

Residential Care and Assisted Living

Residential care was a common topic for discussion during the Conversation on Health. The importance of addressing issues related to the accessibility of beds and facilities, the delivery of services, patient safety, costs, and health human resources in long term care, were highlighted in many discussions and submissions. Here is a selection of what British Columbians had to say on the subject of residential care and assisted living.

Accessibility of Beds and Facilities

Many believe that there are not enough residential care beds for the number of seniors who need them. There is widespread agreement that the health care system needs additional publicly funded, long-term care beds, and that these beds would relieve pressure on emergency rooms. Stories of people having to leave their home communities for long-term care placements due to bed shortages occur. The lack of assisted living facilities for middle-aged patients who have suffered strokes or other chronic debilitating conditions is also a concern for participants. Many feel younger people with long-term care needs should not be in residential care designed for seniors. Several participants suggest that, to relieve stress on family caregivers, long-term care facilities could also have accessible respite care beds for family care and support.

Many recommend that facilities need to be geographically accessible and flexible to ensure that elderly couples can stay together and that seniors can be close to their families and friends. Family care homes are an alternative that can support aging-in-place (meaning in their home and community). Many also discuss the potential of multi-level care facilities and the Campus of Care model, which allows patients to move from assisted living to complex care in one facility when their needs increase.

Follow through on promise to provide 5000 long-term beds in British Columbia. Have enough staff to provide care for residents

- Regional Public Forum, Cranbrook

Delivery of Services

Participants voice concerns about a lack of transportation and recreation services available to residents of long-term care homes. Some suggest assisted living facilities are sometimes used as an extended care option, but without the resources, which leaves more to be covered by seniors. Many recommend modelling service delivery after facilities that work well, suggesting that better monitoring and medical care provided within facilities will decrease transfer rates to emergency. Others recommend changing assessment tools to ensure that patients receive the appropriate level of care early, decreasing the chances of needing acute care intervention and minimizing complications.

Participants also feel that the long-term care system lacks communication between facilities and clients. Some emphasize the lack of understanding for assisted living, and that people have to be able to direct their own care. Many recognize the importance of addressing the gap between assisted living and extended care. Participants suggest that increasing staff-to-patient ratios and involving family members in facility care are essential steps to improving the delivery of services in long term care.

Patient Safety and Quality of Care

Many discuss the importance of making facilities safe for residents. Some participants perceive that there have been budget cuts and privatization of services have decreased the quality of care in facilities. Concerns related to patient safety in facilities include: the lack of stimulation for residents; psychiatric patients in long-term care as a threat to other residents; poor food quality; outdated facilities not up to standards; and seniors facing potential neglect and abuse.

Quality of care is also a focus of discussion. Many are concerned that there are no systems in place to ensure that facility managers and owners are accountable for the quality of care provided in their facilities. Participants also suggest there needs to be a better transition between independent and residential living. Many feel the criteria for acceptance into long-term care are too high, which results in patients being very ill when they finally enter the system. They also suggest the level of care available in assisted living facilities should be raised. Many commend facilities adhering to a 'gentle-care' philosophy for Alzheimer's patients and those following co-operative housing models. Others focus on the importance of culturally appropriate long-term care facilities for Aboriginal people.

Many agree that long term care facilities have to be more accountable to residents and their families. They believe that facility accreditation or licensing should be mandatory and that advocating for residents is important to help them get the appropriate care. Some recommend creating strict standards for care and an accessible complaints resolution process.

Funding and Costs

Many suggest the funding of long-term care has to change to recognize the complexity of the services needed. They emphasize that while public funding largely appears to cover costs, there is a lack of transparency regarding the range of daily rates, and why one facility enjoys greater funding than another. Participants suggest the shortage of publicly funded beds and the high cost of private care makes long-term care facilities inaccessible for many lower income residents, increasing the pressure on the acute care system. Some feel that mixed public/private funding creates a negative environment in long-term care facilities, and believe that privatization of these services should end. Others suggest encouraging private sector construction of intermediate and long-term facilities with short-term tax incentives. Many believe specific funding is needed to support: non-profits to deliver quality care; more Campus of Care style facilities; rehabilitation services in facilities; and, dental care.

Allow for tax deductible contributions to co-operative-type funds to finance the building of facilities that those who contributed funding get to live in when they are seniors

- Regional Public Forum, Richmond

Health Human Resources

Participants emphasize that, though staff in facilities try to provide quality service, they are being overworked and are not responsive to residents' needs, which negatively affect patient care. Some participants indicate that seniors in facilities have no access to physicians after-hours and that indigenous elders in facilities face racism. Others think that staff in facilities do not address residents' increasing need for bed-side care and socialization. They also feel that residents in smaller communities also face limited availability of service providers.

The suggestions for improving health human resources in the long-term care system are many and various. Several participants recommend increasing physician support for long-term care facilities. They also recommend hiring more staff and providing them with higher levels of training. Other participants suggest having more recreational care coordinators and care aides to provide bed-side care and socialization. Many believe that multi-disciplinary teams of health professionals in facilities that include doctors, nurse practitioners, pharmacists, rehabilitation personnel and nutritionists, could also reduce trips to acute care.

Conclusion

There is widespread concern that the demands on the long-term care system will continue to increase as the population ages. Participants agree that the system should provide secure, quality, affordable, dignified care to those in long-term care and assisted living to meet all levels of care needs.

Residential Care and Assisted Living

This chapter includes the following topics:

- Accessibility of beds, facilities and services**
- Delivery of Services**
- Patient Safety and Quality Care**
- Funding and Costs**
- Health Human Resources**

Related Electronic Written Submissions

[Submission to the BC Conversation on Health](#)

Submitted by the Victorian Order of Nurses for Canada

[Submission to the Conversation on Health](#)

Submitted by the Certified Dental Assistants of B.C.

[HEU Submission to British Columbia's Conversation on Health](#)

Submitted by the Hospital Employees' Union

[Report to the Conversation on Health](#)

Submitted by the BC Cancer Agency

[Advocates for Seniors Care - Vernon](#)

Submitted by the Advocates for Seniors Care – Vernon

[Submission to the Conversation on Health](#)

British Columbia Government and Service Employee's Union

[Submission to the Conversation on Health](#)

Submitted by the B.C. Nurses' Union

Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: [Wait-Lists and Wait-Times](#); [Home Care and Support](#); [Residential Care](#); [Assisted Suicide](#); [Palliative Care](#); [Health Care Spending](#) and [Seniors](#).

Accessibility of Beds, Facilities and Services

Comments and Concerns

[Specific Facilities/Regions](#)

[Multi-Level Care Facilities](#)

[The Separation of Couples and Moving the Elderly](#)

[Assisted Living](#)

[Bed and Facility Shortages](#)

- **Comments on specific facilities or regions:**
 - The Kootenays used to have two seniors facilities with 112 beds, however these facilities have been replaced by one facility with fewer beds despite the aging population and larger area that now falls into the boundaries of the region.
 - There is a shortage of beds and facilities in many areas. In Prince Rupert there are currently not enough beds and although a new facility is planned, by the time it is constructed, it will do very little to address the shortages.
 - There are no private facilities in north eastern British Columbia and public facilities are full.
 - In Williams Lake, as well as other small communities, there are concerns about access to publicly run and funded seniors extended care and assisted living facilities.
 - Residents in the Kamloops Seniors Village cannot go from assisted living to residential care without going to the Interior Health Authority to be assessed and then must wait until their name comes up on the waiting list. This causes stress for patients.
 - In 2003, the closure of Parkholm Lodge in Chilliwack, an 85 bed facility was precipitated by budget restraints in the Fraser Health Authority. This caused a major backup of long-term care patients in the hospital. To this day there are on average fifteen to twenty long-term patients waiting for care.
 - England uses a model that has specialized buildings for elders, with small homes/courtyards.
 - There is a rumour that when the newest construction is complete in the Rotary Manor, the Pouce Coupe and Peace River facilities will be closed. What will be done with these buildings?
 - In Richmond the city is trying to implement universal building standards which would make every living space a potential living space for seniors and disabled people.

- The assisted living facilities in Nakusp are wonderful.
- **Comments on multi-level care facilities:**
 - The Campus of Care model is more challenging in smaller communities.
- **Comments on the separation of couples and moving the elderly away from their communities:**
 - The separation of couples in facilities due to location or levels of care required is unacceptable.
 - People have to leave their home communities for long-term care placements due to bed shortages.
 - The elderly often have no say in where they are placed.
 - When families try to move their elderly from out of province, there is no availability of treatment or care.
 - At least there is now some acknowledgement that senior couples should not be separated if possible.
- **Comments on assisted living:**
 - There is a shortage of publicly-funded and affordable assisted living and long-term care residences/beds.
 - Assisted living is not a replacement for long-term care options.
 - There is a lack of assisted living facilities for middle aged patients who have suffered from strokes or other chronic debilitating conditions, multiple sclerosis for example.
- **Comments on bed and facility shortages:**
 - There is a lack of respite beds in long-term care facilities.
 - The significant reduction of residential care beds in BC has placed considerable pressure on the acute care system as more people residing in acute care beds wait to be placed in residential care facilities. Many hospital beds are occupied by patients who would be better served in nursing homes, convalescent care or at home with the appropriate community supports.
 - There are not enough residential care beds for the number of seniors who need them. This shortage leaves seniors in hospital beds, waiting to be placed in long-term care. An expensive consequence of these cuts is the potential for increased transfers from residential to acute care.

- Bed closures and closures of long-term care homes are causing misery and pain among seniors.
 - There are no facilities for intermediate care.
 - Specific housing/beds for dementia care is lacking.
 - There is a realization that long-term care is necessary, and communities are starting to develop assisted living and complex care facilities.
 - Options for chronic and extended care for seniors are limited.
 - Geriatric and Assessment Units are not being utilized as intended. They are now being used for acute care beds for long-term patients as there is no room in the community.
 - Accessible, affordable public senior housing options are limited.
 - There are excellent facilities that are available.
 - We need some long term beds and palliative beds especially in the interior and up north but 5000?
- From 1977-1978, the continuing care, long-term care, and the home care system in BC was put in place from absolutely nothing to being fully implemented.

Ideas and Suggestions

[Specific Facilities/Regions](#)

[Multi-Level Care Facilities](#)

[The Separation of Couples and Moving the Elderly](#)

[Assisted Living](#)

[Bed and Facility Shortages](#)

- Ideas on specific facilities or regions:
 - Campus of Care models exist, such as the Elim facility in Surrey, which will take you from entry into the system through long-term care, and hospice until death.
 - Do not close the Deni House long-term care facility in Williams Lake.
 - Increase options for seniors in Williams Lake.
- Ideas on multi-level care facilities or service delivery models:
 - Campus of Care, which allows patients to move from assisted living to complex care in one facility as their needs increase, is an excellent model.
 - There is a need for multi-level care facilities.

- Campus of Care developments should be built so that middle-income seniors can buy into them using a co-op type model. These would incorporate independent living townhouses at market prices through to smaller assisted living apartments and facility-like long-term care options.
 - Seniors' residences should ideally be multi-level, with a wing (or floor) for dementia patients, a wing for patients who are pretty much bedridden and need continuous nursing care, and a wing with private rooms for singles and couples who are somewhat independent but need to go to a central dining room for meals. There needs to be a recreational program and an attached (or at least on the same property) complex with low-cost apartments for seniors who are still able to be cook for themselves and be independent.
 - In rural areas, rather than a single facility that supplies a continuum of services, there should be a series of small units catering to each particular stage of care.
 - More needs to be done to provide facilities throughout the Province that are designed to meet the more complex medical and care needs of those now being placed in residential care and to do so in a truly 'residential' style facility that is a part of the community. Perhaps with a look at integrating residential care facilities within communities; perhaps incorporating onsite day cares (designed well) could meet a need for additional day care spaces for both staff and others in the community as well as provide ready entertainment for residents.
 - Having a multi-health-level care-facility on reserve would help limit travel for family. If Elders are close to home, mental health is better.
- Ideas on the separation of couples and moving the elderly away from their communities:
 - Facilities need to be geographically accessible and flexible to ensure that elderly couples can stay together and that seniors can be close to their families and friends.
 - Support the construction of graduated facilities to enable continuing relationships. Include end-of-life care within those facilities and support elderly couples to stay together through to the end of their lives.
- Ideas on assisted living:
 - Localized assisted living is needed for Aboriginal elders.
 - Assisted living facilities should be community based, in smaller, neighbourhood-based facilities.
 - There is a need for special-living homes for Alzheimer's patients.

- Build low-cost small apartments that are staffed at all times with a caretaker, nurse, first aid attendant, etcetera. Do not build "luxury hotels" that leave most seniors almost destitute.
 - Cluster housing for seniors, or group homes where meals, housekeeping services, and on-site care options are available can work well.
 - For smaller communities a more amalgamated housing system is needed, lowering the criteria for assisted living or supportive housing options to keep people out of hospital.
- Ideas on bed & facility shortages:
 - There is a need for additional long-term care facilities. These would also relieve pressure on emergency rooms.
 - More publicly-funded long-term care beds and assisted living facilities are needed.
 - Recognize that over-crowding in the emergency rooms and surgical wait lists are directly linked to a lack of residential care. Problem solving in these areas should reflect this connection.
 - Re institute public care homes.
 - Fulfill the promise of long-term care beds in British Columbia by relieving the congestion of seniors in our hospitals who are taking up acute care beds.
 - Private facilities provide the elderly and their families with choice in long-term care options.
 - Convert closing schools into seniors' facilities.
 - There is a need for more publicly run nursing homes with different levels of adequately staffed care.
 - Use cruise ships as seniors' facilities. They cost the same as top of the line care facilities but provide their passengers with better care.
 - Every city of 100,000 or more should have a chronic care facility, public not private, with an emergency room on the ground floor from which patients can be admitted if necessary. If people want to pay to be sent to a nicer, private facility, that is their choice.
 - Enable charities or non-profits to build seniors facilities in urban areas.
 - Family care homes can provide excellent care to frail elderly. would allow the caregiver to be employed in the home while caring for their family member. As our population ages, the demand for residential care and respite services will

outpace our ability to build and fund them. This is an alternative system of care which appears to be not only less costly but more effective than what we now have.

- Long-term care facilities could have accessible respite care beds for family care and support.
- Need active senior living residences, which teach seniors to be active partners in their health care.
- The location of senior care facilities should be in the heart of the community, not pushed to the outskirts, so that seniors can stay active and involved, thus increasing the social capital of communities.

Delivery of Services

Comments and Concerns

[The Coordination of Service Delivery](#) [Service Delivery in Long-Term Care Facilities](#)

- **Comments on the coordination of service delivery between levels of care:**
 - There is a lack of communications between facilities and clients.
 - Records and medications are not always transferred when patients are moved to another facility.
 - Once assisted living patients move to acute care, they are often not accepted back into assisted living facilities.
 - There is a trend to control health care costs by reducing the length of stay in acute care hospitals as well as making residential care facilities necessary only for the very end of life. Home care services are provided by healthcare agencies in the community or by family, friends and neighbours. Assisted Living provides support for elders wanting to live in congregate settings, but these people must be able to 'direct their own care' and thus are quite independent. For these reasons, the people who now come to live in residential care are truly 'complex', meaning they have multiple illnesses and require round the clock care.
 - Assisted living often does not meet the needs of patients and is frequently used as an extended care option without the resources, leaving more to be covered by seniors, many of whom are already at the poverty line.

- Assisted living is a welcomed component to the mix, but does not replace intermediate care. The shift of care from institution to community must be a true shift, not simply the loss of service in the residential care system.
- Before treatment is over, address survivorship - letting people know that there is a range of post-treatment reactions: emotionally, cognitively, physically.
- **Comments on service delivery in long term care facilities:**
 - Patients in long-term care beds do not receive adequate services.
 - There is a lack of transportation available to the residents of long-term care homes.
 - Limiting the participation of certified dental assistants to government-approved dental public health programs restricts the public's access to oral health promotion and preventive services.
 - In many facilities there is a lack of privacy, individuality and timeliness of care.
 - There is a lack of understanding of residential care and what we can safely offer families.
 - Some facilities are fabulous and should be used as an example and model for others.
 - There are inconsistent and/or poor standards of care in long-term care facilities.
 - The best way of supplying quality of life to seniors is to have as great a population of seniors as possible within a condensed area or a facility where they can be offered a range of services on a cost effective basis.
 - Measure patient satisfaction first and medical indicators second. By mandating and monitoring measures that first look to satisfaction or quality of life indicators (qualitative) and are balanced by quantitative indicators, a more meaningful assessment of 'value' would be obtained.
 - Establish and communicate the Government's 'guaranteed' services: Healthcare should consider defining clearly what is part of the 'Government guaranteed services' for Residential Care and by default, the industry would be able to establish 'optional extras' that could be purchased privately outside of that guarantee.
- Patients with dementia receive is quality care, but there are not enough facilities available.
- Younger people with long-term care needs are misplaced in residential care that is geared towards seniors.

- Long-term care facilities are not built on a medical model.
- There was a study for Health Canada where we looked at actual systems of care delivery across Canada for the elderly people with disabilities, kids with special needs, and people with chronic mental health issues.

Ideas and Suggestions

[The Coordination of Service Delivery](#) [Service Delivery in Long-Term Care Facilities](#) [Service Delivery in Supportive Housing](#)

- Ideas on the coordination and movement between levels of care:
 - Better monitoring and medical care provided within seniors' facilities will decrease transfer rates to emergency and long-term care.
 - The gap between assisted living and extended care needs to be addressed.
 - A lot of people do not understand what assisted living means. People have to be able to direct their own care.
 - Integrate care under one roof. Connect independent living with long-term care.
- Ideas on service delivery in long term care facilities:
 - Ensure that residents of care homes are provided with a variety of recreational activities.
 - Care homes must provide transportation.
 - Music and exercise are important in residential care. Use music therapy for connection to greater community.
 - Provide access to dental hygienists in long-term care facilities.
 - Respite care should be provided in facilities or at the very least the knowledge of available resources.
 - Day care programs should be offered through long-term care facilities.
 - It is important to have culturally relevant care for elders in facilities.
 - Facilities for seniors should not be like a hospital, they should be more home-like.
 - Increase staff to patient ratios, and add social component to senior facilities.
 - More space should be available at care homes for family visits.

- Involvement of family in care of family members in facilities is vital and each caregiver needs support.
- Coordinate and maintain an equipment lending program.
- The establishment of on-site infirmaries in long term care staffed by Registered Nurses assisted by visiting physicians ' with at least one RN on duty around the clock ' would go a long way to reducing the number of costly transfers to emergency rooms, and facilitate quicker discharges from the hospital back to long term care.
- Ideas on service delivery in supportive housing or assisted living:
 - For safety reasons reinstate funding for housekeeping services. Services to take seniors shopping and to appointments are necessary as private services are too expensive for low-income seniors.
 - Create more affordable housing in settings with communal supports, for example: laundry, emergency pull cords, meals supplied, and activities for physical and social wellness.
 - Respite bathing programs are needed to provide a break for caregivers.
 - Use local non-profit, community-based societies to deliver services such as home support and assisted living.
 - The Government of British Columbia needs to increase the number of supportive housing units and implement the appropriate personal support programs that allow individuals to maintain their independence and remain living independently for as long as possible.
 - Assisted living homes should be registered through the Ministry of Health rather than the Ministry of Forests and Housing.
- The majority of new seniors' facilities are entrepreneurial ventures and there needs to be quarterly evaluations performed, especially in the first year, to review practices and determine if seniors are receiving proper care.
- There are integrated care facilities in Vancouver, however they are too much a distance to travel for some seniors.

Patient Safety & Quality Care

Comments and Concerns

Physical Safety of Facilities

Quality of Care

Transitions between Care Levels or Facilities

- **Comments on physical safety of facilities:**
 - Former safety measures, such as bed rails, are now considered restraints and are not allowed.
 - Many facilities are outdated and not up to standards, such as heating and cooling systems, wheelchair access etcetera.
 - Old regulations do not always work with new facilities in terms of size etcetera.
 - Seniors have contributed to their communities in the past, so they should not be stuck in inadequate quarters at this point in their life, even if it is temporary in nature.
 - Seniors are being moved to other communities to fill private care facilities and some of these facilities are not even fully completed.
 - Many of the new assisted living facilities are beautiful and provide the right kind of care.

- **Comments on quality of care:**
 - In some care homes there is a lack of stimulation, both mental and physical.
 - Psychiatric patients in long-term care can be a threat to the elderly.
 - The average age of residents is increasing and many have older or no families. The incidence of Alzheimer's is increasing and most require fulltime assistance with feeding, toileting and bathing.
 - There is poor food quality in long-term care.
 - Some facilities for seniors are not looking after residents properly. For example diapers not getting changed enough and they are not welcoming to visitors.
 - Residents that are lower functioning get missed for rehabilitation, recreation and musical therapy.
 - There are many indicators that the care and quality of life provided in facilities is far short of ideal, far short of appropriate, far short of acceptable.

- Mixed (both male and female) long-term care facilities could lead to embarrassing situations for residents.
- Seniors can face neglect and abuse in care homes and facilities.
- The process of long-term care service delivery can be inhuman: isolation, intimidation, disrespect, and harassment can occur and increase the stress and illness of residents.
- For the past four years I have witnessed an alarming decrease in the quality of care delivered in long-term care facilities. We are suffering from lack of proper funding to adequately care for the residents in my facility. This lack of funding has caused a shortage of staff, which has lessened time available for each resident, while also cutting into the funding for equipment and services, including laundry and cleaning.
- There is regular theft of seniors' jewellery, medication, clothing, etcetera. occurring in facilities.
- Abuse and overall poor care in private settings has historically been alarming. Today, these concerns are still there. For example, there is no monitoring as to the quantity of food or liquid that residents are consuming. Dehydration is a problem and premature death may occur as a result. Lack of staff may also be a problem and may result in neglect of patients.
- The Deltaview facility is an exemplary facility that incorporates the 'gentle care' philosophy for seniors with Alzheimer's.
- Families often complain that their loved one deteriorated after going into care. Sometimes the facility is blamed for the continued downward spiral after admission. The fact of the matter is that often the loved one requires an increase in care because their condition is in the process of deterioration. Although the process continues following admission, families often have expectations that more care will reverse the situation. Usually it does not.
- Performance monitoring has become even more prescriptive in nature as can be seen in the direction of Health Authorities, stipulating the minimum number of direct care hours by facility without any specific acknowledgement of client mix and/or acuity levels. As there is a lack of any other accurate and reliable measure for quality, closer controls are needed to be intimately managing the output. The current result is a system that is micromanaged using expensive resources (people, technology, etc.) without any confirmed assurance that the quality of healthcare services, as received by the clients, is even close to satisfactory.

- [Comments on transitions between care levels or facilities:](#)
 - The transition from independent living to assisted living can be difficult.
 - Seniors in my town were treated with little respect when existing care facilities were phased out before new assisted living facilities were in place.
 - Seniors are often given no choice as to which home they are placed in.
 - A small pilot project in Salmon Arm tested a document called the 'Passport to Care'. The Passport to Care was something to assist the elderly specifically in the transition from community to residential care. Multiple caregivers were involved: the home and community care, mental health providers, and acute care staff. This passport was put together and given to patients at their initial home care assessment and included everything they needed to know: relevant numbers, people to contact, and little pouches to put in things like their Power of Attorney, and their advanced directives. They are now beginning to come back with the resident as they enter residential care and it seems to make that transition a little bit easier.
 - In the late 1980s and early 1990s the Continuing Care System in British Columbia was viewed by international experts as one of the best, if not the best system in the world at that point in time. In the 1990s there were fiscal pressures and changes in the allocation of resources that started sending things in another direction, but without the proper supports.

Ideas and Suggestions

[Physical Safety of Facilities](#)

[Quality of Care](#)

[Transitions between Care Levels or Facilities](#)

- [Ideas on physical safety of homes, and facilities:](#)
 - Injuries to the elderly are reduced if they are in proper care facilities and have access to proper and better home support.
 - Facility accreditation or licensing should be mandatory. Some strict standards are needed.
 - A complaint resolution process in long-term care facilities that patients and their relatives can easily access is essential.
 - When designing seniors facilities, do not make tiny rooms. In a small suite include a kitchen and a separate bedroom and living room.

- Rest homes need a separate wing for Alzheimer's patients.
- How many facilities will be needed to safely address the needs of the baby boomer generation needs to be determined.
- Build larger areas in extended care units for patients to wander around in. Include activity stations and behavioural cues for patients with dementia (colour, common room themes).
- Have more facilities adhere to the 'gentle-care' philosophy for patients suffering from Alzheimer's (constructed in a circular form so that they can be more mobile independently). Build pathways through gardens in courtyards next to extended care units. Provide a "Love, Hugs, No Drugs" environment for patients.
- Allow seniors to bring belongings with them into facilities and provide them and their families with a supportive and dignified environment for them to age in.
- Renovate long-term care facilities.
- Allocate suites in care homes for out-of-town family members who cannot afford to travel or live without their spouse. In return these family members can take care of the patient twenty-four hours, seven days a week without any monies paid.
- Long-term care facilities should provide total care with secure and non-secure units.
- There should be increased camera surveillance in senior's facilities and increased penalties for people abusing seniors.
- **Ideas on quality of care:**
 - There is a strong need to advocate on behalf of ailing parents because care is no longer up to the standard it used to be.
 - At the care home, quality food should be served.
 - The board of directors in seniors care facilities should include members who live there.
 - Install complaint boxes in senior's facilities.
 - Strong regulation of assisted living homes is needed so that they cannot charge exorbitant fees, but must provide a certain level of medical care using properly trained staff.
 - Have advocates available for those living in care who are unable or do not want to advocate for themselves.
 - Don't warehouse seniors, put them in appropriate homes. It's all about respect.

- Government must get involved in regulating the industry, for example standard wages and level of education for workers.
- Attach seniors' facilities to schools to promote intergenerational learning.
- Support long-term care facilities for Aboriginal people where they receive the proper diet and proper care. This would benefit both seniors and younger generations.
- Provide secure, quality, affordable, dignified care for all levels of our seniors needs.
- Implement a robust Performance Management System that prioritizes and focuses strongly on satisfaction. In particular, it would align with the evidence that one's quality of life is measured by our mental experience and not the physical state.
- To ensure quality of care and caring in residential facilities in British Columbia we need mandated and funded Family Councils (independent of facility management or Health Authority control) in all residential care facilities; a network of regional family councils; and ongoing dialogue and consultation with family councils.
- We need strengthened inspection and compliance mechanisms. Create a mandatory requirement for all Residential Care facilities in BC to establish an internal Facility process for the receipt and resolution of care concerns.
- **Ideas on transitions between levels of care or facilities:**
 - Physicians can best recommend what level of care a patient needs.
 - Assisted living costs less than residential care and allows for a higher quality of life for the patient.
 - Revisit Intermediate Care or increase the level of care that is available in Assisted Living Facilities.
 - Co-operative or co-housing can be a good option. The Grandview Seniors Housing Co-Operative in Castlegar provides an excellent model, with apartments getting cheaper as residents move to smaller rooms. These facilities can provide spa-like living with good healthy food, physical activities, problem solving action and support of like-minded people.
 - The criteria that has to be met before being allowed to access long-term care and home support is too high, resulting in patients being very ill when they are finally permitted to enter the system. These criteria should be lowered.
 - Something needs to be done to facilitate overnight transitions from acute care to long-term care.

- The experience in Holland shows that if we have a multi-disciplinary team of providers and infirmary services in place in long-term care, we can significantly reduce ambulance transfers from long-term care to emergency rooms.

Funding and Costs

Comments and Concerns

Costs to the Patient

Funding and Resources

Involvement of the Private Sector

- **Comments on costs to the patient:**
 - Care in long-term care facilities is only available at a high cost.
 - There are too many patients with serious recurrent chronic problems who should be in chronic care facilities or have extensive home-care nursing but can't afford either.
 - The responsibility to cover items required by long-term care residents falls on the family, such as: replacing lost dentures, hip protectors and wheelchairs as well as paying for medications not covered by Pharmacare.
 - Seniors and their families are being conned by care homes run for profit by foreign and Canadian companies with their aggressive advertising.
 - Seniors should not have to sell their assets, such as their home, to pay for care of an unknown number of months remaining in their life, in a privately operated care facility.
 - Assisted living costs are getting higher and supporting it is expensive.
 - There are no systems in place to ensure that facility managers and owners are accountable for the operations and quality of care provided in their facilities.
 - New assisted living funding does not cover people with cognitive impairments.
 - The current Client User Fee system does not honor or respect the economic realities of life and the resulting choices we all need to make. The client contribution is determined solely based on their income and bears no reference to the cost of the housing and accommodation service received. In contrast, at all other times of life, people make choices to pay for accommodation that they can afford and accept the options available to them. This system does not acknowledge nor incorporate that fact.

- The current Client User Fee rates do not adequately reflect the cost of hospitality and accommodation services in new facilities and the system of placing individuals does not reflect the cost differences associated with capital differences.
- **Comments on funding and resources:**
 - More funds are needed to create more long-term care beds. Where can this funding come from?
 - The funding allotted for non-profits is not adequate for the provision of quality care.
 - Funding for facility care has been reduced.
 - Public funding appears to largely cover costs in long-term care, but there is a lack of transparency as to the range of daily rates, and why one facility enjoys greater per resident/day funding than another.
 - Facilities have been encouraged to contract out services, but recent resident/day funding increases did not apply to contracts, even though those costs are also rising.
 - Public/private funding creates a negative environment in long-term care facilities.
 - There is inadequate funding for new Campus of Care housing. The construction standard is too high for what should be simple facilities. That is \$250,000 a unit versus \$80,000-\$100,000 per unit for the new homeless support housing.
 - There has been partial acceptance of the idea of Campus of Care by government policy makers and they have started to receive some funding.
 - Too much money is wasted by keeping patients who should be in long-term care facilities in acute care beds.
 - The Northern Health Authority is frequently informed by other health authorities that they have too many long-term care beds in their area in relation to the population. This is not true.
 - Long-term care patients are associated with high emergency room costs.
 - The current Client User Fee system does not 'blend' into the private pay system which creates a large gap in costs and therefore, encourages individuals to seek out Government subsidy. Currently, client user fees for Residential Care services are based on a model that establishes the client's hospitality and accommodation contribution to ranges from \$28 per diem to \$65 per diem, depending on income levels (relative a total service cost that ranges between \$160 -\$200 per diem.) In

contrast, the equivalent private pay rate for Residential Care ranges between \$140 per diem to \$180 per diem depending on client needs.

- The 'base services' set an extremely high standard and further discourages private pay. As the service provider contracts require the delivery of 'complex care' (which is a very wide band of services) and the definition of these services are not clearly defined publicly, there is tremendous upward pressure to continuously find new ways to respond to increasing demands without additional funds to do so. Through the vague description of service and a limit on what can be an additional charge, clients expect that all needs are met by the system and it works to reinforce the entitlement mentality.
- [Comments on the involvement of the private sector:](#)
 - The private sector doesn't understand issues in long-term care and assisted living.

Ideas and Suggestions

[Costs to the Patient](#)

[Funding and Resources](#)

[Involvement of the Private Sector](#)

- [Ideas on costs to the patient:](#)
 - Create Campus of Care to provide support for patients with middle or variable incomes, and increase the capital budget for this model.
 - Considering that long-term care facilities receive a considerable amount of funding per resident, all medications required should be paid for.
 - Increase the accountability of long-term care facilities to the client and their family.
 - Allow for tax deductible contributions to fund co-operative building of facilities. Those who contributed should then get to live in these facilities when they are seniors.
 - Promote the development of alternate facilities for seniors. The provincial government should provide subsidies for individuals to live in alternate facilities, lowering the costs of treating them unnecessarily in the hospital.
 - Make resident day rates available at various facilities.
 - Seniors living in long-term care should be covered for dental care.

- It is recommended that the client user fee model in facilities should extend such that there is marginal difference between a person paying privately and the least subsidized level of Government care (i.e. the maximum user fee). The objective is to create a blended system that inspires individuals to consider private pay as well as motivating private investment in the creation of alternative healthcare services.
- Create a client user fee model that better reflects the true cost of accommodation and introduces choice for the client. It should be reasonable that a newer facility would have an accommodation cost that is higher than its older counterpart. In the new Client User Fee model, a client would still qualify for a particular user fee rate based on income. However, that level would align with various designated facilities that have a corresponding cost of accommodation.
- **Ideas on funding and resources:**
 - The funding of long-term care has to change in recognition of the complexity of services that are needed.
 - Beds for seniors should be allocated based on need not on population.
 - Funding and systems should be put in place to create a home-like facility as opposed to institutional settings.
 - The resident or patient should be funded, not the bed and facility.
 - More strategic planning efforts should be directed towards solving long-term care issues.
 - The money government spends on long-term care beds should be transferred to private care facilities with patients paying the difference.
 - Encourage the marketplace to respond to the need for independent housing and communal health care.
 - Targeted funding is needed for rehabilitation in long-term care facilities. It is important to keep these patients mobile.
 - More core funding is needed for volunteer groups such as tax credits and senior outreach groups.
 - More resources are needed for assisted living.
 - Prepare now for the aging population to come: build facilities with long-term care beds.
 - Allocate funding increases equitably between those who followed government pressure to contract out and those who did not.
 - More funding should be allocated towards chaplaincy services.

- Health Authorities must develop renewable 5-year plans for increasing the number of funded and staffed residential care beds and assisted living units in their region.
- Spend money on education for people with elderly parents to learn about care.
- We need to give proper recognition and resources to continuing care such as home support, assisted living and residential care. With adequate resources and funding, we can reduce pressures on the acute care system. We need seamless, interdisciplinary networking.
- Services received under the Government paid system could be modest and reflect a minimum acceptable level of service while providing the ability for individuals to supplement those levels, if they so choose. Through the process of establishing clearly defined services, this future system would incorporate education and communication to ensure individuals proactively assume responsibility for planning their later years.
- Align funding and incentives with a performance management system. By pairing the monitoring focus with money and/or recognition, there is a clear direction for behaviours to follow. This solution is age-old and well proven: we motivate what we measure and recognize.
- It seems wise to consider some of the sources of the 'cost' of care amid the current practices in residential care to assess their 'cost' and, perhaps, feasible effective and efficient alternatives. This could include comparing the costs of expensive continence products with the cost and benefit of some additional Residential Care Attendants who are clearly responsible for implementing an appropriate resident focused toileting plan. Another common area of cost is food wastage 'unappealing food is often refused and discarded. As a result the residents are not receiving nourishment ' although monies are spent.
- Ideas on the involvement of the private sector:
 - Care should not be dependent on income. Stop the privatization of these services.
 - From an outcome based approach, further the progress of private public partnerships in residential care and assisted living homes.
 - Encourage private sector construction of intermediate and long-term facilities with short-term tax incentives.
 - The future system will seek out a means of promoting options to funded health services by establishing Government systems and practices that minimize the disruption on 'natural market forces'. By considering new approaches to funding and labour cost management combined with proactively supporting operators

that deliver creative service options, a dynamic, integrated and complimentary system will evolve between private pay and the funded system.

Health Human Resources

Comments and Concerns

Staff in Facilities

Community-Based Health Care Providers

- Comments on staff in facilities:
 - Nurses and care aides in facilities are overworked, which negatively affects the care of patients.
 - There is a lack of physician support for large long-term care facilities.
 - Seniors in long-term care have no access to physicians during off-hours.
 - Racism is a serious concern for indigenous elders in long-term care.
 - Based on current research, we know that without enough staff to monitor changes in residents' health, ensure that they get proper nutrition and fluids, turn them in bed or assist them with walking, results in residents who are more likely to end up with pressure sores, pneumonia, dehydration, malnutrition and broken bones from falls. These are conditions that often result in hospitalization.
 - Because there are fewer long-term beds, the acuity levels of patients in care are rising and there is a need for more staff and higher levels of training for these staff members. However, staffing levels have not kept pace with changes in resident needs.
 - There are staff members in long-term care facilities who have very low levels of training.
 - Many of the staff in facilities work very hard to provide patients with the best care possible.
 - Bill 37, which was introduced in 2004, rolled back wages for thousands of workers in long-term care facilities by 15 per cent. Although there were increases in the last round of bargaining, they did not make up for this cut. The workers affected by this cut in wages are still very unhappy and are not encouraging friends or family members to seek training and employment in the industry. Ongoing staff shortages have created unsafe conditions for both workers and residents,

resulting in increased injury rates and higher instances of work related stress and burnout.

- There is a lack of registered nursing staff in long term care facilities. This limits the amount of nursing time available for residents on a daily basis.
- **Comments on community-based health care providers:**
 - The availability of service providers in smaller communities is limited.
 - Caregivers, often relatives and friends who are not professionals, are often extremely overloaded which can cause them to have to give up their jobs or get sick.
 - A multi-disciplinary team of health professionals that includes doctors, nurse practitioners, pharmacists, rehabilitation personnel and nutritionists, also reduces trips to acute care. In the Netherlands, where they have introduced these kinds of care teams into their nursing home sector, transfer rates to acute care are below 10 per cent a year.

Ideas and Suggestions

Staff in Facilities

Community-Based Health Care Providers

- **Ideas on staff in residential facilities:**
 - Better use should be made of nurse practitioners and clinical nurse specialists in residential care. Perhaps a practicum in residential care could be a requirement for accreditation for these professionals.
 - More staff are needed to look after patients discharged from acute care. 4 hours of transitional care for a patient moving to long-term care is not enough.
 - Have enough staff to provide care for residents, there are currently not enough people in training to meet the demands. There must be adequate provider/patient ratios, based on the available research and evidence.
 - Have doctors spend more time in residential care homes.
 - Salaried doctors, or nurse practitioners, should work in residential care.
 - Residents need more bed-side care, and socialization. Hire more recreational care coordinators and care aides.
 - Registered nurses need to be brought back into the long-term care system.

- It would be beneficial to have a staff nurse or practical nurse on site to assist individuals with medications, education and their health care needs.
 - There should be full-time nurse practitioners and gerontologists in long-term care facilities.
 - Human resources are needed to provide quality of life and support for families with members in long-term care.
 - More dieticians are needed as well as more staff in senior facilities to help feed patients
 - Changes should be made to the Residential Care Act. To increase the quality of services provided, ensure the proper ratio of care providers to patient need, and provide adequate attention to evaluating the needs of patients. A different workload management tool that distributes work in response to an accurate assessment of the needs of each client should be used.
 - Retired nurses could be encouraged to help out in care facilities.
- **Ideas on community-based health care providers:**
 - In seniors housing complexes, have a staff or practical nurse on site to assist individuals with medications, education, etcetera to result in fewer 911 calls, less ambulance use and shorter hospital stays.
 - Long-term care managers should assess each senior after discharge, on the first day, with a reassessment within two to four days, and another a week later.
 - Maintain or reintroduce the community health nurse to support the seamless delivery of care and to improve communication, quality and continuity of care.