CORE
Public Health Functions for BC

Evidence Review:

Healthy Community Care Facilities and Assisted Living Residences

Population and Public Health
BC Ministry of Healthy Living and Sport

This paper is a review of the scientific evidence for this core program. Core program evidence reviews may draw from a number of sources, including scientific studies circulated in the academic literature, and observational or anecdotal reports recorded in community-based publications. By bringing together multiple forms of evidence, these reviews aim to provide a proven context through which public health workers can focus their local and provincial objectives. This document should be seen as a guide to understanding the scientific and community-based research, rather than as a formula for achieving success. The evidence presented for a core program will inform the health authorities in developing their priorities, but these priorities will be tailored by local context.

This Evidence Review should be read in conjunction with the accompanying Model Core Program Paper.

Evidence Review prepared by:

Evidence Review accepted by:
Population and Public Health, Ministry of Healthy Living and Sport (June 2010)
Core Functions Steering Committee (June 2010)

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EXECUTIVE SUMMARY

Introduction

A core program on healthy community care facilities and assisted living residences has been identified as a core public health program for regional health authorities in BC, encompassing the following programs:

- Child day care;
- Assisted living residences, including time-limited residential treatment and rehabilitation programs for people with mental illness and problematic substance use;
- Adult and child/youth residential care, including care for people with developmental disabilities, mental illness and those requiring treatment for substance use, and hospice programs (under the *Community Care and Assisted Living Act* (CCALA)).

This paper was prepared to identify evidence and best practices, based on a review of the literature, to provide a basis for supporting and informing decisions related to the development of a performance improvement strategy for a health authority core program on community care facilities and assisted living residences.

A limited number of quantitative studies were located in this field; however, a number of qualitative and analytical reviews of effective service delivery were identified. These include comparative analysis, longitudinal studies, program evaluations, expert opinion of "better practices" from professional groups and associations, and program audits. It is recognized that many health promotion and preventive interventions are not amenable to research using randomized controlled trials, the "gold" standard in health research, as the focus is on specific population groups rather than on individuals, which present difficulties in establishing the necessary research controls. The evidence and "best practices" discussed in this paper are graded according to a standard system for assessing the quality of research evidence.

This paper includes both information related to regulatory oversight and the promotion of quality service delivery. Specifically, it:

- Provides an overview from the literature of qualitative and quantitative studies and the opinions and views of professional associations and researchers in the field; and
- Discusses principles and practices that have been adopted in other jurisdictions in order to provide information and considerations on future directions that may be relevant for a British Columbia model core program.

In particular, the paper discusses strategies related to the following components:

- ***Regulatory Oversight/Health Protection*** – in the case of licensed facilities, this includes licensing processes, monitoring and inspection, investigation of complaints and/or other concerns, enforcement, and education. In the case of assisted living, health authority activities involve program support, contract management and promotion of quality services.

- ***Promotion of Prevention Services*** – including promotion of immunization, prevention and control of infections, prevention of unintentional injury prevention such as prevention of falls, and prevention of medication errors.
- ***Promotion of Quality of Care and Quality Improvement*** – including promotion of key principles, goals, organizational values and strategies.

It is recognized that in British Columbia, many of statutory and regulatory responsibilities related to community care facilities and assisted living residences do not rest with the health authorities, but involve provincial level authorities. In the case of assisting living, the regulatory role rests entirely with the provincial Office of the Assisted Living Registrar (OALR). It should be noted that this paper does not focus on the various roles and responsibilities related to BC programs, but simply provides a review of prominent principles and practices in the field that may be relevant to the work of health authorities. The appendices to this evidence review include background information on current BC legislation, the respective roles of the provincial Director of Licensing, the OALR, and other BC agencies that have an oversight role with respect to community care and assisted living.

Child Day Care

1. Regulatory Oversight - Health Protection

BC legislation and regulations establish minimum standards for the provision of licensed child day care. Providers are required to adhere to the legislation and health authorities manage and administer the regulatory oversight function. They ensure compliance by child care providers through: licensing of facilities with appropriate approval processes; monitoring of compliance with legislation through the use of risk assessment and other measurement tools; inspection of facilities; follow-up on problems and complaints through investigation and enforcement as necessary (utilizing expertise and advice to support positive enforcement where appropriate and where this is unsuccessful, escalating enforcement to punitive or negative enforcement strategies). Some of the strategies considered to be best practices in regulating facilities focus on effective ways to influencing care providers in complying with legislation. These strategies include strengths-based inspections, support for root-cause analysis, praise, education and persuasion, responsiveness, gradually 'raising the bar' for continuous improvement.

Some experts note that the quality of a child care centre should influence the purpose and focus of licensing professionals in relation to child care providers. They note that in ensuring that children are safe in facilities in the low to mid range of the quality continuum, licensing professionals need to focus on enforcing regulations to eliminate/reduce hazards and regulate to ensure compliance with regulations. However, for those facilities in the higher end of the quality continuum, licensing professionals should focus on consultation and support. The provision of technical assistance, advice, and guidance to an operator of child day care facilities can be effective in supporting not only regulatory compliance, but in encouraging the upgrading of services to meet and exceed requirements and to enhance the health of clients.

2. Promotion of Prevention Services

Although child day care providers are responsible for appropriate injury and disease prevention measures, regulators can promote and encourage prevention strategies that enhance the health and safety of children.

The literature highlights the need for prevention to reduce childhood injuries from falls in child care centres. These include enhancing the safety of playgrounds, the site of the majority of falls. It also highlights research demonstrating that less formal outdoor play spaces can enhance creative play, contribute to cognitive development and literacy development, and foster empathy for living things.

Studies indicate that 'constructive' or positive risk taking can assist children in gaining new experiences and perspectives: it can enable them to test their strengths and recognize their limitations, thus allowing children to understand the concept of trial and error while also enhancing self-esteem and resilience as they establish boundaries and cope with both success and failure.

Encouraging compliance with the BC Centre for Disease Control immunization schedule for children is important for the prevention and control of communicable diseases in child day care centres, along with education and training related to prevention measures such as handwashing, cleaning methods, family education, etc.

Child care workers are in a good position to recognize child neglect and abuse and can provide emotional and educational support for families in stressful situations or in crisis, to assist in preventing child abuse. Staff education can raise awareness of the risk and protective factors associated with child neglect, maltreatment and abuse and enable them to serve as an extended support system for families by: developing positive, non-judgmental relationships with parents; being alert to signs of stress in parents; providing models for developmentally appropriate practices; communicating regularly about a child's progress; and providing information about community resources. Although most child abuse occurs within families, it is also necessary to have policies and practices that protect young children while they are in child care. Besides criminal records checks, hiring procedures should be thorough and comprehensive and based on observations of healthy interactions with children. Regulating agencies should develop rules or guidelines on appropriate interactions between caregivers and children and use these as a basis for observing and evaluating caregiver interactions.

3. Promotion of Quality Child Care

The most definitive research evidence has identified and demonstrated a linkage between key factors and the level of quality child care, for example factors linked to program quality are:

- Low staff to child ratio (i.e., higher number of staff);
- Pre-service and in-service training of staff,
- Highly qualified staff, and
- Small group sizes.

Additional specific predictors of the overall quality of child care have also been identified to guide providers and to assist in program assessment. For example, a number of tools such as rating scales (e.g., Early Childhood Environment Rating Scale) and risk assessment techniques have been used successfully in assessing the quality of early childhood programs and providing a basis for program improvement.

Assisted Living Residences

1. Regulatory Oversight and Prevention Services

(The provincial Registrar of Assisted Living is responsible for regulatory oversight of assisting living in BC. Regional health authorities are involved in assisted living through planning, funding and management of contracts with providers of subsidized services, collecting data on key performance indicators (as required by the Ministry of Health Services), conducting annual site reviews and resident surveys, and promoting quality improvement among assisted living residences.)

Health authorities must ensure that contracts with assisted living providers require compliance with relevant legislation, as well as with a range of OALR policies and guidelines. In addition, it is important to promote disease prevention and injury prevention in assisted living, including immunization and prevention of seniors' falls (addressed under Residential Care Facilities).

Assisted living residences provides permanent independent living arrangements in conjunction with a variety of personal support services for people who require some assistance in maintaining their freedom, dignity, and autonomy. In addition, specialized assisted living residences accommodate program-based temporary living arrangements for recovery and rehabilitation of people with mental health and/or substance use disorders.

2. Promotion of Quality Improvement

Health related attributes of quality assisted living residences for seniors, people with disabilities and others who are permanent residents, are the primary focus of discussion in this section. Attributes of quality include independence and personal choice, strong resident social identity and personal networks, as well as flexibility and other factors that contribute to quality improvement. A discussion of these factors provide background information to support health authorities in assisting and encouraging assisted living residences in the process of continuous quality improvement.

Independence and personal decision-making are fundamental elements in assisted living. Researchers have found important links between seniors' health and socio-economic status,: in particular, social status and "a sense of control". Studies have illustrated that people with few opportunities to participate in decisions that affect them may feel stigmatized by relatively low rank, feel "less worthy", perhaps angry, humiliated and experience low self-esteem. Research has consistently found that having "control"/"sense of control" is linked to positive health, and that "no control", has a negative impact on health and well-being.

Living up to the promise of independent living can be a challenge for assisted living managers and staff. It can also be a challenge for the seniors themselves, who may not aware of their options and rights, or feel that they must accept an unnecessarily restrictive living environment. Studies have found a significant gap between what residents want and the level of independence they are given. Helpful techniques that have been identified to overcome obstacles and encourage independence include: encouraging management and staff to recognize resident independence as essential to both resident well-being and the financial health of the facility (low self-esteem fosters helplessness and higher care needs); identifying and analyzing barriers to independence and making modifications as possible; training staff to listen to and respect resident choices; supporting the right of residents to make informed choices about living with risk; and educating families to understand that competent residents must be allowed to make their own choices to the extent possible.

Researchers have also identified "social identity" and "social support" as important health-promoting factors that are important to assisted living residents. Social identities determine the way people feel about themselves and their place in the social world and these ultimately influence health and well-being. Social support "prevents and/or mediates the effect of disease and promotes health and well-being." Examples include financial aid or help with the housework, information and guidance about where and from whom to get help and psychological backing such as encouragement, comfort and intimacy. Researchers have identified specific characteristics of supportive personal networks; accordingly, health authorities can promote and encourage assisted living providers to create environments and opportunities that foster these characteristics.

It should be noted that the temporary assisted living residences for recovery and rehabilitation of those with mental health and/or substance use disorders involve a different set of goals and services than those discussed above. Although clinical and therapeutic factors are not the focus of this paper, a number of principles and standards for these program-based residences are discussed, including: no wrong door; availability and accessibility; matching, choice and eligibility; flexibility and responsiveness; collaboration and coordination.

Residential Care

1. Regulatory Oversight and Health Protection

BC legislation and regulations establish minimum standards for the provision of licensed residential care, based on administrative law. Providers are required to adhere to the legislation and health authorities manage and administer the regulatory oversight function. They ensure compliance by residential care facilities through: licensing of facilities with appropriate approval processes; monitoring of compliance with legislation through the use of risk assessment and other measurement tools; inspection of facilities; follow-up on problems and complaints through investigation and enforcement as necessary (utilizing expertise and advice to support positive enforcement where appropriate and where this is unsuccessful, escalating enforcement to punitive or negative enforcement strategies). Some of the strategies considered to be best practices in regulating facilities focus on effective ways to influencing care providers in complying with legislation. These strategies include strengths-based inspections, support for root-cause analysis, praise, education and persuasion, responsiveness, gradually 'raising the bar' for continuous improvement, and support for participatory approaches which can enhance objectivity and resident empowerment.

Overall, researchers and experts in the field generally agree on the following characteristics of an effective approach to managing effective regulatory oversight in health care:

- ***A focus on improvement***.
- ***Responsiveness*** – Regulatory responsiveness is tailored to individual organizations depending on their response and behaviour, using a range of different detection and enforcement mechanisms.
- ***Proportionality and targeting*** – A focus on areas where performance problems are known or suspected, and interventions are appropriately matched to the size and importance of the problems or issues.
- ***Rigour and robustness*** – Standards are developed through available evidence, and tested for validity and reliability, as possible (e.g., some requirements are recommended by the Coroner or other independent agencies concerned with health and safety, or based on negative experiences which are not amenable to testing).
- ***Flexibility and consistency*** – Sufficiently flexible to allow discretion in responding, while also ensuring an appropriate level of consistency.
- ***Cost-consciousness*** – Cost and benefits are taken into account, both for the regulatory agency, and the regulated organizations.
- ***Openness and transparency*** – Information on the regulatory process, and on findings, are easily available to stakeholders and the public. Information is disseminated on emerging and changing practices.
- ***Enforceability*** – The regulator has access to appropriate incentives and sanctions to secure change.
- ***Accountability and independence*** – Mechanisms are in place for holding the regulator accountable for its actions, while also ensuring independent decision-making on the part of the regulator.
- ***Evaluation and review*** – Systems are in place to monitor and evaluate the impact of regulations and regulation systems.

Specific best practices in monitoring and inspecting licensed care homes include the following:

- Use of risk assessment tools, which take into account the potential severity and scope of harm;
- The use of unannounced/unscheduled inspection visits including evening or weekend visits, to observe actual operating conditions;
- Including residents and resident councils in meetings or interviews during inspection visits, as well as observation of medication administration and resident meals, to broaden the depth and scope of information gathering;

- Exit conferences with the director of care and/or management staff at the end of an inspection to clearly review the findings of the inspections and any improvements that are required.

2. Promotion of Prevention Services in Residential Care Facilities

Regulatory officials frequently require information on preventive approaches to assist them in advising and supporting operators of care facilities on ways of safeguarding the health and safety of residents/clients. This paper does not aim to provide a comprehensive overview but does include quantitative research evidence on some of the issues of major importance, such as prevention of falls, prevention of communicable diseases, and prevention of medication errors. (Further information on topics that may affect the health and safety of residents in community care facilities in BC is available in the Evidence Review on Adverse Effects of the Health Care System, prepared for the Ministry of Healthy Living and Sport, 2008).

Falls are the cause of significant adverse health effects for seniors as well as other adults with risk factors such as poor balance, muscle weakness, medication use, etc. Effective prevention of falls in adult care facilities/residences includes, in summary:

- The development of an organization-wide comprehensive falls prevention plan;
- Fall risk screening and assessment for residents;
- Individualized multifactorial risk management strategies; and
- Staff education and training programs on falls prevention.

The prevention of infections and communicable diseases is also a key consideration in all types of community care facilities. Regular immunization programs are necessary in community care facilities, and strongly recommended in assisted living residences, including annual influenza immunization where appropriate (based on BCCDC guidelines) along with infection control policies and procedures, a risk management plan, and staff training on prevention measures.

Prevention strategies for addressing medication errors, a common occurrence in care facilities, include: interdisciplinary case management; medication reviews; practice feedback and benchmarking; and educational outreach.

3. Promotion of Quality Improvement in Residential Care Facilities

To support the process of continuous quality improvement in the delivery of care services, this section provides a brief overview of key principles and key elements that contribute to quality community care services. It is intended to support regulatory officers in providing advice and encouragement to care providers on ways they can enhance the quality of their programs.

Overall, health promotion strategies can be effective in enhancing the health and safety of clients. Strategies encompass the promotion of healthy policies, creation of supportive environments, strengthening of community action and development of personal skills. With respect to community care facilities these factors relate to strengthening overarching values, goals and activities that enhance and sustain the health, well-being, safety and care of clients,

while others relate to initiatives targeted toward staff knowledge and wellness, well-informed families of clients, and supportive communities. Important health promotion issues include healthy living including nutritious diets, physical exercise, appropriate physical, social and recreational activities, good oral health and regular dental examinations.

Quality of care is difficult to assess, particularly within the context of residential aged care which involves lifestyle issues as much as health issues. However a number of promotion measures have been shown to contribute to quality of care including:

- Guidance, advice, training and support to enhance knowledge and skills levels of managers and staff;
- Promotion of leadership and organizational values which foster a positive, creative and supportive environment focused on meeting residents needs;
- A focus on client-centred care and client empowerment;
- Support for building a culture of safety to enhance commitment to, and coordination of risk assessment and proactive safety measures;
- Family and community education, awareness and support; and
- Performance assessment processes.

Assessment and quality assurance processes focused on supporting improvements in the level of care have been developed by many jurisdictions. Also efficient, comfortable, well-designed buildings are an important component to healthy care programs. The elements of healthy design to enhance workflow, staff productivity and staff health, resident care and resident health, as well as reduce stress, health care associated infections, and violence in the workplace are addressed in the Evidence Review on Adverse Effects of the Health Care System, prepared for the Ministry of Healthy Living and Sport, 2008).

Public information and education about the care-giving industries, including facility directories, facility inspection reports, information on the nature of services provided, characteristics and capabilities of different facilities, fees and costs, as well as selection tips, can benefit families as well as providers. Consumer education on the different service models, quality indicators, standards and regulations are important to support informed choices by the public as well as informed input and advocacy by clients, family and community members to encourage and promote quality improvement by facilities.

4. Promotion of Quality Care for Persons with Intellectual Disabilities, Developmental Disabilities and/or Mental Illness

Guiding principles have been adopted by many jurisdictions to guide and promote the delivery of residential services for persons with developmental disabilities. These include:

- Quality of life factors - autonomy and individual choice, privacy and dignity, support for personal relationships and social contacts;
- Personalized health care;
- Individualized approach to maximizing personal development;
- Safety and protection from abuse;
- The right to informed decision making and consent; and
- A supportive, accessible home environment.

In addition, it is recognized that government and service providers should collaborate with a shared vision and that health, community services, education and justice professionals should coordinate their involvement through inter-sectoral and cross-agency strategies. Assessment and evaluation processes have been developed to assess quality, including services, values, and success in meeting client needs.

With respect to mental disorders, principles include:

- Treat all persons with respect and dignity;
- Managed care is based on "best practices', model programs, innovation and continuous quality improvement;
- Services are tailored to individuals needs and preferences, provided in the least restrictive and most natural setting possible, and build on the strengths of the consumer and family;
- Services for adults directly include a continuum of care consisting of, but not limited to, a comprehensive arrange of flexible community living supports including prevention, treatment, rehabilitation, intensive case management residential treatment, crisis, and self-help services, and also provide effective linkages to other health and social services;
- Services for children directly include a "wrap around" approach consisting of, but not limited to, flexible, individualized, strengths-based, family-driven services incorporating respite care, case management, day community-based services and also provide effective linkages to other health and social services.

5. Promotion of Quality Hospice Care

The delivery of quality hospice palliative care is based on a set of values and guiding principles which provide a foundation for quality. These are:

- The intrinsic value of each person as an autonomous and unique individual;
- The value of life, the natural process of death, and the fact that both provide opportunities for personal growth and self-actualization;
- The need to address clients' and families' suffering, expectations, needs, hopes and fears;
- Care is only provided when the client and/or family is prepared to accept it;
- Care is guided by quality of life as defined by the individual;
- Caregivers enter into a therapeutic relationship with clients and families based on dignity and integrity; and
- Recognition that a unified response to suffering strengthens communities.

The principles also highlight the importance of services which are: patient/family focused; safe and effective; accessible; adequately resourced; collaborative; knowledge-based; advocacy-based, and research-based.

1.0 OVERVIEW/SETTING THE CONTEXT

In 2005, the British Columbia Ministry of Health released a policy framework to support the delivery of effective public health services. The *Framework for Core Functions in Public Health* identifies healthy community care facilities and assisted living residences as one of the 21 core programs that a health authority provides in a renewed and comprehensive public health system.

The process for developing performance improvement plans for each core program involves completion of an evidence review used to inform the development of a model core program paper. These resources are then utilized by the health authority in their performance improvement planning processes.

This evidence review was developed to identify the current state of the evidence-based on the research literature and accepted standards that have proven to be effective, especially at the health authority level. In addition, the evidence review identifies best practices and benchmarks where this information is available.

1.1 An Introduction to This Paper

A core program on healthy community care facilities and assisted living residences has been identified as a core public health program for regional health authorities in British Columbia. The decision emerged from 2008 discussions between the Ministry of Healthy Living and Sport and a community care planning group: it was subsequently confirmed by the Steering Committee on Core Programs. Both groups included representatives of all health authorities along with the Ministry of Healthy Living and Sport, which has facilitated the project.

This core program is focused on providing regulatory oversight as well as the promotion of continuous quality improvement. The 2008 Planning Group and Steering Committee on Core Programs determined that the following facilities/residences would be encompassed within this core program:

- Child day care;
- Assisted living residences, including time-limited residential treatment and rehabilitation programs for people with mental illness and problematic substance use;
- Adult and child/youth residential care, including care for people with developmental disabilities, mental illness and hospice programs (under the *Community Care and Assisted Living Act (CCALA*). (Private hospitals and extended care facilities not currently within the scope of *CCALA* are not included.)

It was further agreed that the strategies should include the following components:

- ***Regulatory Oversight / Health Protection*** – in the case of licensed facilities, this includes licensing processes, monitoring and inspection, investigation of complaints and/or other concerns, enforcement, and education. In the case of assisted living, health authority activities involve program support, contract management and promotion of quality services.

- ***Promotion of Prevention Services*** – including promotion of immunization, prevention and control of infections, prevention of unintentional injury prevention such as prevention of falls, and prevention of medication errors.

- ***Promotion of Quality of Care and Quality Improvement*** – including promotion of key principles, organizational values, accountability, etc.

Core programs are defined in *A Framework for Core Function in Public Health*[1] prepared in consultation with representatives of health authorities and experts in the field of public health. Each of the designated 20 core programs are long-term public health programs provided by health authorities, each with clear goals, measurable objectives, best practices and benchmarks (where such exists). Each program is informed by: an evidence review (or in this case, a discussion paper); other key documents related to the program area; and by key expert input obtained through a Working Group with representatives from each health authority and the Ministry of Healthy Living and Sport. An approved core program constitutes a model of good practice that constitutes a performance improvement process to be implemented over several years by health authorities.

This paper was prepared to identify evidence and best practices, based on a review of the literature, to provide a basis for supporting and informing decisions related to the development of a performance improvement strategy for a health authority core program on community care facilities and assisted living residences.

A limited number of quantitative studies were located in this field; however, a number of qualitative and analytical reviews of effective service delivery were identified. These include comparative analysis, longitudinal studies, program evaluations, expert opinion of "better practices" from professional groups and associations, and program audits. It is recognized that many health promotion and preventive interventions are not amenable to research using randomized controlled trials, the "gold" standard in health research, as the focus is on specific population groups rather than on individuals, which present difficulties in establishing the necessary research controls.

This paper includes both information related to regulatory oversight and the promotion of quality service delivery. Specifically, it:

- Provides an overview from the literature of qualitative studies and the opinions and views of professional associations and researchers in the field; and

- Discusses principles and practices that have been adopted in other jurisdictions in order to provide information and considerations on future directions that may be relevant for a British Columbia model core program.

It is recognized that in British Columbia, many of statutory and regulatory responsibilities related to community care facilities and assisted living residences do not rest with the health authorities, but involve provincial level authorities. In the case of assisting living, the regulatory role rests entirely with the provincial Office of the Assisted Living Registrar (OALR). It should be noted

that this paper does not focus on the various roles and responsibilities related to BC programs, but simply provides a review of prominent principles and practices in the field that may be relevant to the work of health authorities. The appendices to this evidence review include background information on current BC legislation, the respective roles of the provincial Director of Licensing, the OALR, and other agencies with an oversight role.

The paper is organized according to the according to the major program categories:

- Child day care;
- Assisted living residences; and
- Residential care facilities (for children, youth and adults).

Under each of these programs, literature on the following topics is discussed: regulatory oversight where this applies, promotion of prevention services, and the promotion of quality improvement.

2.0 METHODOLOGY

An online literature review was conducted using a search strategy and search terms (Appendix 3) that included the following online bibliographic sources:

- Medline (National Library of Medicine through OVID) files;
- Cochrane Database of Systematic Reviews;
- EBSCO research databases including Academic Search Elite and MasterFile Premier (multidisciplinary databases with more than 4,000 titles/serials, many of them peer-reviewed), and
- Websites of many organizations and agencies, research networks and institutes related to child day care, assisted living and community health care facilities.

In addition, a number of references and information sources were provided by licensing professionals in the Ministry of Healthy Living and Sport, the OALR, health authorities and BC academic organizations.

Many documents describing and analyzing factors which contribute to the effectiveness of healthy community care facilities and assisted living residences were reviewed. As noted earlier, a number of qualitative analyses and studies were identified, including recommendations, guidelines and/or best practices issued by regulatory or professional organizations, as well as theoretical discussions and reviews of policies and practices written by academic researchers, experts in the field and care providers. There are a limited number of quantitative research studies as research in this field in not amenable to randomized control trials since the use of control groups is generally not feasible in an environment of regulated services. Although the evidence is weak on some topics, it is substantive with respect to several preventive issues, for example, there is strong quantitative research on the prevention of falls and prevention of medication errors (some of this material was drawn from the *Evidence Review on Prevention of Adverse Effects* (2008), prepared for the Ministry of Healthy Living and Sport).

2.1 Quality of Research Evidence

The quality of research evidence used in this paper has been rated based on The Canadian Task Force on the Periodic Health Examination (CTFPHE). In 1976, this group adopted a plan to use explicit analytic criteria to guide its evaluation of research. The following table provides the criteria for assessing various grades to published literature. The level or type of evidence is noted in brackets after each cited document in the paper e.g., (Type II-3).

I	Evidence from at least 1 properly randomized controlled trail (RCT)
II-1	Evidence from well-designed controlled trials without randomization
II-2	Evidence from well-designed cohort or case-control analytical studies, preferably from more than 1 centre or research group
II-3	Evidence from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments could also be included here.
III-1	Opinions of respected authorities, based on clinical experience, descriptive studies or reports of expert committees.
III-2	Opinions of respected authorities with experience in program management, administration, and/or audits and financial accountability.

Note: Category III-2 has been added to this table to include opinions of authorities who have expertise in management, administrative and financial effectiveness, rather, than expertise in health services.

The relative lack of quantitative evidence in this field, and the variable quality of available evidence gives rise to a number of critical knowledge gaps. Assessing these gaps provides the opportunity to establish research priorities that will allow for future decision-making input in key topics.

3.0 CHILD DAY CARE

3.1 Regulatory Oversight and Health Protection

The Provincial/Territorial Directors of Child Care acknowledge licensing requirements provide a minimum floor of acceptable care. They note that

> licensing regulations represent the mechanism for addressing quality assurance in child care…They are the tools for establishing basic standards. Basic standards should focus on the aspects deemed most critical to maintaining children's safety and their healthy development both in terms of immediate physical health and well-being, and their long-term well-being in all areas of development… At minimum, standards for licensing of facilities, combined with other regulatory requirements such as environmental health codes, zoning provisions, building and fire safety codes, define the floor for acceptable care that all child care programs must meet[2] (Type III-1).

There is general consensus that the regulation of child day care is linked to the quality of services provided and to outcomes for children. In the United States, studies have found the overall quality of care to be higher in States with more stringent licensing requirements[3] (Type II-2) [4] (Type II-2). For example, a study comparing regulated and non-regulated child care[5] (Type II-1) in the US assessed the rate of accidental injury among children. The children in regulated child care were found to benefit from safer environments while those in unregulated care experienced higher rates of injury. It was concluded that unintentional childhood injury may be mediated by child care regulations, most-notably the requirement for training beyond high school for caregivers, which reduced the incidence of both fatal and non-fatal accidents[6] (Type II-1).

The regulatory oversight role of health authorities involves several phases including: a due diligence or inquiry phase; application phase; investigation phase (i.e., investigation of application); licence issuance; and compliance monitoring. These are described in the following sections.

3.1.1 Licensing Processes

Regulatory officials provide information that will enable a potential applicant to make an informed and responsible decision about whether to make a formal application. *Towards A Best Practices Framework for Licensing Child Care Facilities in Canada[7] (A Best Practices Framework)* (Type III-1) suggests that the licensing package include: relevant provincial legislation; municipal regulations; guidelines on developing the service plan; fire preparedness policy; sample forms for medications, emergency, medical attention, field trips, incident reports, etc.; protocols for handling allegations of child abuse; information on parent subsidies; toy list/outdoor play space requirements; criminal record search information; fact sheet on child welfare checks; medical reference form; first aid courses for child care, etc.

Many regulatory agencies also encourage, or require, inquirers to attend an orientation training session before providing an application form. The purpose of the orientation is to explain the licensing process and the agency's expectations[8] (Type III-1). As well, it ensures that applicants have sufficient information to make a sound decision about whether to establish a care facility.

In the review of an application to establish a child day care, *A Best Practices Framework*[9] (Type III-1) suggests that the regulatory agency:

- Consider the need for any additional information or clarification;
- Conduct, process and review security clearance/criminal records reference/child abuse register checks;
- Request references as required;
- Provide ongoing advice and/or engage in consultation with the applicant as required;
- Consider service plans and floor/site plans;
- Assess suitability of the applicant via interview, investigation, documentation, etc.;
- Conduct onsite inspection to assess the program, based on the Act and Regulations;
- Review and discuss facility policies with applicant; and
- Recommend the approval, or denial, of a licence, and if it is granted, any terms/conditions that may apply.

3.1.2 Compliance Monitoring, Inspection, Investigation and Enforcement

A Best Practices Approach to Regulated Child Care within a Framework that Supports Good Outcomes for Children[10] (Type III-1) discusses the quality continuum that determines the purpose, roles, and activities of licensing professionals in relation to child care providers. They note that in ensuring that children are safe in facilities in the low to mid range of the quality continuum, licensing professionals focus on enforcing regulations to eliminate/reduce hazards and regulate to ensure compliance with regulations. However, for those facilities in the higher end of the quality continuum, licensing professionals focus on consultation and support. The provision of technical assistance, advice, and guidance to an operator of child day care facilities can be effective in supporting regulatory compliance as well as encouraging the upgrading of services to meet and exceed requirements and to enhance the health of clients[11] (Type III-1).

A discussion of the full range of compliance monitoring, inspection, investigation and enforcement practices and strategies is presented under Residential Care Facilities in section 5.0. Rather than duplicate this discussion, the reader is referred to this section as many of the same strategies may be applied to regulatory oversight of child day care programs.

3.1.3 Other Strategies

Finally, several examples of best practices related to regulatory oversight of child day care provide additional strategies that could support the work of licensing officers[12] (Type III-1):

- The Child Day Care division of Saskatchewan Social Services has moved towards increasing the use of technology in the process of licensing and monitoring child day care. A database called "Maximizer" is used for file management (for access and review by management, to track statistics, monitor status, and so on). All child day care consultants have laptop computers that can access the main network, portable printers for use when out of the office, and cell phones for use when out of town.

- A risk assessment tool for child care has been developed in Alberta to contribute to manageable caseloads for the compliance management system. The tool prioritizes day care centres and tracks their performance on non compliance to five critical standards: staff to child ratios, supervision, staff qualifications, child guidance, and meeting developmental needs of children. Priority categories trigger inspection frequency with more frequent visits to problematic day care centres. High priority centres are inspected six times in six months; medium priority inspected twice a year; and low priority centres, once a year.

3.2 Promotion of Prevention Services

While it is the responsibly of child day care providers to provide appropriate injury and disease prevention services, regulators can promote and encourage prevention measures that enhance the health and safety of children. The following information discusses strategies related to several key prevention measures.

A valuable resource on the health and safety of children in child care centres is *Well Beings: A Guide to Health in Child Care* (2008) (Type III-1). This is a comprehensive reference for child care centres, agencies and home-based providers, early childhood instructors, students, public health professions, parents and physicians. It includes information on the daily care, health and safety of children from birth to preschool years.

In addition, there is considerable research information and support for healthy child development, healthy nutrition, and physical activity in the ActNow program, as well as the following evidence reviews prepared for other core program papers which impact the health of children: *The Evidence Base for a Core Program on Healthy Living: A Consolidated Evidence Review* (2006)[13]; *Core Public Health Prevention Functions: Early Childhood Health and Development, Evidence Paper* (2007)[14]; *Evidence for Healthy Child and Youth Development Interventions* (2008)[15]. As well, information on food safety, prevention and control of communicable diseases, and food security initiatives are addressed in the respective evidence reviews and core program papers on these issues.

3.2.1 Children's Injury Prevention

In BC, a child or youth is hospitalized every 40 minutes on average, with over 12,000 children hospitalized each year as a result of unintentional injuries.[16] On average, 200 children and youth die from unintentional injuries each year[17] (Type II-3). In *Well Beings: A Guide to Health in Child Care* (2008) (Type III-1), a systematic approach to injury prevention is recommended including: active and positive supervision, safe space arrangements, developmentally appropriate programming and preventive policies and procedures.

Among all unintentional injuries sustained by children, falls are a leading cause of emergency hospital visits for those under the age of five years[18] (Type II-3). In general, studies have shown that falls from playground equipment are responsible for 60–80% of all medically attended playground injuries[19] (Type II-3): child day cares were found to be the location of: 2% of all playground injuries sustained by children under the age of two years; 54% of injuries sustained by children 2-4 years old; 42% of injuries sustained by children 5-9 years old; and 2% of injuries sustained by children 10-12 years[20] (Type II-3).

The BC Injury Research and Prevention Unit (BCIRPU) conducted a study in 2006 of injuries that occurred to children in child care services in the Vancouver Island Health Authority (VIHA)[21] (Type II-3). The analysis identified key areas related to injuries at child care centres, for example injuries were found to be more common among boys and younger children. As well, socio-emotional factors and the level of physical safety within the centre were linked to the incidence of injury. Overall, falls were the most common cause of injury. Superficial injuries from falls were the most common nature of the injuries and the scalp/skull was the most common anatomical site of the injuries. Finally, most injuries occurred in the playgrounds. The evidence suggested that risk factors for these injuries included: inappropriate choice of playground equipment, inappropriate or inadequate surfacing under and around the equipment, and insufficient equipment maintenance and inappropriate supervision.[22] The report also documented studies which provided evidence on risk factors and protective initiatives to reduce playground injuries among children. Based on these, BCIRPU recommended the following strategies:

- Selection and installation of labeled age-appropriate play equipment to meet the needs of children of different ages in various child care settings[23] (Type II-3);
- Use of the following protective surfacing: loose-fill (i.e., sand, pea gravel,
- shredded wood products), and/or unitary synthetic/rubber surfacing, or synthetic/rubber mats, or a combination of these materials[24] (Type II-3);
- Use of TRIAX 2000 (a device for measuring the G-max and Head Injury Criteria of the surface) to test for quality assurance in identifying improper installation of surfacing systems and to support compliance with industry standards[25] (Type II-3);
- Use of maximum equipment height of 1.5 meters for preschool-aged children and 2.3 metres for school-aged children[26] (Type III-1);
- Development of innovative play spaces with lower overall heights[27] (Type III-1);

- Development of a budget for inspection and maintenance at the time of purchase and installation of equipment;
- Development of a maintenance guideline and an ongoing inspection program;
- Provision of active supervision, a combination of proximity and attending, that is, watching, listening and staying close[28] (Type III-1);
- Staff education in child safety and proper training of adults and children[29] (Type II-3); and
- Implementation of the Stamp-in-Safety program, a low-cost, easily implemented behavioural reward system for safe behaviour, which has shown promise in reducing pediatric playground injuries at child care centres[30] (Type II-3).

In addition, the document *Unintentional Injury Prevention in British Columbia: A Review of the Literature*, prepared by the BC Injury Research and Prevention Unit (2006) as a basis for developing the model core program paper on prevention of unintentional injuries, provides an extensive description of research on a wide range of childhood injuries and prevention strategies that can be applied in many settings.

3.2.2 Outdoor Play Spaces

It should be noted that there is no requirement in the BC Child Care Licensing Regulation for playground equipment. In fact, Susan Herrington, researcher at the University of British Columbia, has found an association between playground equipment and incidents of aggression, and evidence that equipment results in less creative play in comparison with other forms of playground design[31] (Type II-2).

Researchers note that the outdoor physical environment influences the cognitive, emotional and physical development of children. Less formal outdoor play spaces has been shown to: provide learning opportunities for children to manipulate elements of the outdoor setting; contribute to literacy development; and foster empathy for other living things[32] (Type II-2) [33] (Type III-1) [34] (Type III-1). An Iowa State University study found that landscape interventions altered children's cognitive understanding and expanded their use of the yard[35] (Type II-2). The social hierarchy was changed as spaces for fantasy play were made and the children began to take ownership of the yard.

A California State Education and Environment Roundtable explored the use of the outdoor environment as a context for learning—92% of students attending schools where the schoolyard was integrated into the curriculum outperformed the students where the integration did not occur[36] (Type II-2). A Children and Nature Network (www.childnature.ca) represents a growing movement to reconnect children and families to nature for improved health and well-being.

3.2.3 Risk Taking

Positive risk taking, associated with differentiating between healthy risk and destructive risk taking, is a consideration in planning healthy play. The literature indicates that some risk-taking is necessary to gain new experiences and perspectives. Children, who are constantly growing, developing and maturing, need to experience risks in order to test their strengths and recognize their limitations. This allows children to understand the concept of trial and error: success will build the child's self-esteem and inevitable failures will help them acknowledge their boundaries and provide an opportunity to cope with accompanying negative emotions. If children are too frightened to take risks, they may become stagnant within their comfort areas, and while avoiding the pain of failure, will also avoid many of the benefits associated with undergoing physical, mental and emotional growth[37] (Type II-3).

Healthy risk promotion includes the encouragement of constructive risk-taking such as participation in adventurous, thrill-seeking, sensation-seeking, exhilarating experiences that fulfill one's needs, and are healthy and legal. It involves weighing the potential benefits and harms of one choice of actions over another. It is also important in adolescence growth and development as it builds self-confidence and resiliency, promotes autonomy and self-identify and helps to gain peer acceptance and respect[38] (Type III-1).

3.2.4 Prevention and Control of Infectious Diseases

BC Centre for Disease Control (BCCDC) has issued an *Immunization Program Manual* for immunization providers, which includes an immunization schedule for children. Compliance with the immunization schedule for children is important for the prevention and control of communicable diseases in child day care centres.

A number of key communicable disease prevention and control strategies are discussed in section 5.4.2 (under Residential Care). These also apply to child care as they encompass: infection control policies and procedures; infection control education for staff members; and prevention measures such as handwashing, education for family members, environmental review, and monitoring. Evidence-based studies on immunization are included in *A Core Program in Immunization: The Evidence Base*, prepared by BC Centre for Disease Control in 2006 for the model core program paper on prevention of communicable disease.

3.2.5 Prevention of Child Abuse and Neglect

Child abuse or maltreatment includes physical abuse, sexual abuse, psychological abuse and general, medical and educational neglect. It can be difficult to recognize, especially if the victim is too young to talk about the abuse or identify the perpetrator; however, child care workers' frequent contacts with children put them in a good position to recognize abuse/neglect. Not only do children suffer acutely from abuse, they may also endure long-term consequences, including delays in reaching developmental milestones, anxiety disorders, increased likelihood of future aggressive behaviours, personality disorders, post-traumatic stress disorders, substance use issues, etc.[39] (Type II-3). Considerable research has been conducted on risk factors for child abuse which include a complex set of interrelated factors encompassing parent, child, community and societal issues[40] (Type II-2). Several evidence reviews conducted for the Ministry of Health for other core program papers include information on risk and protective factors for healthy child

development: *Core Public Health Prevention Functions: Early Childhood Health and Development, Evidence Paper* (2007),[41] *Evidence Review: Mental Health Promotion,* (2007),[42] and *A Mental Disorder Prevention Evidence Review Paper* (2007).[43]

Child care centres can provide emotional and educational support to families in crisis or in stressful situations, to assist in prevention of child abuse. (Parents who abuse their children generally experience high levels of stress and inadequate supports). Child care centres can serve as extended support systems for families by:[44] (Type III-1)

- Developing positive, non-judgmental relationships with parents;
- Being alert to signs of stress in parents;
- Providing opportunities for parents to become involved in their child's care;
- Communicating regularly with parents concerning a child's progress;
- Providing parent education by modeling developmentally appropriate practices; and
- Providing information about community resources.

Although most reported child abuse occurs within families, there are also reported cases occurring in child care settings. Thus it is important to have policies and practices that protect young children while they are in child care. Beyond criminal record checks that are mandated for child care workers, hiring procedures should be thorough and comprehensive and based upon observations of the future employee's interaction with children. For example, child care workers who grab or yell at children or who stand apart from children instead of interacting with them, or who show no respect for a child's right to privacy are likely to be inappropriate caregivers[45] (Type III-1).

NARA[46] (Type II-3) has addressed the process of regulating adult/child interaction in its research and recommendations and notes that children who lack warm, nurturing, responsive interaction from consistent caregivers will likely develop: behaviour and aggression problems; antisocial behaviour; social difficulties relating to others; learning and attention difficulties; avoidance and resistance; and can result in death. "Focusing only on physical health and safety will not adequately protect children from harm, in fact, it can leave young children at great risk for developmental harm"[47]. NARA suggests that Licensing Agencies develop rules, assess compliance and enforce what is appropriate interaction to protect children. Specifically[48] (Type II-3).

- The development of rules requires a commitment by top leadership to the importance of regulating interactions, identifying specific rules, clarifying the interpretation of each rule, and developing training and other processes for observation of interactions;
- Key elements in the observation of caregiver interactions with children are: caregiver enragement or disengagement including; presence or lack of face to face interaction; eye contact; warm, caring facial expressions; listening to child; respectful talk with each child; and allowing exploration and creativity by the child rather than isolating, ignoring, or restraining children; and
- Education and technical assistance for providers related to the rules and their interpretation to clarify what licensing staff will be assessing during visits.

3.3 Promotion of Quality Child Care

As noted earlier, for those facilities in the higher end of the quality continuum, regulatory professionals generally focus on consultation and support[49] (Type III-1). The provision of technical assistance, advice, and guidance to an operator of child day care facilities can be effective in supporting not only regulatory compliance, but also upgrading services to meet and exceed requirements. Many advocates believe that licensing officers should be knowledgeable about proven practices for effective delivery of child care in order to provide appropriate support to providers[50] (Type III-1). Thus best practices associated with quality child care are discussed in this section to support health authorities in promoting and encouraging the delivery of quality services by child day care providers. (It should also be noted that some regulatory officials believe that licensing officers should not be experts in the field, but rather focus on outcome based results and to this end, provide coaching to the provider on problem solving processes and encouragement to identify solutions themselves.)

3.3.1 Factors Associated with Quality Child Care

Dr. Clyde Hertzman, Human Early Learning Partnership at University of British Columbia has studied and mapped the influence of early development on physical, social, emotional, language and cognitive skills on health, well-being and learning skills over the lifespan. He has found that the determinants of healthy child development in Canada and the United States include, on a societal level, access to "quality" care arrangements (as well as family income, education and parenting style, neighbourhood safety/cohesion)[51] (Type II-3). Similarly, a New Zealand study found that early childhood care programs supported family resilience by improving the ability of families to cope with and recover from significant adversity or stress, and enhanced their ability to protect against future adversity.

A Best Practices Approach to Regulated Child Care with a Framework that Supports Good Outcomes for Children (Type III-1) notes that research consistently identifies the following structural factors as most related to quality in early childhood programs, that is, programs that protect children from development impairment and improve their well-being. These factors are:

- Small groups of children with a sufficient number of adults to provide sensitive, responsible care-giving and adequate supervision;
- Higher levels of general education and specialized preparation for caregivers as well as program administrators; and
- Higher rates of compensation and lower rates of turnover for program personnel.[52]

The National Association of Regulatory Agencies echoes these findings and notes that studies conducted by university researchers have linked specific rules to outcomes. "For example, low staff:child ratios, pre-service and in-service training of staff, highly qualified staff, and small groups are all examples of regulatory variables that have been identified as surrogates to program quality that produce positive outcomes for children"[53] (Type II-2).

3.3.2 Predictors of Quality

Richard Fiene, Director of Early Childhood Institute at Pennsylvania State University prepared a synthesis of research literature on health and safety standards for out-of-home child care, for the US Department of Health and Human Services, entitled *13 Indicators of Quality Child Care: Research Update*[54] (Type II-1). The research was conducted to assist in developing weighting and predictor indicator systems for child care. The following were found important in predicting the health and safety of children and the overall quality of child care programs:

- ***Prevention of abuse*** – Initiatives that help curb child abuse include: increase caregiver support such as high staff child ratios and sufficient breaks; inform caregivers of their legal responsibilities; focus on positive behaviour; evaluate the program with feedback to staff; provide sufficient training opportunities; and offer social support, parent networking, and informal counselling to troubled parents.

- ***Immunizations*** – Reviewing and monitoring child care centre records was shown to increase the reported rate of correctly immunized preschool children.

- ***Staff child ratio and group size*** – Two of the best indicators for determining quality, the research notes that higher staff child ratios and smaller group sizes improve the care giving behaviours of staff, the safety of children, and result in more secure attachments and improved school readiness.

- ***Staff qualifications and training*** – Educated and trained caregivers are more likely to promote the physical and mental health, safety and cognitive development of children in their care. They are also more likely to continue in child care employment which impacts turnover and helps with attachment and bonding with very young children. Staff training programs have been shown to help reduce the transmission of infectious diseases, reduce the number of accidental injuries, and facilitate a positive learning and socialization environment. (A number of States have recognized that staff qualifications appear to be the most important variable affecting the quality of child care and are focusing their efforts in this area. For example, both Oklahoma and North Carolina offer incentives to providers to encourage them to pursue training through the Teacher Education and Compensation Help or T.E.A.C.H.)[55]

- ***Supervision/discipline/guiding behaviour*** – Proper supervision and guidance of behaviour reduces certain behavioural problems and decreases injury rates.

- ***Fire drills*** – Regular fire drills are important as children under the age of 5 are twice as likely to die from fire as any other childhood age group.

- ***Medication administration*** – A child care program must have a written policy and clear procedures on administering and storing medications.

- ***Emergency plan/contact*** – Child care staff requires first aid and CPR training, and emergency medical policies and procedures need to be in place.

- ***Outdoor playground*** – The majority of child care injuries occur in outdoor playgrounds. Lowering the height of playground equipment and providing resilient surfaces can reduce injury risks.
- ***Inaccessibility of toxic substances*** – Prevention and management of environment hazards in the child care centre has been shown to be necessary.
- ***Proper handwashing/diapering*** – Hand washing is the single most effective way to interrupt the transmission of infectious diseases. Child care programs must provide continuous training and assistance in hand washing procedures.

Inclusion

The principles of inclusion in early learning have been adopted by UNESCO. Inclusion is described as "a developmental approach seeking to address the learning needs of all children, youth and adults with a specific focus on those who are vulnerable to marginalization and exclusion"[56]. Martha Friendly[57] (Type III-1) of the University of Toronto notes that children's well-being and future prospects can be enhanced by developmental, inclusive, enriching child-focused environments.

> Social inclusion is not only about mitigating vulnerabilities and reducing risk, but also about ensuring that opportunities are not missed… Early childhood education and care contributes to the process of social inclusion by helping to make equality of life chances and a basic level of well-being possible for all children and families.

All provinces and territories have made some provision for the inclusion of children with special needs in child care settings. These arrangements commonly provide the opportunity for service planning and consultation, staff training and support, resources and referral services as well as funds to enhance child:staff ratios[58] (Type III-1). The principles of inclusion, advocated by Child and Family Canada are: no child is ever excluded for reasons of level or type of disability; programs include children with disabilities roughly in proportion to their occurrence in the general population; children with special needs have the same range of child care options; necessary supports are provided so that all children can participate in some way in all activities; programs actively promote legislative and policy changes to support inclusion[59] (Type III-1).

3.3.3 Quality Rating Scales

The *Early Childhood Environment Rating Scale (ECERS)*, revised in 1998, was developed by Harms, Clifford, and Cryer[60] (Type II-2) to provide detailed quality standards for use in assessing the quality of early childhood programs and to provide a tool for program improvement. The *ECERS* has been piloted extensively in a variety of settings to establish predictive validity. Numerous research projects in the US and other countries have used the *ECERS* to assess quality and have discovered significant relationships between *ECERS* scores and child outcome measures, and between *ECERS* scores and teacher characteristics, teacher behaviours and compensation levels[61] (Type II-2). It includes 7 categories as follows:

- ***Environment*** – space, furnishings for play/relaxation/comfort, space for privacy, etc.;

- ***Personal Care Routines*** – meals/snacks, naps, toileting, safety, etc.;
- ***Language/Reasoning*** – books and pictures, encouraging communication and development of reasoning skills;
- ***Activities*** – fine motor, art, music/movement, dramatic play, nature/science, math/numbers, etc.;
- ***Interaction*** – supervision of gross motor activities, discipline, staff-child interactions, interactions among children;
- ***Program Structure*** – schedule, free play, group time, etc.; and
- ***Parents and Staff*** – provisions for parents, provisions for personal needs of staff, staff interaction and cooperation, supervision and evaluation of staff, opportunities for professional growth.

A variety of rating scales have been developed using the *ECERS* format, each with its own improvements and refinements: *Family Day Care Rating Scale* (Harms & Clifford, 1989), *Infant/Toddler Environment Rating Scale* (Harms, Cryer & Clifford, 1990), and *School-Age Care Environment Rating Scale* (Harms, Jacobs & While, 1996).

3.3.4 Other Considerations

Perspectives on Quality

There are differing viewpoints on factors that are considered important quality indicators. Martha Friendly, a the University of Toronto researcher and child care advocate for non-profit child care, notes that research in Canada, the United States, Australia, New Zealand and Britain points to significant quality differences between for-profit and not-for-profit programs.

> This holds true whether quality is measured using observational measures—such as the early childhood environmental rating scale—or structural indicators such as staff training, wages, working conditions, professional development opportunities, staff morale, continuity for children, compliance with regulations, staff-to-child ratios, and how funds are used[62] (Type III-1).

She notes that research also shows that it isn't easy to regulate centres into better quality. A 2007 US study found more stringent regulations are associated with higher quality in non-profit but not for-profit child care programs[63] (Type unknown).

Many other professionals in the field support a mixed model that incorporates different types of care and a range of options including both non-profit and for-profit child care to provide families with a choice. They note that the research supports specific key criteria such as the level of staff training as the key indicators of quality for child care centres and that these can serve as an effective proxy for assessing quality.

British Columbia Research

Important considerations in developing effective child care programs include those factors which have been identified as priorities to parents. In focus groups conducted on community care licensing in British Columbia[64] (Type III-2), a number of qualities and indicators were emphasized by parents. These included:

- Safety;
- Cleanliness;
- Stimulation and activities for children with specific mention of programming and activities that reflect children's needs and are age-appropriate;
- Staff ratios;
- The attitude of the caregivers toward the children;
- Professional staff and training in Early Childhood Education;
- Access to information about the facility; and
- Updates on how the child in care is doing[65] (Type III-2).

As well, Dr. Alan Pence, University of Victoria, School of Child and Youth Care has written extensively about early childhood development. These resources are well-respected in the field and may provide helpful support to licensing officers. They include: *Professional Child and Youth Care: The Canadian Perspective* (1993); *Perspectives in Professional Child and Youth Care* (1990); *Family Day Care: Current Research for Informed Public Policy* (1992); and *Valuing Quality in Early Childhood Services: New Approaches to Defining Quality* (1994).

4.0 ASSISTED LIVING RESIDENCES

4.1 Background

Assisted living or supportive housing is considered a "middle option" of health/housing in Canada in the seniors' housing continuum. This continuum includes independent living at one end of the continuum, and 'high-level' long-term residential care at the other. Assisted living, or supportive living housing as it is described in some jurisdictions, is independent living that includes some form of personal and health services[66] (Type III-1). Assisted living residences provide both housing and support services while enabling residents to have maximum freedom, dignity, autonomy and choice. In this housing model, residents are able to make personal choices about the level of support and risk they wish to accept in order to maintain their independence.

Assisted living is a relatively new housing option for seniors. In Canada, interest in social housing opportunities expanded in the 70s and 80s including a growing interest in senior's housing needs and "independent living" opportunities for persons with disabilities[67] (Type III-1). During this period there was also a national discourse on health care needs of the population, including senior's health, which fostered discussion and development of supportive housing/assisted living[68] (Type III-1). Assisted living for seniors grew significantly, in both for-profit and not-for-profit markets in the 1990s and into the 21st century.

As this is a relatively new form of housing/support, few research studies have been conducted in this area. As a result, there is little evidence available on which to develop health authority initiatives to support and promote quality service delivery by assisted living providers.

It is also important to recognize that registered assisted living residences are expected to increasingly accommodate program-based temporary living arrangements for recovery and rehabilitation of people with mental health and substance use disorders. (The CCALA provides a regulatory framework for residential substance use facilities that provide 1 to 2 prescribed services.) Although there is limited evidence related to the regulatory oversight and quality considerations for these programs, they are discussed separately as their goals and standards differ from those that provide permanent living arrangements for seniors and others who reside in assisted living residences. They are discussed later in this section.

4.2 Regulatory Oversight and Protection Services

The provincial Registrar of Assisted Living is responsible for regulatory oversight of assisting living in BC, through the enforcement of health and safety standards and the investigation of complaints.

Regional health authorities are involved in assisted living through planning, funding and management of contracts with providers of subsidized services, collecting data on key performance indicators as required by the Ministry of Health Services, conducting annual site reviews and resident surveys, and promoting quality improvement among assisted living residences. As noted earlier, this paper focuses on the health authority role, particularly the promotion of quality improvement (discussed below).

With respect to legislation, health authorities must ensure that contracts with providers require compliance with relevant legislation and health and safety standards. These include: complaint resolution processes, food safety practices, meal and dietary services, personal assistance guidelines, resident entry and exit practices, etc.). An overview of the *Community Care and Assisted Living Act* is provided in Appendix 1, and the range of agencies involved in some capacity in regulatory oversight of the CCALA is included in Appendix 2.

The promotion of disease prevention and injury prevention in assisted living, including immunization and prevention of seniors' falls, is addressed in section 5 under Community Care Facilities.

4.3 Promotion of Quality Improvement – Assisted Living for Permanent Residents

Literature on key principles and elements that support quality assisted living residences are discussed in this section to support health authority promotion initiatives. The majority of the evidence focuses on those who live permanently in assisted living residences, including seniors and people with disabilities. (In addition, there are specialized assisted living residences which provide temporary living arrangements in conjunction with recovery and rehabilitation programs for people with mental health and/or substance use disorders. These programs are discussed separately in section 4.4).

4.3.1 Independence and Personal Decision-making

In 1998, the federal government engaged in a broad consultation initiative to develop a principles-based framework as a basis for national policy for seniors. Older adults from across the country were engaged in a national consultation to determine what social and cultural values were most important to people as they age. "Independence" ranked in the five most important and overarching themes[69] (Type II-3). It was defined as "being in control of one's own life, being able to do as much for oneself as possible and making one's own choices". (The other four key principles were "dignity, fairness, participation, and security")[70] (Type II-3).

In addition, knowledge of health-promoting factors has evolved with awareness of the important links between health and socio-economic status: for seniors in particular, key factors are social status and "a sense of control"[71] (Type II-3). Studies[72] (Type II-3) have illustrated that people with few opportunities to participate in the planning and execution of activities that affect them have little chance of deciding important matters, are less able to prevent undesirable events from occurring or to cause good things to take place. They may feel stigmatized by their relatively low rank, may feel 'less worthy', perhaps angry, humiliated and degraded. Their self-esteem is low. These observations provide a context for interpreting the consistent finding that having 'control'/'sense of control' is linked to positive health. Having 'control' is a function of social power and social resources; without decision-making power in a given social context there is no 'control'[73] (Type II-3). Thus, lack of prestige, status and power is, in itself, deeply demoralizing and has a negative impact on health and well-being, or "inequality makes people sick"[74] (Type II-3).

Assisted living offers seniors the promise of a living situation that helps them maintain independence in and control over their lives, while also providing the care and support they require as they get older. However, living up to that promise is often a challenge for assisted living managers and staff. It can also be a challenge for the seniors themselves, who sometimes are not aware of their options and rights, or may feel that they must accept an unnecessarily restrictive living environment. A 3 year study[75] (Type II-2) of assisted living in New York State, found a significant gap between what residents want and the level of independence they were given. The researchers note that such a gap is understandable, as assisted living providers have the dual obligation of providing a good lifestyle while helping people to live safely. Assisted living managers and staff may have concerns about how residents' chosen activity may affect their safety, or have challenges such as family members who feel they are entitled to make lifestyles decisions for their relatives, or staff who are concerned that different lifestyle choices for each resident makes their jobs more difficult or time-consuming. In response to this study, researchers worked with the assisted living industry to review obstacles and identify helpful techniques to encourage and support independence[76] (Type II-2):

- ***Importance of Maintaining Independence and Control*** – First, encourage managers and staff to recognize that maintaining resident independence can significantly affect both resident well-being and the financial health of the facility. When people lose autonomy, they experience low self-esteem and feelings of helplessness, which in turn can create a community with higher care needs and a less desirable living environment. Second, suggest a thorough review of the choices that residents have and don't have, and identify the barriers to resident choice.

- ***Addressing Rules and Restrictions*** – Once barriers and restrictions to resident choice have been identified, involve both residents and staff in analyzing the impact of these barriers, and identify modifications where possible and appropriate.

- ***Staff Training*** – Training should increase staff awareness of the need to listen to residents carefully and respond with respect for their choices as much as possible.

- ***Taking Appropriate Risks*** – Having independence and control carries with it the right to take risks, thus it is important for staff to recognize and respect the right to make informed decisions about living with risk. Staff training should include processes for evaluating the risks that residents wish to take, and identifying ways that assistance and/or oversight may help to reduce the level of risk.

- ***The Role of Families*** – It is crucial that families understand that competent residents must be allowed to make their own choices to the extent possible. Family education sessions are suggested, rather than attempting to resolve conflict on a case-by-case basis. As part of this education, it is important to describe the process developed for evaluating risk and for reducing the potential for negative consequences, as well as to discuss the importance of resident choice and control. Involvement of social workers and psychologists in education presentations has been effective.

4.3.2 Social Networks and Social Support

The literature illustrates that, where the basic necessities of life are present, it is the 'social status' component of socio-economic status (SES), not income, that determines the health of individuals. While this has some relationship to independence and personal decision-making, discussed above, it extends to micro social environments and personal networks of individuals[77] (Type II-3).

The concept of 'social identity', which refers to all the social roles an individual plays in society, helps to illuminate the nature of the link between SES, social network characteristics and health[78] (Type II-3). Social identities are embedded in personal networks and are validated through interaction with network members. They reflect the nature and value of a person's participation in the major life spheres and are the source of self-esteem. Each stage of life includes a social field that forms the social identity of the individual. Social identities determine the way people feel about themselves and their place in the social world and ultimately influence health and well-being.

An underlying component to social networks and social interactions is 'social support'[79] (Type III-1), "which prevents and/or mediates the effect of disease and promotes health and well-being"[80] (Type III-1) [81] (Type III-1). Social support is defined as "an action or behaviour that functions to assist a person in meeting his/her personal goals or in dealing with the demands of any particular situation."[82] Typically "the emphasis is on the emotional and instrumental benefits of interaction with close ties."[83] Examples include financial aid or help with the housework, information and guidance about where and from whom to get help and psychological backing such as encouragement, comfort and intimacy[84] (Type II-3).

Based on an analysis of available research findings, Burnside[85] (Type II-3) compiled the following list of personal network characteristics that appear to be health promoting. It is composed of "indicators of an integrating, supportive, identity-enhancing personal network"[86] (Type II-3):

- "Large in size;
- Contains multiple role sectors;
- Delivers achieved as well as ascribed role identities;
- Linked to community organizations and/or informal 'people settings';
- Includes intimate ties (measured behaviourally by relationship category and frequency of interaction);
- Contains many 'friends';
- Contains more friends and acquaintances than relatives;
- A relatively loose-knit structure with at least one dense clique;
- Has some degree of homogeneity (others 'like' the self)';
- 'Active', that is, there is regular, relatively frequent interaction with network members."

These health-related personal network characteristics are identified in order to provide health authorities with a basis for understanding the characteristics of personal networks so they can promote and encourage assisted living providers to create environments and opportunities that support strong social identities and social support for residents.

4.3.3 Other Quality Considerations

Flexibility is an important attribute to support adaptability to the needs of seniors, adults with mental disorders and/or substance use disorders, and adults with physical disabilities or acquired brain injuries. The fundamental concepts of resident choice, privacy, individuality, dignity and respect can be applied to each of these groups in a way that addresses their unique characteristics and allows for the necessary adaptations that respond to diverse needs.

A range of quality improvement initiatives were identified in an evaluation report[87] (Type III-1) of a BC supportive living residence. Although many of these are common practice, they provide helpful points related to quality improvement processes which health authorities may wish to promote in their work with assisted living providers:

- Provide updated information for tenants concerning the financing of their tenancy in order to reduce anxiety over how their care in being paid for, as well as a clear plan of anticipated rent increases if possible;
- Have an advanced practice nurse assess the needs for medical attention and examine the potential for an "after hours" nurse who could be on call for the evening and night staff of the region's assisting living homes;
- Case management of tenants may require examination and clarification to ensure interconnected roles of family (if available), the assisted living support team and the long-term care assessor to address variations in tenant needs and available supports;
- Encourage owners/operators of assisted living residences to establish relationships with local senior centres and other community social and recreational venues, to facilitate socialization of the tenants;
- Provide transportation to outside venues, perhaps through shared use among assisted living operators of a small bus or minivan;
- Implement a system of integrated electronic charting to improve communications between interdisciplinary team members;
- Take into account the frailty of the residents with regard to design features, in order to create a safe, barrier-free environment that allows for maximum independence, ease of movement and fire safety practices;
- Take into account, in environmental design, residents' need for storage of personal belongings and a space for doing hobbies;

- Assist clients without families in managing such needs as shopping, attending church, writing letters, etc, though such options as greater use of volunteers, information on "paid companions" or other sources of support.

Quality Improvement in US Assisted Living

Assisted living has become well established in the United States in recent years with a focus on supporting independent lifestyles. However, the form it takes is not consistent across the county as legislation varies with each State, primarily in terms of the level of care that is associated with assisted living.

The US federal government has monitored developments in assisted living and subsequently issued, through the US General Accounting Office (GAO), a number of reports which reviewed quality of care and consumer protection issues. The focus of these reports have been on: (1) residents' needs and the types of services provided in assisted living 'facilities'; (2) the extent to which facilities provide consumers with information sufficient to help them choose a facility that is appropriate to their needs; (3) a description of state approaches to oversight of assisted living; and (4) the type and frequency of quality-of-care and consumer protection problems. A 1999 survey sampled four States and found that one-fourth of the facilities reviewed were cited by state licensing, ombudsman, or other agencies in the previous year for five or more quality-of-care or consumer protection related deficiencies. Following this report, the federal government formed a committee of stakeholders to develop recommendations for States and other entities to ensure the quality of assisted living services across the country. The committee developed 110 recommendations to address the following key themes:

- Enhancing the information provided to potential residents;
- Having States consider offering providers technical assistance to address state licensing standards; and
- Expanding federal and state support for assisted living residents with complaints about their facilities.

The GAO was subsequently asked to review state efforts in these three selected areas and seek out notable state initiatives. Experts from academia and selected assisted living organizations, consumer advocates, and state regulators were interviewed along with available research and evaluations to develop reports on each of these three topics in order to describe different approaches that the States may wish to emulate. As legislative requirements are somewhat different than in BC, these approaches are not described in this paper; however, the GAO reports provide background material, if desired, including extensive philosophical discussions and description of options on assisted living practices. These reports (Type III-1) include:

- US Government Accounting Office (1999). Assisted Living: Quality-of-Care and Consumer Protection Issues in Four States. GAO.
- US Government Accounting Office (2004). Assisted Living: Examples of State Efforts to Improve Consumer Protections. GAO.

4.4 Promotion of Quality Improvement - Assisted Living for People with Mental Health and/or Substance Use Disorders

Time-limited recovery and rehabilitation programs provided in residential settings are one component of a continuum of clinical and therapeutic support for people with mental illnesses and/or problematic substance use. Assisted living residences offer a safe, supportive environment in which these clients can acquire knowledge and skills that will enable them eventually to live in more independent settings in the community and to pursue educational opportunities or meaningful employment.

The OALR is in the process of developing, through research and consultation with health authorities and operators, the general terms of operation that apply to assisted living residences for people with mental health and/or substance use disorders. This initiative has emerged with implementation of the CCALA, which requires that all assisted living residences register with the OALR. A draft *Mental Health and Addictions Residences Service Profile* has been developed by the OALR for review and consultation, and as of April 2010, has not been finalized.

The CCALA defines six areas of personal assistance services that can be offered in a Mental Health and Addiction (MH&A) residence. These services commonly include psychosocial rehabilitation, medication services and management of resident cash for clients with mental health and substance use disorders. These personal assistance services may be provided at a less intensive 'support level' or at a more intensive 'prescribed level' (the services and levels are described in the draft *Service Profile*). Operators ensure that all individuals performing staff functions are appropriately oriented, training and supervised for the services they deliver.

Limited evidence was located on regulatory oversight or quality improvement related to mental health and substance use residential treatment and recovery programs. Although there are a number of studies and best practice documents available on effective diagnostic, treatment and rehabilitative approaches, these are outside the scope of this review. Related public health information can be found in the evidence review, which supports the core program on promotion of mental health and prevention of mental disorders, and the core program for prevention of harms associated with substances.

4.4.1 Problematic Substance Use

Two types of residential services and supports in BC are:[88]

- ***Supportive Programs (Supportive Recovery, Stable/Transitional Living)*** – These residences are temporary settings providing safe housing and basic level of support appropriate for longer-term recovery from problematic substance use. They are suitable for people who require low-moderate intensity of services and require stabilization and support to reintegrate into the community.

- ***Residential Treatment*** – These programs provide time-limited treatment in intensive, substance-free, live-in environments. Residents are most likely to be those with more complex or chronic substance use. Treatment includes ongoing assessment, education and structured individual group and family counselling-therapy.

The Ministry of Health Services has drafted *Service Model, Standards and Guidelines for Adult Residential Substance Use Services and Supports* (n.d.) as a starting point in a longer-term process of developing a consistent, coordinated, robust and integrated system of substance use services. Suggested principles for residential services, based on the 2008 National Treatment Strategy (NTS)[89] (Type III-1) include:

- ***No wrong door*** – Every person receives the necessary support, from whichever health professional that person first seeks help from for her or his substance use, to get the services she or he needs;

- ***Availability and accessibility*** – Every person who can benefit from residential services and supports is able to access them promptly and in a location that can best promote her or his recovery.

- ***Matching*** – Every person participates in a full and collaborative assessment in order to match her or him with the most appropriate services. The assessment process respects each person's diverse needs, strengths and preferences.

- ***Choice and eligibility*** – Every person can choose among the residential supports and services for which she or his is eligible.

- ***Flexibility and responsiveness*** – Residential programs respect each person's diverse needs and circumstances and provide care that is as client-centred and individualized as possible. The programs respond to each person's changing needs and goals as she or he progresses on her or his treatment journey.

- ***Collaboration and coordination*** – Residential programs build and maintain strong partnerships with community-based services and supports and share client information securely and appropriately in order to ensure that each person receives the care she or he needs when it is needed.

5.0 RESIDENTIAL CARE FACILITIES (CHILD, YOUTH AND ADULT RESIDENTIAL CARE)

5.1 Background to Regulation of Residential Community Care

Tremblay[90](Type III-1) notes that "despite widespread use of regulation in health care environments, there is little research examining the impact of regulation on the performance of health care organizations. Research on this topic is difficult to conduct because most health care organizations are regulated to some extent and the use of control groups is not feasible. There are however, several qualitative studies that point to problems resulting from a lack of regulated care. The Ontario *Report of the Commission of Inquiry into Unregulated Residential Accommodation*[91] reported extensive levels of neglect and abuse (physical, emotional, and sexual) of vulnerable adults in unregulated care homes in Ontario (1982). Also, a study[92] (Type II-3) conducted in the province of Quebec, where unregulated facilities house 60% of the dependent older population, found that more than 25% of the facilities were judged to experience major difficulties in responding promptly and adequately to the needs of their residents, a situation attributed in part to a lack of qualified and experienced care providers. Bravo et al.[93] examined the relationship between regulatory status, quality of care, and mortality of residents in Quebec nursing homes. They found that a resident's length of survival was influenced by the quality of the nursing home, regardless of the regulatory status. For example, median survival was 28 months among residents receiving inadequate care compared to 41 months for those receiving adequate care.

With regard to specific regulatory requirements such as processes for the prevention of medication errors, the prevention of falls, wound care, or the use of restraints, there is considerable quantitative evidence which is discussed under the specific topics in this section.

It should be noted that most of the evidence in this section is related to residential care for seniors, people with disabilities and/or other disorders who require long-term care. Private hospitals and extended care facilities are not addressed in this paper (as they are not currently within the scope of the CCALA). For the most part, discussion of residential care for people with mental health disorders and problematic substance use is addressed in section 4.0 on Assisted Living Residences.

In recent years, regulatory legislation of long-term care in many jurisdictions has shifted from a rules-oriented prescriptive approach to one which incorporates performance-based processes focusing on desired outcomes. Outcomes are considered primarily in terms of the impact on care recipients. This shift has taken place in many Canadian provinces, the UK, American States, and in Australia. It was reflected in the 1997 BC Allen Report *Community Care Facilities – A Focus on Licensing*[94] (Type III-1), and in BC legislative revisions adopted since that time. While performance-based legislation aims to specify the intended outcomes and allow the providers to decide how to achieve them, it is often balanced with some minimum requirements. Performance-based legislation is seen as advantageous as it provides an opportunity for greater flexibility and encourages innovation in achieving desired outcomes[95] (Type III-1).

In England, significant regulatory changes have occurred in recent years[96] (Type III-1). In 1997, the Hospital Advisory Services rejected a rule enforcement model in favour of a consultancy model for nursing homes[97] (Type III-1). There was a national requirement for inspections but no national standards as guidelines were set at the district level. However, there was a shift from a 'decentralized value-for-money auditing' approach in 2000 with introduction of National Minimum Standards. Organizational restructuring occurred in 2002 with establishment of a National Care Standards Commission which integrated social care inspection for services for children, adults and the aged, including takeover of aged care home inspections from local councils and district health authorities. This was followed by implementation of the Commission for Social Care Inspections which further integrated its work with other social care work of the Audit Commission and the former Social Services Inspectorate. In effect, nursing home and residential home inspections were merged 'with a social care perspective'. Social work rather than nursing became the dominant profession and represented an ideological shift to emphasize empowerment of residents and their social needs in inspections. In part, this was also due to a national shortage of nurses[98] (Type III-1).

In the US, the States have responsibility for licensing nursing homes and for establishing and enforcing standards. However, the federal level provides funds and establishes standards for care of people who qualify for Medicare (health insurance) and Medicaid (health coverage for low-income persons). Many Americans rely on these programs so few nursing homes survive without Medicaid certification. As a result federal standards predominant with federal control of what regulatory activities are funded and what are not. State 'surveyors' (i.e., inspectors) administer the system but the federal government has regional offices which send out surveyors to check that state surveyors are following federal protocols. Federal surveyors also take their own enforcement action on problems they discover.

There were efforts in the US during the 1980s to deregulate nursing homes. However, consumer and community backlash was significant and the government asked the Institute of Medicine to make recommendations. The ensuing report proposed increased regulations, not less, and since that time there has been substantial regulatory growth of nursing homes including requirements for the training of nursing home staff, introduction of new residents' rights, quality assessment and assurance obligations on nursing homes, as well as substantial strengthening of enforcement and enforcement options in circumstances of non-compliance[99] (Type III-1).

Similarly in Australia, there was a strong movement to resist deregulation efforts in the 1990s, which resulted in increased regulation and centralization of regulation at the national level. This was implemented along with a movement toward more emphasis on social care, quality of life and resident rights[100] (Type III-1).

In countries such as the US, which have seen an increase in regulations and rules, these is concern about the problem of regulatory 'ritualism', which has been defined as the process of focusing on specific, detailed regulations, rules and requirements. The concern is that this approach tends to focus on objective analysis and avoids subjective assessment, problem-solving and outcomes analysis. It may also focus on details that may not be meaningful, reasonable or appropriate in all contexts[101] (Type III-1).

5.2 Strategies for Strengthening Regulatory Compliance

A number of strategies have been highlighted in the literature as effective practices used by inspectors in the process of strengthening regulatory compliance by care providers (e.g., a comparative analysis[102] (Type III-1) of regulatory process in England, the US and Australia points to best practices in nursing homes). These are described to provide information that may assist health authorities in planning and implementing their regulatory oversight practices:

- ***Strengths-Based Inspection*** – Although the inspection process is designed to correct weaknesses, it is common (in the US, England and Australia) for inspectors to have a strengths-based philosophy. This approach is based on the belief that the best way to improve is to build upon existing strengths, and that ultimately these strengths will expand to overcome weaknesses or to compensate for them. Contemporary health care professionals that support regenerative care and restorative nursing tend to be hospitable to a strengths-based approach. This strategy can assist inspectors in building good relationships, which can then facilitate open discussion of problems.

- ***Catalyst For Cure of Root Causes*** – A common compromise for inspectors who want to help solve problems without disempowering a provider is to consult in a non-directive way—called diagnostic inspection[103] or catalytic inspection[104]. Often catalytic inspection takes the form of enforced self-regulation. For example, instead of telling the nursing home how to solve a problem, the inspector would require the home to develop a written plan to solve the problem and evidence that the plan was implemented and was working. The diagnostic/catalytic inspection implicitly looks for root causes and systemic solutions that work[105] (Type III-1).

- ***Praise*** – The most important communication tactic for building strengths is praise. It is recognized that care staff receive many of their job rewards from evidence that they have done something which has helped a person who is suffering. A quantitative study from 410 Australian nursing homes found that inspection teams who used praise as a key regulatory strategy improved compliance in the two years following an inspection significantly more than inspection teams that did not.[106] This remained true after efforts to control for how deserving of the praise homes were. The study concluded that when collectivities are praised, all involved individuals feel they share in the credit. In contract, when collectivities are blamed or punished, each involved individual tends to believe it is someone other than themselves who are responsible. Informal praise was considered a more powerful form of social control of collectivities than blaming[107] (Type III-1).

  The literature also notes that ‘pride’ and ‘shame’ are repeatedly used by Australian regulators and are viewed as key motivators. To avert a displacement of shame into ‘accusing the accusers’, inspectors have found they must be procedurally fair in everything they do. In evidence from 341 Australian nursing home inspections, procedural justice on the part of inspectors was associated with improved compliance, injustice with declining compliance. The strong message from the data was that inspectors must confront non-compliance firmly while treating managers and professionals respectfully[108] (Type III-1).

- ***Education and Persuasion*** – Kagan and Scholz[109] (Type III-1) argue that for care providers considered to be 'amoral calculators', who cut corners to increase profit, the use of tough and prompt deterrence is the best strategy. Those that are 'political citizens' generally feel an obligation to comply with law, but are prepared to disobey in domains where the law seems unprincipled, capricious or unreasonable. In these cases, the authors commend persuasion as the most appropriate regulatory strategy. A third category is the 'organizationally incompetent', which fails to comply because of a lack of managerial or technical competence. For these care providers, Kagan and Scholtz[110] (Type III-1) suggest education and consultancy as the most appropriate strategies. Similarly, a study[111] (Type II-3) of British local government inspectorates found that more "educative" regulators achieved much better compliance outcomes for small and medium-sized enterprises and concluded that regulatory education both helps these smaller organizations to understand requirements and helps them remove blockages to the complexity and level of compliance. While enforcement-oriented and consultancy-oriented inspectors tend to disagree on the virtues of praise, they tend to agree that an important part of regulatory strategy is to educate providers on what the standards require and persuade them that the standards are desirable. Consultants consider themselves in a good position to do this, while those with an enforcement approach prefer to deal with education and persuasion through training courses rather than the inspection process[112] (Type III-1).

- ***Responsiveness*** – Responsive regulatory strategies hypothesize that it is best to have a presumption in favour of trying persuasion first, generally reserving punishment for when persuasion fails. However, it is argued that persuasion will normally be more effective than punishment in securing compliance when the persuasion is backed up by punishment. The first step is the most restorative, dialogue-based approach that can be crafted for securing compliance with a just law, followed as necessary with more and more demanding and punitive interventions when dialogue fails[113] (Type III-1).

- ***Gradual 'Raising of the Bar'*** – Many regulators adopt the approach that gradual incremental improvement is necessary over time to achieve desired change. This theory is based on the belief that stringent demands for improvement by providers do not necessarily result in desired outcomes, but rather there is an optimal level of stringency to entice providers to maximize improvements, and that gradual improvements over time can achieve major change. It also follows that the level of improvement required for some providers will be sub-optimally low for others who have already achieved significant improvements. For example, a head of nursing home inspection in Australia noted that "you want to encourage the best homes to leapfrog ahead to become frontrunners and take pride in the fact that you hold them up as an example of excellence. Then try to get the poor performers to catch up as much as they will voluntarily"[114] (Type III-1).

- ***Continuous Improvement*** – Over time, there has been increased emphasis on evidence of continuous improvement in Australian regulatory inspections. Rather than monitoring specific standards, inspectors require evidence of improved outcomes. A new burden of proof was shifted to nursing homes in the 2000s to demonstrate with evidence that they were improving. This has encompassed a shift from a minimum outcome mentality to continuous improvement. This process has required education and training to assist

providers in root cause analysis, how to differentiate between outputs and outcomes, and the development and documentation of quality evidence[115] (Type III-1).

- ***Participatory Approaches*** – A best practice by regulatory officials, based on US and Australian experience, is to meet with the residents' council and a wide variety of staff as part of their inspection process to provide a richer and more objective context than simply talking to the director of care or to professional staff. This avoids the potential for 'capture', the process of undue influence by the care provider on the perceptions of the licensing officer or inspector[116] (Type III-1). Exit conferences held by inspectors following their review, are participatory in the US and Australia, in terms of inclusion of residents, relatives and different levels of staff. Overall, fuller participation of staff in decision-making has been shown to improve care[117] (Type III-3). There is also evidence that engagement of relatives with the nursing home including regular visits, improves the quality of care[118] (Type II-3).

- ***Resident Empowerment*** – Resident councils and complaints systems are well established in the US and Australia and act to support the empowerment of residents. Also, US care plans, which are thorough, multidisciplinary and tend to be 'living documents', are updated on a regular cycle through a participatory process that involves the resident and involvement of the resident's relatives[119] (Type II-3).

The literature also points out that improvements to the quality of services result not only from legislative requirements and the work of regulators within the bureaucracy, but from the combined efforts of the network of advocacy groups, business innovators, and professional groups and associations.

5.3 Regulatory Practices

Practices that are considered effective in administering regulatory oversight activities (i.e., licensing, monitoring, inspection, investigation and enforcement) are discussed in this section. Additional approaches recommended by the National Association of Regulatory Administration can be found in Appendix 4.

Regulatory oversight activities are based on administrative law, which like constitutional law and criminal law, are part of public law. Administrative law establishes legal rules that govern the exercise of powers by public bodies. There are two main aspects of administrative law:

- Procedural fairness rules that provide participation rights to persons about whom decisions are made by public bodies; and

- Legal rules relating to how closely an appellate tribunal or court will examine decisions of public decision-makers. There latter rules are known as the "standard of review."[120]

Ten dimensions or factors that are characteristic of effective regulation practices in healthcare are identified in *Regulating Healthcare: A Prescription for Improvement?*[121] (Type III-1). These were based on empirical evidence on US healthcare regulation and took into account both the ideas of responsive regulation as well as the work of the UK Better Regulation Unit.

They are:

- ***An improvement focus*** – improvement is a primary objective;
- ***Responsiveness*** – adaptable to individual regulated organizations depending on their response and behaviour, with access to a range of different detection and enforcement mechanisms;
- ***Proportionality and targeting*** – focus on areas where performance problems are known or suspected, and interventions are appropriately matched to the size and importance of the problems or issues;
- ***Rigour and robustness*** – regulations are developed through a rigorous process, based on available evidence, and tested for validity and reliability in use;
- ***Flexibility and consistency*** – sufficiently flexible to allow discretion in responding to situations, while also ensuring consistency;
- ***Cost-consciousness*** – costs and benefits to the regulatory agency, and to regulated organizations, are calculated and taken into account;
- ***Openness and transparency*** – information on the regulatory process, and on findings, is easily available to stakeholders and the public;
- ***Enforceability*** – the regulator has access to a wide range of incentives and sanctions to secure change;
- ***Accountability and independence*** – there are mechanisms for holding the regulator accountable for its actions to patients, the public, funders, providers and policy-makers, while also ensuring independent decision-making on the part of the regulator;
- ***Formative evaluation and review*** – systems are in place to monitor and evaluate regulation systems and their impact.

The above characteristics of effective practice were developed to address and offset common problems of regulatory failure. Walshe[122] (Type III-1) identifies reasons for regulatory failure, and notes that "understanding the causes of regulatory failure is crucial if they are to be avoided or ameliorated". He notes that some common problems of regulatory failure include:

- ***Capture*** – the regulatory process is "captured" by particular sectional interests which exercise undue influence over decisions to promote their own self-interest;
- ***Goal displacement*** – the original purposes of regulation are replaced or overlaid with other objectives, often quite different in character;
- ***Proliferation*** – the systems of regulations expand over time and increase in scope, complexity, and cost and become disproportionately extensive and intrusive;

- ***Ossification*** – regulations inhibit or hinder natural processes of change, innovation, and development both by prescribing and putting in place ways of doing things and by focusing on compliance rather than on improvement;
- ***Unaccountability*** – insufficiently accountable to the policy process which created it or the legal system within which it operates;
- ***Juridification or legalism*** – regulation becomes progressively more legalistic in character, style and process.

5.3.1 Licensing

A licensing process involves several interrelated phases, each with a specific purpose and function. Phases include: a due diligence or inquiry phase; application phase; investigation phase (i.e., investigation of application); licence issuance phase; and compliance monitoring.

The purpose of the due diligence or inquiry phase is to provide information and knowledge that will enable a potential applicant to make an informed and responsible decision about whether to make a formal application. A person who requires an application should receive: licensing statutes; explanation of rules, an application form, and other explanatory materials. Many agencies encourage or mandate inquirers to attend an orientation training session to explain the licensing process and the agency's expectations[123] (Type III-1).

Application for a licence is critical to the licensing process. A number of additional documents may be required to complete an application including: staffing plans; staff certification; program proposals; operational policies; information handouts; layout plans, references; resume; TB screen; medical clearance; service plan, insurance coverage; policies and procedures; forms; funding; and/or interim board of directors. A review of the licensing application is a systematic and objective examination of the intent, characteristics, and qualifications of an applicant to determine compliance with licensing rules[124] (Type III-1). (The CCALA requires that the Medical Health Officer (or delegate) "investigate every application for a licence to operate a community care facility or any other matter relevant to the application.")

5.3.2 Compliance Monitoring and Inspection

Compliance monitoring is official observation to determine ongoing or continued compliance with regulatory requirements. Its purpose is preventive in that it is undertaken to reduce noncompliance[125] (Type III-1).

The approach to monitoring and inspection varies considerably in different countries. In the UK, principles for monitoring and inspection by regulatory officers are:[126]

- Pursue the purpose of service improvement;
- Focus on outcomes;
- Take a user perspective;
- Be proportionate to risk;

- Encourage self-assessment by managers;
- Use impartial evidence that is validated and credible, wherever possible;
- Disclose the criteria used in forming judgments;
- Be open about the processes involved;
- Have regard for value for money, including that of the inspection body; and
- Continually learn from experience.

English nursing home inspectors are called 'street-level bureaucrats' in the literature, reflecting the fact that they are public servants who have frequent face-to-face interactions with the public and are granted significant discretion in how to conduct the interaction. Their power comes not from formal enforcement regulations but from influence over approval of new beds, new homes and buildings as well as influence on the reputation of a nursing home[127] (Type III-1). American inspectors (or surveyors) tend to be regimented: by the detailed nature of the national regulatory regime they must comply with, by federal inspectors who check that they are following correct protocols and procedures, by documentation requirements, and by rigorous supervisory arrangements at the state level[128] (Type III-1).

As inspections are the accepted primary practice to ensure compliance with licensing requirements and a number of factors should be considered in determining the type and frequency of inspections. These include the following:

Consistency

Consistency in applying the regulations is an issue that is raised repeatedly in the literature. It is equally necessary in the licensing approval process mentioned earlier, as in the monitoring, inspection and investigation process.

The New Brunswick Auditor General recommended that documented policies and procedures be used to guide inspectors in conducting consistent inspections, as "without documented policies and procedures guiding the inspection process, there is an increased risk of inconsistency in how inspections are performed"[129] (Type III-2). The following practices were recommended to enhance consistency in licensing:

- New inspectors receive on-the-job training that includes shadowing a co-worker and then being shadowed;
- Common forms are used by all inspectors when preparing for, conducting, and documenting inspections;
- Inspection review meetings are held regularly to discuss inspection results and enhance consistency in reporting infractions; and
- Review of inspection reports are analyzed to determine consistency in the number of infractions reported by inspectors.

As well, it should be noted that some experts point to the importance of balancing consistency with flexibility. Walshe[130] (Type III-1) notes that effective regulation should be sufficiently flexible to allow discretion in responding, while also ensuring an appropriate level of consistency. These considerations are relevant to British Columbia as exemptions are allowed (in some sections only) from a requirement of the Act or the regulations "if there is no increased risk to the health and safety of persons in care."[131] Flexibility is also important as a way to avoid the problem of regulatory 'ritualism' which focuses on specific, detailed regulations, rules and requirements, and thus may overlook the analysis of outcomes and problem-solving of root causes, while focusing on details that may not be meaningful or appropriate in all contexts[132] (Type III-1).

In BC, it is recognized that a consistent and standardized approach to requirements for the licensing officer occupation is necessary, particularly to respond to the Ministry's 'outcome-based' approach to health care. A publication on the *Licensing Officer Occupational Profile*[133] (Type III-1), completed in 2009, identifies the skills and knowledge necessary for competent performance in this field, and the related background required to perform each of the skills.

Standards

Legislation identifies minimum standards that are acceptable in a jurisdiction, and these provide the basis for determining compliance. However, it may also be appropriate for health authorities, as recommended by the Auditor General of Alberta, to clarify the standards in the form of performance expectations for residential care facilities. In a 2005 *Report on Seniors Care and Programs*[134] (Type III-2), the Auditor General of Alberta recommended that health authorities have systems to develop and maintain current standards, or performance expectations, for services provided in long-term care, as regulated "basic standards" can be unclear or become outdated. The *Report* recommended that health authorities should:

- Have policies and guidelines which define standards for services provided in long-term care;
- Periodically review the standards (performance expectations) to ensure they are current and relevant;
- Use information gathered from monitoring compliance with standards to determine whether changes are required;
- Consider the results of complaints, incidents and investigations when reviewing the standards;
- Periodically obtain feedback on the standards from key stakeholders such as professional organizations and facilities;
- Establish a process to recommend and approve changes to the standards; and
- Communicate the standards to facility operators.

The Alberta Report also recommends public disclosure of basic standards, rather than the existing situation where the "Department makes the Basic Standards available to those individuals that request them but they are not readily available, and Authorities are not required to advise residents of the basic standards." Stakeholder groups had informed the Auditor General of Alberta that residents and family members of long-term care facilities were not familiar with the standards, and therefore, were unsure of the level of service they should expect.

Similarly, a key outcome in *A Review on the Quality of Care Homes in Scotland, 2004*[135] (Type III-1) was

> The aim must be to continue to make it easier for people in care homes, their families and friends, to speak up, and air their views. The Care Commission intends to help raise their expectations so that they can lead as rich a life as possible.

In 2005, the Scottish Commission on Regulation of Care issued the National Care Standards in a readable, accessible form to assist residents and their families in identifying their rights as they seek quality care.

Risk Assessment

Risk assessment is defined as the process of estimating the likelihood specific undesirable event occurring, the severity of the harm or damage that may be caused, together with a value judgment concerning the significance of such harm. It therefore has two distinct elements: risk estimation and risk evaluation[136] (Type III-1). The potential frequency and impact of events is analyzed as part of a risk evaluation process. This will include adverse effects that are rare but as Brown[137] (Type III-1) notes "very rare errors with high immediacy and causality generate concerns over safety." More frequent events with low immediacy and causality, such as failure to vaccinate, are often conceptualized as quality rather than safety issues. However, at a population level, incidents of high frequency but lower harm, immediacy or causality, may contribute more harm overall (e.g., failure to detect or respond to deteriorating patients, or to address the problem of falls in hospitals).

The Provincial Auditor of Ontario recommended implementation of "a formalized risk-assessment approach for its annual inspections that concentrate on facilities with a history of non-compliance, [in order to] prioritize inspection procedures"[138] (Type III-2). The Report proposed that "full inspection may not be warranted for facilities that have historically always been in compliance and have received few or no complaints, while facilities with chronic problems may warrant more in-depth inspections"[139] (Type III-2).

Similarly, the Auditor General of New Brunswick (Type III-2) has also recommended a formalized risk management approach for prioritizing nursing home inspections. It was noted that "a risk management system would result in more frequent and/or in-depth inspections in nursing homes assessed as having a higher risk". It also pointed out that "size and risk are often related. We consider larger nursing homes to have a higher risk due to the number of residents involved."

In the Brookings Institute publication *The Regulatory Craft: Controlling Risks, Solving Problems and Managing Compliance*, Sparrow[140] (Type III-1) discusses the importance of collaboration and partnership in the development of a risk assessment process or tool. He states that

> Regulators also need to engage others quite deliberately during the analytical stages of problem solving or risk assessment. They need to present draft analyses and options outside the agency, engaging communities in weighing the pros and cons of each, and ferreting out potential contributors to a solution. Regulators should be able to gather and test ideas and perspectives from outsiders without offering them a veto or vote, without suffering the paralysis that results from trying to find unanimous consensus, and without negotiating away their capacity to take adverse actions against those they regulate.

A new publication entitled the *Character of Harms: Operational Challenges in Control* (2008), by Malcolm K. Sparrow, of Cambridge University Press (Type III-1) discusses the task of controlling or mitigating potential harms in society generally through regulatory aspects of governance. Although not focused on health care services, it provides a background to risk assessment, risk management and risk reduction.

Other key documents in the field of patient safety are *Patient Safety and Healthcare Error in the Canadian Health System: A Systematic Review* (Baker and Norton, 2004) (Type II-2) and *Patient Safety; Achieving a New Standard of Care* (U.S. Institute of Medicine of the National Academies, 2004) (Type III-1).

(It should also be noted that *A Manual for Risk Based Inspection* and a related *Risk Based Inspection Checklist* is under development by the BC Ministry of Healthy Living and Sport (June 2009). The new risk assessment approach will utilize the Enterprise Wide Risk management (ERM) approach that has been adopted by the Government of British Columbia. These will provide a common tool for decision-making across the province to facilitate consistency, inter-rater reliability, dialogue between health authorities and comparative analysis to facilitate improvement in licensing practices. This tool will recognize that the regulatory threshold is set at the minimum acceptable level and that most violations/contraventions pose a degree of risk for persons in care and some violations will pose significantly more risk than others.

Measurement Tools and Systems

Instrument-based program monitoring is a movement within licensing and regulatory administration that supports the use of measurement tools, ranging from qualitative to quantitative forms of measurement. The move toward quantitative systems began in the 1970s as a result of the increasing number of facilities and demands on licensing staff, combined with a growing need to understand compliance trends. Some of the key measurement systems that have been introduced [141] (Type III-1):

- ***Checklists*** – comprehensive measurement tools that measure compliance with rules in a yes/no format. Either the facility is in compliance with the rule or not;

- ***Indicator system*** – a measurement system utilizing a shortened version of a comprehensive checklist measuring compliance with rules through a statistical methodology using only key predictors. The key indicator checklist is used for inferential inspections where only a portion of the full set of rules is measured;
- ***Rating scales*** – rating tools that measure performance, going from more to less, or high to low. Rating scales are not used in measuring compliance with rules (as partial compliance is not acceptable), but with program quality assessment systems;
- ***Weighting systems*** - used to determine the relative risk to individuals if there are violations with specific rules. Weighting systems are generally developed by sending a survey to a selected sample of people in order for them to assess and ranks the relative risk associated with violation of specific rules;
- ***Outcome-based systems*** – used to measure outcomes, not processes. A facility would be assessed by the outcomes it produced with individuals (e.g., the number of consumers - children and adults - developing normally free from abuse, the number actively involved in the community, and so on). This approach has been controversial give that "the purpose of licensing is to prevent harm to consumers – a purely outcome-based system would potentially harm consumers who were in the facilities later determined to "fail" the outcomes test. Moreover, there is…insufficient agreement on what are acceptable outcomes"[142] (Type III-1).

Inspection Frequency

Although some jurisdictions take into account the level of risk and operational history to determine the frequency and the depth of inspection, others apply regular schedules. For example, the Ontario Ministry of Health and Long-Term Care has a policy that "reviews will be conducted at least once in a calendar year. The objective of the annual inspection is to monitor and evaluate the quality of resident care and services, the quality of programs, and the overall operation of each facility"[143] (Type III-2).

Annual inspections are increasingly being considered the best practice in inspection frequency. The Auditor General of New Brunswick noted

> We believe nursing homes should be inspected at least annually. This expectation is practical given government's inspection frequency for day care facilities and restaurants. It is also reasonable given other government's inspection frequency for nursing homes. In Nova Scotia, nursing homes are inspected at least twice each year. In Ontario, nursing homes must be inspected at least once each year[144] (Type III-2).

In the US, "every nursing home receiving Medicare or Medicaid payment must undergo a standard survey (inspection) not less than once every 15 months, and the state-wide average interval for these surveys (inspections) must not exceed 12 months." (CMS generally interprets these requirements to permit a state-wide average interval of 12.9 months and a maximum interval of 15.9 months for each home)[145] (Type III-1).

Announced/Unannounced Inspections

Announced inspection visits are accepted practice and appropriate for inspection of new facilities, regularly scheduled inspections, and visits to isolated or remote locations when there is a need to ensure availability of providers, etc. In addition, unannounced visits are widely accepted as a best practice in the inspection of community care facilities. Braithwaite notes that unannounced visits, including evening and weekend visits provide the opportunity to observe and gather information on practices such as food quality and meal arrangements, processes for awakening residents and preparing them for the day, medication administration, staffing levels in the evening, etc[146] (Type III-1). A number of Auditor General reports have also recommend the use of unannounced inspections, for example:

- In 2002, the Provincial Auditor of Ontario[147] (Type III-2) recommended the use of "surprise inspections of high-risk facilities to reduce the risk that facilities will prepare for an inspection". The Auditor's Report stated that a facility may be notified up to a week in advance of an upcoming annual inspection, and some facilities may use this time to "prepare" for the inspection. As such, the inspection results may not be reflective of the ongoing care provided at the facility; and

- The Auditor General of New Brunswick[148] (Type III-2) noted in 2004, that

> Normally inspections are more effective when there is no notification. The element of surprise is important to obtaining a true representation of operations. While we understand advance notice results in the inspection being more convenient for both the nursing home and the inspector, it provides the opportunity for the nursing home to 'prepare' for the inspection and it may inhibit an inspection of the true operations. Conducting surprise inspections periodically could improve day-to-day compliance with the standards, as the nursing home would know the inspector might arrive any day.

Data collected from 40 different states/provinces/territories in 1996[149](Type III-1), representing child care, child welfare, drug and alcohol, adult resident, adult day care, mental health and developmental disabilities, identified their practices using announced and unannounced licensing inspections. The results of the study[150] (Type III-1) indicated that:

- 81% of the respondents indicated there were written requirements specifying if licensing inspections should be announced or unannounced.

- Compliance inspections – 49% conduct unannounced inspections, 40% conduct either announced or unannounced inspections depending on the circumstances, and 11% conduct announced inspections.

- New facility inspections – 88% conduct announced inspections, 11% conduct either announced or unannounced inspections, and 1% conduct unannounced inspections.

- Interim inspections – 47% conduct unannounced, 45% conduct announced, and 8% conduct both announced and unannounced depending on the circumstances.

- Frequency of unannounced inspections – 39% conduct announced inspections on a random basis, 39% conduct unannounced inspections once a year, 13% conduct unannounced inspections twice a year, and 2% conduct unannounced inspections every 2 years.
- Few state/provinces/territories have any formal targets for conducting unannounced inspections, however of those who do, the criteria for targeting licensed facilities for unannounced inspections include: repeat violations; complaint history; negative sanction history; recent staff turnover; violation history; recent serious violations; changes in program; whether facility is accredited; and the type of licence.

5.3.3 Investigation

Investigations may be prompted by complaints, reportable incidents (e.g., aggressive behaviour, abuse, neglect, etc.), reports on the operation of unlicensed facilities, observations by health care providers, or observations made during routine investigations. When there is an allegation or report that a licensed facility is not in compliance with the licensing statute and/or rules, the licensing agency has an obligation to investigate. The goals of the process are to obtain accurate information about alleged violations; adhere to due process and fairness: and balance the need for the safety of persons in care and the rights of the licensee and the alleged perpetrator[151] (Type III-1).

The Provincial Auditor of Ontario recommended that

> to better protect the health and safety of residents of long-term-care facilities, it important to ensure that all:
>
> - Complaints are investigated and responded to in a timely manner;
> - Unusual occurrences and outbreaks of contagious infections are reported to the Ministry and recorded in its Facility Monitoring Information System on a timely basis; and
> - Complaints, unusual occurrences and outbreaks of contagious diseases are assessed in relationship to annual facility inspection results to identify and resolve systemic problems.[152] (Type III-2)

The Auditor General of New Brunswick recommended[153](Type III-2) that "documented policies and procedures are needed to ensure complaints received from the public are investigated promptly, documented consistently, and monitored to identify trends…" Furthermore, it was proposed that compliance with the documented procedures be monitored to ensure the proper processing of complaints received from the public.

5.3.4 Enforcement

Compliance levers vary considerably across jurisdictions. In England, there is much 'bargaining and bluffing' using praise and disapproval to influence care providers. Although influence plays an important role in the US and Australia, there are greater enforcement powers and centralization of decision-making which support tougher compliance measures. Serious exit conferences are characteristic of most US and Australian jurisdictions[154] (Type III-1).

Experts in the field argue that education and persuasion will normally be more effective than punishment in securing compliance if it is backed up by punishment. The first step is the most restorative, dialogue-based approach that can be crafted for securing compliance with a just law[155] (Type III-1).

In the Brookings Institute monograph *Regulatory Craft: Controlling Risks, Solving Problems, and Managing Compliance*[156](Type III-1), Sparrow conceptualizes graduated responses to noncompliance in the form of a pyramid. Rather than a continuum, he discusses a hierarchy of responses and a balance among them, "wherein the softer approaches (at the base of the pyramid are employed more frequently, and the tougher sanctions (at the apex) are applied, but applied least often". The enforcement sanctions (starting at the bottom of the pyramid) are: persuasion; warning letter; civil penalty; criminal penalty; licence suspension; and licence revocation. He also notes that "regulators should always retain the capacity to apply tough sanctions, because a strategy based entirely on persuasion and self-regulation will be exploited when actors are motivated by economic rationality. He notes that having the big guns may prevent regulators from the need to use them very often and make persuasion and lower-level sanctions more effective.

> Regulators will do best by indicating a willingness to escalate intervention…The greater the heights of tough enforcement to which the (licensing) agency can escalate, the more effective the agency will be at security compliance and less likely that it will have to resort to tough enforcement[157] (Type III-1).

When positive approaches to enforcement are unsuccessful, increasing levels of more demanding and punitive interventions are necessary[158](Type III-1). The type of negative enforcement strategy is determined in part by the degree and extent of violation of the rules/statute and the degree of risk to the consumers. "The use of negative sanction is not to 'punish' the violator, but to compel compliance to protect the consumer. Licensing should use the least amount of force over the shortest period of time necessary to safeguard the public"[159] (Type III-1).

Licensing actions typically fall along a continuum that ranges from the least intrusive/least enforcement to the most intrusive/most enforcement. The degree to which a facility falls on this continuum depends on the degree of risk to the individuals in the facilities care. In other words, if an operator shows evidence of proactive, safe care, licensing intervention is primarily supportive in nature. If however, the operator is unable or unwilling to maintain basic safety standards, licensing moves toward enforcement actions up to and including the cancellation of the licence[160] (Type III-1).

Reconsideration/Appeal

An appeal by a licensee or applicant should prompt an impartial review by a statutory decision maker, or designated hearing officer. It is important to follow the principles of due process with evidence submitted by both the licensee or applicant and the agency, in an attempt to persuade the hearing officer that action should or should not be taken against the licence[161] (Type III-1).

5.4 Promotion of Prevention Services in Residential Care Facilities

This section provides information to assist health authorities in promoting initiatives for disease and injury prevention in community care facilities. Included are: falls prevention for adults (children's falls prevention in included in section 4.2), prevention of infections and communicable diseases, and prevention of medication errors. Other key prevention initiatives such as the prevention of pressure ulcers, which is based on nursing practices and standards is beyond the scope of this review and is addressed, along with a number of other key prevention issues, in the *Evidence Review: Prevention of the Adverse Health Effects of the Health Care System.* Additional issues that may negatively impact community care facilities are addressed in evidence reviews which support the core public health programs on air quality, water quality, food safety and healthy community environments.

In addition, it is important to note that a wide range of positive health promotion initiatives such as rehabilitation, physical exercise and nutrition programs, could also be considered appropriate as prevention measures. Rather than citing evidence related to these categories in this document, health authorities can refer to the evidence reviews which support the core program on healthy living (physical activity and nutrition), the core program on promotion of mental health and prevention of mental disorders, and the core program on prevention of harms associated with substances.

5.4.1 Prevention of Adult Falls in Residential Care Facilities

Fall Risk Screening and Assessment

There is strong evidence for the use of fall risk screening and assessment followed by the development and implementation of tailored interventions ranging from single interventions to a multifactorial approach[162] (Type II-3). (The new BC Residential Care Regulation requires falls prevention screening and falls prevention plans for all long-term care facilities.)

Risk factors for falls include those that are not amenable to change, such as age and sex, as well as factors that can be changed, such as poor balance, muscle weakness, medication use, etc. The latter group of potentially changeable factors are the focus of the studies reported below. However, knowledge of all risk factors can help in identifying those at greatest risk and assist in designing appropriate prevention strategies[163] (Type II-3).

In a review of assessment tools, Scott[164] (Type II-2) reported that, in residential or long-term care settings, six studies examined ten different tools: sensitivity scores ranged from 43 to 91% and specificity from 39 to 82%. The Mobility Fall Chart showed 85% sensitivity and 82% specificity in a developmental study but only 43% sensitivity and 69% specificity in a follow-up study. The Downton index demonstrated high sensitivity yet failed to produce acceptable specificity. A

number of tools failed to measure outcomes in some categories. Scott suggests that it might be argued that development of screening tools to predict falls in high-risk populations, such as residents of long-term-care homes, is of limited use as all residents should be considered high risk and therefore receive an assessment linked to evidence-based interventions[165] (Type II-2).

Multifactorial Risk Management Strategies

There is overall consensus among a number of literature reviews on falls prevention that multifactorial falls prevention strategies are the most effective approach in demonstrating a reduction in the number of fallers and the frequency of falling, and that a multifactorial approach should be implemented as part of an overall, comprehensive falls prevention program[166] (Type II-3).

In long-term care and residential care settings there is some evidence for appropriate multifactorial interventions for all residents (not only those with dementia and cognitive impairment), as follows:

- Medications
    - Reduction of medications was a prominent component of effective fall reducing interventions in community-based and long-term care multifactorial studies[167] (Type II-2).
- Vitamin D and calcium supplements
    - The use of Vitamin D and calcium to enhance bone and muscle strength have been found by a number of researchers to be supported by strong evidence[168](Type II-2) [169] (Type II-3).
- Exercise
    - Exercise as a fall prevention strategy in nursing homes has been linked to improved muscle strength, gait and endurance[170] (Type II-2) Todd[171] (Type II-2) also notes there is evidence to support exercise programs for those at high risk, as well as gait training and advice on appropriate use of assistive devices.
    - The American Geriatrics Society[172] (Type II-3) found evidence on exercise to be the strongest for balance training, with less evidence for resistance and aerobic training and little data regarding the intensity or type of exercise. They report that successful programs have consistently been over 10 weeks duration and that exercise needs to be sustained for continuing benefit. Exercise programs work best within a multifactorial fall-prevention program but there is evidence that they work alone as well.
- Hip protectors
    - Hip protectors have been demonstrated to substantially reduce hip fractures in older people in residential care settings. Their effectiveness depends on the model, correct placement and adherence. The available evidence for hip

protectors reveals that: hip protectors do not reduce the incidence of a second hip fracture in community-dwelling older people; adherence to hip protector wear is improved by staff education; investigation of osteoporosis risk and appropriate interventions is an important complementary strategy[173] (Type II-2).

- Other devices
    - Footwear, environmental modifications, ambulation devices, bed alarms and surveillance systems are examples of devices for which there is limited evidence. Scott[174](Type II-3) notes these common sense strategies and practical solutions have not been studied using rigorous research methods, or have only been tested as part of a package of multiple strategies and not yet shown to be independently effective in reducing falls or fall risk factors; however, many of them are in common use in institutional settings and are supported in the non-scientific literature.

Staff Training

A number of researchers have noted the value of staff education and training as a component in multifactorial fall prevention programs:

- Staff education programs on fall prevention in long-term care and assisted living settings are recommended as a guideline by the American Geriatrics Society. Rubenstein[175] (Type II-2) also found staff education to be a component of successful nursing home programs.
- There is little evidence for educational strategies when given in isolation of other interventions. However, education is seen as an important component of other strategies[176] (Type II-2).

Further best practices for an organization-wide comprehensive falls prevention plan are described in the following papers:

- *A review of the literature on best practices in falls prevention for residents of long-term care facilities* (2003), by V. Scott, M. Donaldson, & E. Gallagher.[177]
- Multifactorial and functional mobility assessment tools for fall risk among older adults in community, home-support, long-term and acute care settings (2007), by V. Scott, K. Votova, A. Scanlan, & J. Close, in *Age and Ageing*.[178]
- *Clinical guidelines for seniors falls prevention* (2006), by V. Scott, & B. Duncan.[179]

5.4.2 Prevention of Infections and Communicable Diseases

Immunization

For providers of adult care, appropriate immunization practices are essential for the prevention of infectious diseases. BCCDC provides recommendations and general principles for immunizations of adults who are at high risk for vaccine preventable diseases, immunosuppressed individuals and those with other specific conditions. In light of the potential for an influenza pandemic, it is particularly important to include annual influenza immunization for both persons in care and staff.

Evidence-based studies on immunization are included in *A Core Program in Immunization: The Evidence Base*, prepared by BC Centre for Disease Control in 2006 for the Model Core Program Paper on Prevention of Communicable Disease. As well, the *Evidence Review on Prevention of Adverse Effects of the Health Care System*, prepared in 2008 for the Ministry of Healthy Living and Sport for a model core program on patient safety and quality of care issues, includes a Chapter on Prevention of Occupational Injuries from Infectious, Toxic and Hazardous Agents.

Health Care Associated Infections

Elderly persons in care are particularly susceptible to infection[180] (Type II-2). The CDC estimates that 1.5 million health care associated (nosocomial) infections occur annually in residents of long-term care facilities in the US: this translates to an average of one infection per resident per year. The studies found nosocomial infection prevalence rates ranging from 2.7% to 32.7%, and incidence rates ranging from 10.7% to 20.1%, or 2.6 to 7.1 infections per 1,000 resident days. The most common infections found in long-term care facility surveys are urinary tract infections (UTIs), respiratory infections (influenza, pneumonia), infected pressure ulcers, gastroenteritis, and conjunctivitis[181] (Type III-1).

The prevalence of methicillin-resistant *Staphylococcus aureus* (MRSA) in nursing homes in the US is now 9–34%. Similar data for Canada are not available, but prevalence rates are thought to be lower[182] (Type III-1). Even though the frequency may be low, multi-drug resistant organism (MDRO) infections can cause serious disease and mortality, and colonized or infected long-term care residents may serve as reservoirs and vehicles for MDRO introduction. PHAC notes[183] (Type II-3) that most long-term care residents with antibiotic resistant infections (i.e., MRSA or VRE organisms) became colonized during admission to acute care centres. Because of persistent carriage and slow turnover of residents, there is a cumulative increase in prevalence over time. The BC Auditor General recommends that health authority contracts with providers of residential care services identify requirements in the Performance Management Framework for contractors including infection control policies and procedures; a wound management policy and procedure; a risk management plan; and a staff training plan before opening[184] (Type III-2).

The value of education for infection control staff of long-term care facilities has long been recognized and confirmed by surveys. For example, one study analyzed the effects of a 2-day, intensive basic training program on 266 infection control personnel. Trainees not only demonstrated an increase in post-course knowledge but, at 3- and 12-month follow-up, had a significant increase in implementation of key infection control practices[185] (Type II-2).

Experts note the importance of the following key prevention practices in long-term care facilities[186] (Type II-2) [187](Type II-2):

- Handwashing is the most important infection control measure in long-term care facilities. Unfortunately, inadequate handwashing has been noted in long-term care, as in other settings. (Smith, 1997).
- Additional precautions, as well as routine practices, are necessary to prevent infections transmitted by the airborne or large droplet routes. These may be indicated for residents with certain highly transmissible or epidemiologically important microorganisms (PHAC, 1999).

- Residents of long-term care facilities and their families should understand the nature of their infectious disease and the precautions being taken, as well as the prevention of transmission of disease to all family members and friends (PHAC, 1999).
- Transportation services should have policies and procedures in place for transporting residents with transmissible infections. If any additional precautions are indicated during transport, the facility should inform the personnel transporting the resident (PHAC, 1999).
- The program should be involved in quality management (QM), environmental review, antibiotic monitoring, product review and evaluation, and reporting of diseases to public health authorities (Smith, 1997).

In BC, PICNet (Provincial Infection Control Network) has outlined staffing suggestions for residential care in the report, *An Assessment of Infection Control Activities across the Province of British Columbia. Assessment Part Two: Staffing and Training Final Draft* (p.12) (Type III-1).

5.4.3 Medication Errors in Residential Care

Adverse drug events (ADEs) have been linked to preventable problems in elderly patients such as depression, constipation, falls, immobility, confusion, and hip fractures[188] (Type III-1). An example of common medication problems is illustrated in a study on Saskatchewan residential care[189] (Type III-1) which found:

- ***Polypharmacy***: Individuals were dispensed an average of 8.8 different drugs, as classified by different generic drug names;
- ***Benzodiazepines***: More than 1/5th of elderly residents were chronically dispensed a benzodiazepine. Of the chronic users, 1 in 9 were dispensed two or more concurrently, and almost 1 in 4 were chronically dispensed a dosage above the maximum recommended amount for an elderly person (Benzodiazepines increase the risk of adverse effects in the elderly, such as falls, confusion, and delirium—these risks increase significantly with higher doses, even among long-term users);.
- ***High-risk, potentially avoidable drugs*** (Beers criteria[190]): 28% of elderly residents received at least one high-risk, potentially avoidable drug from the Beers list, on a chronic basis.

Prevention strategies for addressing medication errors in nursing homes include [191] (Type III-1):

Interdisciplinary Case Management

A growing body of evidence suggests that physicians, pharmacists, nurses, and other providers working in an integrated team can significantly improve health outcomes and system efficiency. The evidence also strongly supports the pharmacist's role on the team. Randomized controlled trials have evaluated team models where clinical pharmacists have key responsibilities in providing direct patient care, developing resources to help patients understand their medications, coordinating drug management between the acute and primary care settings, and promoting

optimal prescribing. These models have been shown to reduce use of benzodiazepines, non-steroidal anti-inflammatory drugs and inappropriate medications, and to decrease costs. As well, some evidence, although weaker, supports the inclusion of other team members (e.g., one observational study demonstrated benefits of a physician, nurse and pharmacist team, and another involving geriatricians, pharmacists, social workers, nurses, dieticians and other staff showed fewer inappropriate medications after implementation of the team) [192] (Type III-1).

Medication Reviews

Wasko-Lacey et al assessed the impact of a 1999 policy implemented in a Saskatchewan Health District, which mandated that each resident receive a medication review at least every three months, preferably by an interdisciplinary team. Residents who received the medication review (41%) were less likely to experience a drug related adverse event and were less likely to be physically restrained [193] (Type III-1).

Practice Feedback and Benchmarking

Practice feedback (providing prescribing data as feedback to an individual medical provider or a facility) has been shown to be a powerful motivator for change when combined with benchmarking (benchmarking provides a reference point against which the feedback can be measured). It allows providers and managers to identify areas of practice that can be improved, as well as track progress toward improvement goals. Practice feedback and benchmarking have been extensively studied in the long-term care literature. These studies consistently suggest that effective use of practice feedback and benchmarking improves prescribing patterns and reduces overall drug costs. This strategy is also most effective when it is interactive (e.g., one-on-one review of feedback reports vs. mailed feedback reports) and when it is combined with other interventions such as educational outreach or academic detailing [194] (Type III-1).

Educational Outreach

Educational outreach strategies have proven to be effective at improving prescribing in the long-term care environment. They are commonly used in conjunction with other quality improvement initiatives such as practice feedback and benchmarking, or the use of decision support tools. Educational outreach is intended to complement other quality improvement strategies; it is not a stand-alone initiative (passive distribution of educational materials has usually shown little impact on providers' practice). The literature indicates that effective outcomes occur when: outreach is interactive; all members of the care team are included (e.g., nurses, special care aides, physicians, pharmacists, recreation therapists, etc.); decision supports or written information are provided for future reference; and it is combined with other interventions (e.g., practice feedback and benchmarking)[195] (Type III-1).

5.5 Promotion of Quality Improvement in Residential Care Facilities

Health authorities can play a pivotal role in encouraging community care providers to enhance the quality of care they provide and to support continuous quality improvement. A number of measures that have been shown to contribute to quality services in community care: these are discussed below to provide background information for health authority activities in this area.

The World Health Organization[196] (Type III-1) notes that health promotion efforts should encompass a number of strategies: building healthy policies, creating supportive environments, strengthening community action; developing personal skills, and reorienting health services. Some of these factors encompass strengthening overarching values and commitment to enhanced health and care of community care clients, while others relate to increased participation of families, communities and the public in healthy community care.

5.5.1 Provider Training and Support

Health authorities can provide technical assistance, advice, and guidance to operators of residential care to support them in not only complying with regulations, but encourage them to exceed requirements and enhance the health of clients. This can also assist in improving relationships between regulators and providers. The support can take the form of explanations and/or provision of written material or other informational resources[197] (Type III-1).

Although staff training is ultimately a responsibility of the care provider, health authorities can assist by addressing new training requirements, developing training resources and/or facilitating access to training opportunities.

In 2005, the Ontario government provided funding to promote the dissemination and uptake of nursing best practices guidelines in the long-term care sector. A process evaluation was conducted in 2006 and found that[198] (Type II-3):

- Coordinators had been effective in increasing awareness and uptake of best practice guidelines and resulted in benefits for both residents of the homes and staff members;
- The best practices used most frequently by homes included those related to falls prevention, skin and wound care, least restraints and promoting continence;
- The process of implementing best practices in long-term care is a slow and time consuming process and some homes struggle to facilitate implementation due to challenges including sufficient staff and other resources;
- Staff require appropriate training in order to understand and implement best practices;
- Recommendations included continued staff in-service training and information sharing on best practices with resident/family councils on a regular basis.

It is generally recognized that education, training, resources and advocacy are necessary to inform, support and enhance healthy living initiatives in community care facilities to enhance the health of residents. This includes information and promotion of nutritious diets, opportunities for

physical activity, tobacco cessation programs as well as good oral health care and access to regular dental examinations. Information on these specific needs is available in the evidence reviews related to core public health programs on healthy living and dental public health.

5.5.2 Leadership and Organizational Values

A qualitative study comparing high-performing and low-performing nursing homes[199] (Type II-3), using select complexity science principles, highlighted key differences in organizational performance. Leadership in the high-performing homes emerged as distinctly different from that in the low-performing home. Leaders in the high-performing homes behaved congruently with the nursing home's stated mission by fostering connectivity between staff, ample information flow, and the use of cognitive diversity. In contrast, leadership in low-performing homes behaved disharmoniously with the stated mission, which confused and eroded trust and relationships among staff members, contributed to poor communication, and fostered role isolation and discontinuity in resident care[200] (Type II-3).

The evaluation offers insights into fostering positive organizational change in nursing homes. In summary [201] (Type III-1):

- First, creating a positive, coherent and explicit organizational mission/identity, one that is consistent with fundamental human values, will serve as an attractor to foster trust and staff connectedness. The organizational mission/identity must not only be stated explicitly but also be acted upon, so that it is evident in resident-family-staff-administrative relationships, both lateral and hierarchical relationships. These relationships form the foundation for innovation and improve decision-making. When people work from a shared sense of purpose, trust is fostered and individual differences of opinion lessen in importance.

- Second, in high-performing organizations, staff self-organize in positive and creative ways to get the work done. In low-performing homes, staff relationships are fragmented: they work in isolation and often redirect problem-solving.

- Third, activities in the high-performing homes suggest that fewer, more flexible rules, when grounded in trusting relationships and a clear mission, will empower staff and allow greater creativity in meeting resident needs.

The study found compelling evidence that the explicit and implicit missions were very different between high-performing and low-performing homes with respect to the centrality of resident-centred care and the focus on economic profitability. Low-performing homes gave mixed messages implying that the primary mission was economic profitability rather than resident care. The lack of congruence between the publicly stated mission (resident-centred) and the lived mission created tension within and among staff at all levels. Hierarchical behaviours based on command-and-control approaches to management further served to erode staff cohesion and trust, staff connectivity, the flow of information, and the sharing of diverse opinions. Rules were the predominant basis for problem solving.

The implication for nursing home leaders is that the 'perception' of economic viability as an end, may be counterproductive to economic goals. Organizational leaders who have a genuine interest in the well-being of residents, engage with staff, and demonstrate behaviours that resident care is a priority, are noticed by staff across the organization. Staff members expect authentic and visible leadership to promote hierarchical and lateral communication. A lack of these characteristics may lead to high staff turnover, economic distress for the nursing home, and an unfulfilled mission of providing humane and sensitive care of residents [202] (Type III-1).

5.5.3 Promotion of a Culture of Safety

A culture of safety is often referred to in the literature as a key best practice in improving patient safety. The literature stresses the need for organizational commitment to a thorough analysis of injuries and near misses, followed by the development of actions to reduce injury rates, verification of implementation, their effectiveness, and identification of any unanticipated secondary effects[203] (Type III-1). Leadership involvement in, and coordination of, all these activities is deemed necessary for an effective process, as is commitment to open communication throughout the organization. These commitments begin with leaders setting clear expectations regarding patient safety through publicized organizational goals. It includes open sharing of patient injury results, both within and outside the organization (i.e., with frontline representatives and health care overseers) as part of a transparent care delivery system[204] (Type III-1).

The American Hospital Association[205] (Type III-1) summarized the organizational tactics and strategies needed to achieve a culture of safety. It highlighted the following:

- Demonstrate patient safety as a top leadership priority;
- Promote a non-punitive culture for sharing information and lessons learned;
- Routinely conduct an organization-wide assessment of the risk of error and adverse events in care delivery processes;
- Actively evaluate the competitive/collaborative environment and identify partners with whom to learn and share best practices in clinical care;
- Analyze adverse events and identify trends across events;
- Establish rewards and recognition for reporting errors and safety-driven decision making;
- Foster effective teamwork regardless of a team member's position of authority;
- Implement care delivery process improvements that avoid reliance on memory and vigilance; and
- Engage patients and families in care delivery workflow process design and feedback.

5.5.4 Client-Centred Care and Client Empowerment

Commitment to Care: A Plan for Long-Term Care in Ontario (2004)[206] (Type III-2) recommends enhancing the quality of life for long-term care residents by engaging families, volunteers to better integrate long-term care into the vibrancy of the surrounding community. Proposed initiatives include more education and aware consumers, more volunteer coordination, mandated Family Councils, working in partnership with Residents' Councils, an annual resident satisfaction survey in facilities, an emphasis on creating more of a home environment, sharing of best practices, and more attention to new dementia therapies.

Initiatives to empower residents of long-term care facilities have been raised frequently in the literature. The Ontario *Report of the Commission of Inquiry into Unregulated Residential Accommodation*[207] recommended a number of initiatives to empower residents of rest homes (as well as recommendations for minimum regulations to attain minimum standards in safety, health, and physical environment). The aim was to redress structural imbalances in the power relationship between operators and residents by assisting residents to assume control of their lives to the maximum extent possible. The empowerment strategy included: a Rest Home Residents' Bill of Rights, which contains protections and entitlements regarding physical accommodation and the quality of care; an 800-telephone number, staffed continuously, for easy and rapid access to a Rest Homes Tribunal by residents (and printed signs posted with the telephone number in every rest home), etc.

The New Mexico Medical Review Association established a quality improvement initiative called High-Quality Culture Change Coalition for the Long-term Care Community[208] (Type III-1). It includes New Mexico nursing home leaders from the provider community, along with representatives from the state survey agency and Ombudsman program, as well as consumers and other advocates. It is dedicated to enhancing the lives of elders residing in New Mexico's long-term care facilities, nursing homes, assisted living facilities and other long-term care and service providers. The "aim is to advocate and facilitate deep, systemic change in long-term care and transformation in our culture of aging". They "promote a resident-centred model of care vs. a traditional, institutional model of care. Empowering long-term care residents to be the primary decision makers about their health care in an environment that reflects the comfort, safety and privacy of home is key" to improving resident quality of life. The Coalition:

- Offers resources and training for those interested in culture change;
- Promotes culture change in long-term care;
- Creates an environment for networking, problem solving and support for individuals and organizations in culture change; and
- Identifies and promotes transformation in practice, services, public policy and research by educating local and state officials, regulators, surveyors, and the general public and community.

A number of organizations have sponsored education activities to assist clients and their families in becoming more involved in client care. In the United States, several state-based patient coalitions have developed and disseminated patient education materials, and the joint commission on Accreditation of Healthcare Organizations launched the SPEAK UP campaign to help patients/clients become involved in their own care[209] (Type III-1).

5.5.5 Family and Community Education, Awareness and Support

Health authorities can promote consumer education on services, quality indicators, standards and regulations to support informed choices by the public. For example, some jurisdictions provide program directories, services provided and selection tips. It has found that providers benefit from and feel supported by these activities as an aid to their marketing and reputation enhancement efforts [210] (Type III-1).

A series of focus groups conducted in British Columbia with family members in 2004[211] (Type III-2) identified qualities and indicators which were important to them in choosing a residential care facility. Family members emphasized a number of qualities, including:

- The quality of the staff, in particular whether they were qualified, respectful and caring;
- The length of the waiting list;
- The level of cleanliness in the facility;
- The stimulation and specialized programming to meet specific needs;
- The availability of information about the facility, including the willingness of the facility to provide information, and the facility's openness and transparency in communicating with family members;
- The necessity of having an advocate for people in care who do not have family or friends; and
- Participants further emphasized that consistency and stability in staffing was of great importance, as "the staff become like family for the residents"[212].

Family members of clients are in an ideal position to provide knowledgeable input on quality of care. As part of a residential care quality indicator process, Fraser Health Authority conducted a Family Satisfaction Survey[213] (Type III-2) to obtain feedback from families of residents in regional care facilities. Satisfaction with the quality of care in nine domains (i.e., admissions, choice, receptionist, direct care, nurses, meals and dining, activities, and laundry) was measured. Domain scores were compared according to facility size and per diem group – for the majority of domains there were no statistically significant differences between mean scores of small, medium or large facilities with the exception of meals and dining (the mean score was much higher for small facilities than for medium or large facilities). However, family members were very appreciative of the opportunity to provide feedback on the care received by the resident, and the input provided solid feedback on the quality of care provided by the homes. It provided a vehicle to identify needs and issues and a tool to identify potential quality issues.

Recommendations that information on specific facilities and services be made available to the public have been frequently included in the literature. For example, the Centers for Medicare & Medicaid Services (CMS) in the United States have placed a high priority on including quality indicator data on its public website. The Agency launched Nursing Home Compare in 1998, and has progressively expanded the information available on the website. In addition to data on the deficiencies identified during standards surveys, the website now includes data on the results of complaint investigations, information on nursing home staffing levels, and quality indicators such as the percentage of residents with pressure sores. An important CMS objective of sharing information with the public on nursing home quality is to use market forces to help drive quality improvement [214] (Type III-1).

NOTE: In Canada, a number of provinces are publicly posting the results of annual inspections. In BC, the new Residential Care Regulation includes a requirement that licensed adult residential care facilities post their routine inspection results (beginning October 2009). As well, health authorities now post summary reports of inspections on adult long-term care facilities on the Internet. There is also a project to discuss expanded public reporting on all other types of BC residential care facilities.

5.5.6 Performance Assessment

Manitoba Health has developed an extensive assessment tool for use by a multidisciplinary team in measuring the performance of personal care homes (PCHs as Manitoba nursing homes are called) in complying with *Personal Care Homes Standards Regulation* (2004/05) (Type III-1). A variety of specific performance measures are described for evaluating 27 standards, including: bill of rights; resident council; eligibility for admission and information on admission; freedom from abuse; use of restraints; nursing requirements and nursing services; dietary services; pharmacy services; recreation, spiritual and religious care; qualified staff and staff education; complaints and reports about occurrences; participation in care plans; integrated care plans and communication of care plans; safety and security; and disaster management.

Manitoba Health also requested that the University of Manitoba develop a means of using administrative data (records of physician billings, hospitalization, personal care home use and prescribed drugs) to measure the quality of care offered by PCHs in Manitoba. To that end, the researchers developed 10 measures[215]—called Quality Indicators—that offer a good picture of what is happening in the nursing homes. Six quality indicators (QIs) look at adverse events (i.e., hip fractures, non-hip fracture, falls, respiratory infections, bed sores or fluid and electrolyte imbalances) and four look at medication (i.e., the number of residents taking: 9 or more drugs at one time; benzodiazepines; antipsychotic medication; and drugs considered high risk for seniors). Rates for all QIs were adjusted for resident sex, age, and level of care to help ensure fair comparisons. Considerable variation was revealed between the homes in each regional health authority. The results also highlighted some conclusions that provided a basis for improvement strategies[216] (Type II-3).

A number of jurisdictions have issued standards to build upon and supplement legislative requirements as well as to provide a basis for quality assessment. For example, Alberta Health and Wellness has issued extensive standards for continuing care health services and long-term care accommodation. They provide 23 standards with accompanying explanations and

descriptions of accountability. Standards include: waitlist management, client/family information and feedback, promoting wellness, standardized assessment, client/family involvement in care planning, integrated care plan, service coordination, client health information, medication management, therapeutic nutrition and hydration, oral health, dental services, podiatry, hearing and vision services, specialized health service equipment and medical-surgical supplies, operational processes, quality improvement, and reporting.

In the UK, the Commission for Social Care Inspection (CSCI) was formed to unite regulation, inspection, and performance assessment, to encourage increased collaboration among regulatory and government agencies, and to consider issues of quality alongside those of efficiency in their assessment. The CSCI is expected to encourage improvement, with particular regard to improving availability and access, quality and effectiveness, economy and efficiency. A major change involves an increased focus on interviewing persons in care during inspections, and obtaining feedback on their experiences. This requires a shift to focusing on results for users.

Additional quality assurance initiatives that can be considered in the process of assessing and enhancing the quality of care include:

- Accreditation can assist organizations to improve the quality of their performance, raise the level of patient care and demonstrate accountability. It is a voluntary model of self-regulation, with an independent agency setting standards and procedures for quality measurement. Accreditation generally encompasses quality assurance and quality improvement processes, and also provides some form of credential to indicate the organization has met the necessary requirements of the accrediting agency.

- Audits provide independent evaluations of performance along with recommendations for improvement. Audits may be commissioned by independent experts—auditors of most government funded organizations are private sector firms (although the Auditor General of BC may initiate an audit on approval by the Legislative Assembly's Select Standing Committee on Public Accounts). As an example, BC's six health authorities worked with an independent company to develop a tool to measure safe food-handling levels and to conduct an audit on food-handling in hospitals and long-term care facilities (http://www.phsa.ca);

(In BC, Ministry of Health, Home and Community Care Branch has issued 'Model Standards' along with 'Long-Term Care Standards' established by the Canadian Council on Health Services Accreditation (CCHSA). It has also developed a *Provincial Performance Management Framework for Residential Care Facilities* (2008), which includes performance standards, performance measures, reporting of progress, and the related quality improvement measures.

5.6 Quality Care for Persons with Intellectual Disabilities, Developmental Disabilities and/or Mental Illness

The United Nations Convention on the Rights of Persons with Disabilities was adopted in 2007 and ratified by Canada the same year. With reference to residential services, it states[217] (Type III-1):

a. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equality basis with others and are not obligated to live in a particular living arrangement;
b. Persons with disabilities have access to a range of in-home, residential and community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community; and
c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

In BC, the responsibility for persons with disabilities rests primarily with the Ministry of Children and Family Development and with Community Living BC. However, coordination and collaboration with health authorities is often necessary to ensure healthy living arrangements and quality care services within the residential settings. Multi-sectoral coordination has been recognized by a number of jurisdictions as an important component to ensure that government and service providers operate with a shared vision and work together for the same ends[218] (Type III-1).

A document entitled, *Included in Society: Results and Recommendations of the European Research Initiative on Community-Based Residential Alternatives for Disabled People* (2004) (combination of Type III-1 and Type II evidence) provides an extensive set of recommendations and activities for national, regional, and local governments in Europe, as well as non-government organizations and services providers.

There are a number of evaluation approaches to assess residential services/supports for people with disabilities. For example, Chamberlain and Brice[219] developed People, Lifestyle, Attitudes and Needs (PLAN) to assess services, values, and success in meeting client's needs from the perspective of the client. Timko and Moos[220] (Type II-3) describe the Multiphasic Environmental Assessment Procedures, which includes four dimensions (Resident and Staff Information Form, Physical and Architectural Features Checklist, Policy and Program Information Form, and Sheltered Care Environmental Scale).

Oakes[221] (Type II-2) describes an evaluation system for a long-term residential support for people with learning disabilities, called Quest. It includes a Service Profile (facts about the structure of the services); a Support Questionnaire (measures the quality of the opportunities available to the clients), Observation Profile (assesses the interactions between members of staff and clients), and Occupational Stress Indicator (a measure of staff stress). The relationship between different measures is examined: it has been shown that there are significant associations between staff interaction styles, staff stress levels and the quality of services provided to residents.

With respect to mental disorders, principles for managed care from the US National Mental Health Information Center include[222] (Type III-1).

- Treat all persons with respect and dignity;
- Managed care is based on "best practices', model programs, innovation and continuous quality improvement;
- Services are tailored to individuals needs and preferences, provided in the least restrictive and most natural setting possible, and build on the strengths of the consumer and family;
- Services for adults directly include a continuum of care consisting of, but not limited to, a comprehensive array of flexible community living supports including prevention, treatment, rehabilitation, intensive case management residential treatment, crisis, and self-help services, and also provide effective linkages to other health and social services;
- Services for children directly include a "wraparound" approach consisting of, but not limited to, flexible, individualized, strengths-based, family-driven services incorporating respite care, case management and day community-based services, and also provide effective linkages to other health and social services.

It should be noted that these principles are consistent with internationally accepted principles, particularly those endorsed by the World Health Organization[223] (Type III-1).

5.7 Quality Hospice Care

In a collaborative process led by the Standards Committee of the Canadian Hospice Palliative Care Association, providers, organizations, consumers and governments across Canada shared their experiences and developed a vision for hospice palliative care entitled *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice* (2002)[224] (Type III-1). The Model promotes care aimed at "relieving suffering and improving quality of life throughout the illness and bereavement experience, so that patients and families can realize their full potential to live even when they are dying."

A central element in the Model is the delivery of hospice palliative care based on a set of values and guiding principles which provide a foundation for quality care. The values are[225] (Type III-1):

- The intrinsic value of each person as an autonomous and unique individual;
- The value of life, the natural process of death, and the fact that both provide opportunities for personal growth and self-actualization;
- The need to address patients' and families' suffering, expectations, needs, hopes and fears;
- Care is only provided when the patients and/or family is prepared to accept it;
- Care is guided by quality of life as defined by the individual;

- Caregivers enter into a therapeutic relationship with patients and families based on dignity and integrity;
- A unified response to suffering strengthens communities.

The 'Guiding Principles' include a patient/family focus; safe and effective; accessible; adequately resourced; collaborative; knowledge-based; advocacy-based; and research-based. The *Model* also discusses the domains or issues associated with illness and bereavement: disease management, physical, psychological, social, spiritual, practical, end of life/death management, and loss/grief. For each of these domains/issues faced by patients and families, there are processes for providing care. These processes include: assessment, information sharing, decision-making, care planning, care delivery and confirmation. The combination of domains/issues and the related processes of care for each are termed "The Square of Care". Each step is described with principles, norms of practice, preferred practice guidelines for each issues, and data collection and documentation guidelines[226] (Type III-1).

A study on effective palliative care in Europe found that patients, caregivers and families identified several conditions that were essential to good palliative care. These were: sufficient time to get to know patients, a caring attitude among caregivers, competence in providing creative and active care, interdisciplinary team work, and settings characterized by small units, homelike infrastructure, and non-hospital environments. These strategies were used to ensure that patients enjoyed life as much as possible even in the face of death and permitted patients and relatives to experience effective and high quality palliative care. The researchers concluded that palliative care involved a specific concept of care with the central focus on life and the goal of optimizing quality of life. This care involved two strategies: creating space to live, by taking the focus off the illness, and filling the space as meaningfully as possible so that patient could fully enjoy life[227] (Type II-3).

Fraser Health Authority developed *Fraser Health Hospice Residences: Creating a healing and caring environment at the end of life* (2007) (Type III-1) to provide standards and guidelines for planning, developing and operating hospice residences in the region. The document is based on the above *Model* developed by the Canadian Hospice Palliative Care Association, and includes practical evidence-based strategies to support, encourage and assist in developing hospice bed capacity and quality hospice care. The goals include continuity of care across all settings and among care providers; consistent standards across the region; and timely assessment and placement of palliative individuals to meet their care needs in the most appropriate and cost-effective environment. The principles include commitment to excellence; partnerships with service providers including shared responsibilities during planning and start-up of a hospice; and responsiveness to the unique needs of each community. Development and operational processes are also included (e.g., systems and clinical standards, detailed work plans, and staffing and admissions processes).[228]

(In 2006, the BC Ministry of Health Services released a document entitled, *A Provincial Framework for End-of-Life Care*, and set performance targets to increase end-of-life care outside of acute care settings.)

6.0 CONCLUSION

Although there is limited quantitative research evidence on regulatory practices that are effective in enhancing compliance and care in community care facilities, a long history of regulatory experience, comparative analysis and professional expertise has resulted in respected models of practice and strategies that have contributed to enhanced quality of care and quality of life for clients/residents. In several areas there is clear evidence of factors that influence the quality of care: for example, staff education and training in all settings is a key indicator of quality, as is a central focus on client-centred care. In child care, the staff-to-child ratio and small group sizes are also key factors that contribute to quality services.

Exemplary practices in licensing, monitoring, inspection, investigation and enforcement are primarily the result of consensus views of experts in the field. Policies and procedures that ensure thorough, fair, responsive, consistent, and accountable risk assessment and regulatory oversight are acknowledged to be successful in influencing legislative compliance. As well, a range of provider support services and family, community and public education contribute to enhancing the quality of care.

Experts point to the importance of regularly updating standards through consultation, in response to findings and experience, and with sensitivity to diversity and changing societal values and expectations. As well, the development of assessment processes and quality indicators are important to ensuring informed choices by the public and encouraging continuous quality improvement by providers.

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APPENDIX 1: KEY ELEMENTS OF BC LEGISLATION ON COMMUNITY CARE AND ASSISTED LIVING

BC enacted the *Community Care and Assisted Living Act* (CCALA), and associated regulations. A new Residential Core Regulation was passed by Cabinet in March 2009 and implemented October 1, 2009, at which time the Adult Care Regulation was repealed. The new Regulation also includes residential care requirements for child care and youth care, which had been removed from the Child Care Licensing Regulation.

The Health Authority Licensing Council and the Regional Directors of Health Protection, which include representatives from each health authority and the Ministry of Health, play a role in coordinating the management and administration of the legislation as it applies to community care facilities. The Assisted Living Registrar administers Part 3 of the Act, which applies to assisted living residences.

Community Care Facilities (Adult Care and Child Care Facilities)

The legislation includes specific requirements for the licensing of community care facilities which encompass residential care facilities for adults, children and youth, and day care. Residential care covers long-term care facilities, some stand alone hospices, residential homes for persons with developmental disabilities, mental health group homes, residential detox and intensive residential treatment facilities (on October 1st, it will also cover all child and youth residential care.) Homes/facilities which care for 3 or more adults are covered by licensing legislation.[1] Child care includes group day care, preschools, family child care, in-home multi-age child care, multi-age child care (centre-based), and occasional child care. Again, homes/facilities which care for 3 or more children are required to be licensed.[2]

> "Care" is defined in the CCALA as "supervision that is provided to:
>
> (a) a child through a prescribed programs,
> (b) a child or youth through a prescribed residential programs, or
> (c) an adult who is:
> - vulnerable because of family circumstances, age, disability, illness or frailty, and
> - dependent on caregivers for continuing assistance or direction the form of 3 or more prescribed services."

With respect to community care facilities, licensing staff in the health authorities across BC are responsible for implementing and enforcing relevant sections of the Act and Regulations. Section 15 of the CCALA summarizes the duties of the health authorities, as follows:

> (1) "Within the area for which he or she is appointed, a medical health officer must
> (a) investigate every application for a licence to operate a community care facility or any other matter relevant to the application,
> (b) investigate every complaint that:

(i) an unlicensed community care facility is being operated, or
(ii) a community care facility is being operated that does not fully comply with this Act, the regulations or the terms or conditions of its licence,

(c) carry out inspections of any community care facility that is being operated, and

(d) perform additional duties in the administration of this Act or the regulations that the Lieutenant Governor in Council, the minister or the director of licensing may order

(2) A medical health offer may continue and complete an investigation of a licensee or a former licensee after

(a) the licensee has expired or been cancelled or suspended, or

(b) the licensee has surrendered the license."

In 2003, there were approximately 22,000 adults and 1,000 children in residential care, and in May 2009, just under 91,000 in licensed, funded child day care, in British Columbia.

Assisting Living Residences

Assisted living is a semi-independent form of housing that is regulated by the Assisted Living Registrar under Part 3 of the CCALA. The Act defines an assisted living residence as:

> a premises or part of a premises, other than a community care facility,
> (a) in which housing, hospitality services and at least one but not more than 2 prescribed services are provided by or through the operator to 3 or more adults who are not related by blood or marriage to the operator of the premises, or
> (b) designated by the Lieutenant Governor in Council to be an assisted living residence.

Assisted living residences:

- Provide housing, hospitality services and personal assistance services for adults who can live independently but need help with day-to-day activities;
- Are designed to meet the needs of seniors and adults with disabilities;
- Provide an option other than a community care facility to the growing number of seniors who have needs beyond home support;
- Are available both through public subsidized and private-pay operators.
- If a residence or a part of a residence meets the definition of an assisting living residence in the *Act*, the operator must register the residence before opening and beginning to operate. Before approving an application for registration, the Assisted Living Registrar must be satisfied that housing, hospitality services and personal assistance services will be provided to residents in a manner that does not jeopardize their health or safety. The Assisted Living Registrar is also responsible for investigating and responding to complaints about resident health and safety in assisted living residences.

Proposed Child Health Screening Regulation (as of April 2010)

The BC Government announced its intention in 2008 to support health authority provision of child health screening in licensed childcare facilities and school settings through a proposed child health screening regulation under the *Public Health Act*. The proposed regulation formalizes existing public health processes in school settings and extends the benefits of existing health authority school health practice to the preschool age population. Specifically, the proposed regulation will provide parents with better access to child health screening services and allow health authority public health staff to use the same processes in licensed child care facilities that are currently used in school settings. The purpose of the screening program would be to screen and refer children for diagnostic assessment at a young age, in an effort to identify and treat early, those with vision, hearing or dental disorders.

APPENDIX 2: BC AGENCIES INVOLVED IN REGULATORY OVERSIGHT

There are a variety of agencies and roles associated with administering the regulations and providing oversight of community care and assisted living programs in BC. These include the following:

Ministry of Healthy Living and Sport

Within the ministry, Community Care Licensing (part of Health Protection, Population and Public Health), is responsible for the development and implementation of legislation, policy and guidelines to protect the health, safety, well-being and dignity of persons cared for in licensed community care facilities. The Director of Licensing is a statutory decision maker appointed by Minister's Order as required by the *Community Care and Assisted Living Act* (CCALA). The Director provides overall stewardship for community care licensing, and leads the development and implementation of regulations and policies. The statutory powers of the Director are discretionary powers and are set out in the CCALA. The legislation also specifically allows the Director to delegate or assign the powers and duties of that position to individuals who in the director's opinion "possesses the experience and qualifications suitable to carry out the tasks (s.3(2) (a))."

Ministry of Health Services

The role of the Ministry of Health Services is to set the overall direction for the health care system, develop legislation, policy, and standards, allocate funding, monitor performance and act to improve performance. The Ministry of Health Services is the major point of contact between health authorities and central government.

Health Authorities

Health authorities are responsible for the delivery of community care licensing programs. At the health authority level, these programs report to medical health officers, who are employees of health authorities. In addition to being employees of health authorities, medical health officers have a reporting relationship to the Provincial Health Officer, who is the chief medical officer of the Province of BC, and is an employee of the provincial government. In practice, medical health officers delegate most of the day to day licensing activities to licensing officers, who carry out licensing functions within their health authority.

The primary statutory responsibilities of medical health officers under the CCALA are to investigate applications for licensure, to carry out ongoing inspection and monitoring, to investigate allegations that community care facilities do not meet the requirements of the Act and regulations, and to take action, if necessary, to protect the health and safety of persons in care. If circumstances exist that put the health, safety and well-being of a person in care at risk, and the licensee is unable or unwilling to take appropriate action, the medical health officer may take action, from attachment of terms and conditions to cancellation or suspension of a licence. While the CCALA does not provide explicit authority for medical health officers to delegate their duties and powers, in practice, they delegate the duties and powers through letters of delegation.

Licensing officers carry out duties on behalf of the medical health officer through a letter of delegation. The primary duties of licensing officers include:

- Monitoring and inspection of licensed community care facilities to ensure that they are meeting the requirements of the CCALA and its regulations;
- Providing information and education regarding community care licensing to potential applicants, licensees, funding partners, and the public;
- Consulting with individuals, groups or organizations on all aspects of the licensing process;
- Assessing applications to operate community care facilities and provide assistance and guidance throughout the application process;
- Assessing the suitability of applicants (licensees) and/or their designated managers to ensure that they meet the requirements of the Act and regulations;
- Investigating complaints and/or allegations that a community care facility does not meet the requirements of the CCALA and regulations;
- Investigating and following up on reportable incidents.

In carrying out their duties, licensing officers are part of a broad team that works together to reduce risk of harm to persons in care, and to ensure that the health, safety and well-being of persons in care is promoted and protected. Other members of this team include the licensee (service provider), the funding program (if the facility is funded), the medical health officer, environmental health officers, and a number of allied health professionals that provide services to persons in care.

Health authorities are also designated agencies under the *Adult Guardianship Act* and mandated to receive and investigate complaints that an adult is abused or neglected (including self neglect), to determine whether an adult needs support and assistance.

Within mental health and substance use residential care, health authorities contract with residential care providers and assisted living providers to ensure a range of housing options are available to these individuals.

Environmental Health Officers are responsible for inspecting care facilities that are required to have a food premises permit, as well as those that have therapeutic pools or personal service establishments such as hair salons.

In addition, health authorities provide a range of home and community care services for eligible residents who have acute, chronic, palliative or rehabilitative health care needs. Community-based services include home health services (home support), adult day programs, meal programs, as well as assisted living, residential care services and hospice care.

Assisted Living Registrar

The mandate of the Assisted Living Registrar under the CCALA is to protect the health and safety of assisted living residents. The Registrar administers the assisted living provisions of the CCALA, which require assisted living operators to register their residences and meet provincial health and safety standards. To meet this mandate, the Registrar:

- Administers the registration of all assisted living residences in British Columbia, whether they are publicly subsidized or private-pay.
- Establishes and administers health and safety standards, policies and procedures.
- Ensures timely and effective investigation of complaints about the health and safety of assisted living residents.
- Has authority to inspect residences if there is a concern about the health or safety of a resident.
- Refers issues that are not within the Registrar's jurisdiction to the appropriate authorities.

Community Care and Assisted Living Appeal Board

The Community Care and Assisted Living Appeal Board is an administrative tribunal that hears appeals under section 29 of the CCALA. The Board handles the adjudication for contested decisions concerning the licensing of community care facilities, the registration of assisted living residences, and the certification of early childhood educators. The Board consists of members and one chair, appointed by the Lieutenant Governor in Council to represent the various regions and sectors in both the fields of community care and assisted living in BC. Members are selected to include professionals, academics and industry service providers.

OTHER GOVERNMENT AGENCIES INVOLVED IN COMMUNITY CARE

Ministry of Children and Family Development

The ministry has a variety of roles including funding of resources for child and youth residential care in BC, as well as subsidies, referrals and other resources for child day care. In addition, the Child Care Licensing Regulation assigns responsibility to the ministry for the registration of certificate holders working in the Early Childhood Education field. The Early Childhood Educator Registry program provides:

- Training information to those interested in pursuing early childhood education careers;
- Information regarding the requirements for a licence to practice as an Early Childhood Educator, Infant/Toddler Educator, Special Needs Educator, or Early Childhood Educator Assistant;
- A system for individuals who wish to practice in these areas;

- Approval, support and monitoring of training institutions offering early childhood education; and
- Investigation of licensed educators when concerns arise regarding their practice.

Ministry of Housing and Social Development

The Ministry of Housing and Social Development administers the BC Employment and Assistance program, which provides temporary assistance, disability assistance, supplementary assistance and employment programs for British Columbians in need. This program is guided by the *Employment and Assistance Act* and the *Employment* and *Assistance for Persons with Disabilities Act*. This ministry's clients may live in or use the services of licensed community care facilities. The ministry also provides funding to the Community Living BC, which in turn provides licensed residential care resources for persons with developmental disabilities.

Community Living BC

The *Community Living Authority Act* establishes the mandate of the Community Living Authority. The Authority is funded by the Ministry of Housing and Social Development and is accountable to the provincial government through the ministry. The authority is responsible for a variety of community living supports and services for children and adults with developmental disabilities and their families. It has a board of self-advocates, family and community members, as well as staff located throughout the province. Many of the authority's clients live in or use the services of licensed community care facilities.

Local Government: Municipalities and Regional Districts

With respect to licensed care facilities, municipalities have a variety of roles such as issuing business licences, issuing a variety of permits, considering applications for zoning, and conducting fire and building safety inspections.

Representative for Children and Youth

The Representative advocates on behalf of children and youth to ensure services meet their needs. The Representative also advocates for improvements to the system of services for children, youth and their families. It is the responsibility of the Representative to initiate reviews and investigate government agencies that provide services to children in BC.

Office of the Public Guardian and Trustee

The Public Guardian and Trustee, established under the *Public Guardian and Trustee Act*. is mandated is to serve:

- Children and youth under the age of 19 by protecting their legal and financial interests;
- Adults who require assistance in decision-making through protection of their legal rights, financial interests and personal care interests; and

- Heirs and beneficiaries of deceased persons when there is no one willing or able to administer their estates, the estates of missing persons, and the beneficiaries of personal trusts.

The Office of the Public Guardian and Trustee may become involved with licensed care facility in situations regarding abuse or neglect or where a resident requires assistance in making financial decisions or where there is no one to make health care decisions for an incapable adult.

Ministry of Public Safety and Solicitor General

The Ministry of Public Safety and Solicitor General administers the *Criminal Records Review Act* that was designed to help protect children from individuals whose criminal record indicates they pose a risk of physical or sexual abuse. All individuals who work with children, or have unsupervised access to children in the ordinary course of their employment, or in the practice of an occupation, or during the course of an education program and who are employed by or licensed by, or receive operating funds from the provincial government are included under the *Criminal Records Review Act*. Child care providers are one the groups whose records must be checked. Volunteers and residents age 12 and older at a licensed or licence-not-required child care facility are also included under the Act.

APPENDIX 3: LITERATURE SEARCH STRATEGY

Community care facilities
Assisted living
Extended care facilities
Child care (day care and residential care)
Long-term care
Residential care
Mental health and addiction facilities
Hospices
(also additional tailored searches focused on care related to seniors, children, developmental disabilities, substance use, etc.)

AND

1) Health protection
   Health promotion
   Quality of care
   Prevention topics (i.e., immunization, injury prevention, outbreak control, nutrition, dental health)

OR

2) Licensing
   Registration
   Regulation
   Standards
   Guidelines
   Best practices

OR

3) Monitoring
   Investigation
   Education
   Enforcement

APPENDIX 4: RECOMMENDED REGULATORY OVERSIGHT PRACTICES, NATIONAL ASSOCIATION FOR REGULATORY ADMINISTRATION (NARA)[3]

Licensing:

NARA points out the value of licensing as a regulatory approach, explaining that it: "establishes compliance with rules ahead of time (before the program or facility can begin operation); establishes minimum standards or a baseline of protection; and involves a government administrative agency that can regulate and utilize enforcement powers."

NARA proposes the following principles to guide inspectors in managing the licensing process. It recommends that licensing be:

- Authorized by law and related to the regulatory function;
- Guided by the principles of due process;
- Conducted in a fair and impartial manner;
- Reasonable and thorough in gathering and analysis of facts;
- Upfront in explaining the purpose of the inspection or fact finding;
- Judicious in the use of licensing authority and power; and
- Open to sharing information on findings and issues.

Licence Issuance:

This phase requires the licenser to officially notify the applicant of permission to operate (issue a licence), or of a decision to prohibit operation (denial of the licence). NARA recommends that this include:

- A face-to-face exit conference with the applicant to provide a summary of findings pertaining to all areas of compliance/noncompliance prior to completing the licensing report. This provides the applicant with the opportunity to respond to the findings, enables inspectors to confirm the accuracy of facts, and may indicate a need to expand the scope of the inspection. It also gives the applicant an opportunity to begin to correct noncompliance that poses serious risk to clients; and
- A licensing report is completed to officially inform the licensee of the licensing agency's findings, expectations, conclusions and official actions to be taken as a result of the findings and conclusions. (This report also provides an official record of the decision, should the decision be appealed.)

Monitoring and Inspection – Risk Assessment:

In conducting risk assessments, NARA suggests that the following variables be used to gauge risks to persons in care in a facility:

- Complaints reported of abuse/neglect, and a failure of the licensee to recognize or react responsibly to serious hazards of any sort;
- The extent of actual harm that has occurred to one or more persons in care;
- The amount of time the violation could continue before additional harm might result (e.g., a hazardous playground is used throughout the day);
- The historical probability that the violations described have not been corrected or will recur (e.g., the facility has a history of delayed or slip-shod corrections and relapses following inspections);
- The risk-profile for the consumers in the facility or in the portion of the facility involved in the complaint (e.g., infants, toddlers and seriously impaired adults are more vulnerable than are older children and more independent adults);
- The probability of other rules besides those reported that may also have been violated, indicating the likelihood that the complaint violation is not an isolated event but is part of a failure in management and monitoring systems in the facility;
- Relative ease of correction, assuming management willingness to comply (e.g., non-systemic violations, those requiring less financial outlay, or less training or re-tooling); and
- The scope or pattern of violations as it affects risks (e.g., a serious violation that appears to be an isolated error is different from a widespread breakdown).

Monitoring – Provider Support Services:

NARA notes that the provision of technical assistance, advice, and guidance to a provider is an important component to the compliance monitoring process and to encouraging the upgrading of services to meet and exceed licensing requirements. Overall, it is a strategy aimed at: increasing compliance and consistency; improving relationships between licensees and licensors; reducing the need for sanctions; and increasing the support and acceptance of sound regulations. This may include:

- Technical assistance
    - Inspectors should explain the intent and requirements of the rules and suggest options generally available, or available in that provider's situation, which would achieve compliance with the rules; and
    - Provide written materials (or other resources) to providers to help them comply with rules, including pre-packaged information that may be useful in addressing common problems, and compliance problem-solving.

- Training

  Although staff training is ultimately a business responsibility of the licensee, a licensing agency can assist by addressing new training requirements, and developing training resources. Activities could include:

  - Promote and support in-service training through the development of tools, curricula and materials that help providers to orient and train their personnel;
  - Provide quality train-the-trainer sessions in the use of those curricula;
  - Facilitate collaboration with the formal education system at all levels, to respond to the education needs of providers and their staff (e.g., type of classes, distance education, recognition of skills/knowledge, and so on;
  - Make needed resources and materials more affordable (e.g., media lending centres, assistive technology centres, toy or activity lending centres, funding or scholarship programs);
  - Provide direct orientation sessions on the licensing rules, including rule interpretations, interdependent rules, what constitutes compliance, and so on; and
  - Promote or provide topical training, organized around the recognized competencies required for particular occupational classes;
  - Provide support and steady access to information that helps to professionalize occupation groups (e.g., newsletters, training schedules, mini-lessons, etc).

NARA discusses the debate about whether there is a need to separate the "support services role" from the "enforcement role". They point out that relationships often combine these roles, but stress that the licensor must be vigilant in maintaining clarity of roles and responsibilities. "A licensor must be clear about whether he is offering advice or requiring compliance – advice, choices, options, consultation, recommendations or other non-obligatory information should be labelled as such."

Inspections:

NARA recommends that use of unscheduled on-site inspections should be prescribed by written policy.

> Although the use of unannounced inspections is standard in most states, policy or statute may limit unannounced inspections to: those circumstances when inspectors have reason to believe that children or adults in care may be neglected, abused or exploited; or situations where there is serious, repeated noncompliance with the rules.

Care homes/facilities operating without a licence are an example of serious noncompliance which justifies unannounced inspection.

Investigation

Investigation management requires multiple steps and phases. The following are recommended:

- ***Receiving allegations of noncompliance*** – In understanding a complaint, or an alleged violation that was identified by any source, it is important to be courteous, professional, and to avoid expressing opinions or advice, but rather: elicit factual, appropriate, and as complete information as possible; conduct any discussions in a way that allows a preliminary determination of the extent to which persons in care might be in immediate risk of harm; identify, as possible, the motive of a complainant or reporter; provide information about investigation policies and processes; and ensure the allegation is properly recorded following agency protocols.

- ***External notification and coordination*** – According to the nature of the alleged violation, other agencies may need to be notified that a problem may exist or that a joint investigation is needed. Some of the external parties that might need to be involved include: adult or child protective services; law enforcement; advocacy organizations; resource and referral agencies; ombudsman; building, health or fire safety agencies; funding agencies; fraud investigation unit; and so on.

- ***Risk assessment*** – Risk assessment must be done in a preliminary way to determine how fast and with whom to proceed with the investigation.

- ***Investigation planning*** – Determine methods of inquiry and information-gathering that will be effective considering the information required and the informants who will be contacted.

- ***Investigation*** – Conduct the investigation using the following techniques, as appropriate:

    - Review administrative records, such as personnel files, payroll/wage records; attendance and supervision logs; inspection reports from other agencies, files for persons in care (i.e., special health needs, medication records, incident report forms, financial records) and so on;

    - Interview those with first-hand knowledge of the situation, ensuring complete and accurate documentation, and affidavits and written statements from the witnesses;

    - Take photographs and videotapes to document relevant physical information;

    - Draw diagrams, floor plans and so on;

    - Obtain documents from other agencies;

    - Involve experts in the investigation, as necessary; and

    - Conduct surveillance to observe relevant activities.

- ***Evaluation of evidence and decision-making*** – The licensing investigator must organize and analyze the information and evidence collected in order to develop findings, reach conclusions and recommend appropriate action. A written investigation report must be

prepared that describes the alleged violation, the investigation, the evidence and the conclusions. If it was determined that violations occurred, a plan for corrective action or enforcement may be necessary if the licensee has not already corrected the problem or resolved the issue.

Enforcement:

Positive enforcement techniques include:

- Technical assistance, consultation, training and other provider support services;
- Incentives and recognition for compliance, for example, specific, carefully worded recognition for innovations;
- Support for a licensee in difficulty, such as problems with zoning, funding agencies, and so on;
- Make levels of compliance public;
- Regulatory diagnosis and assistance in developing a preventive maintenance plan for keeping in compliance;
- Issuance of violation reports accompanied by voluntary or negotiated plans to correct violations; and
- Negotiated consent agreements, or agreements of understanding, to explicitly confirm a corrective action plan.

Negative enforcement techniques include:

- Official warning letters, with an established time period to achieve compliance;
- Changes in the terms or conditions of a licence (i.e., temporary changes until certain conditions are met);
- Changes of licence status (i.e., provisional or interim status pending corrective action);
- Fines or forfeitures;
- Voluntary suspension of operations by the licensee;
- Denial of a licence, or refusal to renew a licence;
- Revocation of licence (i.e., when there is evidence that a facility is unable or unwilling to comply with the rules/statute or terms of the licence);
- Summary suspension of a licence, resulting in the immediate, temporary closure of a facility (i.e., when immediate protection for children or adults is necessary); and
- Injunction through the court system (i.e., when violations are likely to result in serious harm to persons receiving care, and when less drastic means to protect consumers are not available or appropriate, or have already been attempted).

Reconsideration/Appeal:

NARA considers the following as minimum requirements for an administrative hearing procedure:

- A licensee or applicant, who is the subject of a negative action, must be given written notice that contains a statement of the negative enforcement action, the reason for the negative action listing specific statutory or rule violation, the specific statutory authority supporting the negative action, and an explanation of how one requests a hearing and any related time limitations;
- A licensee must have adequate opportunity to present the case, to bring witnesses, to establish all pertinent facts, to argue the case, to refute any evidence, to cross-examine adverse witnesses, or to cross-examine the author of the document offered in evidence;
- The hearing decision-maker must be impartial and must not have been involved in the initial negative action decision; and
- The licensee or applicant must be given a written hearing decision based on evidence introduced at the hearing, summarizing the facts and stating the legal rules supporting the decision.

Consumer Monitoring:

In general, consumers can monitor care in the following ways:

- Monitoring should occur as regularly and frequently as possible, including different times and on different days as a more random pattern of visits and observations will provide a fuller view of the operations;
- Increase monitoring when there are perceptions of concern;
- Changes in circumstances should be a cue to check that care routines have been adjusted and re-established. These changes / cues can include: change in medication, a special diet or treatment regimen; decreases in the resident's ability; changes in resident's appearance, grooming, attitude, emotional outlook and activity level; changes in the facility's appearance, general maintenance, response time or staff attitudes and morale; changes in personnel; and changes in facility ownership;
- Participation on resident/family council activity to establish effective communication and encourage increased responsiveness to residents and family members.

[1] Large extended care facilities covered by the *Hospital Act* are not currently subject to licensing legislation – however, section 12 of the CCALA provides for them to be moved under the CCALA in future so that there is one common system of monitoring and inspection for all facilities (this is a major project currently underway)
[2] The Child Care Licensing Regulations are currently under review and it is anticipate that there might be changes in categories of care.
[3] National Association for Regulatory Administration (2000). *Licensing Curriculum*. Conyers, GA: NARA