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GENTLY INTO THE NIGHT
AGGRESSION IN LONG-TERM CARE

Professor Neil Boyd

WorkSafe
WORKERS' COMPENSATION BOARD

Gently into the Night – Aggression in Long-term Care

Issue:	Violence in long-term care facilities in British Columbia
Agency:	School of Criminology, Simon Fraser University
Representative:	Professor Neil Boyd
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There has been a considerable increase in the number of accepted claims due to workplace violence or force in the long-term care facilities in British Columbia in the past decade. The resident population that caregivers have been servicing is less able to care for themselves, physically more frail, and cognitively much less intact.

Neil Boyd, a professor of Criminology at Simon Fraser University, and his colleges conducted a study in 6 long-term care facilities in British Columbia. They used incident reports, WCB claims, survey questionnaires, personal interviews and behavioral observations to aid in the understanding of the genesis and development of aggression in long-term care. The data showed that most aggression incidents occurred during personal care or attempts to redirect a resident or residents. Less than 10 percent of incidents were random or totally unexpected attacks. Male residents were three times as likely as female residents to engage in acts of aggression. There were only a small percentage of male and female residents who were responsible for aggressive incidents within long-term care facilities.
Recommendations on staffing levels, in-service education, standardization of care aide education and language capacity, work procedures for responding to aggressive residents, and information availability about residents' medical and social history were made.

GENTLY INTO THE NIGHT
AGGRESSION IN LONG-TERM CARE

NEIL BOYD

WORKERS' COMPENSATION BOARD OF BRITISH COLUMBIA

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Neil Boyd is a Professor of Criminology at Simon Fraser University. He is the author of several books, television documentaries and academic articles; his research interests encompass drug use and drug control, homicide, the genesis of male aggression and violence in the workplace.

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of the six sites and delivered an admirably comprehensive mix of incident report analysis, questionnaire responses, and transcribed interviews and observations. Morgan Hocking, who was responsible for compiling incident reports, questionnaires, and observations in four of six facilities, was a delight to work with during the summer of 1997. The many figures found in the body of this report are a reflection of the quality of his contribution; thanks also to Si.

Charis Wahl has again been a most helpful editor, providing clarity and insight in her analysis of the structure and content of this report. David Hamilton of First Folio Resource Group, Inc. has been responsible for taking these pages and creating the attractive monograph that you now have in your hands. Finally, thanks, love, and affection to Isabel Otter for her support and comments on the many drafts of this report.

Neil Boyd
Professor
School of Criminology
Simon Fraser University
March 1998

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INTRODUCTION

During the past two decades the landscape of long-term care has changed dramatically in British Columbia, as in most jurisdictions in Canada, the United States, and Western Europe. A transition from home to institutional care is now made much later in the course of life; home-support services have expanded by leaps and bounds, in large measure to avoid the social and economic costs of institutional placement. Thus, upon admission, the typically elderly residents of continuing care facilities are less able to care for themselves, physically more frail, and cognitively much less intact.

The Continuing Care Division of the Ministry of Health defines the categories of care - personal care, intermediate care, levels 1, 2, and 3, and extended care - according to the following criteria (Province of British Columbia, 1983, policies 3.2.2-3.2.6).

PERSONAL CARE

This level of care recognizes the person who is independently mobile with or without mechanical aids, who needs minimal assistance with the activities of daily living, and who requires non-professional supervision and/or assistance.

INTERMEDIATE CARE, LEVEL 3

This level of care recognizes the psychogeriatric person who has severe behaviour problems on a continuing basis. However, this level of care may also be used for people who require a heavier level of care that involves considerably more staff time than the second level of intermediate care, but who are not eligible for extended care.

The following criteria is to be used to determine eligibility for intermediate care, level 3:

- He or she may disturb others with such anti-social habits as spitting, indecent exposure, voiding and/or defecating in public, etc.
- He or she may exhibit destructive, aggressive, or violent behaviour (e.g. shouting and screaming).
- He or she may continually wander away.
- He or she may endanger his or her own life.

Extended Care

This level of care recognizes the person with a severe chronic disability, which has usually produced a functional deficit, who requires 24-hour-a-day professional nursing services and continuing medical supervision, but does not require all the resources of an acute care hospital. Most people at this level of care have a limited potential for rehabilitation and often require institutional care on a permanent basis.

In British Columbia in 1978, more than 90 per cent of residents admitted into long-term care fell into a category described as "personal care" (Stark and Gutman, 1980). In 1998, less than 10 per cent of residential beds were allotted to personal care; intermediate care, levels 2 and 3, and extended care categories account for more than 90 per cent of residential commitments.

Given the dramatic nature of the shift in the continuing care population, British Columbia's nurses, care aides, and licensed practical nurses find themselves in a significantly changed workplace.The resident population is not only more incapacitated, but more likely to aggress.

Neil Boyd

AGGRESSION IN LONG-TERM CARE: THE RESEARCH TO DATE

The last decade has produced an expanding research literature and corresponding emphasis on the problem of aggression in "nursing homes" and long-term care facilities. This phenomenon (the development of a research literature and specifically focused program responses) is not limited to British Columbia, nor even to North America.

In many, if not most Western cultures, care facilities are now responding to the needs of their burgeoning populations of cognitively impaired residents; demographic projections differ with respect to how significantly this population and, hence this problem, will increase (Alliance for Aging Research, 1997; Carriere, 1997). The specific extent of the anticipated population increase aside, however, it seems prudent to conclude that responding to Alzheimer's, other types of dementia, and neurological disabilities is a challenge that we will continue to face for the foreseeable future.

Most resident aggression takes place in the context of personal care: bathing, toileting, dressing, feeding, and medicating (Ryden and Feldt, 1992; Hagen and Sayers, 1995). For example, a study of resident aggression in a long-term care facility in Kamloops, British Columbia (Hagen and Sayers, 1995) found that more than 75 per cent of aggressive incidents occurred during dressing, changing, bathing, transfer, and turning of the resident. Aggressive incidents were also most likely to occur in the morning, shortly after the residents' waking, or during the early evening.

Bridges et al. (1994) undertook 160 hours of observation in an American nursing home. During that period, they witnessed 28 incidents of physically aggressive behaviour. More than 80 per cent of the aggression was directed towards nursing-home staff during personal-care work. Very little of this aggression appeared to be spontaneous; most incidents were apparently in response to intrusions into the resident's personal space.

There is considerable debate about what motivates resident aggression. The most common source of these aggressive incidents is held to be Alzheimer's and related types of dementia: a confused and compromised population of elderly patients strikes out at caregivers, unable to understand the distinction between assistance and intrusion. However, while it is fair to say that the existence of dementia increases the risk of aggression, there has also been much criticism of this medical model of understanding. Cox (1993) argues that an "ecological" model of aggressive behaviour (thinking about human beings in relation to one another and to their environments) is a more useful context for service delivery than the medical model. Cox suggests that life transitions and environmental stresses lead to frustration and difficulties in adjustment, and that medical diagnosis is therefore less significant than the specific environment in which the resident is living.

Cohen-Mansfield et al. (1992) studied more than 400 nursing home residents in America. They found that the aggressive resident is most likely to be a demented, married male who is inappropriate in his interpersonal interactions. Significantly, such a person tends to have been aggressive prior to entry in the nursing home. In a later study Cohen-Mansfield and Werner (1995) studied agitation in 24 nursing-home residents with dementia. Agitated behaviours increased markedly when patients were alone, physically restrained, uncomfortable at night, or inactive. Decreases in agitation were observed during structured activities and social interactions, and when music was played.

Additionally, some aggressive behaviour may be explained by the inability to manage the pain that is a consequence of an underlying illness. Malone et al. (1993) stressed the importance of looking for the possibility of underlying pain and other physical problems in nursing-home residents who display aggressive behaviour. Ryden and Feldt (1992), in writing of the etiology of

aggressive behaviour in the nursing-home setting, made the following points:

> This content area focused on specific precipitants of aggressive behaviour, including factors both internal and external to the resident. Internal factors included a sense of threat or fear; loss of control or loss of previous structure; frustration with tasks that exceeded ability; misinterpretation of behaviour of staff and other residents; fatigue; impaired perception; pain; and medication effects. The external factors included the physical environment; interpersonal approaches of staff or other persons; nature and degree of environmental stimulation; and use of restraints.

In response to this emerging research literature, governments and long-term care administrators in Canada and the United States have initiated various training modules and videos in order to instruct employees in conflict resolution and avoidance of harm. Keller (1996) developed an eight-hour training program designed to help nursing-home staff members in Philadelphia identify and defuse potentially abusive situations. "Ensuring an Abuse-Free Environment: A Learning Program for Staff" comprised role playing and small group discussions. She focused on recognition of types of abuse, intervention strategies, and the ethical and legal issues involved in reporting abuse. A pilot test in 10 Philadelphia nursing homes revealed significant post-course diminution of conflict with residents and of incidents of resident aggression.

Similarly, Hagen and Sayers, after delivering three 30-minute in-service modules to about 90 per cent of nurses and nurses' aides at a care facility in Kamloops, B.C., found a reduction of approximately 50 per cent in incidents of resident aggression during an eight-day follow-up. The modules focused on (a) the nature and losses of dementia, the relationship between dementia and aggression, and the risk factors for aggression; (b) the goals of care for the demented elderly, and strategies to prevent aggression in that population; and (c) strategies to de-escalate aggression, and possible protective interventions for the health-care worker. Hagen and Sayers noted a number of methodological limitations to their study common to most studies of this kind (e.g. Keller, 1996): there were no control groups

against which to test the effectiveness of the intervention; there may have been differences in staff reporting of the levels and types of aggressive behaviour produced by the intervention; and the follow-up period may not have been sufficient to measure lasting change. The last two criticisms should not be understated or underestimated, as there is a well-documented inclination, particularly in the short-term, to modify behaviour in accordance with individual and institutional expectations.

Mooney et al. (1995) developed a model for managing the socially inappropriate behaviours of 27 male and 10 female nursing-home residents, based on what they termed "applied humanism." The socially inappropriate behaviours of the group included disrobing or masturbating in public, sitting on the floor, physical aggression, eating inedible objects, and pilfering from other residents' rooms. The six principles of applied humanism were "administering no punishment, ensuring success, allowing independent decision making, [residents] experiencing logical consequences, performing gentle interventions, and teaching behaviour change." During a one-month observation period the researchers noted significant decreases in all the forms of socially inappropriate behaviour listed above. Perhaps most striking was their finding that aggressiveness decreased most markedly during the summer, when residents were involved in community programs.

The British Columbia Ministry of Health has clearly recognized the problem of aggression both in long-term care facilities and in health care generally, and has produced two major initiatives: *The Management of Aggressive Behaviour: A Training Program for Staff in Long-Term Care Facilities* (1992); and *Drawing the Line: A Comprehensive Education Program to Prevent and Manage Aggressive and Violent Behaviour Toward Health Care Providers* (1993), which is of more general application. Both these information packages represent government commitments to respond effectively to the problem of aggression in the continuing care system.

There has, however, been little systematic research analysis of aggression in continuing care in British Columbia during the past decade, the period during which Workers' Compensation Board (WCB) disability claims resulting from acts of force or violence have increased tenfold. British Columbia's care aides have

a higher risk of injury from aggression than that faced by the province's police officers (Boyd, 1995). WCB disability claims for acts of force or violence clearly bring to light few of the acts of force or violence in long-term care (Boyd, 1995; Lusk, 1992; Lipscomb, 1992). WCB claims are filed by staff in less than 5 per cent of all reported incidents. Second, it is not clear that all instances of resident aggression will be classified in the appropriate WCB category. Falls and sprains suffered when attending to an unhappy or upset resident may be classified as accidental, hence outside the category of "aggression or force."

Moreover, many assaults by residents are not filed within the facility as incident reports because of staff time constraints and the bureaucracy involved in such record keeping. As well, there are mechanisms other than a WCB claim that enable employees to take time from work for an aggression-related injury. Short-term sick leave may, in many instances, be a preferable or more effective alternative to going through the process of initiating a claim for disability.

Accordingly, the problems of aggression in long-term care have consistently been underestimated. WCB claims for acts of force or violence represent only a small part of the picture. Although the current cost of these claims in British Columbia runs between $500 000 and $1 million annually, the real costs and consequences of this aggression are many times this figure, in both economic and human terms. It is to these costs and consequences that we now turn.

THE STUDY: METHODS OF INQUIRY

It will be useful first to describe our rationale for collecting specific kinds of data and asking particular research questions. First, our research focus was limited to the problem of aggression by residents in long-term care. The problem of abuse of the elderly by caregivers and others is significant, and a substantial research literature has developed in response to this concern (e.g. Cupitt, 1997; Camille, 1996; Boyack, 1997). It is important to state that in studying the problem of aggression by residents there is no attempt to diminish the obverse: the abuse of the elderly by caregivers.

We should also clearly state that in studying the problem of resident aggression, we are not attributing any moral or other blame to the residents in question. Assaults in long-term care are almost never the subject of criminal proceedings; the often demented elderly typically strike in confusion, not with malicious deliberation. Any model of behaviour that holds resident aggression to be analogous to a criminal transgression merely reveals a misunderstanding of the dynamics of long-term care.

Finally, we were attempting to understand why WCB claims related to force or violence in long-term care have accelerated so dramatically during the past 15 years. Professionals involved in service delivery have suggested a number of explanations for the tenfold increase that we have experienced. First, as noted earlier, the nature of the population has changed: there are more demented residents with psychogeriatric difficulties and a greater likelihood of aggressing.

Second, some critics argue that the increase in claims related to force or violence reflects a changing attitude to violence in the

workplace. Specifically, it has been suggested that during the 1970s care aides and nurses tolerated aggression from residents as an element of their job; in the 1990s such behaviour in the workplace is not tolerated and is more likely to form the basis of incident reports and WCB claims. In this view, the nature of work in long-term care has not changed dramatically: there is simply less tolerance of resident aggression. (Our conclusions with respect to this point of view appear later in this report.)

This study has used a number of tools to aid in its understanding of the genesis and development of aggression in long-term care. Our first task was twofold: to identify facilities that had experienced a significant number of WCB claims related to "acts of force or aggression," and to select a number of these facilities for observation, so as to achieve some measure of geographical and regional representation within the province of British Columbia.

In the fall of 1996, we were able, with the assistance of the Ministry of Health, to meet these two objectives. Specifically, we were able to secure the cooperation of six long-term care facilities in the province: three from the Lower Mainland, one from Vancouver Island, one from the Okanagan, and one from the northern interior. To ensure resident and staff confidentiality, none of these facilities will be named in this report.

Through 1996 and 1997, we collected data from incident reports at each of these six facilities. We also constructed a questionnaire (see Appendix A) that was completed by care aides, licensed practical nurses, registered nurses, activity workers and administrators/directors at all six facilities. In addition, we interviewed representatives of each of these employee groups in all facilities, asking for descriptions and discussion of aggression and potential remedies. These interviews were tape-recorded and later transcribed.

Such sources of information were useful, but the questionnaire and interview responses, in particular, were highly subjective. Therefore, in order to balance this necessary subjectivity with some objective measure of aggression, we undertook our own observation sessions in the most difficult units of each facility, typically the special care units. Within each facility we conducted five four-hour sequences of observation - a total of 120 hours of observation in the six long-term care units.

Researchers provided a written chronology of all events in 15-minute segments, essentially encapsulating the social life of the floor during that period of time.

To this point, we had from each of our six facilities incident reports, questionnaire responses, transcribed interviews, and transcribed observations. In order to place these data in a provincial perspective, we then turned to WCB claims data from long-term care facilities in British Columbia from 1987 to 1996. Specifically, we looked at all accepted claims from long-term care related to "acts of force or violence." From each claim file within the decade, we extracted variables of relevance, from which we developed charts, graphs, and tables that illuminated, in some manner, the problem of resident aggression.

In sum, we developed three sources of information from which quantitative data could be extracted: incident reports, questionnaires, and WCB claims files. We also created two pools of qualitative data: transcribed interviews and transcribed observations.

What follows is at least a partial list of the issues that we believed we might be able to address from data gathered by means of the methods described above:

1. How much on-the-job experience do long-term care employees in B.C. typically have?
2. How often are care aides assaulted in one workweek? What kinds of assaults do they experience?
3. How often are nurses assaulted in one workweek? What kinds of assaults do they experience?
4. How often are other long-term care employees assaulted in one workweek? What kinds of assaults do they experience?
5. What remedies do long-term care employees see as most useful for responding to resident aggression?
6. What remedies do care aides see as most useful for responding to resident aggression?
7. What remedies do registered nurses see as most useful for responding to resident aggression?
8. What remedies do administrators/directors see as most useful for responding to resident aggression?
9. As evidenced by incident reports and WCB claims, under what circumstances does resident aggression occur in long-term care?

10. What do WCB claims and incident reports reveal as the most common kinds of aggression causing injury?
11. On the basis of incident reports and WCB claims, how do male and female rates of aggression compare?
12. Which types of employees are most likely to suffer injury from acts of force or violence by residents?
13. What can we deduce from incident reports about the percentage of the resident population that is responsible for acts of force or violence?
14. What can we deduce from incident reports about the percentage of the employee population that is subject to acts of force or violence?

These empirical questions can be answered by analysis of incident reports, questionnaires, and WCB claims data. The interviews and observations, as transcribed, add a rich context for understanding the nature of the problem. Together, the analysis and context lead to the discussion and recommendations that form the final section of this report.

ANALYSIS

(A) INCIDENT REPORTS

There are a number of significant findings that emerge from our analysis of the incident reports, not the least of which is that these findings support, for the most part, the conclusions of the existing research literature. We gathered incident reports at all six facilities. For the year 1996, we were able to obtain complete reports in all locations; but for the years prior to 1996, our ability to access these records was more limited. Nonetheless, clear patterns emerged. Women, who comprise slightly more than 90 per cent of all employees in the six long-term care facilities under study, were victims in 92 per cent of all incidents; male employees were victims in the remaining 8 per cent of all incidents (see Figure 1). Those employees who are directly involved in personal care (care aides and licensed practical nurses) are most likely to appear in incident reports. Assaults on employees other than nurses, care aides, or licensed practical nurses are relatively rare (see Figure 2).

As well, most incidents of resident aggression occur during personal care. Our analysis, which provided more detail than was available in previous descriptions, revealed that toileting, dressing, bathing, and waking accounted for about 50 per cent of all incidents; feeding and medication, 10 per cent; and redirection and/or restraint, which involves reading a situation in which aggression might occur and redirecting or temporarily restraining a resident so that a conflict does not occur, accounted for slightly more than 20 per cent of all incidents of aggression (see Figure 3).

An example of redirection might be useful. In one of the facilities we observed, the pacers' route took them past the nursing

FIGURE 1

Staff Victims of Resident Aggression: Incident Reports, All Facilities, 1992–96

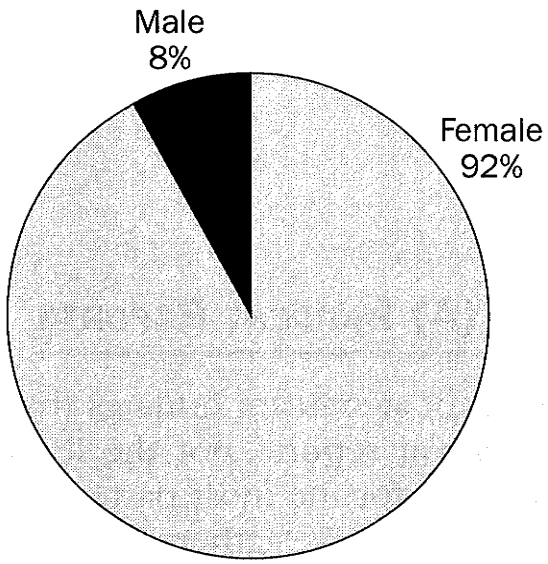
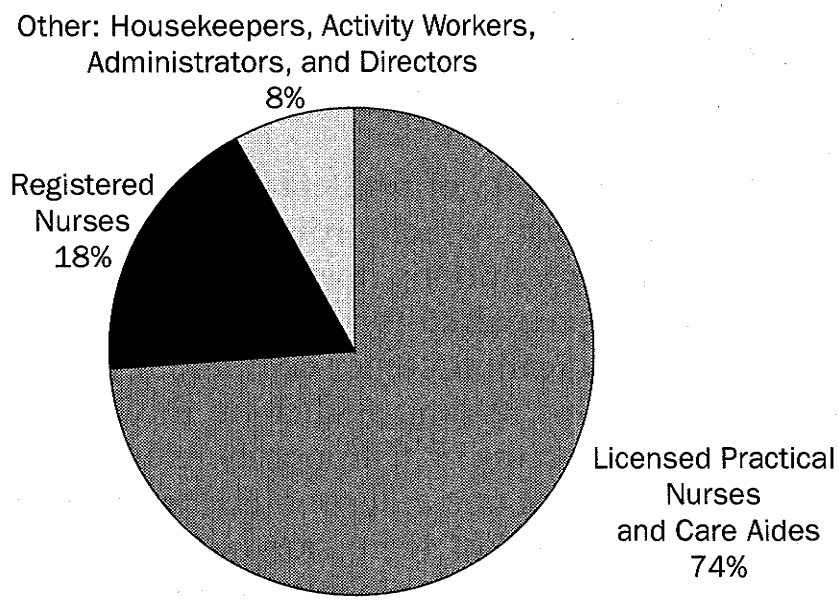


FIGURE 2

Staff Experiences of Resident Aggression: Incident Reports, All Facilities, 1992–96

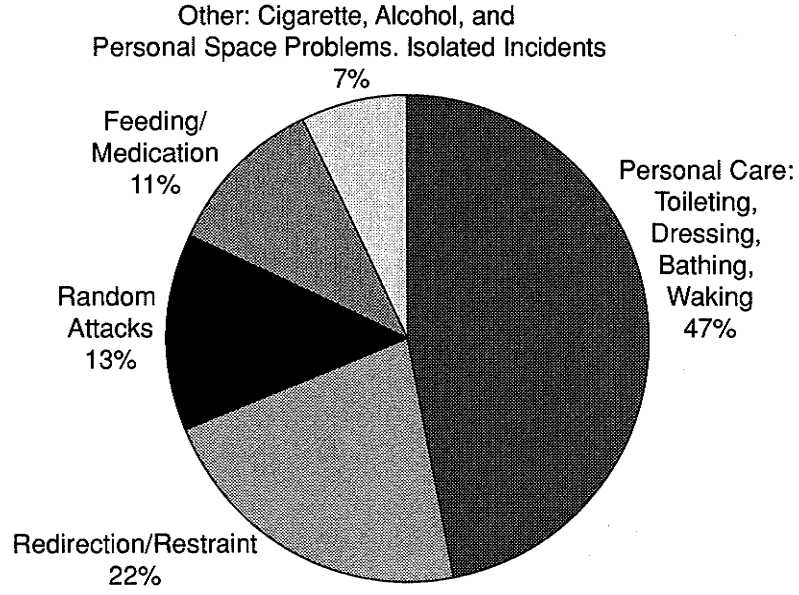


station. On each leg of their pacing they would have to avoid residents who gathered near the nursing station. Every minute or two, one or more of the pacers would walk by the nursing station en route to the far end of the hall; he or she would then turn around and walk back, once again passing by the nursing station. One morning Herman was chugging along the corridor and each time he passed Walter, a burly former logger, he asked Walter to get out of his way, by saying "beep, beep" in a high-pitched voice. Walter was becoming annoyed. When it was suggested to Walter that he might like to sit down in the dining room for a chat, he was only too happy to oblige. Thus, a conflict was averted through redirection of the resident. Unfortunately, all redirection is not always so successful.

Only 13 per cent of incidents of aggression are classified as random attacks (see Figure 3). In other words, in almost 90 per cent of these instances there is a dynamic between the resident and the staff member that establishes a context, whether rational

FIGURE 3

Circumstances of Resident Aggression: Incident Reports, All Facilities, 1992-96



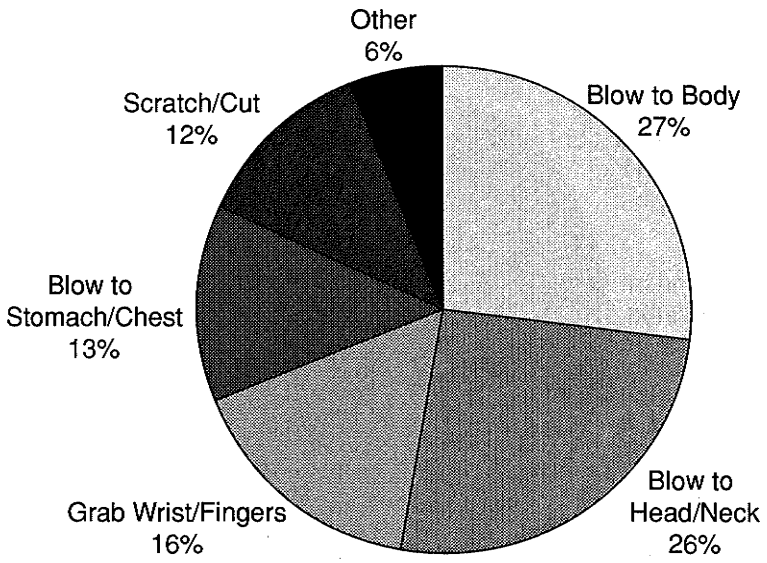
or irrational, for the resident's outburst. To the extent that we can change these contexts, we have the potential to alter the extent of aggression within long-term care facilities. (Indeed, this is the crux of British Columbia's initiatives *Drawing the Line* and *The Management of Aggressive Behaviour*.)

Figure 4 details the nature of injuries to staff, as disclosed by incident reports. In two-thirds of these cases, staff were struck by residents' blows to the head, neck, body, stomach, or chest. About 16 per cent of cases involved grabbing and twisting by the resident, and a further 12 per cent of cases involved scratching or cutting. These injuries, while they sometimes cannot, and usually do not, result in WCB claims, typically inflict significant pain and result in time lost from work, either during the shift, or during the next day or two. Moreover, such attacks obviously have a negative impact on the morale of the staff member affected, and may compromise her future ability to provide a high quality of patient care.

If we are to look more broadly at the kinds of aggression

FIGURE 4

Nature of Injuries to Staff: Incident Reports, 1992-96



engaged in by residents (as distinct from the nature of staff injuries), we find that verbal abuse is most common, followed by hitting, punching, grabbing, twisting, and kicking (see Figure 5). Acts of aggression by male residents are more numerous than those by female residents, although males comprise relatively small numbers of residents in long-term care.

Figure 6 expands on this finding, illustrating the rate of aggression per resident per year based on our extraction of data from incident reports. Our analysis of five facilities revealed an average rate of a little less than .20 aggressive incidents per resident per year. More strikingly, however, we found that the male rate of aggression was more than three times as high as the female rate of aggression. We excluded one of the six facilities from this calculation as it has only male residents.

This finding is consistent with virtually every other study that has explored gender differences with regard to violence and aggression. From early infancy, through adolescence, and in

FIGURE 5

Aggression by Residents: Incident Reports, All Facilities, 1992-96

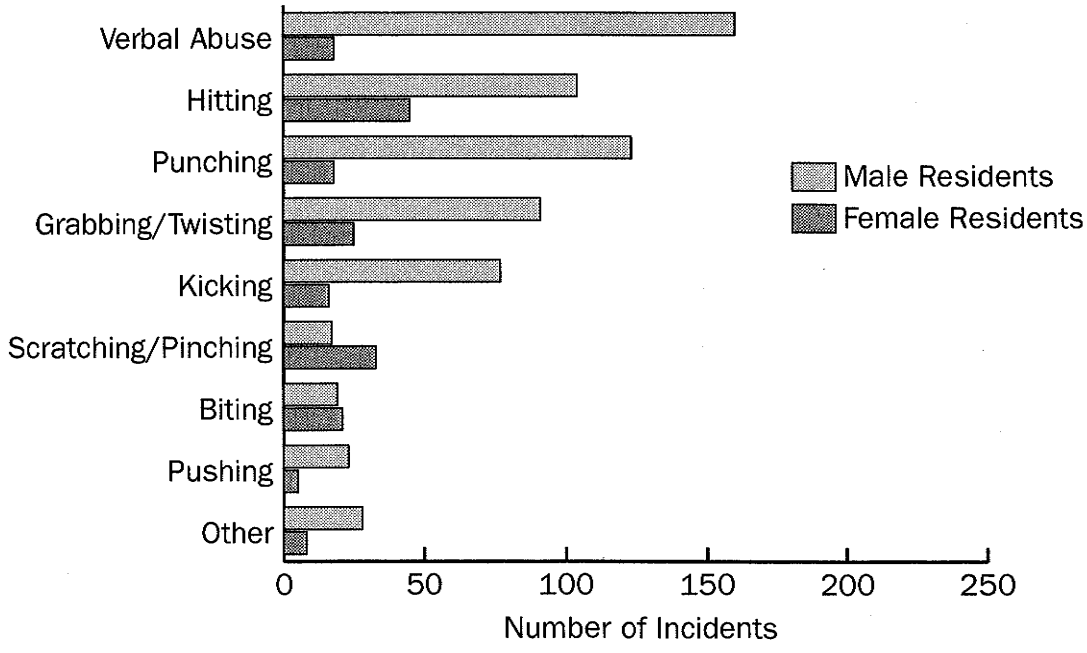


FIGURE 6

Average Rate of Aggession per Resident per Year: Incident Reports, 1996

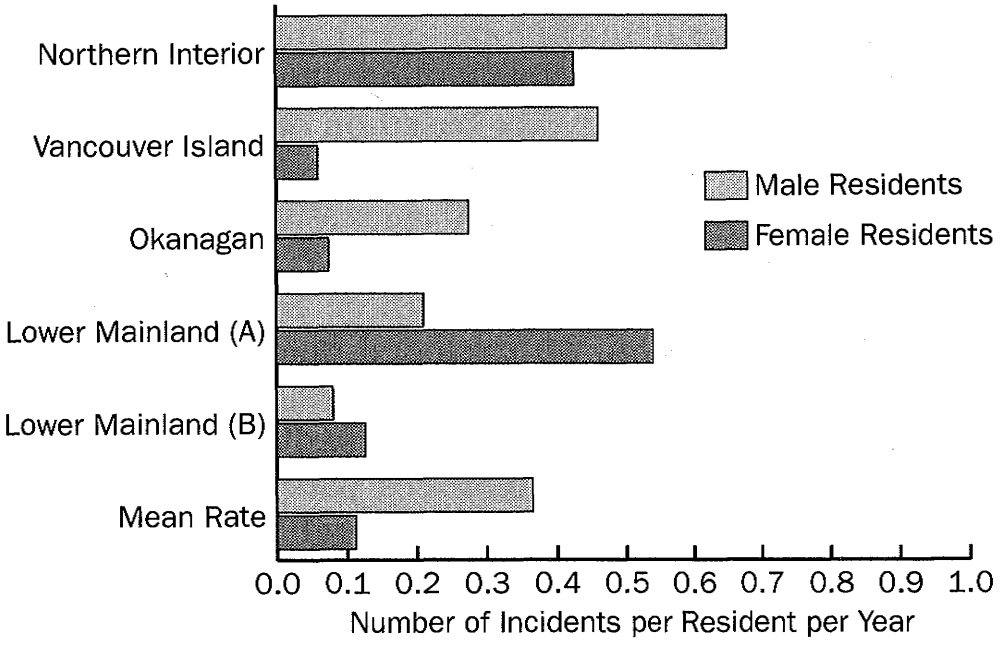
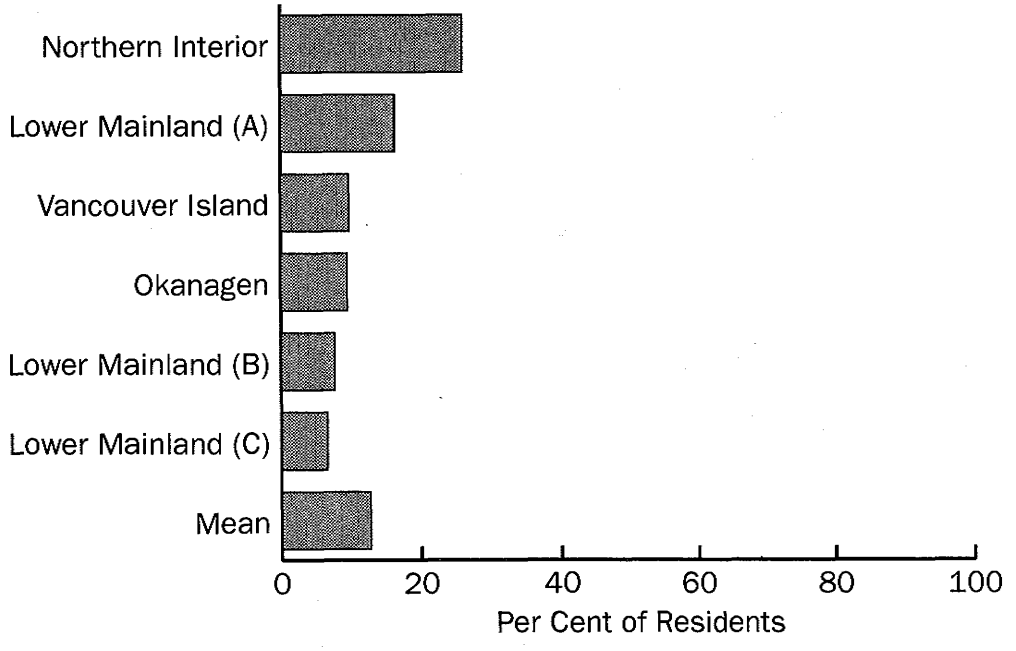


FIGURE 7

Percentage of Residents Responsible for 100 Per Cent of Incidents: Incident Reports, All Facilities, 1996



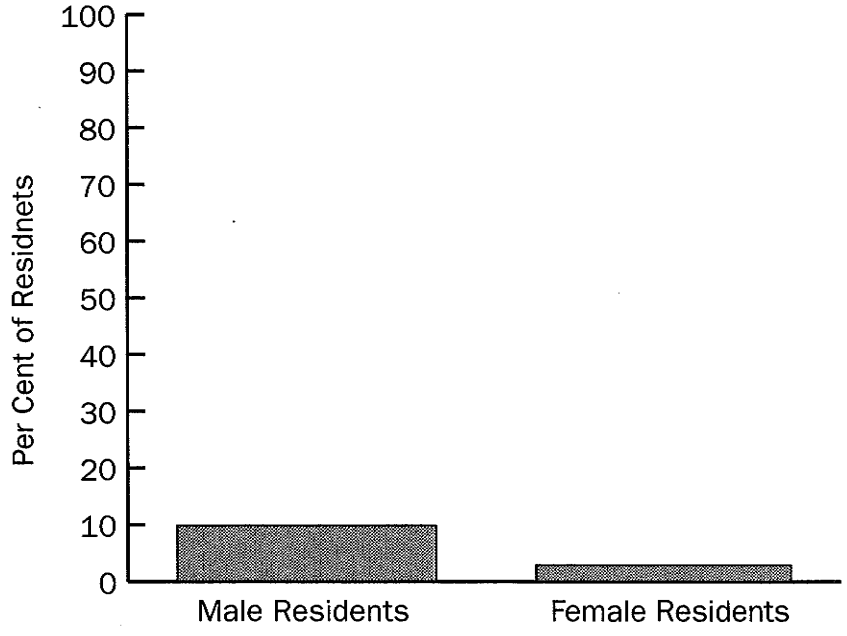
adulthood, males are more likely than females to aggress.

Finally, we looked at the extent to which aggression could be traced to the actions of a relatively small number of residents. We found that about 10 per cent of residents are responsible for all incidents reported (see Figure 7). As well, slightly over 3 per cent of female residents were found to be responsible for all incidents involving females and about 10 per cent of male residents for all incidents involving males (see Figure 8). In sum, aggression is rooted in the actions of a relatively small percentage of residents in long-term care. In light of this finding, response strategies geared to aggressive and potentially aggressive individual residents would appear to have considerable merit.

It should be noted that we also investigated the other side of this coin: whether a relatively small number of care aides might be involved in a disproportionate number of incident reports. However, analysis of incident reports did not support such an assertion. We found that between 30 and 40 per cent of care aides

FIGURE 8

Percentage of Residents Responsible for 100 Per Cent of Incidents: Males and Females, All Facilities, 1996



were represented in 1996 claims, a level of distribution of involvement that one would expect to occur when the aggression was experienced by chance. While there may well be extreme instances in which a few care aides are over-represented within incident reports, we found no evidence of such a tendency in our data across all six facilities. To put this finding more bluntly, we found no evidence that caregivers contribute to the problem of resident aggression.

(B) Workers' Compensation Board Claims:

One of our initial tasks in the analysis of WCB claims was to compare our incident-report findings with claims data. When we looked at the circumstances of aggression that led to accepted claims (Figure 9), we found substantial agreement between our two sources of data. A little more than 80 per cent of all accepted claims emerged in circumstances of personal care, feeding and medication, or redirection and restraint. Only about 15 per cent of the claims could be defined as random acts of aggression.

When we compared the circumstances of claims from care aides with the circumstances of claims from nurses, some predictable differences emerged. Injuries to care aides were likely to occur during personal care (see Figure 10); while during medication, injuries were more likely to occur to nurses than to care aides (see Figure 11). Nurses also appeared to be almost twice as likely as care aides to be the victims of random acts of aggression, i.e. assaults for which there was no apparent cause.

Figure 9

Circumstances of Aggression in Long-term Care: WCB Claims, 1987-96

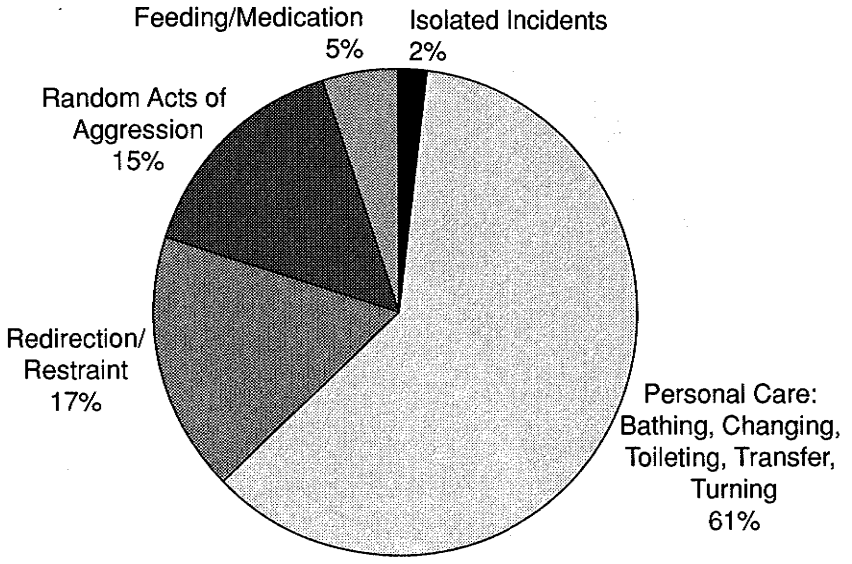


FIGURE 10

Circumstances of Aggression Against Care Aides in Long-term Care: WCB Claims, 1987-96

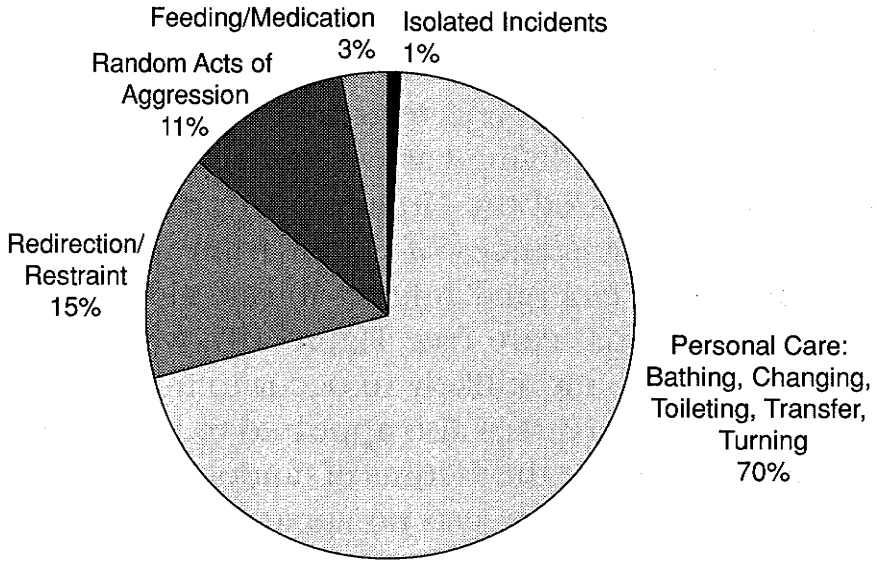
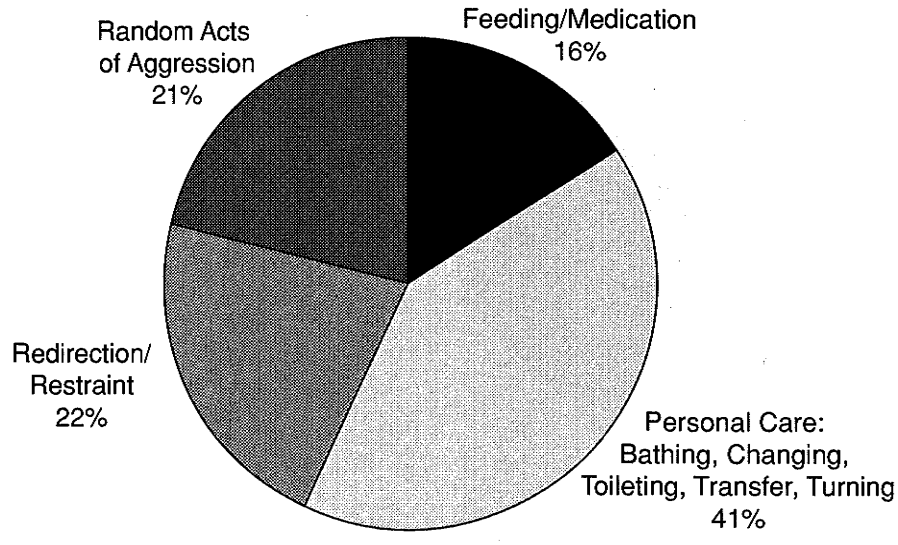


FIGURE 11

Circumstances of Aggression Against Registered Nurses in Long-term Care: WCB Claims, 1987-96

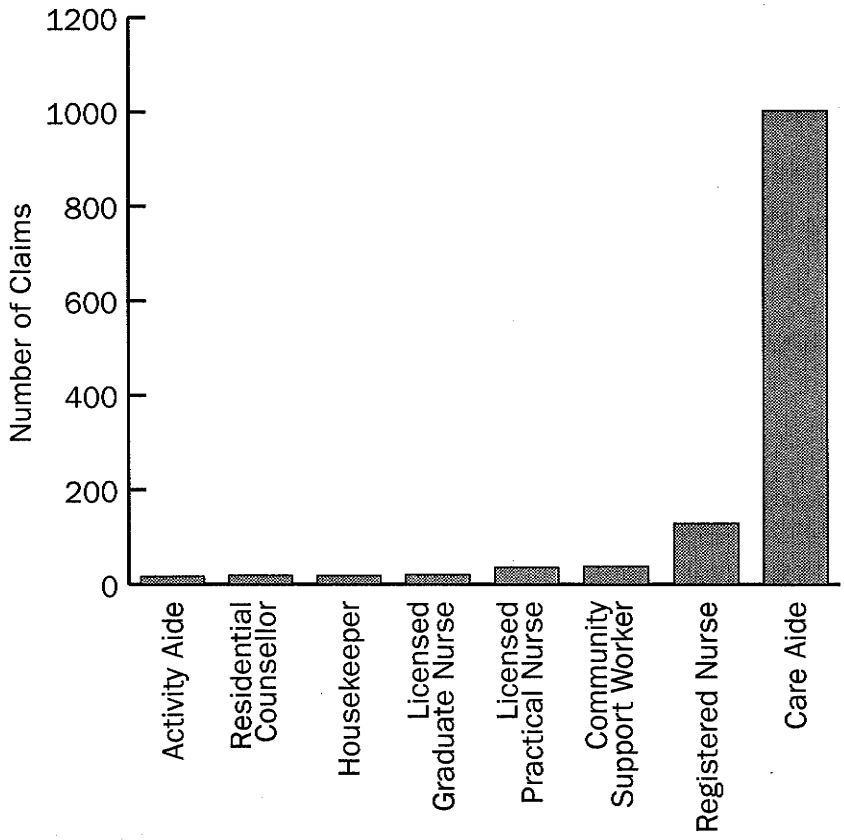


Most striking, however, was the fact that claims by care aides related to acts of force or violence outnumbered claims from every other group of employees in long-term care by a ratio of almost 10 to 1 (see Figure 12). Aggression in long-term care is, overwhelmingly, aggression against those who deliver frontline care. Accordingly, the focus of any strategy to reduce incidents of force or aggression must be on our province's long-term care aides.

When we consider the nature of aggression against care aides that results in WCB claims, we find a slightly different picture from that presented in incident reports. Although striking out by residents (punching, kicking, hitting, and pushing) accounts for almost 40 per cent of claims, aides are more commonly injured by residents' grabbing and twisting or pulling and yanking, again typically during personal care. Such claims account for almost

FIGURE 12

WCB Employee Claims in Long-term Care, 1987–96



50 per cent of all claims. Figure 13 sets out the kinds of aggression and their relative contribution to accepted WCB claims.

Although the number of claims related to force or violence increased dramatically during the 1980s and into the early 1990s, there was a very slight decline in claims in 1995 and 1996, the most recent years for which data are available (see Figure 14). While the costs of these claims are almost 10 times as high as the costs of comparable claims in the mid-1980s, the modest declines of 1995 and 1996 are encouraging; they suggest, specifically, that government educational initiatives in 1992 and 1993 (*The Management of Aggressive Behaviour* and *Drawing the Line*) may have been effective in reducing injuries among care aides.

Finally, when we looked to the contributions of male and female residents to WCB claims between 1987 and 1996, we found data similar to those revealed by incident reports. In every year of the decade the rate of aggression by male residents resulting in accepted claims was three times that of the rate for female residents (see Figure 15).

FIGURE 13

Nature of Aggression by Residents to Care Aides: WCB Reports, 1987–96

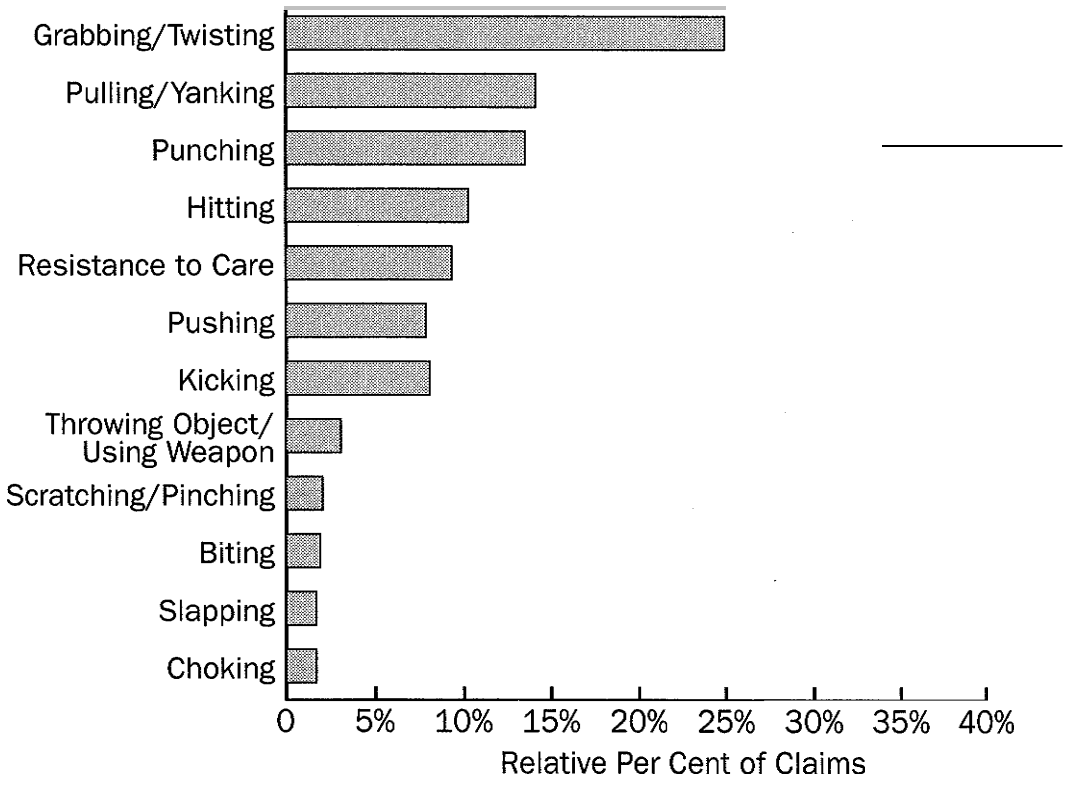


FIGURE 14

Acts of Force or Violence in Long-term Care: WCB Claims, 1987-96

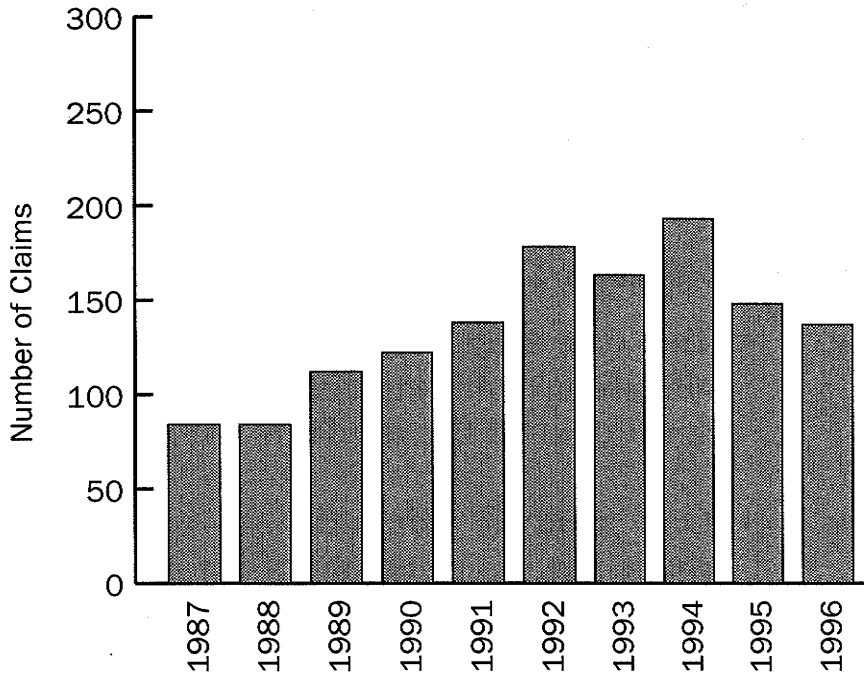
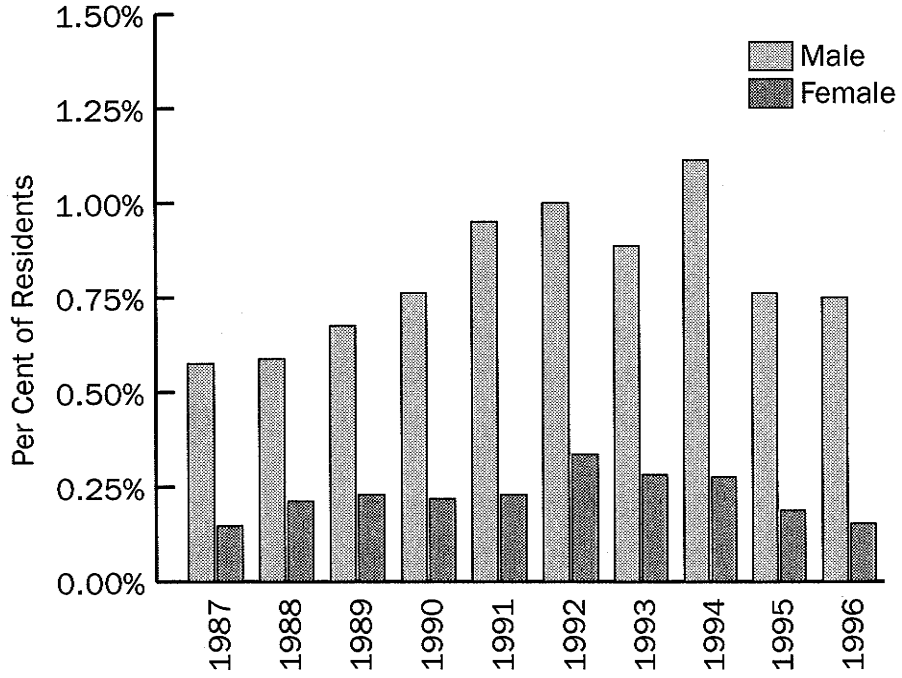


FIGURE 15

Rate of Male/Female Resident Aggression Within Continuing Care in B.C.: WCB Reports, 1987-96



(C) Context:
A Snapshot of Life in a Long-term Care Facility

Typical descriptions of several hours in the life of two of our province's special care units follow. This type of material forms the real-life context for the data presented in the preceding analysis. For reasons of protection of privacy, the names of all individuals have been changed or withheld.

Take One: Special Care Unit, Four-hour Observation

6:00 A.M. • Two care aides come on shift, some residents are already up and wandering. The aides begin personal care for the residents who are still in bed.

6:15 A.M. • One resident wanders into another resident's room. She is pushed out of the room and yelled at by the occupant. A different resident walks into another room and there is no incident.

6:30 A.M. • It comes to the attention of the nurse on duty and the two aides that one resident has fallen in her room and has injured herself. They all go to care for her. They put her back in her bed and tend to her injuries.

6:45 A.M. • Two aides go to do some personal care on one resident who has a history of striking out at staff. The staff approach the man in a calm manner and speak to him in a friendly voice. While they dress him, one holds his hands and the other puts his clothes on him. They assist him to the bathroom, change his diaper, and give him a quick wipe-down with a washcloth. The resident responds well to the care.

7:00 A.M. • The staff move on to another male resident. This resident does not have a history of aggression, but two staff are needed to manage him physically. They dress him, change his diaper, and complete his hygiene without incident.

7:15 A.M. • The aides report to the nurse who has just come on duty. A resident wanders into another's room and is redirected by staff. In the common area, one female and one male resident are in an embrace. They are separated by staff and redirected. They respond well, and there is no incident.

7:30 A.M. • One staff member completes the care of a female resident. The resident is given a sponge bath, diapered, and dressed. The staff talks to the resident throughout the process, and no incidents occur.

7:45 A.M. • Two staff members then proceed to the room of a resident who has a history of aggressive behaviour. While getting the resident out of bed and into a standing position, the resident resists. He does not strike out, but arches his body and pulls away from the staff. When the staff have the resident in a standing position, he resists walking to the bathroom. The situation is physically difficult for the two female staff members as this man is large and over six feet tall. The resident then complies and goes to the bathroom. The staff work very fast to complete his hygiene and do so without the resident striking out.

8:00 A.M. • More residents are up and wandering around. They are entering other residents' rooms, sitting in chairs waiting for breakfast, and walking around the common area. The staff complete the morning hygiene of two more residents; there are no incidents.

8:15 A.M. • Residents are waiting for breakfast and wandering around. The nurse is setting up the meds.

8:30 A.M. • The nurse administers meds to the residents. The residents are divided into two groups. The residents who are higher functioning and can feed themselves are placed on one side of the common area, while the residents who require assistance are directed to the other side. The doors between the two areas are locked.

8:45 A.M. • The higher functioning residents are being given coffee. On the lower functioning residents' side, a male resident walks up to a female resident. He hits her in the face and grabs her arm. She doesn't respond, and he lets go of her. No staff witness this.

9:00 A.M. • Breakfast is served to the residents. On the lower-functioning side, one staff member struggles to feed everybody, as most of the residents will not stay seated. She has to physically prompt some residents to sit down and eat. A female resident is struck by another female resident and the aggressor is moved to another table.

9:15 A.M. • Some higher-functioning residents have finished their breakfast and are wandering around, others are still eating.

9:30 A.M. • The doors separating the two rooms are opened and the residents wander back and forth. One female resident who is being fed by a staff member puts a piece of paper in her mouth. The staff member has to physically remove it and take it from her.

9:45 A.M. • Most of the residents are wandering around by this point. Some are sitting; others are walking in and out of bedrooms.

Take Two: Special Care Unit, Five-hour Observation

8:00 - 8:30 A.M.
- Residents begin to congregate in hallways, after their morning care, asking about breakfast.
- A resident, annoyed at being moved from the middle of the hallway, angrily swipes her wooden dominoes from a table tray to the floor.
- Residents seem curious about the presence of the researcher, but no questions are asked.

8:30 - 9:00 A.M.

- Residents seem to be in a good mood overall and are having friendly interactions with staff, other residents, and myself.
- Care aides are directing residents to the dining area for breakfast. Many residents have come by the nursing desk where I am sitting - they are telling me that they are hungry.
- Residents are seated at tables. Some are chatting with others, some are non-communicative.
- One care aide is preparing coffee for a male resident, when the resident starts yelling, "No, no, no, Jesus Christ! Shit! No, no, no." Another resident in the dining room begins to echo the "no, no, no."
- A resident is walking around with the stem of an unpeeled banana in his mouth. An aide tries to remove it, and he tries to evade her. The aide successfully gets the banana, and peels it for him. He sits alone at a table, eating his banana.
- One woman is eating alone in the lounge area. Earlier, she was sitting alone with a couple of teddy bears; now she is dining with the bears.

9:00 - 9:30 A.M.

- Residents are finishing breakfast.
- A middle-aged man with Huntington's chorea is waiting in the hallway outside the dining room; he seems to want to enter, but is not venturing in. He is engaged in incomprehensible banter with the brain-injured "domino woman," who is laughing. Her brain injury is from a beating sustained about three years ago - she was found near a lake, left for dead. The nurse says she was also raped.
- Residents have finished breakfast and

are now moving back to the hallways and to their rooms.
- One resident has locked himself in the "time out" room.

9:30 - 10:00 A.M.

- A group of residents congregate in the hallway, chatting with care aides.
- Two residents are pacing the hallways
- I ask one resident, Papa, if he enjoyed his breakfast. "I don't know. I don't remember. I'm wondering if I'll miss the bus," he replies.
- A care aide is directing the man who locked himself in the time out room to an outside, fenced yard.
- The barber is cutting another resident's hair.
- A resident with Huntington's is constantly moving, pacing the hallways.
- One resident keeps coming by the nursing desk to check things out.
- There seems to be a lot of "wandering" behaviour; most residents are unoccupied while aides attend to care duties.
- An aide attempts morning care with a man called Ray, who has wandered out of his room.Another aide comes to assist her.

10:00 - 10:30 A.M.

- A resident has a seizure.
- An Asian resident speaks to the clerk in Japanese; it doesn't seem to matter that the clerk doesn't understand her.
- A resident is wearing somebody else's jacket. He is confused; he cannot find a T-shirt. The clerk asks him what his room number is. He tells her the number, but he gives that of his old room. (He has recently changed rooms.) The clerk helps him find a shirt to wear. He asks, "What am I supposed to do?"Anything he wants,

he is told, so now he's wandering.
- Aides are getting some residents' coats and encouraging them to go outside to get some fresh air.
- Another resident comes and asks us, "What am I supposed to do?" The reply is "anything." She goes into the dining room and announces that she wants "the full price for that chair," repeating her words several times.
- The barber is still cutting hair.
- A new resident arrives at the ward with her husband; staff begin the admission process.

10:30 - 11:00 A.M.

- Papa comes by to tell me he missed the bus (again).
- A resident, Willy, keeps pacing the perimeter of the hallway.
- There are physical problems with another resident; a nurse is called from admission duties to check.
- Other residents are wandering the halls.
- A resident in his room begins yelling for no apparent reason. Now he's shouting "My leg!" An aide is attending to him.
- Some residents are sitting in their rooms; some with visitors, others watching TV.
- A male resident is shouting from behind a closed door.
- A couple of male residents who were awake through the night are sleeping.
- The special unit is getting noisier now. There are a couple of male residents shouting from behind closed doors in their rooms.
- Papa is wandering the hallways. Several other residents are sitting in the dining room, not communicating with one another. Papa keeps coming to the

nurses' station, pleasantly addressing all women as "Momma."
- An aide is reprimanding Mrs. L. for rummaging through the garbage.

11:00 - 11:30 A.M.
- Willy is still pacing the hallways with his characteristic shuffle, holding a stuffed gorilla.
- Dave is not thrilled with his haircut, but is settled now. He has got a booming voice. "It's cold!" he exclaims, as another resident is wheeled in from outside. He gets louder and more annoyed every time the door from outside the dining room is opened, and cold air comes in. The RN advises him to get a sweater.
- A resident has gone to his room and is yelling at the cleaner, who has tried to enter the room.
- Aides are preparing for lunch.
- Dave has put his sweater on. "You look good in red," says the nurse. "It's cold," he replies. He is surly.
- One sleeping resident is now awake (he was yelling a while ago) and is moving around the halls in his geri-chair.
- Aides are rounding up residents to come for lunch.
- Dave keeps shouting, "Mom!"

11:30 A.M.- 12:00 P.M.
- Residents are eating lunch in various locations: some in their rooms, Nora in the hallway (because, the nurse says, she behaves best there), some in the lounge, and some in the dining room. Aides are spoon-feeding some residents.
- Dave continues to shout, "Mom!"
- Rob is shouting angrily at someone who opened the dining room door to the outside.

12:00 - 12:30 P.M.

- A doctor has arrived to do his rounds.
- Most residents are finished eating and are beginning to wander.
- Dave is still shouting, "Mom."
- Gillian comes to the desk and asks where she can pee.
- One care aide turns to me and says, "It's too bad you were here on such a quiet day."
- Papa comes by with a female resident; they are going for a walk.
- Mrs. L. brings a juice cup to the nursing station and makes a request for something in Chinese. She continues to speak in Chinese and won't leave the counter. The aide says she wants the garbage can from Mrs. L. (Mrs. L. sometimes likes to pee in it). Mrs. L. continues burping and chatting to herself or me. She tries to get onto a chair and climb over the counter. Mrs. L attempts to get the chair on the other side of the nursing station, but I prevent her. She gets ticked off and speaks to me faster, it seems, in Chinese.
- Other residents are sitting in the dining room, most preoccupied with themselves. It's quiet in there.
- Papa and the female resident are still pacing the ward together.
- Six residents have left to go bowling.
- Dave comes up to a care aide saying, "Mom, no, please, Mom, may I play with..."
- One resident approaches another at the nursing station, and wheels him away.

These nine hours of description tell us about life in two special care units. The descriptions clearly tell us something about the circumstances in which resident aggression occurs. The care aides are constantly busy attempting to provide personal care, but wary of the tendencies and inclinations of many of the residents. The residents are questioning, insistent, bored, upset, irritated, asleep, agitated, verbally abusive, physically aggressive, and confused.

(D) What Do Employees Perceive as Solutions?

Our survey of six long-term care facilities in British Columbia determined that most employees have made a significant commitment to this field of work: almost 70 per cent of workers have more than six years of experience in delivering services within long-term care (see Figure 16). Our conversations with care aides, nurses, and administrators/directors supported the empirical perception of job commitment. With rare exceptions, the mostly female work force is committed to giving high quality care, sensitive to the needs of residents, and coping with a relatively heavy workload.

When we asked employees for solutions to the problems of resident aggression, two remedies dominated the discussion. The most popular remedy, by a slim margin, was increased in-service education; it was followed closely by increased staffing (see

Figure 16

On the Job Experience: Long-term Care Employees in Six B.C. Facilities

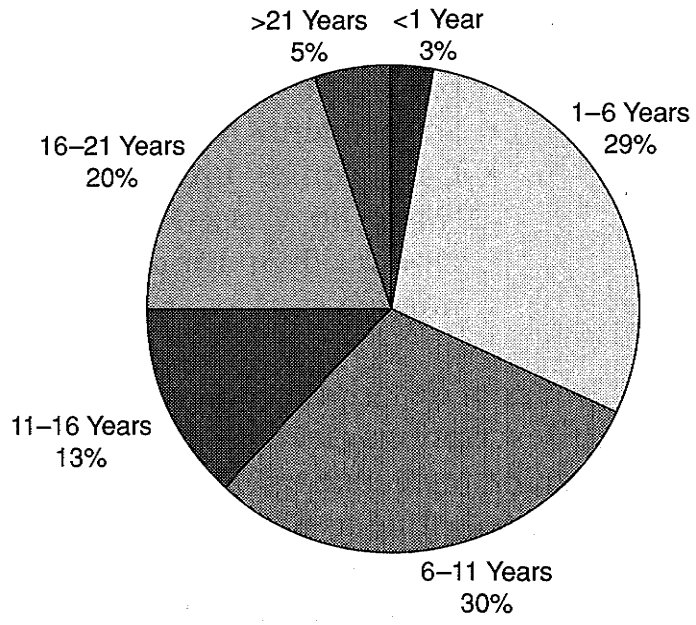


Figure 17). Improved procedures for dealing with aggressive residents, and a more detailed social and medical history of new residents also emerged as critical to responding to the problem of aggression. Less widespread were suggestions to increase or decrease the use of behaviour-altering drugs and to change the deployment of existing staff within the facility.

When we looked to the remedies suggested by specific employee groups, however, we found some significant differences. Care aides overwhelmingly see increased staffing as the most important change needed within the continuing care system (Figure 18). Nurses, however, are committed almost equally to three approaches: increased staffing, increased in-service education, and improved procedures for dealing with aggressive residents (Figure 19). Directors and administrators place very little emphasis on increased staffing, but put considerable emphasis on increased in-service education (Figure 20).

FIGURE 17

Most Popular Remedies for Resident Aggression: Perceptions of All Employees

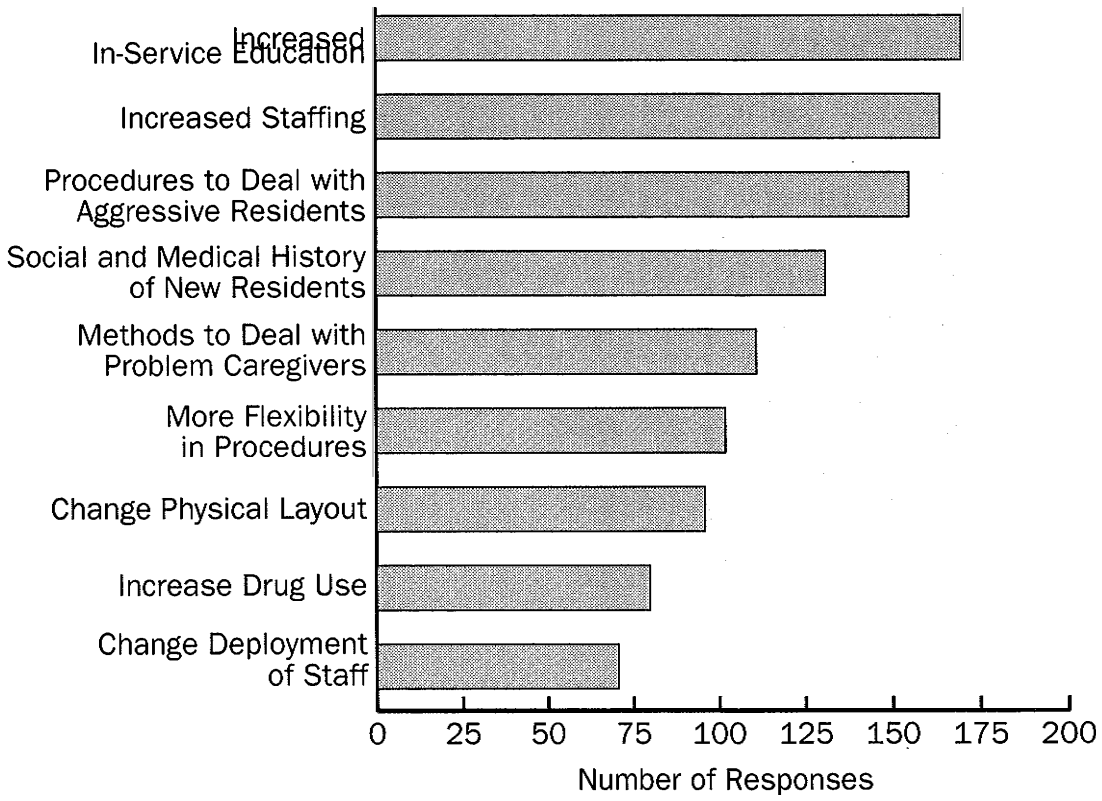


FIGURE 18

Most Popular Remedies for Resident Aggression: Perceptions of Care Aides

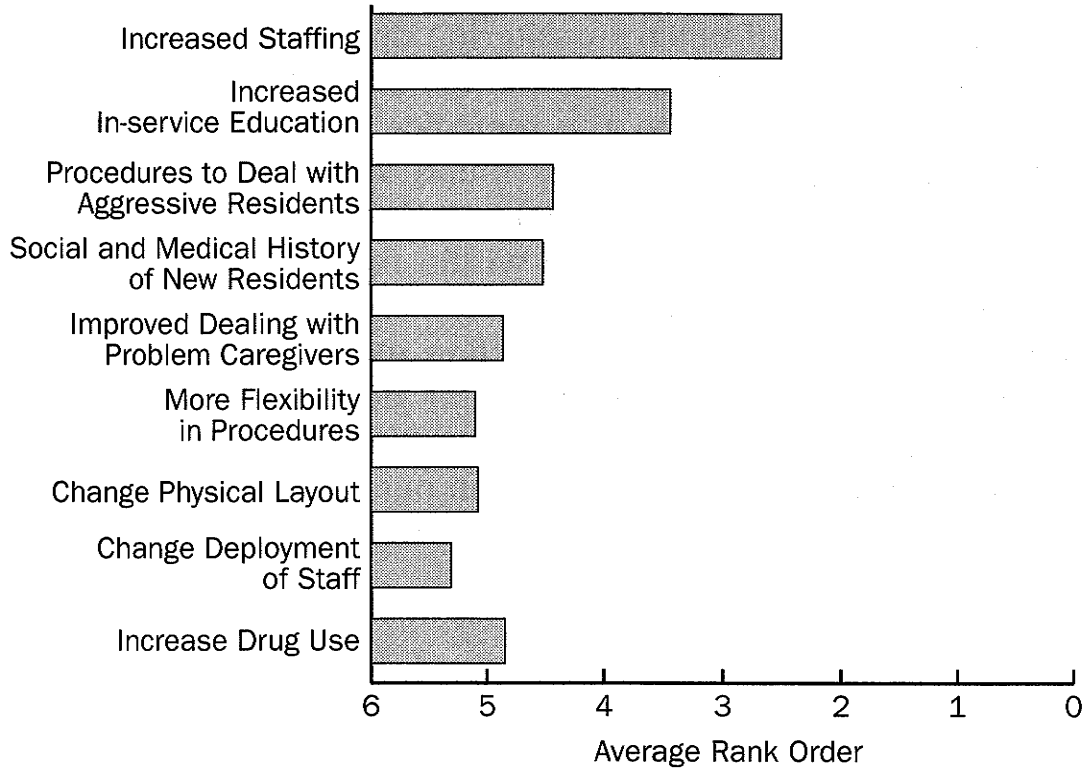
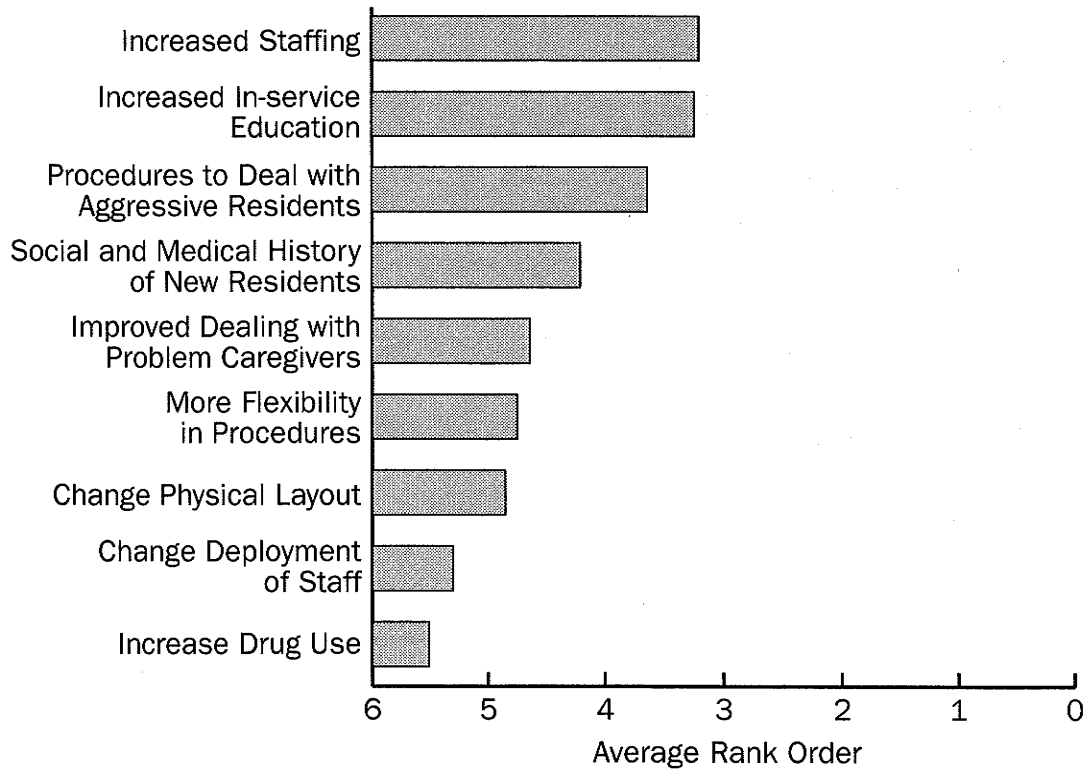


FIGURE 19

Most Popular Remedies for Resident Aggression: Perceptions of Registered Nurses



We asked more than 200 employees at the six long-term care facilities how often they had experienced various types of aggression within the previous week. Not surprisingly, care aides and licensed practical nurses - those in the front line of care delivery - were most likely to experience aggression. In an average workweek, a care aide can expect verbal aggression and grabbing on at least a couple of occasions, plus a single instance of being pushed, slapped, and hit (Figure 21). Less common are pinching, kicking, and scratching; such assaults are expected to occur about once every two weeks. Nurses can expect verbal aggression, verbal threats, and grabbing regularly within a given week (Figure 22). All other employees are exposed to some verbal aggression, but are very rarely subject to hitting, slapping, pushing, scratching, kicking, or pinching (Figure 23).

FIGURE 20

Most Popular Remedies for Resident Aggression: Perceptions of Directors/Administrators

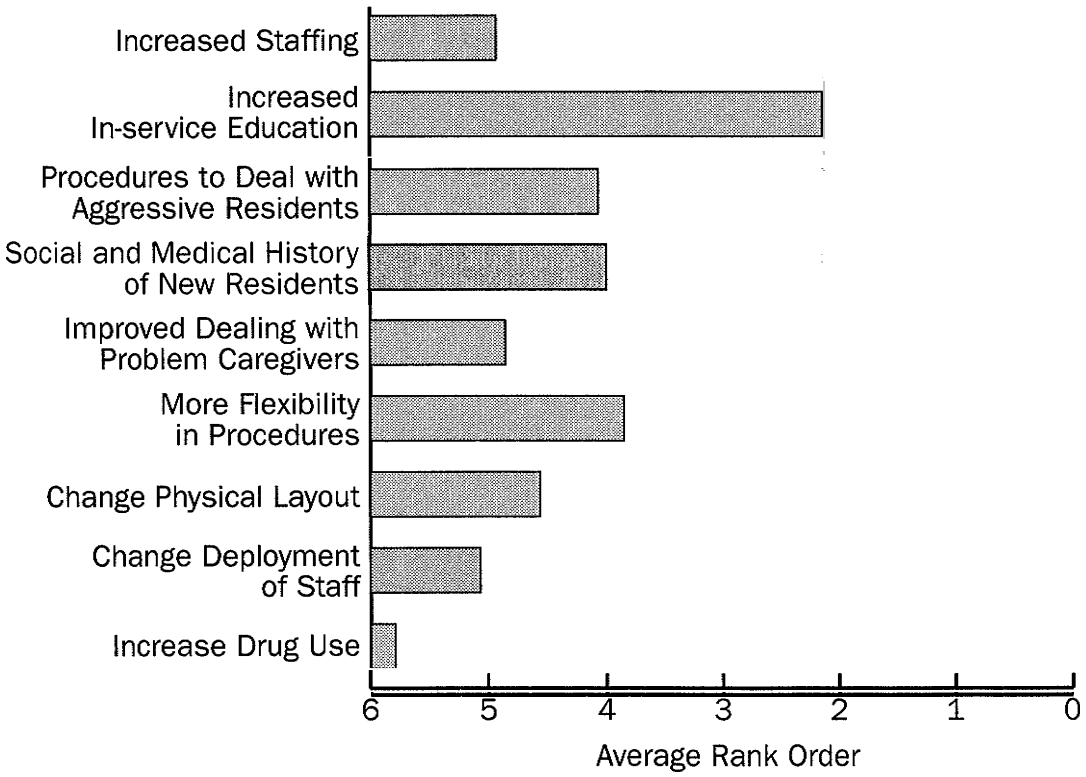


FIGURE 21

Rate of Aggression by Residents: Average Number of Incidents Reported by a Care Aide in One Week of Work

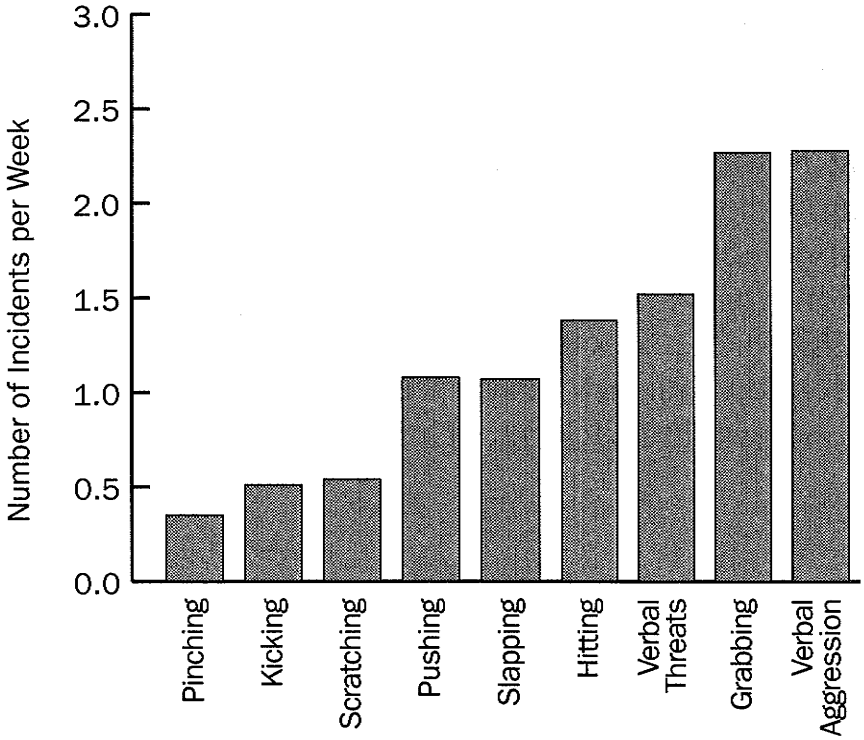


FIGURE 22

Rate of Aggression by Residents: Average Number of Incidents Reported by a Registered Nurse in One Week of Work

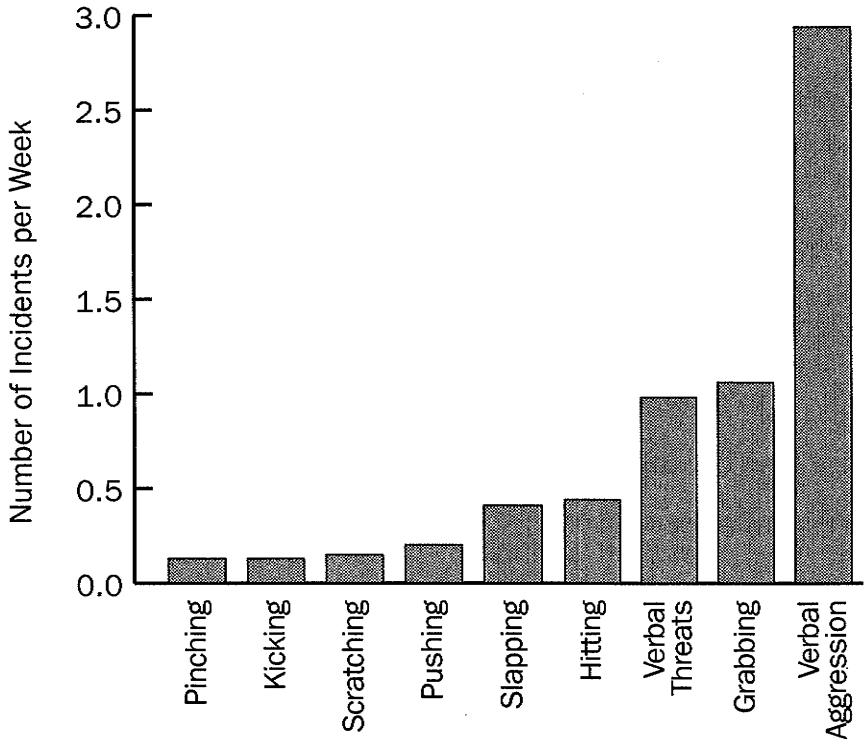
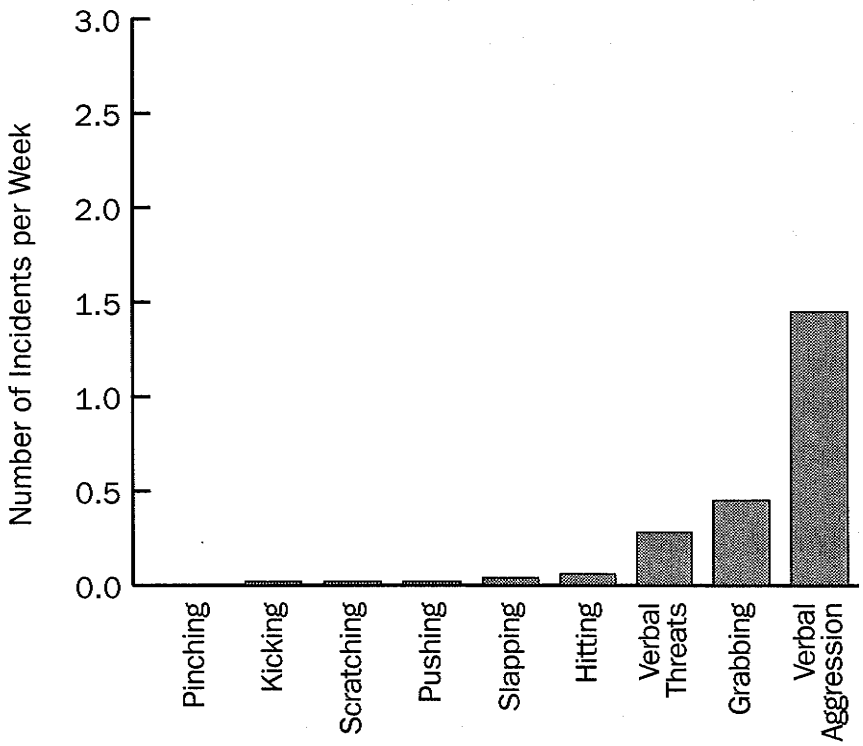


FIGURE 23

Rate of Aggression by Residents: Average number of Incidents Reported by All Other Staff in One Week of Work



(E) In Their Own Words: The Views of Long-term Care Employees

What did employees of long-term care tell us, in tape-recorded interviews, about resident aggression? Questionnaire responses revealed that directors and administrators of care were not particularly focused on staffing level, but were most concerned about in-service education. In contrast, care aides were most focused on increasing staffing levels; nurses urged both staffing increases and more in-service education. What follows is a sampling of their views.

Care aides, although they were almost unanimous in their desire for increased staffing, also strongly endorsed in-service education. Some representative comments follow.

Care Aide A: The workload that we face right now on this unit is ten residents to one care aide.... I would like to see it down around six because the more [staff] that you have, the more times you can intervene in a situation before it happens. And the quality of care is better at that level ... looking after ten people, it is a lot of work over an eight-hour period. In that eight-hour period, we're toileting residents, setting up for dinner,... taking down dinner, putting tables away, doing personal care,... getting people who have been incontinent changed for the whole entire eight hours.... We try to set up a scheduled routine, but the best laid plans of mice and men, it never works....

After supper we have an activity department that comes up and works with the residents that are on the floor. After that, getting people ready for bed and then throughout that whole period, we're constantly interacting and diverting people away from situations. And then once people do get settled we have residents on the floor here who will go and wake them up. So you are returning people back to bed ... which in the summer time is a lot harder than the winter, because it is a lot lighter out. In the winter when it gets darker, people start

to settle a little earlier. But come summer time, we have instances where we go off shift at eleven o'clock at night and there are twelve people up who won't go to bed. They've had snacks, they've had food, they've had some talking to or redirecting or sitting down or watching television, and they just don't settle. And then we go and wake people up and it is just a continuum.

Care Aide B: [With increased staffing] you wouldn't be so rushed and you could take more time, pamper them, make them more comfortable....

I think [education] should be a qualification for work, that you have to take so many in-services during the course of the year. I think that should be a required part of the job ... and if they are on your [off] days you should have something in the line of remuneration for that. But I think it should be a job requirement because you see a lot of things that are being done that shouldn't be done or things that aren't done that should be done.

Care Aide C: I would love to see definitely more staffing of all kinds ... just to give, you know, a hundred per cent care, a hundred and ten per cent care throughout your whole shift. Whereas right now because of the loads and the amount of other duties - other than the one-on-one care that needs to be provided - the most time that you have with your resident is that time you are getting them up and getting them dressed in the morning. And, you know that is not always enough for most of them. You know, everybody needs that human contact and that connection, and so I'm always in favour of more staffing. You know just to make it more personable.

Care Aide D: When I started here in '81 we had three extended-care residents. We had aggressive patients, but they didn't flare up all that often because we were able to ... get our work done and everything. But

we had more staff then, and now we have all extended-care residents - almost all extended care - and the staffing level just automatically keeps on going down.... The work load is very heavy...

I'm all for [in-service education]. I think ... they brought in the PART program, it was about five, maybe longer than five years ago, eight years ago.... It's the Preventive Assault Response Training and it was really good ... how to get out of holds if the patient was choking you, grabbed you ... you can get out of it without you getting hurt and him getting hurt.... But nobody has ever followed up on it.... We've had a few people come up from Riverview and lately we've had people coming up from St. Vincent Hospital and they've also been talking about how to deal with the residents. But mainly they've been targeting [particular] residents ... to find out which [approach] is the best.

It's also like a police officer, you can be trained and trained, only every situation is entirely different, and you don't know if it's going to flare up, when it flares up, how often you're going to have it flare up. So I think just educating staff and just, you know, kind of keeping it active [is important].

We also found relatively strong support for increased staffing among nurses:

Nurse A: One of the primary reasons that increased staffing, from my perspective, makes a difference, is the hurriedness. The hurried factor is one of the biggest things in aggression, and that gets back to the point of being very task-oriented. These care aides work really hard, and they have a lot of work to do. And they want to do a good job - the majority of them are conscientious - so they are trying to work through their tasks. And they become hurried because they fall behind - someone falls down, something else happens. So if someone is demented and you need to break down the com-

mand - from a three-part command to a one-part, and then walk them through that ... to the next part and then walk them through that - it takes five times as long and so, yes, staffing would always impact.

Many nurses expressed the view that while increases in staffing might be helpful, more in-service education would be of greater benefit:

Nurse B: I think people need to be educated and it will help in decreasing aggression if people know what the causes are and what they can do, and how they can deal with it. It will help reduce aggression.... Well, the one course that I am familiar with is called Managing Aggressive Behaviour ... a course that was train the trainers ... it would teach you to become familiar with all the material and then go out there and do your own training. So I was part of developing that into something we use here.... However, the biggest headache we have with this program ... and I think this is the biggest difficulty with in-services ... staff here won't come on their own time. They want to be paid if they come here for half an hour or an hour to get trained ... and [the administration] are not going to do that.

At the same time, however, not all care aides and nurses saw increased staffing as a key to reducing aggression:

Care Aide E: I don't think that is the way to go. Not increased staffing, but better educated staff. Now we have people that do have some education, but I don't think it is reinforced ... you really have to understand dementia. Understand that they don't have control, they are not going to hit you because they want to. There is a reason why and I think that if we understood that better, I think you would have [less aggression]. And I think in that aspect we

need to have more humanity.... I've seen the people get hit, I've seen why they got hit. And I often wanted to say you know, maybe if you just backed away and waited, everything would have been fine.

Nurse C: In this particular unit increased staffing might actually increase agitation because these people need a quiet environment, and so more staff may not necessarily be helpful ... you have more bodies coming and going and it adds to their anxiety ... it is sort of a two-edged sword. On the one hand it would be helpful to have an extra person there because - caring-wise - we have the same staff levels days or evenings, but in the day time there is also the recreation therapist and the housekeeper. On evenings [they aren't there], so you [could] miss those two extra people if you needed them. So ... it is a two-edged sword. It would be handy to have [more staff] there if you had a problem, but at the same time because [the residents] are so agitated, maybe it is better for them if there aren't too many people coming and going.

The directors and administrators of the six care facilities, most of whom have training as registered nurses, were very supportive of more in-service education, but skeptical of the value of increased staffing.

Director A: I don't think increased staffing ... is one of the top [needs]. I think it's increased education for the staff that you have - educating them about different methods of dealing with aggression, or educating them about how you prevent aggression. There has to be education first on preventing aggression - before you have the education on dealing with aggression - because a lot of aggression can be avoided. I can increase my staff levels, but that isn't going to help the aggressiveness. A lot of times when you have extra staff with an aggressive resident, the aggressiveness increases. Mind you, there are other times when I know of

aggressive acts that have happened to staff members that have been non-provoked. They haven't been watching the anxiety as it escalates to aggressiveness. It has been a very unprovoked aggressive act. And there is no rhyme or reason. There was no preventing it. So ... I can increase my staff, but if those people aren't educated it's not going to help at all.

Director B, like Director A, expressed a preference for education, but highlighted its expense. He also lamented many care aides' lack of a knowledge and language base when they enter the field of long-term care:

Director B: Increased staffing would be perfect, but it has to be appropriate staffing, too. I mean, you can throw all sorts of water at a fire, or material at a fire, but it has to be the right kind of material.

Interviewer: One of the consistent suggestions I get from all facilities is more care aides.

Director B: More trained care aides. Training is important. We have a very diverse workforce.... Most of our residents here are Caucasian, most of our staff are not. Dementia and Alzheimer's people - you need to be able to communicate with them properly. So English as a second language is critical. Many care aides go into schools with a three-month or four-month training course. Camosun in Victoria, the Vancouver Community College are excellent programs. There are a whole bunch of other programs that are not excellent, and they are basically geared to tap into the employment-insurance market. So what happens is that a lot of care aides are on UI, get put into these programs, and have really not wanted to be there, don't speak English all that terrific and they come here and get good pay, relatively speaking ... sixteen, seventeen, eighteen dollars an hour is not bad for a grade ten education and three months' training.... So consequently what

happens, your workforce is not always terrific.

What happens is that you are always in a scramble. I mean, you hire your own problems, but what happens if you have a dearth of applicants.... There are some colleges where you pay five thousand dollars to get into the program, so there is some motivation.... Those are the ones that you really want to get in. Or the Vancouver community colleges and things like that, but they get snapped up.... It is a tough market.

Interviewer: What about in-service education?

Director B: It is important. It is incredibly important. I mean education is important in any job. We never have enough of that.

Interviewer: Is that a money issue again?

Director B: Okay. I can't bring in people to do an in-service for two hours. I can't do that because I have to pay them. It is a union thing. I have to pay them. If they volunteer, terrific, but it is not going to happen. I have to yank them out of the work schedule to make it work. I do that occasionally. We haven't done enough of that, we need to do that. Education is the best tool available to any organization, and it is so complicated. So it is money, you're right. It is money and time.

Director C saw more value in increased staffing, but, like Directors A and B, she was skeptical about the value of simply placing more workers in the facility:

Director C: I think increased staffing would work to a certain extent, but I think you would reach a saturation point. Just to give you an illustration, on our special care unit we have a larger contingency of staff for obvious reasons, but we also have a number of colleges that like to send their students in for

practicum on our special care unit. They send them in in groups of ten ... they are an extra pair of hands and they provide that little extra touch for the resident. Two weeks ago we had an overlap of two groups of students by a day and a half. So for one day, we had twenty students up there and it was chaos, absolute chaos. When you think twenty students, sixty residents and we had nine staff members, [the residents] were really confused by all of these people around. Too much stimulus. And I think it is the same thing when looking at staffing levels, we have to reach something that is appropriate, and yes, increased staffing levels for some of our areas would definitely help.

With respect to increased education, Director C was positive about its value:

Director C: I think the new grads are coming out with more awareness and better training ... a lot of the care aide training programs are now adding in that special care component.... As far as in-service and education is concerned, we have a responsibility as an employer to provide a safe work environment, and part of that safe work environment is to give people knowledge and to raise their awareness about working safe. So we provide education regarding approaches to potentially violent, aggressive residents, and also ways to protect yourself should they become aggressive. Those [staff] that come to us as new grads seem to ... grab a hold quicker. Some of the older people, people who have been around for a while have normalized a lot of the behaviours, so they don't see it as that aggressive ... just as part of the job ... but we've done intensive education here and I think it's worked.

Director D also placed education before increased staffing, speaking of the need to improve the quality of education for care aides:

Director D: With the use of geriatric psychiatrists, we're beginning to recognize that residents, or a number of residents, exhibit hallucinations and delirium in relation to urinary-tract infections, chest infections; and I think for the non-professional caregiver, they don't link some of those things, and so I think there's a big educational gap there.

Interviewer: So, the courses that are currently out there for care aides, they should be expanded, in your view?

Director D: Very much so, very much so. I would say that the use of the non-professional caregiver is becoming ... an area of concern for all of us. When residents were being admitted for personal care and intermediate level one care - where the residents were able to do their own activities of daily living and were cognitively, fairly cognitively intact - I think the care aide attendant program, the six-week or the three-month program was maybe okay. But I think in this day and age we need to have a more qualified worker looking after these people, and I truly believe that that can only happen by extending the curriculum within the colleges to provide more learning in the relevant areas of behaviour.

Finally, like all other Directors, Director E expressed a preference for more in-service education:

Interviewer: What about in-service education? I've heard that one of the difficulties [in long-term care] is that there is not enough of a knowledge base about the problems that the residents face.

Director E: I think that's true. I don't know about a longer length of time in an actual formal course, but ... if people had their education six years ago, there are different thoughts and different skills that they could learn to redirect residents or to intervene between two residents that are arguing or fighting.

> And I think that those kinds of skills can be kept up to date with regular in-servicing, newer ideas that come up, and just different approaches that people have found. I mean there are some care aides here who have worked a long time and have never been victims of any kind of physical aggression, they may have had it verbally, but they have never been hit. So what do they do that is different? And I think if we can sort of build on that....
>
> I think you need short, small in-services during the day. I think what would be really beneficial – if you could bring things in that happened yesterday or today ... specific instances, how can I handle that?

There were a number of general themes that emerged during discussion of staffing and education. First, most employees could see substantial benefit flowing from increased staffing, but many were wary about the implementation of such change. Some argued that it was not economically or politically feasible, and hence not worthy of consideration; others worried that increases might not be applied appropriately. Almost all employees believed that where increases in staffing levels were appropriate, an increase in care aides and activity workers was most critical.

Education was almost uniformly valued, but there was a lack of clarity about what was meant by education, and how it might be implemented. Many employees lamented the scarcity of in-service education and the fact that these courses often had to be taken on one's own time, leading to a situation in which educators are "preaching to the converted." There was also substantial concern expressed about the level of education required for work as a care aide and, specifically, about the inconsistency of care aides' knowledge base, given the range in quality of educational programs. Other employees expressed concern about language barriers among care aides, and their inability to communicate effectively with the residents in their care; a number of nurses and care aides suggested that patient frustrations with these language difficulties are a precursor of resident aggression.

The other key remedies identified in questionnaires and interviews by all employee groups were improvements in procedures for aggressive and potentially aggressive residents, and improvements in documenting the medical and social histories of all incoming residents. In light of our findings that a very small percentage of residents are responsible for all aggression, a better knowledge base and improved procedures would appear to be critical.

There is some resistance to identifying aggressive and potentially aggressive residents. A minority of those who work in long-term care believe that by labelling residents as aggressive, we bias caregivers and thereby diminish the quality of care afforded those individuals. There are also some practical and political difficulties in procuring an exhaustive medical and social history for all incoming residents. In many instances family cannot be found or are reluctant to contribute potentially embarrassing information. As well, there is often no one available, outside of family, who can provide a comprehensive background for the new resident.

Director A: We do assessments when they are admitted. Sometimes a lot of the information that we are getting is limited. Whether the resident can't give the information, or ... whether it is a son or daughter giving me information about dad or mom, in their eyes, it's still dad or mom and there are certain things you don't tell other people. [When] it is a spouse talking about another spouse, there might have been - especially with our dementia residents - there might have been some sexual acts or maybe ... he's attracted to other women now. And this is very embarrassing to a spouse of fifty or sixty years. So ... sometimes we don't get very true assessments from family members, because maybe there are things being hidden.

Director B echoed the need for an improved base of knowledge, particularly a detailed medical and social history with respect to new residents:

Director B: [With] street people in particular, many of these people have gone without medical care and social care, and we usually get what is available - but it is minuscule. Real frustration comes in when we are considering a resident for admission and we look at the medical history and the social work work-up from continuing care. We may see absolutely nothing about aggressive behaviour. [It may be] something they didn't recognize or they are afraid if they put it down, we won't accept the resident.... So we do a pre-admission interview with the family and the resident. Sometimes things will show up then - we can read between the lines or the family will tell us something.

But many times the family will withhold information because they are afraid we won't accept the resident. Or they may have normalized the behaviour. But any, any information we can get is very valuable, and certainly the medical history is very important because there may be a physiological reason for the patient's aggression. And pain plays a huge factor - many of the patients we see are used to living with pain. They won't complain, but they are still very cranky, and if we can get the pain under control, we see a completely different resident. So if we have that history, we can start building on that. If we have to start the investigation when they get here, we are probably dealing with a real cranky fellow for a month, two months, until we can get everything under control.

Nurse A, in response to our question about effective procedures for potentially aggressive residents, made the following point, which was endorsed by many directors, care aides and nurses:

Nurse A: Individualize care as much as possible. We have some people who don't like eating breakfast in the morning - fine, feed them [later] when they get up. We have some people who like having

snacks during the night, so have snacks available. If someone is not a morning person, then there is no reason why they have to get up in the morning. Individualize the care as much as possible.

Nurse B lamented the lack of specific procedures for aggressive residents, and the lack of flexibility in her facility:

Nurse B: It is just so cruel to get them up at seven thirty in the morning or you know, quarter to eight, and they are sitting there and they really have nothing to look forward to.... I think there just needs to be flexibility.... I don't like these strict little regimes that they have: at seven thirty you get up, eight thirty is breakfast, and then you are forced to go to activities, you are forced to eat.... The majority of them are out just sitting around. Or even if they are in their rooms, they don't have anything to pre-occupy their time.

Care Aide A emphasized the need for improved procedures to be implemented as a part of in-service education:

Care Aide A: I think that if there is a new resident or client who comes in, and there is the potential for [aggression] to happen, that we should be notified right away. Not necessarily to put a red flag up, but just to let the people who work here know of this person's history. When a person is admitted, there is a certain set of files that are put together, and I think there needs to be a sliding scale on aggression so we know if this resident has been [aggressive]. We know usually where ... they come from to here. If we know resident A came from this place, then we know that is what they were dealing with before they came here, and the signs and signals to look at.... A lot of the in-service could be focused on that.

Two consistent themes that employees spoke about during interviews were the value of more activities for residents and the

importance of a residential design that meets the needs of current and future intermediate care, level 3, residents and extended care residents. Indeed, we were struck by the fact that buildings of the 60s and 70s were designed for an entirely different population. We were also struck by the lack of social involvement available for residents. This problem exists not because staff are lacking interest or compassion, but because they have significant demands on their time. Our observations (Appendix B) are replete with residents asking staff and observers, "What can I do?" The staff are typically concerned about the limited activities available for residents and about the physical environment in which residents are living.

Director A: We have some problems with our physical layout because of our long, long hallways, and I have some genuine concerns for staff members working evenings when the staffing component is down. Should they have need to go to a resident's room right at the end of the hallway, and that resident has a history of aggression or there is a possibility that he could become aggressive, I do have concerns. Because, yes, we do have emergency call systems, our night staff carry radios, the RNs carry radios, but still once you are into a room it can be really scary.

And on our special care unit, the physical layout just increases some of the aggression because of the fact that it is one long hallway that the pacers can use. They get down to the end of the hallway and they are not too sure what to do because it isn't a loop. [The unit] is also too big – sixty residents on a special care unit is too large. We are very much aware of that, and we also know that our physical layout doesn't allow us to create another secure unit for the frail demented resident, so that we could separate the aggressive resident from the frail demented. That is a problem and we know that.

Director B echoed these concerns and spoke of the need for an increase in resident activities:

Director B: If you are dealing in very confined quarters with someone that's in a wheelchair - maybe you are turning the person in the wheelchair - and their feet, their elbow, their arm, hits a wall, well, right away that person is going to react because they have been hurt. And maybe they will fling an arm, or the next time that you touch their foot that was just injured against the wall, when the staff member didn't even notice it, they're going to react and maybe kick out their foot. So you have to have the space ... loops for walking, more sitting areas ... everyone congregates around the nurses' station, and that's very poor for nurses trying to do their job at the station. But residents tend to want to sit where there is activity, where they see other people....

Having things available for them too - juice, food, cookies, more accessible things like that.... We have one lady here that walks miles in a day, and she is hungry ... and maybe she becomes aggressive trying to get her to sit down. We've got to have the things there that we can allow her to eat while she is walking.

It's focusing in on what people can do. We have very limited activity staff. I would rather see an increase in activity staff than in my nursing staff as far as dealing with the residents and preventing anxiety. Because of all the different behaviours that are grouped together, it's very difficult to have an activity ... that is suited to all of the residents. Sometimes activities can mean a small little group of eight people, but meanwhile you have eighty-two other people that aren't having anything.

Nurse A endorsed the value of activities for all residents, regardless of their physical or mental states:

Nurse A: For sure, they are bored, a lot of them. And that is where our new unit manager is real good ... her

background is in gerontology, so she has brought in a bunch of new stuff.... The residents will be happier than hell to sweep. So we have got a bunch of little brooms and activities that will take them outside, and they will be visiting and having coffee and cake and just sweeping on the patio.... There is a lot more activity now than there was. It is all pretty recent, so I don't know how it will affect the aggression. But it will probably lessen it because of less boredom. These were [people] who worked for a living, they may be retired, but even retired people are doing something. There is nothing worse than seeing them like couch potatoes....

Well, sure, everybody does [need activities], even the lower functioning ones. Even if it is just to sit and talk to them. You know, a break in the monotony. And there again, if we had more staff, we could spend more time with [the residents]. Because most of them have fantastic stories. And they are interesting people. They may be demented now, but they were functioning people. And it is nice to talk to them.

Care Aide A echoed these sentiments:

Care Aide A: I think fresh air does wonders for them.... So I would like to have seen a wall knocked down at an end or the front there and had a big patio deck or something where they have access to fresh air.

About two weeks ago when we had that beautiful sunny weather, we took about ninety-eight per cent of residents out to the garden - and you know a few of them did complain so we made sure they were bundled up. And we sang songs, and they were having a great time, you know.... I would have fewer people, more space, bigger rooms. Make it a little homier.

The use of behaviour-modifying drugs was not seen as a key remedy by many of those who work in long-term care facilities.

While most staff indicated that some judicious use of these drugs was occasionally necessary, they were almost unanimous in their opposition to drugging residents as a strategy for behaviour control.And the general direction urged for the future, particularly by administrators and nurses, was less use of psychoactive drugs, and an attempt to discover the reasons for a resident's aggression without resorting to sedation.

Director A: I don't believe in restraining and I don't believe in chemical restraint. I truly believe in finding a happy medium of assessment. If they have to be on medications, let's get them on the right medications, and let's work with them to the level that's best for them to give them the quality of life they deserve.

Nurse A: You have to individualize the drugs, tailor the dose so that you have a minimal amount that does the job effectively and safely. And then once you get someone stabilized, you can begin looking at whether you can decrease the dose. Some drugs work well, some drugs don't. So you have a basic starting idea of what you want to do and what drug may accomplish that. But they all react differently to each medication. So it has to be individualized ... and then monitoring the drug on whether it is working or not.

Care Aide A: There are times when drugs are used too much, and people get snowed. There are times when they are not used enough. It is really difficult to find a balance, especially if you are working with older people.... One of my concerns is ... how can a day nurse take a person off a sleeping pill if she hasn't consulted with the evening nurse.... You shouldn't do it without consulting the other members, but that happens a lot.

CONCLUSIONS

The problem of aggression in long-term care is a reflection and consequence of a changing culture. British Columbia's continuing care facilities, originally conceived as seniors' centres for independent living, have become homes for a segment of the elderly that is cognitively frail and physically challenged. It is from this change in the resident population that the increase in aggression has emerged.

It is our impression from our observations and from the data we have gathered, that the overwhelming majority of staff in long-term care are caring and dedicated individuals; the province's care aides, nurses, administrators, and others work very hard at difficult tasks. During the past decade, with considerable assistance from the Ministry of Health, initiatives have been put in place - particularly *Drawing the Line* and *The Management of Aggressive Behaviour* - in order to respond to the problem of patient aggression. It is encouraging to note that these programs have probably helped to contain the number of WCB claims related to acts of force or violence; in 1995 and 1996, there have been no significant increases within these categories in the continuing care system.

We have concluded that WCB claims related to acts of force or violence have increased dramatically during the past 15 years for a number of reasons. First, the work of the care aide is more difficult than it was 15 years ago, as the current resident population is more likely to exhibit aggression characteristic of psychogeriatric disturbances.

Second, there is less tolerance of violence in the workplace and a greater willingness to report aggression. In the past, there was greater acceptance of victimization as a part of the job. Third, many care aides have not been trained, neither in their

formal training nor within the context of the long-term care facility in which they are employed, to meet the challenging demands of a demented population.

There are a number of other factors that contribute to the problem of aggression in long-term care. Most continuing care facilities have not been designed to deal with the problems of the current residents. In most facilities, there are few opportunities for the many pacers; there is too much congestion around the central nursing station; there are washrooms and bedrooms that have not been designed for, or adapted to, the disabilities in the current resident population; and there is inadequate access to outdoor spaces that are protected and safe.

It seems clear that in some facilities staffing levels are not sufficient to allow care aides and nurses to deliver anything more than a basic level of service: meeting personal hygiene, feeding, and medication needs. There is very little time for social interaction between staff and residents, and very little emphasis on the provision of activities for individual residents. This lack of social interaction emerged again and again in our observations and in interviews. If continuing care facilities are to transform themselves from institutions to homes, we must ultimately change the nature of the facility itself and the kinds of interpersonal contacts that accompany the routines of daily life.

Most incidents of aggression, including those that result in WCB claims, occur during personal care or attempts to redirect a resident or residents. No more than 10 per cent of incidents can be said to be random or totally unexpected attacks.

Male residents are three times as likely as female residents to engage in acts of aggression that lead to time-loss injuries to workers. Moreover, only a very small percentage of male and female residents are responsible for aggressive incidents within continuing care facilities. There is substantial inconsistency from one care facility to the next with respect to the existence of procedures for responding to aggressive residents and the availability of in-service education for employees.

RECOMMENDATIONS

The recommendations in this report are set against the following fiscal backdrop: from fiscal year 1992-93 to 1997-98, there has been no significant change in the number of continuing-care residential beds; the percentage of intermediate care, level 3, beds and extended care beds has continued to increase, however, relative to the percentage of personal care beds and intermediate care, level 1, beds. Continuing increases in provincial funding have been required to meet the needs of this changing population, and the needs of caregivers. In 1993-94 the provincial budget for 16 000 continuing care residential beds was a little more than $408 million; in 1997-98, as a consequence of changes in categories of care, pay equity, and salary increases, the budget for 16 000 continuing care beds was almost $530 million, an increase of about 30 per cent in a span of four years.

1. Those continuing care facilities that produce high numbers of accepted WCB claims related to "acts of force or violence" should receive funding for additional care aide positions on a two-year trial basis.

The claim has consistently been made by care aides and nurses that increased staffing will yield marked reductions in WCB claims and marked improvements in the quality of life experienced by long-term care residents and care aides; it is now appropriate to test these assertions. The Ministry of Health should fund applications from appropriate facilities. These applications should be developed, within each facility, from a partnership of administrators, nurses, and care aides.

In more specific terms, facilities with more than 20 employees and an annual rate of more than two accepted short-term disability claims for acts of violence per 100 person-years of

employment, should receive additional funding for the two fiscal years following a designation. This funding should be reviewed at the conclusion of those two years. Although the precise number of care aide positions should reflect the size of the given facility, it can be expected that approximately 50 facilities of 100 residents would receive an additional five care aides at a cost of approximately $150 000 per facility, or $7.5 million annually across the continuing care system. This represents less than 2 per cent of the current annual budget for continuing care facilities. At the conclusion of the two-year period it will be possible to examine the economic and social costs and benefits of these added resources, and to take appropriate action in relation to further employment.

2. In-service education should be increased, particularly at those facilities that are experiencing high levels of WCB claims related to acts of force or violence. This in-service education should be mandatory, and the responsibility of employers and the Ministry of Health. All employees should receive this training during working hours.

This training should stress successful approaches for responding to aggressive residents, the value of flexibility in institutional approaches to care, the importance of understanding the consequences of various types of dementia, and the need to develop specific safety procedures for responding to residents who are aggressive.

In-service education is seen as the most useful of potential remedies for responding to the problem of resident aggression. As with increased staffing, this idea can be tested empirically. The value of delivering one afternoon of educational programs four times per year at 10 facilities experiencing high rates of aggression can be compared with 10 similarly situated facilities in which no educational programs are offered. At the end of the year or after 18 months, it should be possible to determine whether these in-service efforts have had an impact on the working life of the facility.

This test can also be accomplished at a relatively small cost. If there are, for example, 1000 employees to be educated four times each year at a cost of $100 per session, the net cost to the long-term care system would be about $400 000, less than 0.2 per cent of the current annual budget for continuing care.

3. Care aide education in the province should be standardized to ensure that all care aides have similarly structured courses and a similar knowledge base upon completion of their training.

4. Systems should be put in place, within the realities of the present labour market, to match the language capabilities of care aides with the language capabilities of residents.

5. A gradual conversion of many existing facilities should be undertaken, through carefully designed renovations and new construction, to assist in diminishing staff injuries and to improve the quality of life for residents and staff.

There is a recognition within both the Ministry of Health and the continuing care system that most of our current long-term care facilities were not designed to meet the needs of the intermediate care, level 3, and extended care population. Consultation with current employees (care aides, nurses, and directors) will be critical to the success of this venture.

6. Given that a very small number of male and female residents is responsible for aggressive incidents in long term care, procedures should be developed in each facility for responding to residents who have acted aggressively toward staff or other residents.

Such procedures might include, among others, only attending for care when two staff members are available; increasing flexibility in feeding, waking, bathing, and medication; ensuring that all staff, including casuals, are aware of potentially aggressive residents and the characteristics of their aggression. Such procedures should ensure that aggressive residents are not stigmatized or deprived of quality care as a consequence of their actions or designation.

7. While the possibility of aggression increases with dementia or frontal-lobe injury, residents' medical and social histories are often a key to understanding the difficulties that they may present. Accordingly, coordinated efforts should be made across the continuing care system to improve the quality and availability of information about incoming residents' medical and social history.

8. A program that increases opportunities for socialization is critical to improving the quality of life for all residents and employees in long-term care.

Specific changes must be made to alleviate the boredom, agitation, and alienation that so many residents display, independent of their disabilities. There is an overwhelming need to address the lack of social interaction that characterizes so much of daily life in continuing care and leads to so much of the conflict that exists. Although activity workers attempt to meet some of the social needs of residents, their current numbers are too small and their expense (more than $20 per hour) is too great to be a practical source of the necessary individualized attention.

Accordingly, on a one- or two-year trial basis, community college and university students in psychology, social work, medicine, nursing, and related disciplines should be hired at hourly rates of $9 or $10 per hour (about one half of the current care aide rates), to spend two four-hour shifts per week in a designated facility during the school year (approximately 26 weeks, from September to April). These students would not replace activity workers or perform tasks normally performed by activity workers; their role would be that of spending individualized time with residents.

The utility of such an approach could be assessed on a relatively small scale and on a trial basis. One of the most critical and obvious benefits is that of encouraging intergenerational support, respect, and awareness. Four institutions of approximately 100 residents, each with high rates of WCB claims, could be identified. Two of these facilities would have 20 students assigned to spend two four-hour shifts per week socializing with the residents under the supervision of the director, nursing staff, and care aides. Aggression rates at these facilities could then be compared with the two other facilities in which there was no student presence during the time in question. The cost of such a trial, in terms of student income, would be relatively small, a little more than $80 000. Evaluation of the project would allow insight into the role that improvements in socialization might play in diminishing all forms of injury within long-term care.

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