23 September 2009

Honourable Ida Chong
Minister of Healthy Living and Sport
Government of British Columbia
P.O. Box 9067
Victoria BC
V8W 9E2

Re: Residential Care Regulations

We, the Advocates for Care Reform, are writing to express our appreciation and our concerns regarding the soon-to-be implemented Residential Care Regulations. Advocates for Care reform is a group of concerned citizens dedicated to "improving the quality of care and the quality of life for residents of long term care facilities in British Columbia." As such we appreciate what you have done to improve the regulations for long term care and we also value your openness to our feedback on these Residential Care Regulations (RCR).

Our feedback does not dwell on what we see as the clear strengths of the regulations, such as the clarity with which the physical aspects of a facility could be assessed as well as specific regulations regarding record keeping. There are so many clear benefits to the approach taken in the RCR that we hope our feedback will only enhance what has already been done. Our main concerns center on:

i) a) <u>definitions in the CCAL Act upon which the regulations are based</u>.

In reading the document, "Residential Care Requirements: An Introduction" we inferred that the regulations are based on the "Community Care and Assisted Living Act (CCAL Act)". Our concerns are particular to the following from Part I Definitions and Application of CCLA Act. In particular:

“Definitions 1 In this Act:
"care" means supervision that is provided to

(a) a child through a prescribed program,
(b) a child or youth through a prescribed residential program, or
(c) an adult who is
(i) vulnerable because of family circumstances, age, disability, illness or frailty, and
(ii) dependent on caregivers for continuing assistance or direction in the form of 3 or more prescribed services;”

"hospitality services" means meal services, housekeeping services, laundry services, social and recreational opportunities and a 24 hour emergency response system;

“person in care" means a person who resides in or attends a community care facility for the purpose of receiving care;

Supervision is not an adequate definition of care for residents in long term care. It implies a level of capacity that most residents lack, and it is that very lack that necessitates admission to long term care. Further, hospitality services do not begin to cover the needs of most long term care residents.

b) definitions in the Residential Care Regulations (RCR):

In the RCR “care” is not defined at all. Care plan is defined, types of care are defined, but the act of care is not.

Also worrisome is the view that illness and disability are natural consequences of aging. Though illness and disability are without question more frequent in old age, they are not a naturally occurring part of old age. (See the [1]Lalonde Report re: human biology, environment, lifestyle and health care on views of health of Canadians or views in gerontology that discuss differences between disease and the aging process.)

[1] A New Perspective on the Health of Canadians (Lalonde Report) 1973-1974

ii) the Resident is all but invisible:

While the regulations address some key activities and processes associated with care, the emphasis is on the activity rather than the person. For example, while we can see clearly that food will be well-selected and prepared there is no indication of any regulatory focus on whether or not the resident will be fed, assisted with feeding or, ultimately, adequately nourished. This same applies to the residents being, clean, and taken to the toilet. We recognize (#81, p.31) the "care plan required if more than 30 day stay" and that this regulation will ensure that residents who are able will participate in the planning of care, but it remains unclear to us what this care consists of.

While one might assume that the ministry cannot define all actions and activities, we note that some activates are clearly specified. For example, residents will have some part of their care plan devoted to their oral hygiene. Can we not also consider the rest of the body? Given the regulations detailing the bathrooms in facilities, can there be a regulation to address the need to take residents to these bathrooms on a regular basis and not force adults to wear incontinence attire? Can residents be assisted in maintaining clean dry skin?

iii) professional assessment, planning and evaluation:

There is some inconsistency with which various professions are identified in the regulations. If, as stated in the "Residential Care Regulations: An Introduction" one of the key goals is to reflect evidence-based decisions, it is not clear that professionals with the knowledge of the evidence and expertise to make such decisions will be in place, or even available.

While we are aware that it would not be appropriate for the ministry to address staffing levels or staff mixes, it does seem that (#44, pp 17-18) there needs to be a nutrition manager, a dental health care professional (#54, p.20) and (#69, p. 26) a supervising pharmacist. Is there perhaps a need for a registered nurse to assess and plan for the delivery of nursing care? The need for physiotherapists to assist residents in maintaining their highest level of functioning is conspicuous in its absence. It is also very disheartening to see that the residents of long term care are still to be denied the critical skills of speech language therapists, who are can assess and then facilitate communication for residents who have disorders and disabilities such as aphasia, dementia, Parkinson's Disease and others.

One further point regarding the presence of professionals relates to Part 4 Division 1, General Staffing Requirements, Character and Skill requirements (page 15). In order to assess the employee, the notion expressed in RCR's of "good character" is somewhat vague. One can easily call to mind persons who do not have a criminal record, but who, nonetheless, would not be suitable care providers to persons in long term care.

Further, while the RCR does state that the person must have the ability to work with persons in care, we suggest that a professional (most suitably a registered nurse) with the appropriate educational background is needed to determine whether or not the employee has the knowledge and skills to work with persons in care. The change in wording recognizes that providing care is not a "good deed" but in fact an activity that requires knowledge of the body, the mind and the history of the person receiving care as well as correctly understanding something about the illness or disability affecting the person.

iv) <u>a fuller description of harmful actions (52) is really necessary</u>:

Persons in long term care must not be teased excessively, mocked or deprived of communication aids such as glasses and hearing aids. They must not be "punished" by being isolated, although the need for quiet time and the need to protect other residents is recognized.

We hope you will consider reorganizing "reportable incidents" (Schedule D) into something such as these 3 sections:

Resident generated incidents,
Staff generated incidents, and
Incidents without a visible antecedent.

While better terms may be found, considering the source of the incident could generate a more reflective approach to solving recurrent difficulties.

We also would appreciate a revision to the regulation that relates to family and resident fear of retaliation (specific suggestions in the "addendum"). We would all like to think that this is not an issue, but ACR continually receives calls, email and letters addressing the difficulty of complaining about care or a particular care giver. There must be some way to both keep residents free from retaliation and also keep staff feeling safe.

v) <u>Resident and Family Councils:</u>

Each type of council is important in its own way. In many facilities the council(s), and staff and administration are able to work collaboratively and in such cases care is improved. The assumptions that councils must be "managed" by the facility and that councils are, by nature, adversarial is erroneous. These assumptions must be replaced with recognition of the benefits of collaboration. Again, please refer to the "addendum" for specific points.

In conclusion we want to fully acknowledge the strengths of your work with regulations, and also to express our concerns about the language of care, the visibility of the person receiving care, a safe venue for resident and family concerns and the family council. We have included an addendum that addresses some specific issues that may be easy for you to consider. We hope that you will accept our feedback and see us as a group that shares your key goal, particularly health and safety for citizens of British Columbia who reside in Long Term Care.

Thank you for considering our feedback.

Sincerely yours,

JoAnn Perry and Kathleen Hamilton
Co-Presidents, ACR
On behalf of the board of ACR - Advocates for Care Reform

Attach: Addendum
Cc: K. Falcon, Minister of Health
A. Dix, Health Critic, NDP
K. Carter, Ombudsman for the Province of BC