Spring 2009

Residential Care Health and Safety Guidelines

BC CARE PROVIDERS ASSOCIATION

Establishing guidelines for health and safety based on workload measurement will provide our members with an important tool they can use to make placement decisions that put health and safety first. This resident safety grid will match staffing levels to standards of care and be a transparent tool that facilities can use to monitor the quality of care that residents receive.

—Ed Helfrich, CEO
BC Care Providers Association

Contents

About Us

The BC Care Providers Association is comprised of independently owned organizations that provide quality community care and services to seniors in British Columbia:

- advocating on industry issues such as appropriate legislation, policy and funding
- promoting the provision of quality care through the adoption of recognized standards
- enhancing the profile of its members as providers of high quality, cost effective care and services to seniors
- serving as a credible voice on behalf of the industry
- facilitating timely communications and networking opportunities
- responding effectively to important issues affecting our industry as they arise

Introduction

These health and safety guidelines are created to better protect residents and staff at senior's care facilities across the province. They are easy to use, originally developed by the BC Ministry of Health and are compatible with the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI) tools currently being used at many BC care facilities.

Over the past 10 years, they have been implemented randomly at various facilities across the province – with success. In addition to helping facilities ensure adequate staff is in place to achieve acceptable standards of care, the guidelines will allow facilities to evaluate the increased workload of new referrals and determine whether or not they are able to accept complex cases.

Over the past year, the Auditor General and the BC Ombudsman have launched independent reviews to examine the delivery of residential care and service to the fragile elderly. These speak to the seriousness of the current senior's care crisis.

And, while there are some positive opportunities regarding employment training and construction of senior's housing in the recent BC Budget, it did not respond to the most urgent need in the residential care system – funding to increase staffing levels.

Going forward, it is important to understand and appreciate the legal and ethical responsibilities that apply to resident service providers.

BC's Adult Care Regulations require a facility to ensure accommodation only to those persons for whom safe and adequate care can be provided. Due to lack of funding for staff, more and more of our members are being forced to choose between providing barely enough care and refusing new admissions to protect staff and current residents.

Despite the fact all BC facilities are required to provide the same level of care, facility funding ranges from $110 -$240/resident/day depending on where you are in the province. Staffing levels within BC senior's care facilities vary from 2 hours of direct care/patient/day to 3.2 hours. Recent figures suggest the average ratio in the Fraser Health region is just under 2.3.

BC Health Authorities have adopted 2.8 hours as their benchmark staffing level for new builds projects despite the fact they have not provided funding to existing providers to move up to this staffing level.

Research shows that the level of staffing in a care facility has a direct correlation with positive outcome measures and quality care. A facility with six care aides/shift cannot provide comparable care to a similar site with 10 care aides/shift.

Our goal has to be to raise the level of staffing for a consistent standard in all facilities – not just a few.

These proposed measures reflect the input received from the Association's members and health stakeholders in a series of workshops that took place across the province in March 2009.

2008 AUDITOR GENERAL REPORT

The Auditor General's October 2008 report concluded that the Ministry of Health Services is not adequately fulfilling its stewardship role in helping to ensure that the home and community care system has the capacity to meet the needs of the population.

BC OMBUDSMAN REVIEW

The BC Ombudsman is currently conducting a systematic review of services to seniors who reside in care. Her report is expected in the coming months and our Association has pledged to work with her 100%. Recent media reports suggest the Ombudsman has been "overwhelmed" by the number of people that have contacted her about this issue.

ACTION PLAN

The BC Care Providers Association has developed a comprehensive Action Plan to improve the quality of senior's care across the province. The plan established three goals:

- set a 3.2 hour minimum staffing ratio at BC care facilities
- establish a standardized province-wide contract and funding model
- funding to match the costs associated with delivering complex care

These goals reflect the priorities described by our Association's membership.

Background

In 2002, new policy direction was given by the Ministry of Health to recognize complex care as well as assisted living. The five regional health authorities and the Ministries of Health and Housing developed a public policy framework that supported the provision of funded complex care and assisted living services to fragile elderly residents in BC.

Effective April 15, 2002, policy 6.B.4 of the Home and Community Care policy manual was changed to recognize complex care. A summary of the complex care groupings is outlined in the table below:

GROUP	CARE REQUIREMENTS SUMMARY
A	Residents with severe behavioural problems, destructive, aggressive, violent. May or may not be independently mobile.
B	Cognitively impaired, socially appropriate. Unable to communicate needs, requires directional assistance and/ or requires total care with ADLs. Requires a secure environment for safety. May or may not be independently mobile.
C	Cognitive impaired, socially inappropriate, anti-social behaviours. Unable to communicate needs, requires total care with ADLs. Requires a secure environment for self protection.
D	Physically dependent and cognitively intact with medical needs requiring professional nursing for monitoring or medical intervention. Requires a planned care program. Unable to use wheelchair independently. Requires paraprofessional interventions.
E	Clinically complex requiring professional nursing, monitoring and skilled intervention. May be re-ambulation, hospice/ palliative, medical sub acute (high needs).

The policy was supported by the promulgation of the Community Care and Assisted Living Act, **SBC 2002**, **c.75**, as well as the Community Care and Assisted Living Regulation, **BC Reg. 218/04**, as amended by **Reg. 6/06**.

The *Community Care and Assisted Living Act* specifies:

> **Standards to be maintained**
> **7(1)** A licensee must do all of the following:
> **(b)** operate the community care facility in a manner that will promote the health, safety and dignity of persons in care;

The Adult Care Regulation specifies:

> **Care and Supervision**
>
> **6.10** A licensee must provide to all persons in care a level of care and supervision that, in the opinion of the medical health officer, is appropriate to meet the needs of the persons in care.

The Adult Care Regulation also states (**4.1.1**) that the "licencee must establish and follow an admission screening procedure that ensures accommodation only to those persons for whom safe and adequate care can be provided and takes into consideration:

- staffing
- community care facility design, construction and equipment
- the health, safety and well-being of other persons in care
- any criteria set by the funding program

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Overview: Resident Care Safety Grid

Out of abundance of caution, and to ensure that licensed residential care operators meet their legislative and regulatory obligations, the BCCPA has developed a Resident Care Safety Grid to provide care managers with a tool to ensure safe care can be delivered to a resident prior to admission.

The proposals are easy to use and based on workload management models developed by the BC Ministry of Health. They have been successfully implemented at various locations across the province over the past 10 years and are 100% compatible with provincial MDS system.

- 2 hours of care/resident/day
- 2.5 hours of care/resident/day
- 2.8 hours of care/resident/day
- 3 hours of care/resident/day
- 3.2 hours of care /resident/day

In addition to creating resident safety profiles and complimenting MDS, the proposed guidelines:

- reinforce the need for 3.2 hours of care/resident/day as preferred standard of quality care & 2.8 hours of direct care/resident/day as baseline standard
- adopt BC's complex care groupings & Cognitive Performance Scale/ Global Deterioration Scale to measure cognition
- limit new admissions in the two more complex care groupings "A" and "E" unless the facility is fully staffed
- do not include therapists, dieticians, recreation or considerations for the facility's size or layout
- are based on a 75 bed facility

The Safety Grid encompasses assessments according to four scales:

1. The previous Home and Community Care Assessment scale (IC1, IC2, IC3, EC) developed by the Continuing Care Division of the Ministry of Health
2. The current Complex Care Groupings (A,B,C,D,E) implemented effective April 15, 2002 in policy 6.B.4 of the Home and Continuing Care Policy Manual of the Ministry of Health
3. The Workload Measurement Tool which assigns a time measure to care functions and care needs, and which was earlier developed by the Continuing Care Division of the Ministry of Health
4. The Global Deterioration Scale which is widely used in BC to summarize whether an individual has cognitive impairments consistent with dementia

The safety grid applies workload measurements to seven specific care factors:

1. Feeding & Hydration
2. Elimination
3. Hygiene & Dressing
4. Ambulation & Transfer
5. Leisure, Activities, Portering & Support
6. Special Requirements
7. Indirect Care

Category 1
2 hours of care/resident/day

- Complex Care Grouping: N/A
- Global Deterioration Scale: 1-3
- Workload: 160-175 measures/resident (Based on 75 bed facility)

1 care aide for every 12.5 residents

CARE FACTORS

1

Feeding & Hydration:

Independent

(101) – 12 measures

2

Elimination:

Requires routine toileting with minor assistance & occasional supervision

(202) – 18 measures

3

Hygiene, Dressing, Grooming:

Requires partial assistance & supervision

(302) – 24 measures

Requires afternoon rest

(304) – 6 measures

4

Ambulation & Transfer:

Requires total assistance with wheelchair

(402) – 18 measures

Requires mechanical assistance to/from dining room door but walks with staff assistance from dining room to table and return

(405) – 12 measures

Requires one staff manual transfer

(406) – 11 measures

5

Leisure activities, Portering, Support:

Daily exercises

(501) – 6 measures

Creative Arts

(502) – 1 measure

Group Therapy

(503) – 2.9 measures

Community/family integration

(504) – 6 measures

6

Special requirements:

Routine medications

(601) – 9 measures

Requires use of special adaptive/supportive device or equipment

(608) – 6 measures

7

Indirect care:

Care planning, MDS, conferences, medication management, family support

36 measures

SUMMARY

2.0 hours of care/day
× 75 residents

150 hours/day

150 hours/day
@ 7.5 hours

20 professional /non professional staff required/ per day

- 1 care aide can manage 2200 measures workload/shift
- 6 care aides can manage 13,200 measures workload/ shift (2,200 X 6)
- 13,200 measures @ 75 residents = 176 measures/ resident or 12.5 residents/care aid/shift)

Category 2
2.5 hours of care/resident/day

- Complex Care Grouping: B
- Global Deterioration Scale: 4
- Workload: 220-270 measures/resident (Based on 75 bed facility)

1 care aide for every 8.8 residents

CARE FACTORS

1

Feeding & Hydration:

Requires minor assistance and occasional supervision

(102) – 18 measures

2

Elimination:

Requires constant supervision and/ or resists care

(203) – 36 measures

3

Hygiene, Dressing, Grooming:

Requires total assistance or resists care, requires PM rest

(303) – 36 measures

4

Ambulation & Transfer:

Requires total assistance with wheelchair

(402) – 18 measures

Requires transfer by mechanical lift 4 times/day

(409) – 64 measures

Requires special positioning and turning in bed

(411) – 3.5 measures

5

Leisure activities, Portering, Support:

Daily exercises

(501) – 6 measures

Creative Arts

(502) – 1 measure

Group Therapy

(503) – 2.9 measures

Community/family integration

(504) – 6 measures

Value belief

(505) – 3 measures

6

Special requirements:

Routine medications

(601) – 9 measures

Injectable medications like insulin

(602) – 6 measures

Specimen collection

(607) – 6 measures

Requires use of special adaptive/supportive device or equipment

(608) – 6 measures

7

Indirect care:

Care planning, MDS, conferences, medication management, family support

– 36 measures

SUMMARY

2.5 hours of care/day
× 75 residents

187.5 hours/day

187.5 hours/day
@ 7.5 hours

25 professional /non professional staff required/ per day

- 1 care aide can manage 2200 measures workload/shift
- 8.5 care aides can manage 18,700 measures workload/ shift (2,200 X 8.5)
- 18,700 measures @ 75 residents = 249 measures/ resident or 8.8 residents/care aid/shift)

Category 3
2.8 hours of care/resident/day

- Complex Care Grouping: B
- Global Deterioration Scale: 4-5
- Workload: 270-300 measures /resident (Based on 75 bed facility)

1 care aide for every 7.8 residents

CARE FACTORS

1	2	3
Feeding & Hydration:	**Elimination:**	**Hygiene, Dressing, Grooming:**
Requires major assistance and constant supervision or resists care	Incontinent - urine	Requires total assistance or resists care
(103) – 30 measures	(205) – 18 measures	(303) – 36 measures
	Incontinent – feces	Requires PM rest
	(206) – 18 measures	(304) – 6 measures

4	5	6	7
Ambulation & Transfer:	**Leisure activities, Portering, Support:**	**Special requirements:**	**Indirect care:**
Requires total assistance with wheelchair	Daily exercises	Routine medications	Care planning, MDS, conferences, medication management, family support
(402) – 18 measures	(501) – 6 measures	(601) – 9 measures	– 36 measures
Requires transfer by mechanical lift 4 times/day	Creative Arts	Specimen collection	
(409) – 64 measures	(502) – 1 measure	(607) – 6 measures	
	Group Therapy	Requires use of special adaptive/supportive device or equipment	
	(503) – 2.9 measures	(608) – 6 measures	
	Community/family integration	Therapeutic communication	
	(504) – 6 measures	(611) – 30 measures	
	Value belief		
	(505) – 3 measures		

SUMMARY

2.8 hours of care/day
× 75 residents
210 hours/day

210 hours/day
@ 7.5 hours
28 professional /non professional staff required/ per day

- 1 care aide can manage 2200 measures workload/shift
- 9.5 care aides can manage 20,900 measures workload/ shift (2,200 X 9.5)
- 20,900 measures @ 75 residents = 278 measures/ resident or 7.8 residents/care aid/shift)

Category 4
3 hours of care/resident/day

- Complex Care Grouping: C
- Global Deterioration Scale: 5-7
- Workload: 300+ measures /resident (Based on 75 bed facility)

1 care aide for every 7.1 residents

CARE FACTORS

1	2	3
Feeding & Hydration:	**Elimination:**	**Hygiene, Dressing, Grooming:**
Requires major assistance and constant supervision or resists care	Requires routine toileting with major assistance and occasional supervision	Requires total assistance or resists care
(103) – 30 measures	(203) – 36 measures	(303) – 36 measures
		Requires PM rest
		(304) – 6 measures

4	5	6	7
Ambulation & Transfer:	**Leisure activities, Portering, Support:**	**Special requirements:**	**Indirect care:**
Requires total assistance with wheelchair	Group Therapy	Routine medications	Care planning, MDS, conferences, medication management, family support
(402) – 18 measures	(503) – 5.8 measures	(601) – 18 measures	– 36 measures
Requires transfer by mechanical lift 4 times/day		Elopement and redirection or dysfunctional behaviour, responsive behaviours	
(409) – 64 measures		(610) – 32 measures	
Special positioning and turning in bed		Requires protection from injury. Fall risk.	
(411) 17 measures		(613) – 30 measures	

SUMMARY

3 hours of care/day
× 75 residents
225 hours/day

225 hours/day
@ 7.5 hours
30 professional /non professional staff required/ per day

- 1 care aide can manage 2000 measures workload/shift
- 12 care aides can manage 24,000 measures workload/ shift (2,000 X 12)
- 24,000 measures @ 75 residents = 320 measures/ resident or 7 residents/care aid/shift)

Category 5
3.2 hours of care/resident/day

- Complex Care Grouping: C-D
- Global Deterioration Scale: 5-7
- Workload: 330+ measures/resident (Based on 75 bed facility)

1 care aide for every 6 residents

CARE FACTORS

1

Feeding & Hydration:

Requires major assistance and constant supervision or resists care

(103) – 30 measures

2

Elimination:

Requires routine toileting with major assistance and occasional supervision

(203) – 36 measures

Requires enema/ suppository/ disimpaction regularly

(207) – 6 measures

3

Hygiene, Dressing, Grooming:

Requires total assistance or resists care

(303) – 36 measures

Requires PM rest

(304) – 6 measures

4

Ambulation & Transfer:

Requires total assistance with wheelchair

(402) – 18 measures

Requires transfer by mechanical lift 4 times/day

(409) – 64 measures

5

Leisure activities, Portering, Support:

Daily exercises

(501) – 6 measures

Creative arts

(502) – 1 measure

Group Therapy

(503) – 2.9 measures

Community/family integration

(504) - 6 measures

Value/belief

(505) – 3 measures

6

Special requirements:

Routine medications

(601) – 9 measures

Major dressings & treatments

(604) – 24 measures

Elopement and redirection or dysfunctional behaviour, responsive behaviours

(610) – 32 measures

Requires protection from injury. Fall risk.

(613) – 30 measures

7

Indirect care:

Care planning, MDS, conferences, medication management, family support

– 36 measures

SUMMARY

3.2 hours of care/day
× 75 residents

240 hours/day

240 hours/day
@ 7.5 hours

32 professional /non professional staff required/ per day

- 1 care aide can manage 2000 measures workload/shift
- 12.5 care aides can manage 25,000 measures workload/ shift (2,000 X 12.5)
- 25,000 measures @ 75 residents = 333 measures/ resident or 6 residents/care aid/shift)

Residential Care Workload Measurement

			Emp Type	# of Emp (A)	Freq/day (B)	Units	TOTAL Units (AxBxC)	SCORE/GDS 0.0	0.0	0.0
Care Level:										
1. Feeding and Hydration (select one of 101, 102, 103, 104, 105 & 106)								**1st**	**2nd**	**3rd**
101	Independent	Meals		1	3	3.0	9.0			
		Nour		1	3	1.0	3.0			
		Total	CA				12.0			
102	Requires minor assistance and occasional supervision	Meals		1	3	5.0	15.0			
		Nour		1	3	1.0	3.0			
		Total	CA				18.0			
103	Requires major asistance and constant supervision	Meals		1	3	9.0	27.0			
		Nour		1	3	1.0	3.0			
		Total	CA				30.0			
104	Total feed	Meals		1	3	20.0	60.0			
		Nour		1	3	6.0	18.0			
		Total	CA				78.0			
105	Tube feed with intermittent checks		RN	1	6	13.0	78.0			
106	Tube feed with constant presence		RN	1	6	15.0	90.0			
2. Elimination (select one of 201, 202, 203 & 204). Double value where resident is resistant.										
201	Toilets without supervision		CA	1	1	2.0	2.0			
202	Requires routine toileting with minor assistance and occasional supervision		CA	1	9	2.0	18.0			
203	Requires routine toileting with major assistance and constant supervision or resists care	Day		1	6	5.0	30.0			
		Night		1	3	2.0	6.0			
		Total	CA				36.0			
204	Requires routine use of bedpan/commode		CA	1	6	8.0	48.0			
Select those that apply…										
205	Incontinent of urine		CA	1	6	3.0	18.0			
206	Incontinent of feces		CA	1	2	9.0	18.0			
207	Requires enema/suppository/disimpaction regularly		RN	1	1	6.0	6.0			
3. Hygiene, Dressing & Grooming (Select one of 301, 302 & 303)										
301	Independent with encouragement & supervision		CA	1	2	6.0	12.0			
302	Requires partial assistance & supervision		CA	1	2	12.0	24.0			
303	Requires total assistance, or resists care		CA	1	2	18.0	36.0			
Select 304 if it applies…										
304	Requires p.m. rest		CA	1	1	6.0	6.0			
4. Ambulation and transfer (Select one of 401 and 402, if applicable)										
401	Wheels with partial assistance		CA	1	6	1.0	6.0			
402	Requires total assistance with wheelchair		CA	1	6	3.0	18.0			
Select one of 403, 404 & 405, if applicable…										
403	Walks with assistance to/from dining/ activity area		CA	1	4.5	7.0	31.5			
404	Walks with directional assistance to/from dining/activity area		CA	1	6	1.0	6.0			
405	Requires mechanical assistance to/from dining room door but walks with staff assistance from dining room to table and return		CA	1	3	4.0	12.0			
Select one of 406, 407, 408 and 409, if aplicable…										
406	Requires one staff manual transfer		CA	1	11	1.0	11.0			
407	Requires more than one staff for manual transfer, or resists care		CA	2	11	1.5	33.0			
408	Requires transfer by mechanical lift two times per day		RN/CA	2	2	8.0	32.0			
409	Requires transfer by mechanical lift four times per day		RN/CA	2	4	8.0	64.0			
Select those that apply…										
410	Requires repositioning in chair during day		CA	1	6	1.0	6.0			
411	Special positioning and turning in bed		RN/CA	1	10	3.5	35.0			
412	Maintenance of mobility/ambulation, active-passive exercise		RN/CA	1	1	6.0	6.0			

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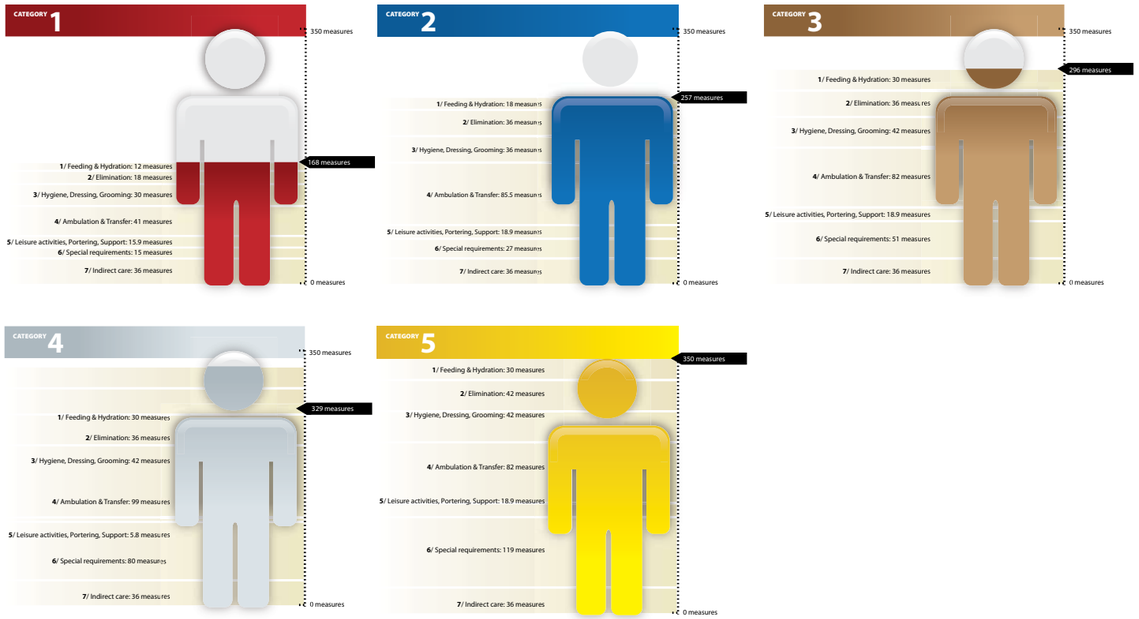
5. Leisure time activities (double values where resident is cognitively impaired.)										
501	Daily exercise		RT/CA	1	1	6.0	6.0			
502	Creative arts		RT/CA	1	0	6.8	1.0			
503	Group therapy		RN/RT	1	0	10.0	2.9			
504	Community/family integration		RN/RT	1	1	3.0	6.0			
505	Value/belief		RN/RT	1	1	3.0	3.0			
6. Special Requirements (Select those that apply; double values where resident is resistive or combative.)										
601	Routine medications		RN	1	3	3.0	9.0			
602	Injectible medications		RN	1	2	3.0	6.0			
603	Dressings/treatments - minor		RN	1	1.5	6.0	9.0			
604	Dressings/treatments - major		RN	1	2	24.0	48.0			
605	Ostomy care		RN	1	3	4.0	12.0			
606	Specimen collection (urine)		RN	1	1	6.0	6.0			
607	Specimen collection (blood)		RN	1	1	6.0	6.0			
608	Requires use of special adaptive/supportive device/equipment		RN/CA	1	2	3.0	6.0			
609	Oxygen, ventolin, suction		RN	1	4	1.5	6.0			
610	Elopment and redirection of dysfunctional behavior		RN/CA	1	16	2.0	32.0			
611	Therapeutic communication		RN	1	1	30.0	30.0			
612	Extraordinary medical needs		RN	1	1	30.0	30.0			
613	Requires protection from injury		RN/CA	1	1	30.0	30.0			
Indirect Care…							36.0			
						Total units per resident per day…		**0.0**	**0.0**	**0.0**



Conclusion

The quality of senior's care varies dramatically in BC depending on where you live.

If funding levels are not increased, many BC Care providers may be forced to dramatically scale back their operations or shut down.

BC Care providers are not prepared to compromise safety no matter how much pressure local health authorities place on them to accept more complex case.

BC care providers should start using these workload measurement guidelines to assess new residents starting April 2009.

Care providers should not proceed with new admissions that exceed the capacity of the facility based on current staffing levels and an unwavering commitment to put safety first.

Refusal of some admissions due to health and safety concerns may result in an increased demand for acute care beds and longer waiting times in emergency rooms at various locations around the province.

The investment required from government to ensure all BC residential care facilities are staffed to the targeted ratio of 3.2 hours of care/patient/day is estimated to be $80 million.

BCCPA should monitor and measure the implementation of the safety guidelines on a regular basis and invite other health care stakeholders that may have an interest in collecting this data to support these reviews.

The BCCPA is committed to ongoing consultation with our members regarding the issues they care about most. The following is a summary of the most frequently asked questions we received from members as we prepared this package. A full list of questions – and answers – is available at www.bccare.ca.

Q+A

1. Q – As a facility owner, manager or Director of Care, how will these guidelines help me?

A - Due to inadequate funding and increasing costs, a growing number of BCCPA members are facing the reality of having to refuse complex clients that exceed their facility's capacity to protect the safety of staff and current residents.

While some members are in better circumstances than others, many are struggling to make ends meet without sacrificing quality of care. To that end, these health and safety guidelines will help facilities:

- document and quantify acceptable standards of care
- evaluate the increased workload of new referrals and complex cases
- justify difficult non-placement decisions
- improve efficiency
- manage staff resources

2. Q – How was the tool and measures prepared? What is it based on?

A - In light of growing concerns from our members about admission pressure from health authorities, the Auditor General's October report and the Ombudsman's current review of seniors care in BC, the BCCPA has taken the initiative to draft a series of health and safety guidelines for our members.

The draft guidelines are based on workload management models developed by the BC Ministry of Health. They have been successfully implemented at many locations across the province for the past 10 years.

3. Q – How difficult is this system to use? How much time will it take? Will I have to do assessments on all my current residents? How much will it cost me?

A – The draft guidelines are 100% compatible with the Minimum Data Set (MDS) and Resident Assessment Instrument (RAI) tools currently being used in most BC care facilities.

In addition to being a transparent tool that facilities can use to monitor the quality of care that residents receive, this tool is very easy for facilities to implement. Directors of Care may require a short training session (2-3 hours) and facilities would need to update their assessments of current residents.

There should be no ongoing costs. On the contrary, facilities that have implemented the guidelines have reported that they find the tool very easy to set-up and once established, it improves efficiency and helps them manage staff and justify difficult non-placement decisions.

4. Q – If I start halting admission of complex cases, won't my local health authority pressure me to accept new residents anyway? What if they threaten to stop referrals or terminate my contract?

A – BCCPA understands the difficult circumstances Health Authorities can occasionally create or refuse admissions. We also understand that some of our members are more vulnerable to this pressure than others. During our workshops, many members have expressed a real fear of retribution from their local Health Authority if they adopt these guidelines.

While we are recommending facilities use these guidelines, participation is voluntary. If you decide not to use the guidelines, BCCPA will still be there for you as an advocate if you are having difficulties with a local Health Authority – as we always have for the past three decades.

For members that are already being forced to choose between providing barely enough care and refusing new admissions to protect staff and current residents, the Association believes these guidelines will be a useful tool to justify your decision making with the Health Authority based on the safety first principle and BC licensing regulations.

If members adopt the guidelines and the Health Authority is pressuring you to lower your standards and compromise safety, we will be there to assist you. We plan to establish a rapid response team to support you that will provide legal advice, media relations and political outreach services in the event of a dispute.

5. Q – My local health authority says they are funding me for a higher staffing level than what I am operating at. How do we address this difference of opinion?

A – This has been an ongoing problem with Health Authorities for years and we unfortunately expect it will not change anytime soon. That is one of the reasons why our Action Plan calls for a province-wide contract and funding model.

The bottom line is that whatever numbers the Health Authority throws around, there is no escaping the fact there is a crisis in senior's care and staffing levels are too low to guarantee the quality of complex care some residents need.

For example, in the case of the Vancouver Island Health Authority, their funding model may state a facility is funded at 3.2 hours of care/patient/day but this measurement does not include allowances for maintenance, dietary aides, therapists or capital costs.

Instead of playing games with numbers and asking our members to sacrifice safety for the bottom line, Health Authorities should consider supporting our Association's care providers at the same rate they support their own.

6. Q – Why is 3.2 hours of care/patient/day the best standard? How did you come up with that number and how many BC facilities are providing this level of care now?

A – This standard of 3.2 hours of care/patient/day reflects the input of our members as a generally accepted care standard. Unfortunately, very few facilities have the staffing levels to provide this level of care. Most fall well short.

Staffing levels within BC senior's care facilities vary from 2 hours of direct care/patient/day to 3.2 hours. Recent figures suggest the average ratio in the Fraser Health region is just under 2.3. It is estimated that facility funding in BC ranges from $110-$240/resident/day. All facilities are required to provide the same level of care regardless of their funding levels.

7. Q – What happens next?

A – Members should use the safety grid and workload management tool to access their current roster of residents and consider any new admissions accordingly. The BCCPA has established a working group that is prepared to help facilities implement the tool. We are prepared to provide staff training, informal legal advice, government relations and media support.

For assistance you can contact David Hurford at 604.736.4233 (x228) or email: info@bccare.ca

Advocating service excellence for seniors

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