Commitment to Care: A Plan for Long-Term Care in Ontario

Spring 2004

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Ontario

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Monique Smith, M.P.P.
Nipissing

Honorable George Smitherman
Minister of Health and Long Term Care
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Dear George,

I am pleased to present my report on recommended changes to long term care facilities in the province. While this review was telescoped into a brief few weeks, there is no doubting the pressing need for reform in the delivery of long term care in government funded homes.

We were guided in our review by several fundamental principles: a basic premise that a long term care facility is a "home" to resident seniors; a need to ensure respect and dignity for our senior population in care; and finally a belief in an entitlement to a life of quality in government funded homes.

The formal review took place between January 15 and March 23, 2004. We visited more than twenty homes over the two month period (Appendix A). These included a broad cross section of funded facilities including municipal, not for profit, for profit and charitable homes for the aged. These homes were located in small rural municipalities as well as large metro/urban centres, all across Ontario. We toured large facilities of 350+ beds and small homes with just 22 beds. We observed a wide range of facility structure (both old and brand new) and were able to visit culturally specific (Chinese, Jewish, Slovenian, Ukranian), and Francophone homes. I also gained some "hands-on" experience during my eight-hour shift shadowing a registered practical nurse at a municipal home.

While the focus of this review was specifically on long term care homes, we included visits to several agencies providing alternative models of care. These included a community health centre delivering outreach service to rural seniors in the East and a small residential group home in Toronto (Ewart Angus Home) serving dementia residents and their families.

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There was an extensive stakeholder consultation process to support the review (Appendix C). We met with close to one hundred individuals during the course of our review. Many of the report's recommendations to improve the system come directly from residents, families, LTC staff and other health professionals, operators and administrators, seniors groups, union representatives, academics, gerontologists, nurse practitioners and others active in the long term care community.

In concluding I will say that we observed a wide range of quality of care in the Ontario homes we visited. Some homes were excellent and obviously provided a safe, professional, compassionate quality of care that one could recommend to a loved one. In other homes we felt greatly disheartened, knowing we had witnessed poor quality of care – not the standard one expects in the province of Ontario.

This report has been developed as a blueprint for action. Recognizing that we are at the beginning of a four-year mandate, I hope you will accept these recommendations as a starting point. I want to thank you for providing me with the opportunity to participate in the "revolution" in long term care and I look forward to working with you as we move quickly but responsibly to ensure that the people in long term care facilities (in future to be referred to as "homes") live in dignity and have the highest possible quality of life.

Yours sincerely,

Monique Smith M.P.P.
Parliamentary Assistant
Ministry of Health and Long Term Care

Executive Summary

In December 2003, the Minister of Health and Long-Term Care George Smitherman asked Parliamentary Assistant Monique Smith, MPP, Nipissing, to undertake a review of long-term care facilities across the province.

The formal review took place between January 15 and March 23, 2004. Unannounced visits were made to over twenty homes, varying in size, ownership structure, location (urban and rural) and serving specific cultural groups. In addition, extensive stakeholder consultations took place with close to one hundred groups and individuals active in the long-term care community.

The government is committed to providing homes where our seniors can live in dignity with the highest possible quality of care. To ensure we achieve this goal, this report focuses on five main areas for government action in the long-term care sector: improving quality of life; ensuring public accountability; developing clear enforceable standards with tougher inspection and enforcement; improving staffing and system administration; amending legislation and reviewing the funding formula.

Improving quality of life

We need to reintroduce the concepts of “home” and “care” into daily life for the over 70,000 residents who live in long-term care (LTC) homes in Ontario. We are challenged in achieving this goal by changing demographics and the increasing acuity of resident care that is now placing a greater burden on long-term care facilities.

Ensuring home administrators have the necessary management training, and that they adopt and integrate a care philosophy in the everyday practice of the home, is an important step in achieving daily quality of life for residents. Implementing nursing best practices is also important. It was our observation that those homes that were providing exemplary care with few or no compliance issues, had organized their staff into multi-disciplinary, resident-focused teams, who met frequently to discuss and resolve issues.

Enhancing institutional life by engaging families, volunteers and by better integrating LTC homes into the vibrancy of the surrounding community is a recommended strategy.

More educated and aware consumers, more volunteer coordination, mandated Family Councils, working in partnership with Residents’ Councils, an emphasis on creating more of a home environment, the sharing of best practices, and more attention to new dementia therapies is required. Further, we recommend a reinstatement of the previous reunification policy to keep couples together in the same facility.

Ensuring public accountability

To implement systems that deliver confidence to the public, openness and transparency in our complaints process is needed. In addition to the previously announced toll free ACTION line and unannounced annual inspections, we recommend immediate action on serious non-compliance cases in a very short time frame. Mandatory yearly resident and family satisfaction surveys should be implemented and a public website created.

Creating a positive duty for all LTC home staff and the general public to report abuse or suspected abuse under new legislation is needed. This legislation should include penalties for non-reporting and whistleblower protection. The creation of a third party advocate or ombudsman to act as a watchdog and advocate on behalf of seniors would be welcomed by the public. Better Ministry collection, analysis and use of data is also vital to ensure public accountability.

New standards, inspection and compliance

The public expects tougher enforcement and swift compliance. Because the current compliance system is not meeting public expectations for ensuring the safety and wellbeing of our seniors, and because LTC operators have also complained that the system is not clear and consistent, the Ministry should create a separate inspection function with clearly articulated enforcement measures. A new risk framework should be designed that identifies graduated offences with contingent triggers and with resulting sanctions including fines. It should focus on public notification and reporting.

Quality of life depends on ensuring our seniors receive high standards of care and be treated with dignity. There must be clear, measurable, enforceable, resident-focused standards with enforceability of standards being key.

The Ministry should make increased use of service contracts and accountability agreements with LTC service providers to spell out reporting requirements and strict compliance to existing standards. The Ministry should target homes with a poor track record or chronic non-compliance. A home's track record must be considered in any future funding decisions, including bed allocations and bed transfers. Finally, homes with a record of good performance should be given a gold standard designation and consideration given to allowing those homes to go to biennial inspections.

To ensure appropriate levels of care, particularly for seniors living with dementia, smaller community-based homes that provide 24-hour staffing and support (non-profit residential alternatives) should be considered.

Improving staffing and continuity of care

Demands for funding are high, although some groups indicated more of a need for a reallocation of existing funding. Increased staff funding and a move towards ensuring more full time staff to provide consistent, resident-knowledgeable care is recommended, even as we recognize the Province's current financial constraints. More nurse practitioners in LTC homes, more attention to activities / activation staff and increased dietitian time would improve the quality of life and care. These resources must be tied to specific outcomes and an annual audit must be undertaken to ensure that the funding designated for specific roles or resources is in fact spent on the intended priorities.

Reinstating the one bath per week standard and doubling it to two baths per week is recommended, consistent with individual preferences, as is returning to the requirement that homes have a 24-hour registered nurse on duty. In the short term, dollars must be concentrated in resident care and therefore any future spending for care should be tied directly to the nursing and personal care envelope to ensure the money goes directly to frontline care.

The Ministry should consider making minimal training a requirement for personal support workers, as well as ensuring higher standards of management expertise for administrators. In addition, all staff should be required to have training in understanding the needs of the elderly, specifically training regarding abuse, communication skills, dementia and palliative care. The Ministry should encourage the use of existing programs offered by the Registered Nurses Association of Ontario, the College of Nurses, the Registered Practical Nurses Association, the Alzheimer Society and others. Finally, strategic efforts need to be developed to promote the long-term care sector as a desirable career option as staff shortages and pay inequities are constant challenges.

New legislation and a review of funding models

Any increase in the accommodation cost for residents in LTC homes should be limited to no more than the cost of living annually. Further, in order to respond to the needs of all seniors, further discussions around the 60 / 40 preferred / basic bed split should be held to respond to the clear need of seniors on waiting lists. The Ministry should also review the proposed new beds that have yet to be developed and determine the actual need, weighing potential penalty costs, potential savings and possible reinvestment in other areas.

A review of redevelopment projects should be undertaken to ensure whether redevelopment is necessary to meet resident needs and if so, whether the proposed design will assist the home to better achieve its care priorities.

Consolidation of the three facility Acts (*Nursing Homes Act*, *Homes for the Aged* and *Rest Homes Act*, and *Charitable Institutions Act*) is needed to ensure uniform standards of care, uniform enforcement, and uniform penalties, as well as to address the issue of elder abuse. Legislation to enable residents in LTC homes and those with Power of Attorney to access their medical files and records should be developed.

Complaints about the current funding process are prevalent throughout the system. In the short term the Ministry should carefully articulate and firmly enforce the boundaries around the funding envelopes. The current ad hoc 'pots of money' approach that has developed over the years needs to be addressed. As well, the current Case Mix Index (CMI) system is problematic. We recommend a review of the entire funding system in the next fiscal year to establish a model that provides homes with a base level of funding for consistency, while still allowing some flexibility for fluctuating levels of care. Stable, consistent funding should ensure more full time, resident-knowledgeable staff and a consistency of care.

The Minimum Data Set (MDS) would assist with evidence-based decision making, increased accountability, patient-focused care planning and a better integration of systems. This new approach would allow for continually assessing the needs of a home above a basic funding level.

This report is a result of visits to over 20 homes and meetings with close to one hundred stakeholders and people active in the long-term care community. It forms a starting point for our "revolution." It is hoped that this report and these recommendations will support those homes that are doing a wonderful job of caring for seniors and begin to address the concerns raised around those homes that are falling behind.

Introduction

Over 70,000 residents live in long-term care (LTC) homes in Ontario. A basic, but sometimes overlooked premise of our system, is that a long-term care facility is a "home" to resident seniors. There is, therefore, a need to provide and protect a quality of life and a level of respect in government-funded homes.

Changing demographics are placing a greater burden on long-term care facilities. The percentage of the population aged 65 years and over and aged 85 and over both almost doubled between 1961 and 2001.[1] Seniors now enter long term care homes at a more advanced age and with greater health concerns. The number of seniors requiring tube feeding, dialysis and catheters, once rare in these homes, is rising. LTC homes are also receiving residents back sooner from surgery. The average age of a resident in long term care today is 83 years. Changes in the family and labour force participation have also affected how families can care for seniors. For example, the number of women aged 15 or older in the labour force doubled between 1961 and 2001.[2] The resulting reality is that we all must play a role in caring for our senior population. While it was beyond the scope of this report to examine the broad continuum of elder care, we recognize that LTC is just one component within a broader seniors' strategy. We also acknowledge that seniors have voiced a preference for "aging in place" with the appropriate community supports.

This report focuses on five main areas for government action in the long-term care sector: (1) improving quality of life, (2) ensuring public accountability, (3) developing clear enforceable standards with tougher inspection and enforcement, (4) improving staffing and system administration and (5) amending legislation and reviewing the funding formula.

I. Improved Quality of Life

The government is committed to providing homes where our seniors can live in dignity with the highest possible quality of care. To ensure we achieve this goal, we need to reintroduce the concepts of "home" and "care" into daily life.

Philosophy of Care

We have observed that the philosophy of care in a home is an important indicator of daily quality of life for residents. The role of the facility Administrator and their approach to this culture of care is particularly critical. Top management in each facility needs to establish expectations around a philosophy of care and ensure its adoption and integration into everyday practice.

We visited many homes where the Administrator set an exemplary standard of care. Many homes are delivering these high standards. For example, we visited one home that had never been cited for non-compliance in its entire ten years of existence. Many of the original staff still work at the home despite higher wages being offered in other health care settings.

Other homes we visited seemed to be missing this "care ethic" direction from the Administrator and management. These were homes that lacked a dignified, nurturing home environment. One suspected inadequate personal care with unmotivated or insufficient staff to give residents more than one bath per week or give them daily exercise to maintain mobility. Residents were warehoused in wheelchairs in front of televisions for most of the day or seen to be lying in bed for long periods of time – too often a sad scene of inactivity and boredom.

> *"It doesn't take any more effort to treat residents with respect."*
>
> Ann Aikens, Director
> North Renfrew Long-Term Care Centre,
> Deep River

The Role of the Administrator

We recommend an internal Ministry of Health and Long-Term Care (MOHLTC) review of Administrators to ascertain qualifications and level of management expertise and to identify further required skills training. We also recommend a Ministry organized educational forum for individual home Administrators (not corporate officials) to develop indicators of a well-run home and reinforce best management practices including a philosophy of care and service.

Long-Term Care Homes by Facility Type

	No.	**Beds**
Number of total LTC homes in Ontario:	577	70,100
For profit homes:	343	38,057
Municipal homes:	102	16,654
Non-profit homes:	68	6,588
Charitable homes:	64	8,801

(Source: MOHLTC March 18, 2004)

The Ministry should also consider assisting the Registered Nurses Association of Ontario (RNAO) with a broader distribution of their Best Practices Guidelines and impressing on all Administrators and Directors of Care the importance of using these best practices and of continuous staff education both in-service and off-site. Multi-disciplinary staff team approaches to care should also be emphasized.

A Role for the Community

Families / Volunteers / Community

A major challenge for all homes is to enhance institutional life by engaging families and volunteers, and by better integrating LTC homes into the vibrancy of the community around them. In this regard, we all share a responsibility in ensuring our communities provide a satisfying and rich life for our seniors. In those areas of the province where strong cultural communities exist, we encourage cultural communities to actively participate in supporting long-term care homes.

Many of the activities that support quality of life for our seniors are made possible by the help of family and community volunteers. At St. Joseph's home in Guelph, for example, their 300+ volunteers are assisting residents with a biography writing project. Other homes have also been successful in inviting the community into the home: at People Care Centre in Tavistock, they have pet visitation by therapy dogs. At the LTC home in Pembroke, junior step dancers hold their concerts in the LTC home's auditorium; the local Grade 3 elementary class also has a reading program with residents. Many innovative initiatives are already underway.

Sadly, however, we saw homes with few visitors, essentially no volunteer structure and little outside activity brought into the home. We were not surprised to later learn that more than one-third of LTC residents (24,651 or 41.3%) suffer from some form of sadness or depression to varying degrees.[3] One smaller Metro home we visited had only eight visitors for the entire month of February. However, others like St. Patrick's in Ottawa have 250 volunteers and a paid volunteer coordinator. Yee Hong in Scarborough told us they have a waiting list for volunteers.

Where it doesn't currently exist, the Ministry should support community and volunteer involvement and outreach by mandating (at a minimum) one dedicated half-time volunteer coordinator in every home. These coordinators would then develop links with high school students needing to fulfill their volunteer hours, Ontario Early Years Centres who could provide intergenerational programs inside the homes, service clubs and community groups who could organize events for residents. The Ministry should also facilitate the sharing of best practices province-wide through a manual produced by LTC activation / activities professionals.

Family Councils, Residents' Councils

Autonomous Residents' Councils and Family Councils act as advocates for seniors in homes. Further, they play a watchdog role for quality of care. No resident or family member should ever feel reluctant to report a complaint or concern in a home or fear reprisals for their loved one as a result of their complaint.

Number of LTC homes in Ontario:	577
Number of Residents' Councils:	178
Number of Family Councils:	154

According to the Ontario Association of Residents' Councils, there are over 250 Residents' Councils currently across the province, 178 in LTC homes. We support the good work of these councils and recommend the Ministry continue to support their efforts. In addition to Residents Councils, a $145,000 Trillium Fund pilot project grant allowed the creation of 154 Family Councils to be established across the province. This project ended in April 2004.

Families should be seen as integral to the life and programming at LTC facilities and therefore we recommend provincial funding for peer facilitators to help establish more Family Councils as a continuation of the Trillium Fund project. Further, we recommend a funding contribution for a Family Councils Best Practices conference taking place in Ottawa in May 2004. It is important to share what works and what has been found to be effective.[4] The Ministry should assist with province-wide notification and promotion of the conference with distribution of results to LTC homes, existing Family Councils and other stakeholders.

We also recommend a directive to all homes to establish a Family Council. These would work separately but in partnership with existing Residents' Councils. Terms of Reference could include that minutes of both Residents' Council meetings and Family Council meetings be posted in a public place, easily accessible to family and residents. Home Administrators and Directors of Care should be encouraged to participate where invited but Councils should remain independent of the homes' administration.

> *"The main purpose of most Family Councils is to improve the quality of life of residents and to give families a voice in decisions that affect them and their loved ones in the facility."*
>
> -Family Councils Project

Creating a Home Environment

We saw many homes where there were laundry carts, wheelchairs and equipment cluttering up the halls, terrible odors, seniors left in hallways, many kinds of restraints (trays, straps, lap belts, etc.), residents not always dressed or well-groomed, crowded homes where activity rooms have been converted for other uses, excessive TV watching (in one instance even when there was no TV – just four or five wheelchair bound residents parked in a cramped activity room in front of a vacant wall where a TV used to be.) In one home, the only cheerful space with windows (the dining room) was closed to residents and locked except during meal hours.

We encourage homes to consider new holistic philosophies of care that address quality of life such as the Eden Alternative,[5] gentle care or a social model of care.[6] We recommend that homes be directed to invite and encourage residents to bring their personal effects to their new homes. Pets and plants and visiting children should be encouraged. Homes should be proactive in encouraging visitors by providing high chairs for children, for example, or organizing activities (e.g. gardening) that are conducive to interactive family / friend visits, particularly with dementia residents.

Residents, where appropriate, should have access to cable and telephones in their own rooms. Some seniors told us that the telephone was their "lifeline" to the outside world. The Ministry should also move to address the reconnect / disconnect fees levied on seniors moving between rooms within the same home.

Where appropriate, independent daily routines should be respected. Waking and dressing residents at 5:00 a.m. so everyone can "fit into" the breakfast time schedule does not respect the resident's autonomy. We visited homes where independent residents had access to small kitchenette facilities so they could fix themselves breakfast at a reasonable hour. This convenience reflected their normal living routine.

New Dementia Therapies

We visited a number of homes that had implemented Snoezelen Rooms (or carts), a sensory environment concept developed by two Dutch therapists in the late 1970s. This therapy is currently being used with some success in children with learning disabilities and autism spectrum disorders. Initial research is showing some promising signs with the elderly suffering from dementia such as Alzheimer Disease, people with mental illness, those in chronic pain

and those exhibiting challenging behaviours. We encourage the Ministry and home Administrators to be aware of new therapies to assist those with dementia. We also encourage the Ministry to continue its base support to the Alzheimer Strategy.

Average age at admission to Long-Term Care:	82 years
Percentage LTC residents 80 years and above:	70%
Percentage assessed at mid to heavy care:	80%
Percentage of residents having some degree of incontinence:	86%
Percentage requiring constant, complete, or total help with eating:	39%
Percentage requiring assistance with transferring:	72%
Percentage having Alzheimer Disease, dementia or mental disorder:	64%
Percentage of residents requiring staff to assist with toileting:	60%

(Source: MOHLTC January 2004)

Keeping Couples Together: Reunification policy

We feel strongly that couples who have lived together for most of their lives should not be separated if one requires a different level of care. We should reinstate the previous policy that gave priority to keeping couples together in the same facility.

Palliative Care Room

The privacy and dignity of a dying resident needs to be protected. We visited homes that did provide a palliative care room for a critically ill resident and their family.[7] However, not all homes have this arrangement. This results in a difficult situation for elderly residents in a shared room with one, two or sometimes three other roommates. We recommend the Ministry consider requiring each home that does not already provide this service, to have at least one palliative care room available in the home. In those homes that are not at maximum capacity, one such room should be designated immediately.

Architectural and Community Considerations

It is our view that “bigger is not always better” when addressing models of care. Therefore, we need to evaluate the 1998 design standards prior to any new developments. Large institutional homes of 250 and 350 or more beds need to work to create smaller homelike settings as size is sometimes a barrier to home-like life. In addition, where possible, LTC homes should strive for a model of community and health service integration, either physically locating next to these services (hospitals, health centres, seniors’ housing) or having services offered on site (foot care, dental services, etc.)

We toured many nursing homes that were fully integrated into the life and social services of the community. In Sturgeon Falls, for example, the municipal home is physically connected to the health centre (hospital); seniors' independent living apartments are also physically joined to the home and many of these seniors work as volunteers in the LTC home itself. They are also able to make use of the facilities there (cafeteria, chapel, pool table, wood workshop, etc.) Many community based services (foot care clinics) are offered to both the public and residents of the home on site. Where possible, we feel nursing homes who do not currently offer this approach, should strive for this kind of model of integration.

Public Education and Awareness

The public requires more education on the normal aging process and the continuum of care for our seniors. They also need to know how to navigate the system and where to find resource information for seniors. The Ministry has a large role to play here with its community partners. In particular, a better strategy needs to be developed with the Community Care Access Centres. For example, one dedicated component / section of every Community Care Access Centre (CCAC) should prehaps, be devoted to information on all seniors services, advocacy groups and organizations.

Organizations who already provide public education (e.g. Advocacy Centre for the Elderly's Long-Term Care Facilities in Ontario: The Advocate's Manual) and Concerned Friends of Ontario Citizens in Care Facilities should be encouraged and assisted in circulating their existing material broadly. Further, we should revise the Ministry's literature (Turning on the Lights) and distribute it widely to every community.

The public also needs to be more knowledgeable about the Ministry's inspection and enforcement system for LTC homes. This includes making the public aware of sanctions at the Ministry's disposal including: suspending admissions to the home; withholding or reducing government operating subsidies; fines; suspending or revoking a nursing home operator's license; Ministry takeover of a facility.

Keeping Our Homes Safe

Ontarians need to have confidence that our most vulnerable seniors are protected from harm. We need to ensure that government-funded homes have appropriate safety and security measures so that dementia residents are never placed in harm's way outside of the home. The Ministry should also undertake an immediate review of safety and security measures in homes.

While all homes are mandated to have a power contingency plan, a small but significant number of homes do not have back-up generation capacity and do not have any contingency plans in place. This means that during a power outage they do not have the capacity to run even one elevator, provide uninterrupted safe provision of medication, oxygen and ventilation, water and sewage services, or safe food services. The Ministry needs to mandate homes to have power contingency plans including back-up generation capacity. An immediate review of homes' power contingency plan capacity is required.

II. Public Accountability

The public is demanding accountability and we need to implement systems that deliver this confidence to the public. We need openness and transparency in our long-term care system to protect residents.

ACTION Line

The Minister of Health and Long-Term Care earlier announced a toll-free Action Line for complaints, concerns and questions (1-866-434-0144). We recommend a public update that outlines the number of calls and referrals with an analysis on the type of complaints to better inform the public and assist with further planning around inspection and compliance.

Surprise Inspection of LTC Homes

The Minister has instituted surprise annual inspections. Targeted surprise inspections should also occur between annual inspections.

Resident and Family Satisfaction Surveys

Many homes have introduced regular satisfaction surveys to continually improve their service and care (see Appendix C). We recommend a mandatory yearly satisfaction survey to be administered by the Family Council or other third party (not staff administered). We encourage homes to seek creative partnerships with organizations that have already developed this expertise.[8] In addition, the Ministry website could provide a downloadable generic satisfaction survey. This (anonymous) survey could be mailed / faxed / emailed to the MOHLTC who would then share the surveys with the facility administrator.

These satisfaction surveys (and a review of previous years' surveys commencing in 2005) would be reviewed as part of the annual Ministry inspection process.

Reducing Immediate Risk

The Ministry must move immediately to address all current serious non-compliance cases in a very short time frame (e.g. six weeks). As of March 10, 2004 the Ministry had identified 48 facilities potentially requiring an enhanced risk review. The Ministry should also maintain a detailed record of those homes in non-compliance and the length of time it takes a home to address the issue and come into compliance.

Public Website / Public Reporting

The public needs to have access to more information in order to make informed decisions about choice of LTC homes. We recommend the creation of a publicly accessible website. Similar hard copies of this information should be made available at each local CCAC and MPP office. Careful attention needs to be paid to the context of information provided as well as the simplicity of its presentation. For example, if wounds (pressure ulcers) are to be measured and reported, then there should be clarity around non-originating wounds (wounds developed outside the LTC home, such as during a hospital stay).

We also recommend that helpful checklists for families' use in evaluating homes produced by groups such as Concerned Friends (Appendix D) be made available on the Ministry website and be broadly distributed to CCACs and family physicians etc.

This website could provide the following types of information:

- Profile of each home (location, number of beds, class of facility, type of ownership, name of owner and contact information – not a numbered company)
- Number of single units, double units, quad units; number of basic units
- Accreditation (yes / no)
- Record of individual compliance reports and compliance record history (beginning in June 2004)
- Number of violations in the last annual review in context (major, minor, etc.)
- Staff profile (number of Registered Nurses, Registered Practical Nurses, Personal Support Workers, social workers, physiotherapists, physicians, nurse practitioners, etc.)
- Staffing levels (staff to resident ratio updated twice yearly)
- Number of hours of staff training per year (also training in specific areas, such as dementia)
- Number of PIECES and U-FIRST trained staff per resident
- Employee retention rate (including tenure of Administrator and Director of Care)
- Complaints mechanism process
- Number, type and rates of complaints (per bed size of facility)
- Community partners profile for each home (e.g. Adult Day Program, Meals On Wheels, Alzheimer Society, etc.)
- Copy of activities calendar for a typical month
- Number of registered volunteers
- Number of volunteer hours for the previous year
- Palliative Care Room (yes / no)
- Number of resident and / or family satisfaction surveys
  (a) distributed and
  (b) collected and analyzed
- Residents' Council (yes / no)
- Family Council (yes / no).

Dealing With Elder Abuse

The government has zero tolerance for abuse and neglect in the long-term care system. To reinforce this policy we recommend greater education for all LTC staff including administrators, physicians, nurses, health care workers, activation staff, volunteers and family members on elder abuse. We recommend that each home have a reporting system in place with visual reporting mechanisms posted (who to call if you suspect abuse).

We recommend creating a positive duty for all LTC home staff and the general public to report abuse or suspected abuse under new legislation. We also suggest implementing fines for not reporting abuse (as with children under Child and Family Services Act) in addition to tough sanctions for elder abuse in new legislation (see Legislation and Funding below). All current and potential employees in LTC homes should be carefully screened (e.g., criminal record checks). Also needed is a review of the police role and definitions on what constitutes elder abuse in that sector. We recommend a meeting with the Ontario Chiefs of Police.

Complaints Process

The mandate requiring all funded homes to provide and post information on the complaints process of that home needs to be better enforced. This information should include who to contact within the home, organizational bodies to contact outside the home (e.g., Concerned Friends of Ontario Citizens in Care, Advocacy Centre for the Elderly, Family Councils Project, Ombudsman, the professional colleges of health care professionals, MOHLTC Inspectors) as well as prominent posting of the new government ACTION Line.[9] MOHLTC should mandate that all of this information should be included in the welcome packages provided to new residents by the home.

Ombudsman / Seniors' Advocate Role

We see a need for a third party to advocate on behalf of seniors in long-term care homes. It has been beyond the scope of this report in its brief timeframe to provide an in depth analysis of all of the options. However, we see merit in the advocacy work being conducted by the Advocacy Centre for the Elderly and suggest they could play a more province-wide watchdog role on LTC homes and compliance processes. The Advocacy Centre is currently established as a legal aid clinic mandated to work for the elderly.

There was also interest expressed by some in having a separate Long-Term Care Ombudsman or a new Superintendent of Long-Term Care. This would ideally be an independent and spirited Ontarian who would advocate for LTC residents and their families. This position could have the power to investigate when all other avenues have been exhausted. They could also advise the Minister directly of trends and issues in provincial inspection and compliance.[10] The appointment of a Superintendent for a two-year term to restore the public's confidence in the safety of all of our homes would be welcomed by many.

Other options we can consider:
(a) Dedicated position within current Ombudsman's office
(b) Rights Advisors
(c) Minister's Advisory Panel

Provincial Coroner

Currently, the Office of the Chief Coroner (OCC) only investigates every one in ten deaths in long-term care homes or where negligence is reported (which many believe is under-reported). We feel the Ministry should review this policy to ascertain if this current process is sufficient to ensure public confidence and accountability.

Data Collection and Analysis

The Auditor's Report criticized the Ministry for not adequately tracking data. The Ministry needs to know more about the homes it funds and it needs to analyze complaint, injury, serious incident reports and inspection records to better evaluate homes and resolve systemic problems to improve care.

In addition, we recommend that the MOHLTC maintain an internal database with compliance records, complaints and other relevant data specific to each LTC facility that can be monitored daily. This facility profile will help provide a composite picture of where problems are occurring or homes with recurring breaches of standards or regulations, and allow for quick action where necessary.

Further, the Ministry needs to better review staffing levels and staffing mixes at all their homes. Only by maintaining statistics can we determine what is the appropriate staffing level for a particular home.

Mandate and Expectations of Long-Term Care Facilities

The Ministry must revise its Long-Term Care Facilities Program Manual to establish clear outcome-based expectations and best practice for all home administrators. All homes, mandated to have a Continual Quality Improvement plan, should be required to provide the Ministry with a current copy yearly. If this is protected information under the *Nursing Home Act*, legislation will be required to address it.

The Ministry has moved to strengthen compliance reporting when it issued its 2004 Service Agreements. "Reasonable efforts" by operators to comply with the program manual have now been replaced with language saying they **will** comply.

Finally, in order to ensure public confidence and accountability, we recommend the Ministry move to implement a one-year hiatus before Ministry of Health and Long-Term Care officials can be employed by any LTC facility or corporation.

III. Standards and Compliance

Broader Consultation

The Ministry is currently reviewing its standards and compliance procedures. It is critical that all parties who will be partners in implementing the new standards participate in their development. We recommend, therefore, a broader consultation process involving more affected stakeholders. For example, we will invite the College of Nurses and other front line staff representatives to be consulted when we draft our new standards.

Clear, Enforceable Standards

Quality of life depends on ensuring our seniors receive high standards of care and be treated with dignity. There must be clear, measurable, enforceable, **resident-focused** standards.

LTC homes have said they want greater accountability and transparency. They welcome tougher inspection but with this must come clear and enforceable standards. For example, there is currently a wide interpretation of the term “restraints.” Some Compliance Advisors consider trays and recliners as restraints while others do not. There is also, for example, a need for clarity of definition and expectations for “restorative care.” Therefore, we support greater clarity and consistency. Standards must be clearly understood by Inspectors and Compliance Advisors and not be open to regional or individual interpretation.

Achieving clearer, better defined standards will require a new code of practice, education, and tools for Compliance Advisors and Inspectors. Further, improved standards will require new reporting and accountability features for Inspection Officers. It should be stated, however, that in clearly defining standards we are not necessarily creating new standards and therefore the redrafting of standards does not necessarily come with an increase in funding.

Standards must also be measurable and encompass some weighting so that serious violations are not mixed in with other complaints or violations. Triggers must also be developed to alert Ministry officials to serious violations when they occur.

Resident-focused standards

Currently, MOHLTC gathers information on complaints, unusual occurrences and compliance reports but these do not relate satisfactorily to quality of life issues. In fact, the 2002 Auditor’s Report said that the Ministry “had not developed outcome measures that addressed the appropriateness of services provided, including the quality of care received by residents.”[11] Therefore, we feel the Ministry should move first to look at redeveloping standards around staff training, abuse prevention, restraints, nurses and personal support workers (PSWs), and recreation / activities staff on a priority basis.

We also need to develop Quality Indicators that will tell us if homes are delivering quality care. In addition to meeting standards, we suggest the following be considered among other possible indicators for quality of care:

- staff satisfaction and resident / family satisfaction surveys
- number and variety of activities (Activation)[12]
- staff skills and staff training
- number of registered volunteers and number of volunteer hours should also be indicators.

Enforceability of standards is key. The Ministry should make increased use of service contracts and accountability agreements in spelling out reporting requirements and strict compliance to existing standards. Moreover, we agree with the 2002 Provincial Auditor's Report[13] calling on a risk-based approach for prioritizing facility inspections: the Ministry should target homes with a poor track record or chronic non-compliance.

Tougher Inspection and Enforcement

There is considerable evidence that the current compliance system is not meeting public expectations for ensuring safety and wellbeing of our seniors. LTC operators have also complained that the system is not clear and consistent.

Creation of Inspection Function

We perceive a conflict in the role of the current Compliance Advisors who work closely with homes to ensure standards are met but are also responsible for the inspection of that same home and any subsequent enforcement process. The Ministry should remove the inspection role from Compliance Advisors and create a separate inspection function. Compliance Advisors will continue to perform an education function with assistance to homes around compliance and be more of a presence in those homes failing to meet standards.

The new inspection function will have clearly articulated enforcement measures. In the past the compliance function has relied too heavily on warnings, negotiations, greater Ministry scrutiny, and voluntary suspension of admissions. This approach is inadequate. The public expects tougher enforcement and swift compliance. We recommend the Ministry design a Risk Framework that identifies graded offences (minor, moderate, serious) with contingent triggers and with resulting, sanctions including fines and a focus on public notification.

Tougher inspection will also mean Ministry mandated standards around inspections. For example, a standard percentage of chart audits and interviews to be completed during annual inspections should be outlined and not left to the discretion of the Inspector. Better training of both Inspectors and Compliance Advisors will be necessary. Further, corporate direction for the new inspection program should be based centrally in the Ministry not delegated to regional offices. We recommend monthly teleconferences and twice yearly meetings of all inspectors to ensure consistency. A web board for Compliance Advisors and a separate one for Inspectors' discussion should also be initiated.

Public Reporting and Transparency

We visited homes where the current Compliance Advisor's report was not posted or was posted behind a **locked** glass cabinet. All residents and family members and prospective residents and their families must have access to these reports. We recommend that the new Inspection Reports must be publicly posted in easily accessible public locations subject to fines for non-compliance. The Ministry must communicate violations and complaints in a language that is understandable to the average family member and respects minimal literacy standards

and language barriers. Violations must be communicated quickly to home administrators (not months later). Finally, LTC administrators must be made aware of the nature of the complaints filed against them; and those filing a complaint must receive a follow-up response on what transpired as a result of their complaint.

Inspectors should be mandated to review the home's annual Inspection Report with both the Residents' and Family Councils.[14] Satisfaction survey results should be included in the facility's annual inspection. Further, we recommend that the Inspector present a full report to the home's Board of Directors, and be available at this meeting to answer questions. For those facilities with no Board of Directors, the Ministry should mandate an annual general meeting to which all residents, family, local MPP and all related agency staff be invited. The Inspector would present her / his report at this meeting and answer questions.

Further, in addition to providing each CCAC with a copy of the annual Inspection Reports and the status of each home in that municipality, copies should be sent to each local MPP. Current Inspection Reports and past copies (commencing June 2004) should be posted on the Ministry website. Copies of all reports should continue to be sent to Concerned Friends of Ontario Citizens in Care, as well as the Advocacy Centre for the Elderly.

Any new review process must include recognition of facilities with a record of good performance (e.g., gold standard designation). We may also want to consider allowing those with a gold standard designation for three consecutive years to go to biennial inspections.

Finally, we feel the public needs more accountability with respect to the home's financial viability during the inspection process. Audited financial statements submitted by each facility should be reviewed by an auditor who is on the provincial Inspection Team.

Appropriate Levels of Care

During our visits to over 20 homes across the province, we saw residents who were "misplaced" – that is, they were inappropriately placed in LTC. There may be some pressure on CCACs to place some seniors prematurely into LTC facilities because of the availability of new beds and the shortage of funding for home care.

In addition, Alzheimer residents who do not require intensive nursing care are sometimes placed in LTC because no other options are available. We suggest redirecting government funding into community alternatives and home care.

The Ministry should consider funding smaller community-based homes that provide 24-hour staffing and support (non-profit residential alternatives). In particular, the Ministry should investigate appropriate care facilities for seniors living with dementia.

Ewart Angus home suggests it costs $2,000 per year less to house a dementia resident in this small complex than at a long-term care facility.

IV. Staffing and Administration

Improve Staffing and Continuity of Care

Some homes are experiencing very challenging staffing issues. For example, we visited homes where there was one registered nurse (RN), one registered practical nurse (RPN) and four Health Care Aids for 160 residents on the night shift.

In addition, long-term care homes are currently staffed by a mix of many part-time nurses, health care aids and personal support workers resulting in "casualization" of this work force. Often, outside agency staff are hired on a short-term basis to care for residents. This results in greater staff turnover levels and the opportunity for increased staff error. One RPN who is providing medication to 50+ residents during a shift will have a much greater challenge (and is prone to error) if he or she is not familiar with the resident population in his / her care.

More full time staff are required to provide consistent, resident-knowledgeable care.

> *"We're really pushing some very good people to the limit."*
>
> Joe Brabant, President,
> St. Patrick's Family Council,
> Ottawa

Minimum Care Levels

Much has been written on the issue of minimum standards for personal care. Both the public and the industry view nursing and personal care hours (staffing) as a proxy for **quality** care. While there was formerly a standard of 2.25 hours of daily care per resident, this standard was dropped by the previous government. The Ontario Long-Term Care Association (OLTCA) estimates that increased operating funding since 2001 has raised care levels from the 2.04 hours per resident per day documented in the much cited 2001 Level of Service (LOS) study to approximately 2.5-2.6 hours. Ministry officials suggest most homes now provide between 2.27 and 2.3 hours. CUPE has requested 3.5 hours.

We recognize that funding and staff shortages do affect standards of care. We were told that staff in some homes are not able to meet the basic care needs of residents such as baths, sufficient changes of incontinent products or helping residents to have a daily walk. Other homes, however, were managing to provide quality care with existing staff. We think most homes are providing at least one bath per week (even without a standard) and we know the good homes are providing up to three baths per week. We recommend reinstating the one bath per week standard (dropped by the previous government) and we recommend doubling that to two baths per week.

Demand for funding is high. The OLTCA and Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS) have called for $420 million over two years. It must be noted, however, that some we met felt there was no need for increased funding but rather a reallocation of existing funding. We recommend increased resources for care in our homes, even as we recognize the province's current financial constraints. These resources must be tied to specific outcomes and an annual review must be undertaken to ensure that the funding designated

for specific roles or resources is in fact spent on the intended priorities. We recommend returning to the 24-hour registered nurse standard. We see a great need to concentrate dollars in resident care and so we strongly recommend that any future spending for care be tied directly to the nursing and care envelope to ensure the money goes directly to frontline care.

Also, strategic efforts need to be developed to promote the long-term care sector as a desirable career option as staff shortages and pay inequities are constant challenges.

Review Roles of Key Staff

It was our observation that those homes who were providing exemplary care with few or no compliance issues, had organized their staff into multi-disciplinary teams who met frequently to discuss and resolve issues. Homes with hierarchical staff arrangements that excluded non-registered staff were not always delivering the best care.

Staffing: Nurse Practitioners (NP)

Nurse practitioners were seen by many stakeholders as a very welcome addition to the staff of nursing homes and an effective antidote to a lack of physician availability in the LTC sector. Their ability to provide **education** to other staff around hydration, dementia, impaired swallowing, pain management, palliative care, and IV therapies was seen as a huge benefit to a home. Other benefits beyond improved quality of resident care include improved communication with residents and families, improved skill level of other LTC staff and reduced Emergency Room visits.[15] In fact, the 17 nurse practitioners in the Long-Term Care pilot project of 2000 were converted to permanent positions in 2003.

We recommend the Ministry fund the addition of more nurse practitioners in the LTC sector. This will require creative solutions in rural and remote areas of the province. Recognizing the limited number of nurse practitioners available in the province, we also ask that the Ministry of Colleges and Universities consider increasing their capacity to graduate nurse practitioners as well as expand their curriculum and scope of practice to better reflect the long-term care setting.

Staffing: Activities / Activation Staff

Residents of all capacities need stimulating activity. As the Eden Alternative philosophy outlines, the three plagues among aging seniors are loneliness, helplessness and boredom. Activities staff play a major role in contributing to resident quality of life and maintaining active living. The activities / activation role is multi-faceted and encompasses: recreation, physical fitness activities, restorative therapies, volunteer coordination, outings and event organization, pastoral and palliative care organization, fundraising, public relations, and holistic therapies. Many of these staff, however, have no standard training and are not considered valued members of the multi-disciplinary care team. Their educational training ranges from university degrees in recreation therapy to little or no formal training whatsoever. MOHLTC needs to pay more attention to this sector.

Activities / activation / recreation staff in funded homes require greater training to prepare them for LTC settings. They need more education in gerontology and elder care. In addition, we should support and encourage all these staff to participate in professional associations like the Activities Professionals of Ontario (APO). The Ministry should partner with this Association to produce a "Best Practices" manual and disseminate it to all activities staff in funded homes across the province.

Through their work, activities staff also help residents to maintain their physical functioning that determines so much of their quality of life. For example, nursing best practices inform us that physical exercise contributes to fall reduction and preventing constipation. Generally, a much greater emphasis needs to be placed on encouraging **physical activities** for all residents in funded homes. We found that the better homes have inclusive activities for all, including dementia residents and those who were not ambulatory. Finally, the majority of nursing home residents are women (72%) and programs should reflect this (e.g. cooking programs for this generation of homemakers).

Staffing: Dietary Staff

Quality of meals varied greatly across the province. Many were inviting meals where residents had no complaints. Other meal plans showed days of cold cereal for breakfast, bologna sandwiches for lunch and pizza for dinner. We recommend that meal plans must not just be "reviewed" but actually **approved** by a dietician. In addition, more time is needed for the dietitian to go beyond assessment of new and high risk residents and to better track the status of residents.

Staff Training

Seniors living in our LTC homes today are more fragile and have more complex health issues than in the past. For example, 64% of residents admitted to a LTC facility have some form of dementia or suffer from cognitive impairment. Understanding and being able to best care for residents with this condition requires special training. Currently, there are no educational standards for health care aids / personal support workers in LTC homes. Some front line workers have no formal training whatsoever. Others have a three to five-month community college training. Administrators have, in some cases, one week of training in addition to minimal management experience. The Ministry should consider making minimal training a requirement.

In addition to more training in gerontology, all staff need specific training regarding abuse (including recognition and prevention), communication skills, dementia and palliative care. The Ministry should encourage the use of existing programs offered by RNAO, the College of Nurses, the Registered Practical Nurses Association of Ontario (RPNAO) and others.

We recommend the Alzheimer Society's PIECES training for nursing staff and U-FIRST training for PSWs. As the present CMI system of funding allocation does not recognize the level of care required by sufferers of dementia, the Ministry should provide bonuses to facilities providing dementia care. We also recommend to the Ministry of Colleges and Universities that they expand geriatric training in all relevant curriculum.

Number of Long-Term Care Beds in Ontario	
Year 2000	57,000 beds
Year 2004 (March)	70,850 beds

(Source: MOHLTC 2004)

Building Capacity For Expertise

The Ministry should consider how to develop better expertise in the long-term care sector including professional development, development of protocols and standards of care, and the dissemination of knowledge and best practices to front line staff. Several suggestions were made to us in this regard including establishing Centres of Excellence and pilot projects that linked an academic research centre to a LTC facility. The Ministry should consider the many options available for achieving these expertise goals.

Medical equipment

Almost three-quarters (72%) of all LTC residents require assistance with transferring. Therefore, more medical equipment such as lifts would be useful in certain homes. While lifts may require two staff for safe operation, they reduce staff injuries and contribute to the quality of life for residents.

V. Legislation and Funding

Accommodation Rates

In Ontario, the government funds care costs while the resident contributes to their accommodation cost through a co-payment. We suggest that the government limit any increase in the accommodation cost for residents in LTC homes to no more than the cost of living annually.

Increased Basic Room Accommodation

Affordable bed availability for our seniors is a priority. We are currently seeing waiting lists for basic accommodation while preferred accommodation (beds in private rooms for which seniors must pay extra) go empty.[16] A MOHLTC January 2004 report stated that private beds in new facilities have a lower utilization rate than basic beds.[17] Further, few semi-private beds are being built in the new facilities, thus further narrowing peoples' choices. In order to respond to the needs of all seniors, we recommend further discussions around the 60 / 40 preferred (private) bed / basic bed split to respond to the clear need of seniors on waiting lists.

Redirection of Institutional Bed Assignments

We recommend the Ministry reexamine the new bed allocations with a view to stopping the building on those not yet in the ground and redirecting this funding savings to home care, recognizing that the potential penalty costs as well as the need will have to be weighted into the equation.

Revisit Redevelopment Projects

In 1998, the Ministry announced the renovation of approximately 13,583 beds (later changed to15,835) in structurally non-compliant homes by 2006. During our province-wide tour, we saw "D" class facilities that were slated for closure or "rebuilding" despite the objections of the home's Board of Directors. In one such case, the move would mean relocating the home to an entirely different and quite distant location. It was almost a certainty that the volunteers would not follow the new development because it was outside their community. We wondered if the staff would also not follow the move, preferring to stay and work in the vicinity of the old location. Would fundraising continue when the home was no longer seen as an integral part of the neighbourhood or community?

We suggest the Ministry review the as yet uncompleted redevelopment projects to determine if modifications are necessary in each instance to reach "care-focused" goals or if the move would undermine the quality of care established at these homes. While we would recommend modifications to buildings that currently house four residents per room, or continue to have hallway washrooms for a number of residents, we believe some middle ground can be found between a complete "rebuild" and such necessary modifications.

Legislation

We recommend consolidation of the three facility Acts (*Nursing Homes Act*, *Homes for the Aged and Rest Homes Act*, and *Charitable Institutions Act*) to ensure uniform standards of care, uniform enforcement, and uniform penalties. For example, frontline staff would be more likely to report abuse or neglect if they were protected from any real or perceived reprisals. Whistleblower protection currently exists under only one of the Acts but without penalties for non-reporting. We recommend a uniform ban on abuse with inclusion of whistleblower protection and a positive obligation to report with penalties for non-reporting.

Secondly, while hospitals are required to grant access to a patient's medical records, residents in long-term care homes and those with Power of Attorney for these residents are not always granted access to medical records. In fact, municipal homes require a Freedom of Information inquiry to access these files. We recommend legislation to enable residents in LTC homes and those with Power of Attorney to access their medical files and records.

Funding Formula

Funding for long-term care facilities is provided through four funding envelopes: nursing and personal care; program and support services; raw food; and other accommodation costs (facility costs, administration, housekeeping, building and operational maintenance and dietary and laundry services.) We heard many complaints about the current funding process. We also heard of many instances where the envelope system was being manipulated. For example, one home was paying $20,000 in legal fees from a wrongful dismissal case against an employee out of the nursing envelope, an unacceptable practice.

The Provincial Auditor also criticized the Ministry for not having sufficient financial accountability: "Financial information submitted by facilities was not sufficient to allow the Ministry to determine whether funds had been used in accordance with the Ministry's expectations." In the short term we recommend that the Ministry carefully articulate the boundaries around the funding envelopes. We also see a need to repatriate incontinence products back to the accommodation envelope from the nursing envelope.

There is also an ad hoc "pots of money" approach that has developed over the years that needs to be addressed (Municipal Tax Allowance, High Wage Transition Fund, Proxy Pay Equity, etc.)

Moreover, the current Case Mix Index (CMI) system is problematic. Based on the medical model, funding is determined based on light, medium and heavy care. Facilities receive more funding for residents who are not well and require more care. However, there is no funding for promoting wellness (e.g., keeping people continent). In fact, many perceive this formula as a disincentive to keeping residents well and healthy. The timing of the CMI calculations is also problematic. Some estimate that 40% of residents' conditions have changed from the time when the classifications are decided in September to when the funding is allocated six months later. We were also told many times that dementia is not sufficiently factored into the CMI.

We recommend revisiting the entire funding system in the next fiscal year to establish a model that provides homes with a base level of funding for consistency while still allowing some flexibility for the fluctuating levels of care. Stable funding is required to ensure more full time, resident knowledgeable staff. Consistency in funding would go a long way to ensuring consistency of care.

We also feel that a system like the Minimum Data Set (MDS), while expensive and requiring computerization, if properly and sensitively implemented could assist with evidence-based decision making, increased accountability, patient-focused care and a better integration of systems. This new approach would allow for continually assessing the needs of a home above a basic funding level. The Ministry should review available evaluation reports on the current use of MDS in chronic care settings in the province and elsewhere to see if there are applicable benefits for the LTC setting and ensure that the proper consultation with stakeholders, who will be implementing and using the tool, are completed.

Finally, a facility's track record (past history of compliance, violations and performance record) must be considered in any future funding decisions, including bed allocations and bed transfers.

Conclusions

Over the last two and a half months, we have had the opportunity to visit over twenty homes and met with close to one hundred stakeholders and people active in the long-term care community. We have seen and read a great deal. It is our real hope that in writing this report and making these recommendations we can continue to support those homes that are doing a wonderful job of caring for our seniors and begin to address the concerns raised around those homes that are falling behind.

I hope that we can continue to work together with our partners to provide quality care for all of Ontario's seniors in LTC homes.

Appendix A

Facility Visits

Au Chateau, Sturgeon Falls

Barton Place, Toronto

Baycrest, North York

Bonnechere Manor, Renfrew

Cassellholme, North Bay

Centre D'Accueil Champlain, Vanier

Copernicus Lodge, Toronto

Derbecker's Heritage House, St. Jacobs

Drs. Paul and John Rekai Centre, Toronto

Dom Lipa Nursing Home, Etobicoke

Extendicare Starwood, Nepean

Extendicare West End Villa, Ottawa

Ewart Angus Home, Toronto

Ina Grafton-Gage Home, Toronto

Marianhill, Pembroke

North Renfrew Long-Term Care Centre, Deep River

Norwood Nursing Home, Toronto

St. Joseph's Health Centre, Guelph

Ukrainian Canadian Care Centre, Etobicoke

Versa-Care Centre of Brantford, Brantford

White Eagle Nursing Home, Toronto

Whitewater Bromley CHC, Beachburg

Yee Hong Centre – Scarborough McNicoll, Scarborough

Yorkview Lifecare Centre, North York

Appendix B

Facility Matrix

Facility & City	Ownership	Structural Classification	Culturally Specific	No. of Beds	Region / CCAC	Urban / Rural
Au Chateau, Sturgeon Falls	MHFA	C	Francophone	162	Near North CCAC (Nipissing)	rural
Barton Place, Toronto	NH for-profit	D		232	Toronto CCAC	urban
Baycrest Centre, Jewish HFA Centre for Stroke and Cognition, North York	NH non-profit	A	Jewish	100	North York CCAC	urban
Baycrest Centre, Jewish HFA, North York	CHFA	A	Jewish	372	North York CCAC	urban
Bonnechere Manor, Renfrew	MHFA	A		180	Renfrew County CCAC	rural
Cassellholme, North Bay	MHFA	B/C		240	Near North CCAC (Nipissing)	urban
Centre D'Accueil Champlain, Vanier	MHFA	A	Francophone	160	Ottawa-Carleton CCAC	urban
Copernicus Lodge, Toronto	CHFA	A	Polish	228	Toronto CCAC	urban
Derbecker's Heritage House, St. Jacobs	NH for-profit	C		72	CCAC of Waterloo Region	rural
Drs. Paul and John Rekai Centre, Toronto	NH non-profit	C		126	Toronto CCAC	urban
Dom Lipa Nursing Home, Etobicoke	NH non-profit	C/A	Slovenian	66	Etobicoke CCAC	urban
Extendicare Starwood, Nepean	NH for-profit	C		192	Ottawa-Carleton CCAC	urban
Extendicare West End Villa, Ottawa	NH for-profit	C		240	Ottawa-Carleton CCAC	urban
Ewart Angus Home, Toronto	Non-profit	n/a			Toronto	urban
Ina Grafton-Gage Home, Toronto	CHFA	D		110	East York Access Centre for Community Services	urban
Marianhill, Pembroke	CHFA	B		100	Renfrew County CCAC	rural
Marianhill Nursing Home, Pembroke	NH non-profit	B		31	Renfrew County CCAC	rural

North Renfrew Long-Term Care Centre, Deep River	CHFA	A		21	Renfrew County CCAC	rural
Norwood Nursing Home, Toronto	NH for-profit	C		60	Toronto CCAC	urban
St. Joseph's Health Centre, Guelph	CHFA	A		144	Wellington County CCAC	urban
Ukrainian Canadian Care Centre, Etobicoke	NH non-profit	A	Ukrainian	120	Etobicoke CCAC	urban
Versa-Care Centre of Brantford, Brantford	NH for-profit	C		79	Brant County CCAC	urban
White Eagle Nursing Home, Toronto	NH for-profit	B		56	Toronto CCAC	urban
Whitewater Bromley CHC, Beachburg	Non-profit	n/a		n/a	Eastern Ontario	rural
Yee Hong Centre – Scarborough McNicoll, Scarborough	NH non-profit	A	Chinese	155	Scarborough CCAC	urban
Yorkview Lifecare Centre, North York	NH for-profit	C		269	North York CCAC	urban

MHFA = Municipal Home for the Aged
CHFA = Charitable Home for the Aged
N/A = not available

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Appendix C

Stakeholder Consultations

Activity Professionals of Ontario (APO)
Advocacy Centre for the Elderly (ACE)
Alzheimer Society
Linda Baker, Family Council Member
Jean Benton, Nurse Practitioner, LTC home
Joe Brabant, Family Council Member
Kathleen Burnett, The Eden Alternative
Canada's Association for the Fifty-Plus (CARP)
Canadian Auto Workers (CAW) Canada
Janet Parcher Cherry, Family Council Member
College of Nurses of Ontario (CNO)
Concerned Friends of Ontario Citizens in Care Facilities
CUPE Ontario
Dietitians of Canada
Sheila Driscoll, MOHLTC Compliance Advisor
Family Council Project
Dr. Jess Goodman, Primary Health Care Transition Fund Project
Dr. Michael Gordon, VP of Medicine, Baycrest
Barbara Hall
Dr. John Hirdes, MDS, Health Studies and Gerontology, University of Waterloo
Theresa Hurd, Clinical Nurse Specialist, Gerontology
Angela Ieroullo, Family Council Member
Bonny Johnson, Nurse Practitioner
Dr. Janice Lessard, Geriatrician
Archbishop Wm. Lawson-Little
Sister Bonnie Maclellan, LTC Administrator (retired)
Alex Munter, University of Ottawa, Ottawa City Councilor (retired)
Nurse Practitioner Association of Ontario (NPAO)
Ontario Association of Community Care Access Centres
Ontario Association of Non-Profit Homes and Services for Seniors (OANHSS)
Ontario Association of Residents' Councils
Ontario Community Support Association
Ontario Health Coalition
Ontario Home Health Care Providers Association
Ontario Long-Term Care Association (OLTCA)
Ontario Nurses' Association (ONA)
Ontario Society of Nutrition Managers
Registered Nurses Association of Ontario (RNAO)
Registered Practical Nurses Association of Ontario (RPNAO)
Marilyn Rook, Exec.V.P. & Chief Operating Officer, Vancouver Island Health Authority
Royal Canadian Legion–Ontario Command
Heather Saar, Geriatric Mental Health Outreach Program
Schedule 5 Physiotherapy Association
Service Employees International Union
Dr. Cathy Shea, Geriatric Psychiatrist, Director of Community Outreach, Royal Ottawa Hospital
Dr. Patricia Spindel
Senior Peoples' Resources in North Toronto (SPRINT)
United Seniors of Ontario
Lynda Welch, RN, Colwel Consulting Inc., LTC Administrator (retired)

Appendix D

Your Opinion Counts

Dear Family Member/Friend;

Thank you for entrusting the care of your family member to the City of Toronto's Homes for the Aged.

Listening closely to our residents and their families is an established tradition with the Homes for the Aged. It is one of our most important measures of customer satisfaction. Through your comments, we become better at meeting our residents' needs. We always try to provide our residents with the care and service that they expect.

Thank you for completing this questionnaire. Your assistance is essential to the planning and ongoing evaluation of our programs.

In addition, should an issue arise at any time in the future, please feel free to contact the Home's Administrator directly.

Yours sincerely,

Sandra Pitters
General Manager
Homes for the Aged Division

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A. Your Satisfaction with our Care and Services

These questions are based on your experiences with the Home within the last 6 months. Please rate each statement on a 5-point scale, by circling the most appropriate number. If the statement is not applicable, please circle N/A.

1.	**Participation**	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a)	The Home provides sufficient opportunities for me to be involved in decisions related to my family member's care.	1	2	3	4	5	N/A
b)	I know whom to approach when I have a concern or problem.	1	2	3	4	5	N/A
c)	I am encouraged and/or asked to participate in in-Home activities.	1	2	3	4	5	N/A
d)	I am sufficiently informed regarding the range of activities available in the Home so that I can support my family member's involvement.	1	2	3	4	5	N/A
e)	I feel comfortable expressing my opinions and feelings about my family member's care.	1	2	3	4	5	N/A
f)	Information and questions regarding my family member's finances are dealt with efficiently.	1	2	3	4	5	N/A

Please comment: ____

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2.	**Personal Care and Service**	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a)	Staff respect my family member's personal and physical privacy.	1	2	3	4	5	N/A
b)	My family member is well cared for.	1	2	3	4	5	N/A
c)	Care is provided in a kind, friendly, and gentle manner.	1	2	3	4	5	N/A

A. Your Satisfaction with our Care and Services (Continued)

2. Personal Care and Service (Continued)	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
d) My family member is given the help that he/she requires to do the following:						
- eating	1	2	3	4	5	N/A
- bathing	1	2	3	4	5	N/A
- dressing	1	2	3	4	5	N/A
- going to the bathroom	1	2	3	4	5	N/A
e) Consideration is given to my family member's food preferences.	1	2	3	4	5	N/A
f) Staff work as a team to support my family member.	1	2	3	4	5	N/A

Please comment: ______________________________

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3. Communication	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a) Staff are readily available to answer questions and to discuss the care of my family member.	1	2	3	4	5	N/A
b) I am satisfied that my questions and concerns are answered and/or followed up.	1	2	3	4	5	N/A
c) I feel comfortable approaching staff about any issue or concern.	1	2	3	4	5	N/A
d) Staff are friendly, courteous, and helpful to me.	1	2	3	4	5	N/A
e) The Home keeps me informed about changes in my family member's status.	1	2	3	4	5	N/A

Please comment: ______________________________

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4. Advocacy

a) I am familiar with the Home's advocacy procedures. Yes ☐ No ☐

Appendix D cont'd

A. Your Satisfaction with our Care and Services (Continued)

4.	**Advocacy** (Continued)	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
b)	The Home's advocacy procedures are useful in responding to the needs and desires of residents.	1	2	3	4	5	N/A
c)	I have confidence that issues raised through the Home's advocacy process will be dealt with in a fair and timely manner.	1	2	3	4	5	N/A

Please comment: ____

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5.	**Living Environment**	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a)	The Home provides a homelike environment.	1	2	3	4	5	N/A
b)	There is space to sit and visit privately with my family member.	1	2	3	4	5	N/A
c)	I am encouraged to personalize my family member's room.	1	2	3	4	5	N/A
d)	The Home provides a safe environment for my family member.	1	2	3	4	5	N/A
e)	The outside grounds are easily accessible and stimulating.	1	2	3	4	5	N/A
f)	Personal laundry services meet my family member's needs.	1	2	3	4	5	N/A
g)	My family member's personal clothing is correctly labelled on a timely basis.	1	2	3	4	5	N/A
h)	The Home provides an enjoyable dining experience (ie. pleasant environment, service, quality of food) for my family member.	1	2	3	4	5	N/A

Please comment: ____

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A. Your Satisfaction with our Care and Services (Continued)

6.	**Quality of Life**	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a)	A community feeling exists in the Home.	1	2	3	4	5	N/A
b)	Staff, volunteers and others demonstrate a genuine concern about my family member's well-being.	1	2	3	4	5	N/A
c)	My family member is encouraged and assisted to maintain or improve his/her level of independence.	1	2	3	4	5	N/A
d)	There are opportunities for my family member to express his/her spiritual and cultural preferences.	1	2	3	4	5	N/A
e)	Staff treat my family member with respect.	1	2	3	4	5	N/A
f)	I would recommend the Home to others requiring long-term care.	1	2	3	4	5	N/A

Please comment: ____

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B. Your Overall Satisfaction

		Strongly Agree	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a)	Overall, I am satisfied with the quality of the care and service.	1	2	3	4	5	N/A
b)	Overall, I am satisfied that the Home is clean and well-maintained.	1	2	3	4	5	N/A

What is most important to you about care and service? ______________________

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Please advise where we exceeded your expectations: ______________________

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Appendix D cont'd

B. Your Overall Satisfaction (Continued)

Please advise where we did not meet your expectations: ___________________________________

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What would you like to see done in the Home to improve residents' quality of life?

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Is there anything we did not ask you about in this survey that you want to tell us about?

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Thank you for completing our questionnaire. Your input is essential for us to improve our service to better meet our residents' needs.

The survey results will be shared with your family member's Home. You may remain anonymous, if you wish. However, if you would like the Home to know how you personally responded to this survey, in order to assist us in addressing any specific concerns, please complete the following information:

Name: ____

Address: ____

____

Telephone: ____

Resident's Name: ____

☐ I would like the Home to contact me.

Thank you for your time – It will make a difference.

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Your Opinion Counts

Dear Resident;

Listening closely to our residents and their families is an established tradition with the Homes for the Aged. It is one of our most important measures of customer satisfaction. Through your comments, we become better at meeting our residents' needs. We always try to provide our residents with the care and service that they expect.

Thank you for completing this questionnaire. Your assistance is essential to the planning and ongoing evaluation of our programs.

In addition, should an issue arise at any time in the future, please feel free to contact the Home's Administrator directly.

Yours sincerely,

Sandra Pitters
General Manager
Homes for the Aged Division

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Appendix D cont'd

A. Your Satisfaction with our Care and Services

These questions are based on your experiences with the Home within the last 6 months. Please rate each statement on a 5-point scale, by circling the most appropriate number. If the statement is not applicable, please circle N/A.

1.	Participation	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Not Applicable
a)	The Home provides sufficient opportunities for me to influence decisions related to my care.	1	2	3	4	5	N/A
b)	I know whom to approach when I have a concern or problem.	1	2	3	4	5	N/A
c)	I am encouraged and/or asked to participate in in-Home activities.	1	2	3	4	5	N/A
d)	I am sufficiently informed regarding the range of activities available in the Home.	1	2	3	4	5	N/A
e)	I feel comfortable expressing my opinions and feelings about my care.	1	2	3	4	5	N/A
f)	Information and questions regarding my finances are dealt with efficiently.	1	2	3	4	5	N/A

Please comment: ____

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2.	Personal Care and Service	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Not Applicable
a)	Staff respect my personal and physical privacy.	1	2	3	4	5	N/A
b)	I am well cared for.	1	2	3	4	5	N/A
c)	Care is provided in a kind, friendly, and gentle manner.	1	2	3	4	5	N/A
d)	I am given the help that I require to do the following:						
	- eating	1	2	3	4	5	N/A
	- bathing	1	2	3	4	5	N/A
	- dressing	1	2	3	4	5	N/A
	- going to the bathroom	1	2	3	4	5	N/A

A. Your Satisfaction with our Care and Services (Continued)

2. Personal Care and Service (Continued)	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
e) The Home's dietary program provides:						
- consideration of my food preferences	1	2	3	4	5	N/A
- sufficient variety of food	1	2	3	4	5	N/A
- adequate portions	1	2	3	4	5	N/A
f) Staff work as a team to support me.	1	2	3	4	5	N/A

Please comment: ______________________________

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3. Communication	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a) Staff are readily available to answer questions and to discuss my care.	1	2	3	4	5	N/A
b) I am satisfied that my questions and concerns are answered and/or followed up.	1	2	3	4	5	N/A
c) I feel comfortable approaching staff about any issue or concern.	1	2	3	4	5	N/A
d) Staff are friendly, courteous, and helpful to me.	1	2	3	4	5	N/A
e) Staff communicate effectively with me about matters affecting my life in the Home.	1	2	3	4	5	N/A

Please comment: ______________________________

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4. Advocacy

a) I am familiar with the Home's advocacy procedures. Yes ☐ No ☐

Appendix D cont'd

A. Your Satisfaction with our Care and Services (Continued)

4. **Advocacy** (Continued)	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Not Applicable
b) The Home's advocacy procedures are useful in responding to the needs and desires of residents.	1	2	3	4	5	N/A
c) I have confidence that issues raised through the Home's advocacy process will be dealt with in a fair and timely manner.	1	2	3	4	5	N/A

Please comment: ______________________________

____

____

____

5. **Living Environment**	Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	Not Applicable
a) The Home provides a homelike environment.	1	2	3	4	5	N/A
b) There is space to sit and visit privately with my visitors.	1	2	3	4	5	N/A
c) I am encouraged to personalize my room.	1	2	3	4	5	N/A
d) The Home provides a safe environment for me and my visitors.	1	2	3	4	5	N/A
e) The outside grounds are easily accessible and stimulating.	1	2	3	4	5	N/A
f) Personal laundry services meet my needs.	1	2	3	4	5	N/A
g) My personal clothing is correctly labelled on a timely basis.	1	2	3	4	5	N/A
h) The Home provides an enjoyable dining experience (ie. pleasant environment, service, quality of food).	1	2	3	4	5	N/A

Please comment: ______________________________

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A. Your Satisfaction with our Care and Services (Continued)

6. **Quality of Life**	**Strongly Agree**	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a) A community feeling exists in the Home.	1	2	3	4	5	N/A
b) Staff, volunteers and others demonstrate a genuine concern about my well-being.	1	2	3	4	5	N/A
c) I am encouraged and assisted to maintain or improve my level of independence.	1	2	3	4	5	N/A
d) There are opportunities for me to express my spiritual and cultural preferences.	1	2	3	4	5	N/A
e) Staff treat me with respect.	1	2	3	4	5	N/A
f) I would recommend the Home to others requiring long-term care.	1	2	3	4	5	N/A

Please comment: ____

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B. Your Overall Satisfaction

	Strongly Agree	**Agree**	**No Opinion**	**Disagree**	**Strongly Disagree**	**Not Applicable**
a) Overall, I am satisfied with the quality of the care and service.	1	2	3	4	5	N/A
b) Overall, I am satisfied that the Home is clean and well-maintained.	1	2	3	4	5	N/A

What is most important to you about care and service? ______________________________

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Please advise where we exceeded your expectations: ______________________________

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Appendix D cont'd

B. Your Overall Satisfaction (Continued)

Please advise where we did not meet your expectations: ______________________________

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____

What would you like to see done in the Home to improve residents' quality of life?

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Is there anything we did not ask you about in this survey that you want to tell us about?

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Thank you for completing our questionnaire. Your input is essential for us to improve our service to better meet our residents' needs.

The survey results will be shared with your Home. You may remain anonymous, if you wish. However, if you would like the Home to know how you personally responded to this survey, in order to assist us in addressing any specific concerns, please complete the following information:

Name: ______________________________

Address: ______________________________

____

Telephone: ______________________________

☐ I would like the Home to contact me.

Thank you for your time – It will make a difference.

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LONG TERM CARE FACILITIES

CHECKLIST

Concerned Friends is a non-profit, volunteer, consumer corporation and registered charity dedicated to reform of the long-term care system and improvement of quality of life for residents.

Concerned Friends of Ontario Citizens in Care Facilities

140 Merton St., 2nd Floor, Toronto, Ontario M4S 1A1 (416) 489-0146

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LONG-TERM CARE FACILITIES CHECKLIST

The Purpose of this checklist is primarily to assist anyone who is choosing a Long-Term Care Facility.

Before assuming that a Long-Term Care Facility is the "best place" to be, however, inquire about alternative services such as Home Care, Home Support, and Supportive Housing.

If you do opt for a provincially regulated long-term care facility, here are some preliminary steps to take before making a choice:

X Obtain a list of facilities from your local Community Care Access Centre.

X Examine facilities closely before agreeing to the admission of oneself, a relative or a friend.

X Resist pressure from either hospitals or the placement coordinator to admit someone to the first available bed. Take the time to thoroughly investigate the options.

X Determine from the Placement Co-ordinator whether a facility being recommended is "under enforcement". The Co-ordinator is required to explain this concept to you, as it reflects the current conditions in the facility.

GENERAL INFORMATION

X Nursing Homes, Municipal Homes and Charitable Homes are formally subject to their own separate provincial legislation and regulations. However, they are all accountable to the Ministry of Health and Long Term Care. **Bill 101** (An Act to Amend Certain Acts Concerning Long-Term Care), passed in June 1993, amended the Nursing Homes Act, and the Charitable and Municipal Homes for the Aged Acts. This Act sets out both the rights of the residents and the responsibilities of the facility. Copies can be obtained from **Publications Ontario, 880 Bay Street, Toronto, Ontario, M7A 1N8 Telephone (416) 326-5300 or toll-free 1-800-668-9938.** It is also available at most public libraries in the reference section.

X **The Ministry of Health and Long Term Care** is responsible for monitoring, evaluating and taking action to ensure that all long-term care facilities comply with the applicable acts and regulations, the terms and conditions of the service agreement, the Program Manual, and Ministry policies and directives. The **Program Manual** sets out the standards and guidelines for the day-to-day operation of the facility. **Compliance advisors** have the primary responsibility for monitoring and evaluating facilities' performance. A resident, family member or advocate who is concerned about the care or conditions in a facility and has been unsuccessful in resolving the problem with the facility, should contact the regional office to make a complaint to the Compliance Advisor. Concerned Friends will also try to advise and support anyone having problems in a long-term care facility.

X It is advisable to receive legal advice regarding the Admission Contract to the Long-Term Care Facility. In particular, check that you are not signing away rights and services that would be covered under **Bill 101**. You are not at present obligated to sign a contract, because without doing so, the provisions of the Bill apply. Only sign the contract if it **ENHANCES** your rights, not if it **DIMINISHES** them.

INITIAL VISIT TO FACILITY

X Meet with the Administrator and, if possible, the Director of Care Planning.

X Obtain written and verbal information about the facility using the attached questionnaire (see page 3)

X Request copies of:
1) Admission Contract
2) Compliance Review Report
4) Residents' Bill of Rights

Numbers 2-4 are posted in a prominent public area of the facility, and are also available from your regional long-term care office.

X Attempt to talk with families of existing residents either in the facility or arrange to meet them off the premises for feedback on their experiences and observations.

Appendix E cont'd

Important Phone Numbers

Ministry of Health and Long-Term Care
General Inquiry 1-800-268-1153 TTY 1-800-387-5559
Long-term Care Hot Line 1-866-434-0144

Regional Offices

Southwest

For the counties of Bruce, Chatham-Kent, Elgin, Essex, Grey, Huron, Lambton, Middlesex, Oxford, Perth

South West Regional Office
231 Dundas St., Ste. 201
London, ON N6A 1H1
Tel: 519-675-7680 Fax: 519-675-7685
1-800-663-3775

Windsor Workstation
215 Eugenie St., W. Ste. 300
Windsor, ON N8X 2X7
Tel: 519-250-0788 Fax: 519-973-1360
1-800-663-3775

Central West

For the counties of Dufferin, Halton, Peel, Waterloo, Wellington

Central West Regional Office
201 City Centre Dr., Ste. 301
Mississauga, ON L5B 2I4
Tel: 905-897-4610 Fax: 905-275-2740
1-866-716-4446

Central South

For the counties of Brant, Haldimand-Norfolk, Hamilton-Wentworth, Niagara

Central South Regional Office
119 King St., W. 11th fl.
Hamilton, ON L8P 4Y7
Tel: 905-546-8294 Fax: 905-546-8255
1-866-716-4446

Central East

For the counties of Durham, Haliburton, Northumberland, Peterborough, Simcoe, Victoria, York

Central East Regional Office
465 Davis Dr., 3rd fl.
Newmarket, ON L3Y 8T2
Tel: 905-954-4700 or 1-800-486-4935
Fax: 905-954-4702

East

For the counties of Frontenac, Kingston, Hastings, Lanark, Leeds and Grenville, Lennox, and Addington, Ottawa-Carlton, Prescott and Russell, Prince Edward, Renfrew, Stormont, Dundas and Glengarry

East Regional Office
47 Clarence St., Ste. 310
Ottawa, ON K1N 9K1
Tel: 613-241-4263 Fax: 613-241-9312
1-800-267-8588

Kingston Workstation
23 Beechgrove Lane, 1st fl.
Kingston, ON K7M 9A6
Tel: 613-536-7230 Fax: 613-536-7231
1-800-667-1062

North

For the counties of Algoma, Cochrane, Kenora, Muskoka, Nipissing, Parry Sound, Rainy River, Sudbury, Manitoulin, Thunder Bay, Timiskaming

North Regional Office
159 Cedar St., Ste. 406
Sudbury, ON P3E 6A5
Tel: 705-564-3137 or 1-800-663-6965
Fax: 705-564-3133

Thunder Bay Workstation
189 Red River Rd., Ste. 403
Thunder Bay, ON P7B 1A2
Tel: 807-343-7631 or 1-800-663-6965
Fax: 807-343-7567

Toronto

Toronto Regional Office
55 St. Clair Ave. W., 8th fl.
Toronto, ON M4V 2Y7
Tel: 416-327-8952 or 1-800-595-9394
Fax: 416-327-4486

Questionnaire

The following is a list of questions that will assist you in choosing a Long-Term Care facility. Most deal with rights legislated in Bill 101, but the questions will clarify these rights for both you and the facility.

Upon your initial visit, you may find it helpful to take the questionnaire with you and also a list of your own questions to ask the administrator.

Be sure to take notes of what you learn on your visit.

1. What is the application procedure?
2. What are the accommodation fee co-payments?
3. What services are included in the fees, e.g. personal supplies?
4. For what services is the resident / family responsible?
5. How and when are residents / families notified of a change in fees / service?
6. What is the facility's policy on restraints and medication?
7. What is the facility's policy on cardiopulmonary resuscitation?
   (It is not necessary to sign a DNR form on admission).
8. Can you continue receiving care from your family doctor after admission to the facility?
9. Is the staff physician a geriatrician?
10. Is a physician on call 24 hours a day?
11. Are the physicians and / or medical director available to take calls from families?
12. Is the staff physician willing to spend time talking to family members regarding medical care of their family member?
13. Are special needs and preferences recognized by the facility?
    For example, do residents have a choice of showering or bathing?
    Do residents have the option of having breakfast in their robes?
14. If English is not the resident's first language, will an Interpreter be available when necessary?
15. Inquire about residents' assessments and care plans:
    a) How often do case conferences occur?
    b) Are residents and representatives (substitute decision makers) involved in the case conferences?
    c) Are the assessment information and care plans available to residents and family (or substitute decision makers)?
       How often are the care plan review meetings?
16. Is there free access to the facility?
    At what times?
    Are people, for example, volunteers, encouraged to visit?
17. Is there a volunteer program in the facility?

18. Are pastors, rabbis and priests encouraged to visit?
19. Are married couples housed together?
20. Are physiotherapy, speech therapy, occupational therapy, bladder and bowel training available? Who arranges for these?
21. Are staff trained to work with the visually impaired and hearing impaired residents?
22. Are dentists and dental hygienists available to provide dental care? Who arranges for this?
23. Are community social work services available at the resident's request?
24. How many residents live in the facility?
25. How many floors are there?
26. How many elevators are there?
27. Are there regular fire drills for all staff (including part-time)?
28. Does the local fire inspector make regular visits?

You may have a list of your own questions to ask.

Nursing Home Checklist

Following your initial visit, review all the material given to you. Make arrangements for an informal visit. Before going for your second visit, review the Long-Term Care Facility Checklist provided below.

Name of Facility: ______________________

Address: ______________________

Date of Visit: ______________ Time: ______________

Care of residents

	Care of residents	Yes	No
1.	Resident are clean. (nails, hair, skin, teeth)	☐	☐
2.	Residents receive proper mouth care. (breath smells fresh, mouth clean)	☐	☐
3.	Residents are free from odour.	☐	☐
4.	Residents are properly dressed.	☐	☐
	a) Residents are wearing clothing which is clean and in good repair.	☐	☐
	b) Residents' clothing fits and is done up.	☐	☐
	c) Residents are wearing shoes and stockings which fit and match.	☐	☐
5.	Residents are wearing daytime apparel in the day, and night-time apparel at night.	☐	☐
6.	Residents appear well groomed. (Men are shaved; residents have clean hair, cut and trimmed.)	☐	☐
7.	Residents are dry and not soiled.	☐	☐
8.	Residents seem to be properly fed. (not too thin and frail)	☐	☐
9.	Residents are receiving sufficient fluids at meal times and with all snacks.	☐	☐
10.	Residents speak freely and openly with visitors. (They do not appear frightened or intimidated.)	☐	☐
11.	Residents are free from restraints. (Restraints include chairs with trays, bed sheets and jacket restraints.)	☐	☐
12.	Staff help residents change their positions in chairs or beds regularly. (Residents are not left slumped over or sliding from chairs.)	☐	☐
13.	Residents are awake and not in bed mid-day.	☐	☐
14.	Residents appear alert.	☐	☐

	Yes	No
15. Residents' eyes are clear; speech is not slurred. (Eyes are not blurry or "far away" which might signal overmedication.)	☐	☐
16. Residents are free from decubitus ulcers. (bedsores)	☐	☐
17. Residents' feet, ankles and legs are free from swelling and ulcerations; or, if swollen, are properly elevated.	☐	☐
18. Residents are free from evidence of injury (bruising, swelling, lacerations, stitches, casts, etc.)	☐	☐

Staff

	Yes	No
1. Sufficient staff are in evidence at nursing stations and on the floor.	☐	☐
2. Staff seem to be properly trained and address residents' needs in a caring and professional manner.	☐	☐
3. Staff smile, appear cheerful and show a caring attitude towards residents.	☐	☐
4. Staff treat residents, family and other staff with courtesy, dignity, and respect.	☐	☐
5. Staff are well groomed.	☐	☐
6. Staff are willing to answer questions and discuss needs of residents with family members.	☐	☐

General Surroundings

	Yes	No
1. There is plenty of room for residents; the home is not overcrowded.	☐	☐
2. The facility is totally accessible to wheelchairs. (wide corridors and doors, ground level access, specially designed bathrooms)	☐	☐
3. There are enough elevators. (Residents don't have to line up for a long time to go to and from the dining room.)	☐	☐
4. Floors and walls are clean, in good repair, and the decor is cheerful.	☐	☐
5. The home looks and smells clean.	☐	☐
6. The home is free of evidence of cockroaches and rodents.	☐	☐
7. There are bright, pleasant lounge areas.	☐	☐
8. There is soft, pleasant music or activity in lounge areas.	☐	☐
9. Confused residents have safe areas in which to wander both inside and outside the home.	☐	☐

		Yes	No
10.	Residents have access to attractive outdoor surroundings with areas to sit or walk.	☐	☐
11.	There are private areas for residents and visitors.	☐	☐
12.	Other visitors are in evidence.	☐	☐
13.	There is coffee, tea and juice available for residents and visitors.	☐	☐
14.	Residents' rooms are bright and home-like, with personal belongings in evidence.	☐	☐
15.	Residents can control heat and light in their bedrooms.	☐	☐
16.	Beds and mattresses are comfortable and not too close together.	☐	☐
17.	There is a call bell at each bed and within easy reach of resident.	☐	☐
18.	There is an easy chair for every resident in each bedroom.	☐	☐
19.	Closets in bedrooms are spacious and easily accessible to resident.	☐	☐
20.	Some residents have phones, radios, and television in their rooms.	☐	☐
21.	There are a sufficient number of washrooms for residents.	☐	☐
22.	Bathrooms are clean and odour free.	☐	☐
23.	Bathing areas are clean and in good repair; tiles are not chipped.	☐	☐
24.	There is sufficient clean linen and towels for residents' use.	☐	☐
25.	Wheelchairs, trays and other equipment are clean and in good condition.	☐	☐
26.	The home has the Residents' Bill of Rights, Compliance Review Report, financial report, and any follow-up reports, posted for public viewing in a conspicuous place.	☐	☐
27.	Staff converse pleasantly with residents and visitors.	☐	☐
28.	Residents' privacy is respected. (Staff knock before they enter and leave when visitors arrive. Privacy curtains are used appropriately and in good condition.)	☐	☐
29.	Residents feel secure and do not appear to fear harm by staff or other residents, or theft of their belongings.	☐	☐
30.	There is an active residents' council.	☐	☐
31.	There is an active, independently run Family Council.	☐	☐

Rehabilitation / Restorative Care

	Rehabilitation / Restorative Care	Yes	No
1.	Age appropriate activity programs are in evidence (e.g. bridge games, poker, gardening, chess, woodworking, ceramics, painting, music, etc.)	☐	☐
2.	Individual orientation programs are in evidence for confused residents.	☐	☐
3.	There are exercise programs for residents.	☐	☐
4.	The majority of residents seem busy and occupied in a meaningful activity during the day.	☐	☐
5.	There is a tuck shop.	☐	☐
6.	The home has a library or visiting library service.	☐	☐
7.	Organized activities are posted for month.	☐	☐

Dietary

	Dietary	Yes	No
1.	Snacks are served between meals and choices of beverages and snacks are available.	☐	☐
2.	Meals appear appetizing and attractive.	☐	☐
3.	Family members are welcome to join the resident at meal time.	☐	☐
4.	Meals can be eaten by residents. (For example, food is chopped, if necessary.)	☐	☐
5.	There are sufficient staff available to assist residents with eating when necessary.	☐	☐
6.	Food meets any therapeutic needs residents may have (e.g. diabetic, salt free, chopped, pureed).	☐	☐
7.	Food seems to be good nutritional value.	☐	☐
8.	Fresh fruit and vegetables served, and there is adequate fibre.	☐	☐
9.	Portions are large enough and residents are offered second helpings.	☐	☐
10.	Residents do not appear hungry and do not indicate that they are hungry or thirsty when asked.	☐	☐
11.	Juices are served in 6-ounce glasses rather than 4-ounce glasses and water is offered between snacks.	☐	☐
12.	Residents are encourage to eat and drink.	☐	☐
13.	Aides sit to assist residents with eating rather than standing over them.	☐	☐
14.	Residents are fed individually, not in assembly-line fashion.	☐	☐

		Yes	No
15.	Dietary staff respect residents' individual eating habits. That is, clean up after meals is not rushed.	☐	☐
16.	Residents are not segregated at meal time according to individual diets (e.g. puree, diabetic, etc).	☐	☐
17.	Menus are displayed in clear view, on all floors and offer an alternative choice.	☐	☐
18.	Staff oversee residents as they eat, whether in dining room, own room or corridors.	☐	☐
19.	Dining room is attractive, pleasant and appropriately decorated.	☐	☐

Scoring

To score this checklist, count one for every "yes" answer.

71 to 80	very well operated facility
61 to 70	has reasonable amenities for residents
below 61	facility should not be considered

Endnotes

[1] See Canadian Policy Research Network (CPRN) report by Family Network Director Jane Jenson entitled *Catching Up to Reality: Building the Case for a New Social Model*, 2004.

[2] See Canadian Policy Research Network (CPRN) report cited above.

[3] Levels of Care data show that 9,358 (16%) of LTC residents have a clinical diagnosis of depression, 15% of whom experience a duration longer than six months (MOHLTC data).

[4] For example, one Ottawa home has a prominently placed 6'x 4' bulletin board dedicated to *Managing Resident / Family Concerns* (with a complaint process flowchart). A second "promoting wellness" board lists many community resources. Both were Family Council initiatives.

[5] The Eden Alternative is a philosophy of care developed by American physician Dr. Bill Thomas to combat the three plagues of loneliness, helplessness and boredom among seniors. Developed in the early 1990s, the ten principles for an Elder-centered community involve moving away from a medical model to ensuring a "human habitat" and "a life worth living." The model strives to change views and values around aging. (www.edenalt.com)

[6] Ewart Angus Home in Toronto espouses a "social model of care."

[7] The palliative care room could also be used by the roommate in recognition that the dying resident may wish to stay in his / her room and be cared for by familiar / their regular staff members.

[8] For example, the Canadian Evaluation Society; various departments in Ontario colleges and universities.

[9] This information needs to be provided in a language that is understandable to the average family member and respects minimal literacy standards and language barriers.

[10] For example, they may consider standard form contracts for admissions to all LTC homes if they feel seniors are vulnerable to current unnecessary procedures.

[11] See *2002 Annual Report of the Provincial Auditor of Ontario*, Long-Term Care Facilities Activity, page 118.

[12] The Centre D'Accueil Champlain home in Vanier audited their Activities for a year and posted a public report.

[13] See Auditor's Report above, page 117.

[14] The Administrator's presence would not be required.

[15] The Ontario Nurse Practitioner in Long-Term Care Facilities Pilot Project, *Interim Evaluation Final Report*, February 2002.

[16] See *Long-Term Care Facility System Analysis: One Year Review* from the Long-Term Care Redevelopment Project, MOHLTC, January 2004, pages 2, 6 and 8.

[17] See above, page 6.

[18] See 2002 Auditor's Report, page 118.

[19] See "Long-Term Care in the Information Age: The Potential of MDS" by John Hirdes, *Excellence in Long-Term Care*, February / May 2000, pages 14-17.

Notes:

Notes:

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