions between residents and staff, fostering a team-oriented culture, and implementing environmental improvements that engage and motivate everyone involved. It required radical

changes in staff roles, training, day-to-day operations as well as to the physical design of the Homes - a process that takes more than a year to plan and implement.

The greatest challenges that they faced were staffing issues, initially increasing the staff to accommodate the changes as the staff becomes more engaged with residents and their life stories. Staff were trained, divided, grouped and matched with their appropriate household and residents based on interviews, screenings and staff appraisals.

According to Intercare care managers, there was a significant change in the quality of care and life of the residents and the butterfly model created a safer environment for staff and residents. There were less agitation, wandering, responsive behaviors and falls, and care times were reduced. According to one care manager, “The improvement in overall morale with the home is a big one. Staff feels safer and residents are happier.” However, when the COVID-19 pandemic hit, the program was not sustained due to challenges in social distancing, time and staffing. Although restrictions has been currently lifted, the organization did not think it was feasible to continue with the model, citing funding and staffing issues to be the top barriers.

It was not the first time that The Butterfly Care Model was adopted or piloted in Alberta. In 2015, Lifestyle Options have commissioned DCM to pilot a one-year long pilot project to implement the Butterfly Household Model in their organizations.[44] An assessment by NorQuest College, provided qualitative data to support the value of using the model and its overall positive impact on residents, families, and staff, as well as highlighted aspects of the BCM implementation in Alberta that could be improved in the future. It was noted that there were positive changes in the resident population, including: fewer behaviors, less aggression, diminished need for redirection, less exit seeking, overall decreased reliance upon medications, increased engagement in activities, and decreased isolation.[45] However, it was noted that families’ feedback included the request to increase the ratio of staff, specifically with regard to HCA’s and Recreation staff, to ensure completion of required care tasks whilst promoting resident safety and engagement. It seems that they understood that this was an underlying issue that needs to be corrected before the ideal model of care can be successfully implemented.

In a success story shared by Malton Village LTC in Ontario to PSHSA,[46] stated that “Two decades of measuring outcomes of the Butterfly model implementation support that this person-centred approach, involving all levels and types of staff, reduces boredom and anxiety for the person living with dementia, increases the overall job satisfaction of the people working there and proactively supports a

violence-free workplace." The pilot project at Malton Village demonstrated a decrease in responsive behaviors towards staff and a reduction in injuries. Additionally, it noted a significant increase in meaningful engagement for individuals living with dementia, enhanced staff job satisfaction, and a decline in incidental sick leave.[46] However, during a CUPE focus group session,[47] staff expressed their commitment to improving residents' quality of life but emphasized the need for sufficient funding to hire additional staff that the model requires. The challenges of understaffing, coupled with a high patient load and the extra time needed to form emotional connections with residents, are creating overwhelming workloads that leave staff both physically and mentally drained.[47]

Despite the challenges and setbacks, the learnings from the Butterfly Care Model has not waned. Care managers and staff from Intercare remain hopeful that with the experiences from the pandemic and with additional resources and adjustments, similar models of care can be more effectively integrated into long-term care homes across Alberta. The lessons learned from the pilot projects and the impact of the COVID-19 pandemic have provided valuable insights into what is necessary for future implementations.

Moving forward, it will be crucial to address understaffing and appropriate staffing ratios and ensure adequate training and support for workers. This means investing in hiring more staff, ongoing professional development and creating a robust support system that can adapt to the dynamic needs of both residents and care providers. Additionally, enhancing family involvement and communication will be essential in fostering a person and family centered approach to care and minimize the risk of violence and aggression that comes from the resident's families.

The Butterfly Care Model represents a transformative strategy for elder care, prioritizing the emotional and psychological well-being of residents. This approach shifts away from a sterile, task-oriented, institutional framework that may trigger negative behaviors from both residents and families. Instead, it fosters an environment and culture that emphasizes feelings and compassionate care, not just for residents, but also instilling a sense of meaning and purpose for the staff. As care homes continue to progress, the principles derived from this model serve as a guiding light for cultivating nurturing and compassionate settings where residents can flourish, while also reducing instances of violence, aggression, and responsive behaviors.

"For workers, the butterfly model translates into knowing the work they do really makes a difference in someone's life, a difference that can be seen and felt every time they work, while proactively supporting a violence-free workplace."

Malton Village LTC Home (PSHSA Success Stories)[46]

Conclusion

Workplace violence in continuing care necessitates a multifaceted and comprehensive approach with shared responsibilities among all stakeholders. This whitepaper advocates for developing and utilizing existing mechanisms to prevent and address violence and harassment. This includes integrating occupational health management systems and collaborating with health ministries and research organizations. It is crucial to incorporate risk management processes into all policies and programs and create an overall strategy to address the hazards of violence in continuing care and healthcare in general.

In addition to these measures, it is vital to cultivate a culture of respect and safety within the workplace that focuses on enhancing the psychological health and safety of continuing care homes and supportive living accommodations. This can be achieved through regular training sessions, workshops, and seminars that focus on trauma-informed approach, conflict resolution, stress and workload management, and effective communication skills. Encouraging open dialogue and providing platforms for workers to voice their concerns without fear of retribution can further strengthen this culture and increase engagement of workers to collaborate on solutions to manage the risks of violence.

Moreover, implementing a robust incident reporting system is crucial. Such a system should ensure that all reports of violence or harassment are taken seriously, investigated promptly, and addressed appropriately. Psychological services, such as counseling and mental health resources, should also be readily accessible to all employees to cope with the aftermath of violent incidents but also fosters a supportive environment that prioritizes the well-being of staff and encourages reporting.

The continuous evaluation and improvement of these strategies are equally essential. Regular reviews and updates to policies and procedures, informed by the latest research and feedback from healthcare workers, can help ensure that the approach remains effective and relevant. By adopting a proactive and inclusive strategy, we can create a safer, more supportive environment for everyone in the continuing care sector.

It is about time to finally say and prove to our workers that, "Violence is NOT part of the job."

Nevertheless, implementing all these measures is pointless if we don't tackle the fundamental issue that often impedes the success of any new programs or best practices aimed at addressing violence and harassment in continuing care – the challenge of inadequate staffing due to limited funding. Although current resident assessments may identify the likelihood of VARB incidents, they are no longer reliable for the current funding model and do not accurately reflect the necessary staffing hours required to deliver high-quality care and services, particularly for residents at a greater risk of violence, aggression, and responsive behaviors. If we fail to confront this root problem, we cannot adopt a preventative approach, and our community will remain reactive, ultimately causing our workers to be the ones who suffer and get injured.

Throughout the years looking back at all the trends, best practice and innovative approaches, there is one unified goal: to protect our workers manage the risk of violence, harassment and responsive behaviors while providing the highest quality care to vulnerable residents. We cannot eliminate the hazard because it is tied to the population that we serve. However, if we stop working in silos and ensure that we all have a unified approach, sending clear and streamlined communication, and coordinating the implementation of training programs or new innovative processes to those that are impacted, we could create a safer continuing care community for our workers and residents.

If we fail to confront this root problem [understaffing and limited funding], we cannot adopt a preventative approach, and our community will remain reactive, ultimately causing our workers to be the ones who suffer and get injured.

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