



**CORE**

Public Health Functions for BC

**Model Core Program Paper:  
Healthy Community  
Care Facilities and  
Assisted Living  
Residences**

*This Model Core Program Paper was prepared by a working group consisting of representatives of the BC Ministry of Healthy Living and Sport and BC's health authorities.*

*This paper is based upon a review of evidence and best practice, and as such may include practices that are not currently implemented throughout the public health system in BC. This is to be expected, as the purpose of the Core Public Health Functions process—consistent with the quality improvement approach widely adopted in private and public sector organizations across Canada—is to put in place a performance improvement process to move the public health system in BC towards evidence-based best practice. Where warranted, health authorities will develop public performance improvement plans with feasible performance targets and will develop and implement performance improvement strategies that move them towards best practice in the program component areas identified in this Model Program Paper.*

*This Model Program Paper should be read in conjunction with the accompanying review of evidence and best practice.*

***Model Core Program Paper approved by:***

Core Functions Steering Committee (June 2010)

Population and Public Health, BC Ministry of Healthy Living and Sport (June 2010)

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## **EXECUTIVE SUMMARY**

This paper identifies the core elements that are provided by the British Columbia government and regional health care system to support and promote healthy community care facilities and assisted living residences. It is intended, as part of the BC Core Functions in Public Health initiative, to reflect evidence-based practice and support continuous performance improvement.

A Working Group of representatives from the Ministry of Healthy Living and Sport, Ministry of Health Services, Ministry of Children and Family Development, the Community Living Authority of BC and the health authorities worked together in the development of this paper. They agreed that the overall goals for health authorities in the healthy community care facilities and assisted living core program are:

### **Child Day Care**

*Goal:* To provide regulatory oversight and encourage quality services which enhance the health, safety, well being and optimal development of children.

#### *Objectives:*

- To enhance healthy physical, social, emotional, language and cognitive development of children in care;
- To reduce risk factors in facilities and maximize full compliance with statutory requirements and quality assurance processes; and
- To increase systemic support for promoting and advancing quality services and early opportunities for children.

### **Assisted Living Residences**

*Goal:* To promote delivery of high quality housing, hospitality services and personal assistance for people who require assistance with daily activities, and/or for supportive housing for rehabilitation and recovery purposes.

#### *Specific Objectives:*

- To promote resident choice, privacy, independence, individuality, dignity and respect;
- To promote the health and quality of life of residents;
- To increase systemic support for promoting and advancing quality services for clients/residents.

## **Residential Community Care Facilities**

*Goal:* To provide regulatory oversight and encourage quality improvements that will protect and enhance the health, safety and dignity of persons in care facilities.

*Specific Objectives:*

- To enhance healthy development and respect for the dignity, choice, needs and aspirations of clients, appropriate to their age, health status and circumstances;
- To reduce risk factors in facilities/residences and maximize full compliance with statutory requirements and quality assurance processes; and
- To increase systemic support for promoting and advancing the quality of care and quality of life for clients/residents.

This health authority core program focuses on regulatory oversight of community care facilities, as well as promotion of quality service delivery by child day care programs, child, youth and adult residential care facilities and assisted living residences. (It does not include private hospitals and extended care facilities under the Hospital Act, although it is recognized that these may be included in the future when section 12 of the *Community Care and Assisted Living Act (CCALA)* is implemented).

It provides a strategic direction for the future and takes a ‘systems’ approach that acknowledges the various levels responsible for planning and program funding, governance and regulatory oversight, the continuum of care, and the continuum across the lifespan. It is intended to support the ability of the regional health care system to plan effectively, ensure continuity, build synergy and cohesion across programs, and heighten awareness among health care partners and the public about the importance and value of quality services. The various continuums that should be considered include:

- ***Continuum of Provincial, Regional and Local Roles*** – Both provincial and regional levels of the health care system have roles and responsibilities in policy development, planning, funding and regulatory oversight, thus forming a continuum in the management and regulation of services. The local level has an important role in advocacy, participation and feedback at the community level.
- ***Continuum of Care*** – Community residential services offer a range of services from assistance to care involving increasingly sophisticated levels of support, from assisted living residences for those who need assistance with daily activities, to licensed community care facilities for those with more complex care needs.
- ***Continuum Over the Lifespan*** – Delivery of programs and services to clients covers the life course, as well as specific vulnerabilities, encompassing: early childhood, at-risk children and youth, children and adults with developmental disabilities, adults with mental health and/or substance use issues, and elderly people with evolving needs for increasing assistance and care as they age.

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Although there are many differences in the types of care and the philosophical approaches taken with the different client groups, there are also many commonalities. Overriding principles or fundamental concepts for delivery of this health authority program include:

- Legislative compliance;
- A developmental approach, optimizing potential of all clients/residents, including physical, cognitive, emotional/psychological, and social potential;
- Individualized client-centred/resident-centred care;
- A lifecourse/lifespan approach in program plans and individual care plans supporting smooth transitions between life stages;
- Autonomy and personal choice, appropriate to age and health circumstances, empowering clients/residents and enhancing their dignity;
- Multi-sectoral collaboration, community development and community engagement to strengthen the quality of care;
- Risk evaluation and assessment to determine potential for harm to persons in community care facilities, assisted living sites, groups homes, and supported housing, and to prioritize inspections; and
- Quality assurance processes as a priority for licensed facilities to support continuous quality improvement and supplement minimum legislative requirements and enhanced quality of care and quality of life for clients.

In addition, there are specific principles that are unique to the different client/resident groups considering their different aspirations, needs and circumstances. For example: child care services stress early learning and developmental processes; assisted living residences place a high value on independence, freedom and choice; services for persons with mental disorders and/or substance use issues focus on rehabilitation, recovery and re-integration into the community, while services for adults and seniors with complex health care needs promote physical and emotional well-being, and care to the end of life.

The Working Group agreed that the key components for a health authority Core Program on Healthy Community Care Facilities and Assisted Living Residences are:

### **Protecting Health**

- Adult and Child Community Care Facilities – Oversight to ensure compliance with legislative requirements through processes for license issuance, compliance monitoring and inspection, investigation management, enforcement and reconsideration/appeal mechanisms;
- Assisted Living Residences – Development of performance objectives for service providers, including requirements for compliance with relevant legislation, as part of contract management for subsidized services, as well as related monitoring for contract

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compliance, and collaboration and information sharing with the Office of the Assisted Living Registrar. (Note: health authorities are not responsible for regulatory oversight of assisted living residences as this is the role of the provincial Office of the Assisted Living Registrar).

### **Promoting Health**

- Initiate service planning and provide funding, management and performance monitoring of community care programs and services (with the exception of some private assisted living residences).
- Enhance systemic understanding, awareness and support for community care facilities/assisted living residences among health professionals, families and the public through:
  - Advocacy for healthy public policies related to community care facilities/residences;
  - Increase public awareness and information initiatives to enhance knowledge and support for quality child care, quality assisted living, and quality residential care;
  - Strengthened community development, capacity building and collaboration to encourage local engagement in enhancing services, support, input and decision-making; and
  - Assistance in ongoing development and educational opportunities related to best practices for public health professionals and staff of community care facilities and assisted residences.

### **Preventing Harm**

- Preventive measures to reduce or eliminate common sources of harm in residential care facilities, assisted living residences and child care centres:
  - Promotion of policies and practices to reduce infections and communicable diseases;
  - Promotion and support for prevention strategies to reduce: developmental harm to children; physical injuries including risk from falls, wandering, etc.; physical, emotional, sexual, financial abuse/neglect, etc.;
  - Coordination with other public health prevention programs to ensure healthy drinking water, food safety, tobacco cessation, immunization, emergency preparedness, etc.

### **Enhancing Quality**

- As regulatory requirements are the minimum level of acceptable care, it is incumbent on health authorities to promote and encourage care providers to exceed these minimum standards and enhance the quality of care and quality of life of clients/residents:
  - Seek agreement from health authority senior leadership to actively promote ongoing quality improvement beyond regulatory requirements;
  - Raise awareness and understanding among care providers, clients/residents, families and the public about the value and characteristics of high quality care;
  - Encourage positive leadership and effective organizational management of community care facilities/assisted living residences.

### **Program Evaluation and Continuous Improvement**

- The Working Group emphasized the need for continuous improvement processes in light of the lack of evidence in this program area, stressing a systematic approach in partnership with appropriate Ministries/agencies, other health authorities and academic researchers to identify gaps and shortcomings as well as strengths and effective practices:
  - Conduct program evaluations, program audits and research studies to determine the value of initiatives;
  - Conduct periodic evidence reviews of the literature to track emerging research to identify proven and/or best practices in the field; and
  - Apply research and evaluation results to ongoing program planning and decision-making processes.

### **Surveillance and Monitoring**

- In partnership with appropriate Ministries/agencies, other health authorities and academic researchers:
  - Identify and collect key statistical information on the level of legislative compliance, complaints (a commitment has been made to the Ombudsman to monitor complaints) and on the quality of care provided by facilities;
  - Encourage partners to collaborate in the collection of consistent statistical data, data sharing and data management processes; and
  - Analyze and interpret data to identify local and regional trends, issues and risk factors.

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Finally, the Working Group noted that an important requirement in providing this core program and enhancing the effectiveness of the health authority regulatory oversight function for community care, is a coordinated provincial training program for licensing officers, including:

- A province-wide certificate-based training program that includes training components as follows:
  - Competencies identified through an occupational analysis described in *Licensing Officer Occupational Profile*;<sup>i</sup>
  - Regulatory requirements based on the *CCALA*;
  - Skills required to respond effectively to the complexity of each stage of the regulatory oversight process;
  - Knowledge and understanding of the specific population groups that receive care, along with key elements and best practices required for effective quality care;
  - Skills in communicating effectively;
  - Skills in collaborative practice development.
- Training opportunities that encompass not only the learning needs of new or aspiring licensing officers, but also the ongoing developmental needs of existing licensing officers across the province.

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<sup>i</sup> Ministry of Healthy Living and Sport. Licensing officer occupational profile. Victoria, BC: Ministry of Healthy Living and Sport; 2009.

## **1.0 OVERVIEW/SETTING THE CONTEXT**

As demonstrated in recent Canadian reports, public health needs to be better structured and resourced, in order to improve the health of the population. The Framework for Core Functions in Public Health is a component of public health renewal in British Columbia. It defines and describes the core public health activities of a comprehensive public health system. This policy framework was accepted in 2005 by the then-Ministry of Health and the health authorities.

Implementation of core functions will establish a performance improvement process for public health, developed in collaboration between the Ministry of Healthy Living and Sport, the health authorities and the public health field. This process will result in greater consistency of public health services across the province, increased capacity and quality of public health services and improved health of the population. To ensure collaboration and feasibility of implementation, the oversight of the development of the performance improvement process is managed by a Provincial Steering Committee, with membership representing all health authorities and the ministry.

What are core programs? They are long-term programs representing public health services that health authorities provide in a renewed and modern public health system. Core programs are organized to improve health; they can be assessed ultimately in terms of improved health and well-being and/or reductions in disease, disability and injury. In total, 21 programs have been identified as “core programs,” of which the program for healthy community care facilities and assisted living residences is but one. Many of the programs are interconnected and thus require collaboration and coordination between them.

In a “model core program paper,” each program will have clear goals, measurable objectives and an evidentiary base that shows it can improve people’s health and prevent or reduce the impact of disease, disability and/or injury. Programs will be supported through the identification of relevant evidence, best practices and national and international benchmarks (where such evidence, best practices and benchmarks exist). Each paper will be informed by an evidence 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.

The Steering Committee has indicated that an approved model core program paper constitutes a model of good practice, while recognizing it will need to be modified to meet local context and needs. In addition, model core programs, over time, will need to be reviewed and updated and a process of renewal is currently being developed by the Steering Committee. While health authorities must deliver all core programs, how each is provided is the responsibility of the health authority, within the context of provincial policies and legislation.

It is envisioned that the performance improvement process will be implemented over several years. During that time the process will contribute to and benefit from related initiatives in public health infrastructure, health information and surveillance systems, workforce competence assessment and development and research and evaluation at the regional, provincial and national levels.

## **1.1 An Introduction to This Paper**

This paper builds on the work of several other important documents that set the context for this model core program. The 2005 *Framework for Core Functions in Public Health*, noted earlier, provides an overall foundation. As well, an *Evidence Review on Healthy Community Care Facilities and Assisted Living*, prepared by Hollander Analytical Service in 2009, with further revisions in 2010, provides a basis for identifying and documenting the evidence, best/promising practices, and some of the key indicators for the program components.

A Working Group for Healthy Community Care Facilities and Assisted Living Residences, formed of experts in the field from the Ministry of Healthy Living and Sport and the health authorities, was established in the spring 2009. The group provided guidance and direction in the development of this paper during meetings in June and October 2009, as well as through telephone and e-mail discussions.

## **1.2 Introduction to the Healthy Community Care Facilities and Assisted Living Residences Core Program**

### 1.2.1 Overview

It is recognized that there is a continuum of care, ranging from supervision, assistance and/or care for young children in child day care, children and youth in residential care, and adults in assisted living or residential care. For example, children's growth requires attention to the stages of growth and learning and involves linkages to the educational system. For people with mental health and/or substance use problems, the focus is on recovery and an increased level of independence. For seniors, health needs may change as they age and require an increasing range of health care and support services to maintain and/or enhance their quality of life. Linkages between home and community care are necessary to allow for a smooth transition to assisted living and, similarly, between assisted living and community care to support further transitions.

For health authority planning purposes, it is also important to note the population projections that anticipate the seniors' population will double in the next 30 years, while the birth rate will expand by about 2% per year in the next 10 years.<sup>1</sup>

### 1.2.2 A Systems Approach to Regulatory Oversight and Promotion of Quality Care

This core program focuses on the role of health authorities including: regulatory oversight of community care facilities; program planning and funding for community care facilities and subsidized assisted living residences; as well as promotion of quality service delivery by child care, child, youth and adult residential care and assisted living providers. It provides a strategic direction for the future and takes a 'systems' approach that acknowledges the various levels of governance and regulatory oversight, the continuum of care, and the continuum across the lifespan. It is intended to support the ability of regional health care systems to plan effectively, ensure continuity, build synergy and cohesion across programs, and heighten awareness among health care partners and the public about the importance and value of quality services. The various continuums that must be considered are:

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- ***Continuum of Provincial, Regional and Local Roles*** – Both provincial and regional levels of the health care system have roles and responsibilities in policy development, planning, funding and regulatory oversight for community care facilities, and assisted living residences, thus forming a continuum in the management and regulation of services. The responsibility for regulatory oversight of community care facilities rests not only with the health authorities but with the provincial Director of Licensing, and for assisted living, it rests solely with the provincial Office of the Assisted Living Registrar.

The health authority planning and funding role may involve contractual arrangements with community care facilities and/or with direct ownership and management of facilities. In addition, it involves funding assisted living services through contractual arrangements for subsidized services.

The local level has an important role in promotion, participation and feedback at the community level.

- ***Continuum of Care*** – Community programs involve a range of residential services, assistance and care that provide increasingly sophisticated levels of support, ranging from supportive housing arrangements, assisted living residences, to licensed community care facilities.
- ***Continuum over the Lifespan*** – Delivery of programs and services to clients cover the life course, as well as specific vulnerabilities. They encompass: early childhood, at-risk children and youth, children and adults with developmental disabilities, adults with mental health disorders and/or substance use problems, and adults with evolving needs for increasing assistance and care as they age, or as their disease progresses.

### 1.2.3 Continuum of Care

The range of services and facilities covered under the *Community Care and Assisted Living Act* (CCALA) for 3 or more persons, are encompassed within this core program on Healthy Community Care Facilities and Assisted Living Residences. (It does not include private hospitals and extended care facilities under the Hospital Act, although it is recognized that these may be included in the future when section 12 of the CCALA is implemented). Included are:

- ***Child Day Care*** – Child day care facilities include group child care, family child care, multi age child care, in-home multi age child care and occasional child care, based on requirements of the Child Care Licensing Regulation (2007). (Child and youth residential care is described under Residential Care Facilities below.)
- ***Assisted Living Residences*** – Assisted living is a semi-independent form of housing that is defined in the Community Care and Assisted Living Act as “a premises or part of a premises, in which, housing, hospitality services, and at least one but not more than two 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”. Assisted living is designed to meet the needs of adults with disabilities and seniors who need help with some day-to-day activities that are beyond home support, but who are able to live relatively independently, and are able to make health care decisions for themselves.

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In the care of people with mental illness, assisted living residences offer a safe, supportive environment where they can acquire knowledge and skills that will enable many to eventually live in more independent settings in the community. For people with substance use disorders, assisted living is a temporary living arrangement where they receive support while addressing their substance use before moving back to the community.

- ***Residential Care Facilities*** – Residential care facilities for children, youth and adults include (based on the Residential Care Regulation, 2009):
  - Community living for persons with developmental disabilities;
  - Time-limited, intensive treatment for mental health and/or substance use issues;
  - Care for persons with acquired injuries (i.e., injuries that have caused limited physical, intellectual or cognitive abilities);
  - A range of short-stay programs such as Convalescent Care, Respite Care;
  - Long-term care for persons with chronic or progressive conditions, primarily due to the aging process; and
  - Hospice facilities for palliative care.

These adult services can be part of a continuum of care that often begin with home and community care services which support clients to remain independent and in their home for as long as possible. Although home and community care programs (i.e., home support programs for clients with acute or chronic health care needs and community-based services such as adult day programs, meal programs, etc.) are not part of this core program, they are a key element in the continuum and an important partner in facilitating seamless delivery of care. The pathways for people with mental health and substance use issues differ although a coordinated and integrated set of community and residential services is also an important factor in delivering rehabilitation and recovery services which improve mental and physical health, and facilitate learning skills that will assist independent living in the community.

A number of provincial ministries play an important role in supporting different components of the continuum of community care, including the Ministry of Healthy Living and Sport, Ministry of Health Services, Ministry of Children and Family Development, Ministry of Housing and Social Development, Community Living Authority of BC, Independent Living BC, Ministry of Education, Ministry of Advanced Education, the Public Guardian and Trustee and the Representative for Children and Youth. The roles and responsibilities of provincial, regional and local organizations that have an involvement in this program are described in section #2.

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### 1.2.4 Protection from Harm

Regulatory oversight to protect and promote the level of safety, health, dignity and quality of life for clients/residents in BC community care facilities is a major responsibility for both the provincial and regional health care system. The risk of harm to individuals with some degree of ‘vulnerability’ is a pressing issue, considering the number of people involved, the range of vulnerability, the scope and potential for harm, and the anticipated increase in the size of the aging population. The current capacity of community care facilities and assisted living residences is:

- There were 90,779 licensed child day care spaces in BC in 2009, including 51,100 group child care spaces, 20,808 preschool spaces, and 14,861 family day care spaces.<sup>2</sup> In the 2008/09 fiscal year, 31,920 unique children received Child Care Subsidy for licensed day care at some point in the year, while 23,716 unique children received subsidy for “license not required care” day care<sup>3</sup>;
- There were 24,210 community care residential spaces (of all types) in 897 facilities in BC, in 2009;<sup>4</sup>
- There were also 6,310 assisted living units in BC in 2009, consisting of 4,342 public (subsidized) units and 1,968 private units.<sup>5</sup>

It is recognized that children, youth and adults in community care facilities or assisted living residences have a degree of vulnerability due to a variety of factors, including, age, cognitive impairments or other health conditions and a reliance on caregivers or staff members for some, or all, of their basic needs or for assistance with daily activities. Protection is necessary from potential harms which could occur as a result of: physical injuries; poor quality or inappropriate supervision and care; developmental harm to children; physical, emotional, sexual or financial abuse; neglect; and/or the spread of communicable disease. For example:

- Elderly persons in long-term care facilities are particularly susceptible to infection: the US Centre for Disease Control estimates that 1.5 million 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;<sup>6</sup>
- Among older people in US ‘nursing homes’, it is estimated that there are 1.5 falls per bed annually, almost three times the rates for community dwelling persons over age 65<sup>7</sup> (Canadian data is not available);
- Child day care centres are the site for 54% of all injuries sustained by children between the ages of 2-4 years, and 42% of all injuries sustained by children 5-9 years of age.<sup>8</sup>
- Although there are no definitive statistics on abuse of adults in long-term care institutions, several small surveys provide an indication of the extent of this problem. An Ontario survey of nurses and nursing assistants found 20% of respondents witnessed abuse of residents in long-term care facilities, 31% witnessed rough handling of residents, 28% witnessed workers yelling and swearing at residents, and 10% witnessed other staff hitting or shoving residents.<sup>9</sup> An American survey found 36% of staff of 31 long-term care facilities witnessed physical abuse, 21% witnessed excessive use of restraints, 15% witnessed slapping or hitting, and 81% witnessed psychological abuse.<sup>10</sup>

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Health authority community care licensing programs are responsible for monitoring licensed care facilities and enforcing the CCALA and related regulatory requirements for community care facilities, including both adult and child care facilities. The medical health officer in each health authority has statutory responsibility for licensing, ongoing monitoring, inspection, investigation and when necessary, enforcement action to ensure compliance. In addition, the provincial Office of the Assisted Living Registrar is responsible for implementing the CCALA regulatory requirements that apply to assisted living residences in the province, including registration, complaint investigation and inspection when required. Health authorities receive funding for publicly subsidized assisted living units and determine the eligibility of individuals for assistance in their region.

### 1.2.5 Promoting Quality

It is not uncommon to find performance-based legislation accompanied by standards, guidelines, best or ‘leading’ practices to supplement legislation to ensure that providers meet and/or surpass the performance criteria set out in legislation. For example, health authorities have evolved their funding contracts to incorporate formal performance expectations, quality improvement mechanisms and, in some cases, to establish or encourage industry standards through accreditation (e.g., Accreditation Canada). Thus, while the focus of regulations is on minimum health and safety standards of a facility / residence, a variety of other initiatives such as contract management, accreditation and pro-active health promotion can build upon the “acceptable floor” of legislation to promote and enhance the “quality” of community care facilities.

In recent years, health promotion professionals have expanded their efforts to create positive environments and strong community action to influence public health, and to use public policy in new ways to support community health.<sup>11</sup> This approach stresses the importance of engaging the community in health decision-making and improving community participation in health promotion, health protection, and disease prevention efforts.<sup>12</sup> It is recognized that healthy community care facilities/residences require not only multi-sectoral involvement but also community engagement to strengthen the knowledge base, expand support and shift societal expectations on the value and importance on quality care and quality of life of those who receive care.

### 1.2.6 Cost Benefit Analysis

Although research evidence on the direct cost benefits of regulatory oversight for care facilities is not available (there are cost benefit studies on specific components such as reducing medication errors), it is clearly understood in the literature and accepted throughout the field that action to reduce the level of harm experienced by clients results in considerable reduction in costs to other parts of the health care system, in particular the acute care system. It also reduces the human suffering that is associated with a wide range of harms including abuse, falls, infections, inadequate care, lack of needed support and limited development opportunities for clients.<sup>13</sup>

### 1.2.7 Regulatory Staff

Staffing competence and staffing levels of licensing officers in BC health authorities are an important element in the review and analysis of regulating community care facilities in the province, as the quantity and quality of staff has a direct relationship on the ability of this program to effectively fulfill its role and responsibilities. In 2008, there were 128 licensing officers in the province.

There are no consistent training requirements or formal training programs (such as certificate or degree programs) for licensing officers in BC (or in Canada). The lack of a certified training program has been a concern for many managers and professionals in this field. Staff members tend to be drawn from a wide range of educational and work backgrounds including early childhood education, while others have undergraduate degrees in fields such as social work, sociology, psychology, or specialized degrees in environmental health or nursing.

## **2.0 SCOPE AND AUTHORITY FOR HEALTHY COMMUNITY CARE FACILITIES AND ASSISTED LIVING RESIDENCES**

In order to develop and enhance healthy community care facilities and assisted living residences, there must be clarity about the respective roles of the Ministry of Healthy Living and Sport, the health authorities, and other ministries and levels of government involved in this area.

### **2.1 National/International Roles and Responsibilities**

On the national level, the Public Health Agency of Canada (PHAC) focuses on policy development, research and strategic analysis of trends in the health of Canadians. Its role is to: promote health; prevent and control chronic diseases and injuries; prevent and control infectious diseases; prepare for and respond to public health emergencies, and strengthen public health capacity in a manner consistent with a shared understanding of the determinants of health and of the common factors that maintain health or lead to disease and injury. PHAC includes:

- A Healthy Communities Division which is a centre of excellence for the issues of physical activity, mental health, family violence, rural health, and injury prevention. It works with partners and stakeholders to develop policy frameworks and national action plans to build community capacity to improve the health of Canadians.
- Health promotion initiatives focus on protecting children from violence, abuse, exploitation, injury and neglect; and promoting safe, supportive environments for children including safe built environments, safe play spaces, safe transportation, water safety and a safe physical/natural environment; as well as promotion of the UN Convention on the Rights of the Child;
- A Family Violence Initiative and the National Clearinghouse on Family Violence;
- Enhancement of senior's health is promoted with a focus on healthy aging, injury prevention, safe medication use and caring for seniors.

Health Canada, First Nation and Inuit Health, provides health promotion and health care services for individuals living on reserves.

Also on a national level, national standards for child care practitioners have recently been updated (*Occupational Standards for Early Childhood Educators*) by the Child Care Human Resources Sector Council, funded by the Government of Canada Sector Council Program.

### **2.2 Provincial Roles and Responsibilities**

#### **2.2.1 Ministry of Healthy Living and Sport**

The mandate of the Ministry of Healthy Living and Sport is to:

- Promote health and prevent disease, disability and injury.
- Protect people from harm.

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- Facilitate quality opportunities to increase physical activity, participation and excellence in sport.
- Support the health, independence and continuing contributions of women and older people.

In its stewardship role, the Ministry of Healthy Living and Sport provides leadership, strategic policy direction, legislation and monitoring for public health and sports programs to support the delivery of appropriate and effective public health services in the province. The ministry has a role in addressing health inequalities, with a specific focus on the development of policies and programs to close the gap in Aboriginal health status. The ministry works with the health authorities to provide accountability to government and the public for public health service outcomes.

Specifically in the area of healthy community care facilities and assisted living residences, the Ministry of Healthy Living and Sport is responsible for strategic policies and legislation as follows:

- Advising the Minister on legislation, policies and guidelines to protect the health, safety, well-being and dignity of persons cared for in licensed community care facilities.
- Overall leadership in implementing regulations and policies to promote the health, safety and well-being of children in child day care facilities and children/youth and adults in residential community care facilities, including requiring the inspection, audit or investigation of community care facilities as deemed necessary;
- Providing leadership in provincial policy development and long-term planning for community care facilities, including collaboration with provincial Ministries and agencies;
- Consulting and collaborating with health authorities, clinical and academic partners in the development of plans, policies, strategies, best practices, data collection and measurement related to healthy community care facilities;
- Monitoring and reporting on provincial progress in promoting healthy community care facilities; and
- Facilitating innovative cross-sectoral, multi-disciplinary projects across the province to assess new approaches.

The following play a key role in the Ministry's administration of healthy community care and assisted living residences:

- ***Director of Licensing*** – The Director of Licensing is a statutory decision maker appointed by Minister's Order as required by the *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

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Director's opinion "possess the experience and qualifications to suitable to carry out the tasks (s.3(2) (a))."

- ***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 assisting living provisions of the *CCALA* (Part 3 of the *CCALA*), including: administering the registration of all assisted living residences in BC; establishing and administering health and safety standards, policies and procedures; investigating complaints of assisted living residents; and inspecting residences if there is a concern about the health or safety of a resident.

### 2.2.2 Ministry of Health Services

The Ministry of Healthy Living and Sport has a unique relationship with the Ministry of Health Services, which is the primary linkage to the regional health authorities, who have responsibility for actual service delivery of public health programs. The roles and functions of the Ministry of Health Services are predominately focused on:

- Leadership for the delivery of health care services and programs.
- Funding and accountability for regional health authorities.
- Ensuring the long-term sustainability of the health care system.
- Improved patient care.
- Leadership, direction and support to health care service delivery partners.
- Setting province-wide goals, standards and expectations for health care services delivery by health authorities.
- Managing the Medical Services Plan, Pharmacare, Ambulance Services and HealthLink BC self-care programs.

With respect to home and community support and community residential care, the Ministry coordinates consultation, planning and funding initiatives with the health authorities. The Ministry's Home and Community Care, and Mental Health and Addictions services coordinate consultation, planning and funding initiatives with health authorities to reflect provincial policies related to residential care (including youth residential addictions treatment), home and community care services. In-home services for eligible clients include home care nursing, rehabilitation, home support and palliative care. Community-based services include adult day programs, meals programs, as well as assisted living, residential care services and hospice care. Case management services are provided in both the home and community.

### 2.2.3 Provincial Health Services Authority

The Provincial Health Services Authority (PHSA) is responsible for ensuring that high-quality specialized services and programs are coordinated and delivered within the regional health authorities. PHSA operates eight provincial agencies including: BC Mental Health and Addiction

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Services, BC Children's Hospital, BC Women's Hospital & Health Centre, BC Centre for Disease Control, BC Cancer Agency, BC Renal Agency, BC Transplant and Cardiac Services BC.

One of PHSA's four key strategic directions is population and public health. A dual role for PHSA is emerging: improvements aimed at streamlining population and public health activities within PHSA agencies and programs, as well as potential provincial coordination in areas such as surveillance, consistent messaging, expert advice, and supporting development of healthy public policy.

### 2.2.4 Ministry of Children and Family Development

The Ministry's general responsibilities include: special needs children and youth; early childhood development and child care; child and youth mental health; youth justice and youth services; child protection and family development; adoption; foster care; programs to assist child care providers in improving the quality of child day care including the Child Care Operating Fund, Child Care Capital Funding Program, Child Care Subsidy, and Child Care Resource and Referral programs.

The Child Care Licensing Regulation assigns responsibility to the Ministry of Children and Family Development for the registration of certificate holders working in the Early Childhood Education field. The Ministry approves curricula, training experiences, learning environments and credentials of college/university educators in this program. The Ministry is also responsible for the Early Childhood Educator Registry that provides: information on training and licensing requirements to those interested in pursuing early childhood education careers (i.e., Early Childhood Educator, Infant/Toddler Educator, Special Needs Educator, or Early Childhood Educator Assistant); and a licensing system for individuals who wish to practice in these areas.

The Child Care Resource and Referral Program provides support, resources and referral services for child care providers and parents in all communities in the province. The Program works with community groups to promote quality child care choices that meet the needs of local families.

### 2.2.5 Other Provincial Ministries/Agencies

#### *Ministry of Housing and Social Development*

The Ministry administers the BC Employment and Assistance program which provides temporary assistance, disability assistance, supplementary assistance and employment programs for British Columbians in need. Ministry clients may live in or use the services of licensed community care facilities.

#### *Community Living BC*

Community Living BC (CLBC) is funded by the Ministry of Housing and Social Development and is responsible for a variety of community living supports and services for adults with developmental disabilities and their families. (The Ministry of Children and Family Development is responsible for children with special needs.) CLBC has a board of self-

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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.

### *Independent Living BC*

This program is also funded by the Ministry of Housing and Social Development in partnership with the federal government through Canada Mortgage and Housing Corporation. It is delivered through the regional health authorities, non-profit and private housing providing. It provides assisted living subsidies for seniors and people with disabilities who qualify for some support to live independently.

### *Ministry of Education*

The Ministry links to child day care through a shared interest and support for effective early childhood education and optimal development during early and middle childhood years. Increasing coordination and integration between these programs is anticipated with development of full-time kindergarten and early learning initiatives and programs.

### *Ministry of Advanced Education*

The Ministry plays a role in health human resource planning and works closely with the health ministries to ensure health program delivery and expansion continue to align with BC's health human resource needs. For example, the Ministry is providing advice and support in pursuing options for the development of a formal Licensing Officer training program. Both public and private post-secondary education institutions provide training for early childhood educators, as well as for a range of health care occupations that provide care for the elderly and those with special needs.

### *Community Care and Assisted Living Appeal Board*

The board is an administrative tribunal that handles 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's members represent the various regions and sectors in both the fields of community care and assisted living in BC.

### *Representative for Children and Youth*

The program supports children, youth and families who need help in dealing with the child welfare system and advocates for changes to the system itself. Responsibilities of the Representative include advocating for children and youth, protecting their rights, and improving the system for the protection and support of children and youth, particularly those who are most vulnerable.

### *Public Guardian and Trustee*

The Trustee is mandated to serve: children and youth under the age of 19 by protecting 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 of deceased persons when there is no one willing or able to administer their estates. The Office of the Public Guardian and

Trustee may become involved 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 administers the *Criminal Records Review Act* 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 who are employed by or licensed by, or receive operating funds from the provincial government are required to have their records checked. Volunteers and residents age 12 and older at a licensed or licence-not-required child care facility are also included under the Act.

2.2.6 Other Provincial Organizations

As well, there are a number of BC organizations and groups that work in collaboration on a provincial, regional, and community level in supporting the healthy community care facilities and assisted living residences. Examples include the Union of British Columbia Municipalities, Healthy Living Alliance, the Social Planning and Research Council of BC.

## **2.3 Health Authorities Roles and Responsibilities**

The overall role of the health authorities is to deliver health services (excluding physician services and BC Pharmacare) to British Columbians in an efficient, appropriate, equitable and effective manner. With respect to healthy community care facilities and assisted living residences, the role of the health authorities is summarized below (section 5.0 provides a more complete description):

- ***Protecting Health*** – Licensing, oversight, monitoring, inspection, investigation, and enforcement of regulatory requirements in community care facilities.
- ***Promoting Health***
  - Service planning, development, funding, contract management and performance monitoring of long-term care, mental health and substance use, and assisted living residential facilities;
  - Enhancement of systemic understanding, awareness and support for community care facilities/residences among health professionals, families and the public.
- ***Preventing Harm*** – Prevention measures to reduce or eliminate common sources of harm in care facilities, such as infections, falls, communicable diseases, etc.
- ***Enhancing Quality*** – As regulatory requirements are the minimum level of acceptable care, it is incumbent on health authorities to promote and encourage care providers to enhance the quality of care and quality of life.
- ***Program Evaluation and Continuous Improvement*** – Program assessment and evaluation can identify gaps and shortcoming as well as strengths and effective practices.

Ongoing analysis and emerging research on best or proven practices can inform continuous quality improvement.

- ***Surveillance and Monitoring***

## **2.4 Local Roles and Responsibilities**

The role of providers in delivering local services in child care centres, assisted living residences and residential care facilities is central to the core program on healthy community care and assisted living residences. Providers have a fundamental responsibility for complying with legislative requirements and offering quality services to their clients.

British Columbia's local governments—municipalities and regional districts—are responsible for planning, fire protection and regulation, recreation and libraries, street lighting, solid waste disposal, the water supply and distribution, sewage collection and disposal, and other services. With respect to care facilities/residences, 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.

## **2.5 Aboriginal Communities**

In BC, First Nations people receive health services through a combination of federal, provincial, and Aboriginal-run programs and services. The Province has responsibility for providing all aspects of health services to all residents of British Columbia, including Status Indians living on and off-reserve. The federal government has a financial responsibility to support the delivery of health services to Status Indians on reserve and pays the Medical Services Plan premiums for Status Indians. The federal government, through the First Nations and Inuit Health (FNIH) department of Health Canada, also provides a range of health programs for First Nations people on reserve. In partnership with FNIH, many First Nations communities have established their own community health facilities and deliver a wide range of health programs and services.

## **2.6 Legislation and Policy Direction**

The legislative and policy direction for the healthy community care facilities and assisted living residences is derived from the following:

- The *Community Care and Assisted Living Act* and the associated Child Care Licensing Regulation, the Residential Care Regulation, Community Care and Assisted Living Regulation, and the Assisted Living Regulation;
- *Public Health Act*; and *Health Act*; *Mental Health Act*; *Employment and Assistance Act* and the *Employment and Assistance for Persons with Disabilities Act*; *Community Living Authority Act*; *Public Guardian and Trustee Act*; *Criminal Records Review Act*; *Continuing Care Act* and *Continuing Care Programs Regulation*; *Communicable Disease Regulation*; *Drinking Water Protection Act* and *Regulation*; *BC Building Code* (under *Local Government Act*); *Fire Service Act* and *BC Fire Code*; *Food Premises Regulation*; and *Freedom of Information and Protection of Privacy Act*;

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- *A Framework for Core Functions in Public Health* (March 2005);
- ActNow BC planning documents approved by the Ministry of Healthy Living and Sport;
- *The Transformative Change Accord: First Nations Health Plan*;
- The United Nations Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities;
- Other government policies on immunization, health emergency planning, nutrition and food safety and tobacco control;
- Specific policies/priorities that may be established by the health authority, the Ministry of Healthy Living and Sport or the provincial government.

### **3.0 GOALS AND OBJECTIVES**

The overall goals for health authorities in the healthy community care facilities and assisted living core program are shown in the sections that follow.

#### **3.1 Child Day Care**

*Goal:* To provide regulatory oversight and encourage quality services which enhance the health, safety and optimal development of children.

*Objectives:*

- To enhance healthy physical, social, emotional, and cognitive development of children in care;
- To reduce risk factors in facilities and maximize full compliance with statutory requirements and quality assurance processes; and
- To increase systemic support for promoting and advancing quality services for children.

#### **3.2 Assisted Living Residences**

*Goal:* To promote delivery of high quality housing, hospitality services and personal assistance for people who require assistance with daily activities, and/or for supportive housing for rehabilitation and recovery purposes.

*Specific Objectives:*

- To promote resident choice, privacy, independence, individuality, dignity and respect;
- To promote the health and quality of life of residents;
- To increase systemic support for promoting and advancing quality services for clients/residents.

#### **3.3 Residential Community Care Facilities**

*Goal:* To provide regulatory oversight and encourage quality improvements that will protect and enhance the health, safety and dignity of persons in care facilities.

*Specific Objectives:*

- To enhance healthy development and respect for the dignity, choice, needs and aspirations of clients, appropriate to their age, health status and circumstances;
- To reduce risk factors in facilities/residences and maximize full compliance with statutory requirements and quality assurance processes; and
- To increase systemic support for promoting and advancing the quality of care and quality of life for clients/residents.

## **4.0 PRINCIPLES**

Although there are many differences in the types of care provided in the range of community care facilities and assisted living residences, there are also many commonalities. Recognizing the health authority role as regulatory oversight and promotion of quality care, overall principles or fundamental concepts for health authority delivery of the Healthy Community Care Facilities and Assisted Living Residences core program are:

- Do no harm;
- Legislative compliance;
- Protection of basic human rights and respect for all people;
- A developmental approach optimizing the potential of all clients/residents, including physical, cognitive, emotional/psychological, and social potential;
- Individualized client-centred/resident-centred care;
- A life course/lifespan approach in program plans and individual care plans supporting smooth transitions between life stages;
- Autonomy and personal choice, including the opportunity to take positive risks, appropriate to age, health and circumstances, to empower clients/residents and enhance their dignity;
- Respect and response to the expectations, needs, hopes and fears of family members;
- Multi-sectoral collaboration, community development and community engagement, strengthening the quality of care;
- Flexible, transparent programs, supporting open communication among all persons involved;
- Risk reductions through an assessment process to determine potential for harm to persons in community care facilities and to prioritize inspections; and
- Quality assurance processes as a first priority for licensed facilities to support continuous quality improvement which supplements minimum legislative requirements and enhanced quality of care and quality of life for clients.

It is also important to consider the specific principles and philosophical approaches that are unique to the different client/resident groups considering their different aspirations, needs and circumstances: for example, child care services stress developmental processes; service in assisted living residences place a high value on freedom, independence and choice; services for people with mental illness and substance use disorders stress recovery, support for personal capability, independence and re-integration into the community; while care for older adults highlight physical and emotional well-being.

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These unique differences are reflected in the following principles:

- ***Children***
  - The “duty of care” for children is the primary consideration;
  - The developmental priority in child care programs acknowledges the long-term importance of physical, social, emotional, language and cognitive skills on a child’s health, well-being and learning skills throughout life;
  - Opportunities for healthy living and healthy lifestyles including physical activity which enables engagement and interaction with the natural environment;
  - Equality of opportunity and social inclusion policies support children who are marginalized or at-risk, whether from developmental disabilities, low parental income or education, ethnic or cultural backgrounds, or other factors that may inhibit access/participation.
- ***People in Assisted Living***
  - Autonomy supports independence, choice and dignity, including the dignity associated with taking appropriate risks, reflecting the need for adults to retain the “ability and right to manage their own lives”.
- ***People in Long Term Care***
  - A focus on client-centred care including respect and empowerment of clients through information sharing, implementation of a Bill of Rights, opportunities to provide input into decision-making, and enhancement of client’s quality of life, appropriate to their age, health and circumstances.
- ***People with Disabilities***
  - Opportunity to choose a place of residence with access to a range of personalized in-home, residential and community support services, providing support for living and participating in the community with dignity.
- ***People with Mental Health and Substance Use Issues***
  - Recovery involving the development of hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills and meaning.
- ***Hospice Care***
  - Care is provided in a manner which respects the intrinsic value and dignity of each person, respects life and the natural process of death while recognizing that both provide opportunities for personal growth and self-actualization.

## **4.1 Foundational Principles/Concepts**

Some of the key principles or fundamental approaches considered by experts in the field to be essential in achieving successful outcomes are described more fully in the following section.

### 4.1.1 Quality of Care and Quality of Life

Increasingly it is being recognized that for ethical reasons, regulatory authorities need to promote both a wellness model and continuous program improvement to enhance the quality of care and quality of life for adult clients in community care facilities.<sup>14 15 16</sup> As outcome-based legislation is common in many jurisdictions, the use of standards or guidelines provide a method to encourage the integration of ongoing quality improvement into program planning and delivery processes.

With respect to assisted living, it is recognized that residents receive assistance with daily activities, rather than care, and that their personal choices and decisions determine the level of service they receive.

With respect to child care, “quality” child care arrangements have been shown to be an important determinant for healthy child development in Canada and the US. Studies on early childhood development programs for at-risk children have demonstrated a number of gains in comparison with control groups, including: emotional and cognitive development; improved parent-child relationships; improved educational outcomes for the child; increased economic self-sufficiency, initially for the parent and later for the child through greater labour force participation, higher income and lower welfare usage; and improved health-related indicators.<sup>17</sup>

### 4.1.2 A Developmental Approach

A developmental approach with clients/residents has been noted by the Working Group as a key philosophical concept. It provides a contrast to a sickness, disease, and/or treatment model as a way to support responsiveness to the unique characteristics and potential of each client/resident, and to encourage a positive, flexible environment which respects the dignity, personal aspirations and choices of each individual. Within mental health and substance use programs, a recovery approach underlies all service delivery with the goal of assisting individuals in achieving greater independence while learning to manage their illness or substance use.

#### 4.1.3 Community Development, Community Capacity Building and Community Engagement

Community development and community capacity building is necessary with a wide range of community groups including municipal authorities, health care providers, community service agencies and local service groups to increase systemic support for, understanding of, and collaboration with local community care facilities and assisted living residences. Information and education enable these groups to, not only enhance support for clients/residents but also assist them in responding to unique local needs and in providing informed input and advocacy.<sup>18 19</sup> Further, as individuals engage with their communities, community capacity, acceptance and awareness can result which supports the overall health and wellbeing of those living in community care and assisted living residences.

Community engagement is the “process of working collaboratively with and through groups of people...to address issues affecting the well-being of those people. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.”<sup>20</sup>

#### 4.1.4 Multi-sectoral Partnerships

As noted by health authority representatives, multi-sectoral participation and partners are necessary with colleagues across a wide range of health programs and health providers, and in multiple community settings to enhance systemic support for, and effective delivery of this core program. A Matrix of key Linkages for the program is illustrated in Appendix III. In summary, primary partners are:

- a) ***Public Health Professionals*** – Collaboration and consultation among public health programs is essential to ensure care needs are met effectively across the continuum of care services to address both current care needs and to plan for transitions to different levels of support and care. Home and community care providers are major partners.
- b) ***Other Health Care Professionals*** – Primary care providers, immunizations providers, dietitians, dental care professionals, mental health and substance use practitioners, etc.
- c) ***Community Agencies*** – Local health care agencies, specialized programs, recreational programs, volunteer programs, education and employment programs, etc. are important partners in planning and delivering quality programs.
- d) ***Local, Regional, Provincial Government Agencies and Bodies*** – As noted earlier, a number of organizations have an involvement in promoting, supporting and/or enforcing health and safety in community care facilities/residences.

#### 4.1.5 Client-Centred Approach

The unique needs of individuals and population groups must be addressed with understanding and consideration of the range of factors that influence their health and safety. For example, the differential impacts of the “determinants of health” (economic, social, cultural and environmental factors) are major influences not only on the life experiences, but the health of many people. The use of a range of “lenses” is necessary to identify individual and group experiences that present risks or vulnerabilities. Special measures are often required to address underlying systemic and equity issues in order to both reduce these risks and create the potential for beneficial opportunities and experiences.

##### *Children*

Research indicates that healthy outcomes for children are directly linked to the level of quality of early care and education programs. “At-risk” children and youth are those who are vulnerable due to socioeconomic status, cultural background or other limiting factors. The principles of inclusion in early learning has been adopted by UNESCO – inclusion is describes as “a developmental approach seeking to address the learning needs of all children...with a specific focus on those who are vulnerable to marginalisation and exclusion.”<sup>21</sup>

##### *People with Intellectual Disabilities, Developmental Disabilities and/or Mental Illness (DualDiagnosis)*

Tailored support services and protective measures are essential to ensure that each individual is supported appropriately; however they must also be balanced with personal autonomy to respect their rights, dignity and privacy. Coordination of care plans between MCFD, Community Living BC, health authority providers, and education officials is necessary to appropriately reduce risks while also maximizing social, emotional / psychological and intellectual growth opportunities particularly through integration and involvement with the community.

##### *People with Mental Illness*

Individuals with a mental illness who are living in residential care or assisted living facilities require a broad range of services and supports that assist in recovery and management of their illness. As some individuals may also deal with complex health, social, economic and environmental factors, integrated care planning and service delivery across a variety of community services may be necessary. When individuals also have a concurrent substance use disorder, treatment needs to be inclusive and coordinated in order to provide the necessary care.

##### *People with Substance Use Disorders*

BC has adopted a focus on substance use services that focus on the whole person, through a “bio-psycho-social-spiritual” approach. Residential substance use programs are time limited and the focus of treatment is on the individual’s return to the community. Consequently, coordination between residential and community services is crucial.

### *Gender Considerations*

Gender has a powerful influence on all aspects of health. Socially constructed differences between women and men – for example, responsibilities, status and power – interact to contribute to differences in the nature of health problems, mental health and the associated responses encountered in the health sector and society as a whole.<sup>22</sup>

A particular concern for vulnerable persons in care, whether children or adults, is the risk of physical and/or sexual abuse. Canadian research suggests that the risk of abuse of people with disabilities may be as high as 5 times greater than the risk for the general population.<sup>23</sup> A number of small scale studies suggest that 39% - 68% of girls and 16% - 30% of boys with developmental disabilities will be sexually abused before the age of 18.<sup>24</sup> The overwhelming majority of the abusers are well-known to the victim. The rate of abuse tends to be high for both women and men who are dependent on caregivers due to age, limited physical or mental capacity, and/or other vulnerabilities. It should also be noted that there is a strong link between physical and sexual abuse disorders and mental ill health.<sup>25</sup>

Gay, lesbian, bisexual and transgendered people's experience of sexual orientation, gender identity discrimination and higher rates of physical and sexual abuse<sup>26</sup>, can lead to higher rates of mental problems and disorders, and problematic substance use, compared to the heterosexual population.<sup>27</sup>

### *Aboriginal People*

First Nations people must be full partners in the design and delivery of health initiatives to benefit them and their communities<sup>28</sup>, and research evidence must be blended with the knowledge and life experience of Aboriginal practitioners and leaders.<sup>29</sup> Rather than integrating aboriginal people into mainstream services, initiatives should include parallel programs and services that are culturally sensitive and situated within an Aboriginal worldview in order sustain long-term, community-based change.<sup>30</sup> Since little evidence was found on effective programs for Aboriginal programs, researchers suggest that programs draw from multi-cultural approaches and support inclusion, mutual respect and holism. Services should be community-based with Aboriginal providers wherever possible to support cultural relevance and community decision-making.<sup>31</sup>

### *Diverse Cultures and Ethnic Groups*

Persons or groups from diverse cultural or ethnic backgrounds face additional health risks due to conditions such as discrimination, marginalization, stigmatization, loss or devaluation of language and culture, and lack of access to culturally appropriate health care and services.<sup>32</sup> BC is home to a significant number of people who have migrated from other countries, thus culturally sensitive care is an important consideration for both child and adult services. This is an important feature in training and staff competence as knowledge and sensitivity to the diverse range of population groups who receive care is key element in the quality of care and a client-centred approach.

## **5.0 MAIN COMPONENTS**

The major components for a health authority program on healthy community care facilities and assisted living residences are:

- Protecting health;
- Promoting health;
- Preventing harm;
- Enhancing quality;
- Program evaluation and continuous improvement;
- Monitoring and surveillance.

Strategies for each of the main program components are described in each of the following sections.

### **5.1 Protecting Health**

#### 5.1.1 Adult and Child Community Care Facilities

The effective oversight of community care facilities requires the following measures to protect clients from harm and support their health, safety and dignity: (see *also A Guide to Community Care Facility Licensing in British Columbia*<sup>33</sup>, for a full description of these activities):

- Licence issuance
  - Investigate the suitability of applicants, proposed facilities and programs; and
  - Approve/deny a license.
- Compliance monitoring and inspection
  - Conduct formalized risk-assessments to determine the risk level and associated inspection frequency for each facility (based on the *BC Manual for Risk Based Inspection*<sup>34</sup>);
  - Monitor and inspect facilities to assess compliance with legislation, utilizing a combination of announced and unannounced visits, and a frequency rate determined by the level of risk (as noted above);
  - Assess credentials of facility staff members to ensure compliance with requirements (With respect to early childhood educators, this is a joint responsibility with MCFD);
  - Assess and approve exemption requests, as appropriate, to allow flexibility while also protecting the health and safety of those in care.

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- Investigation management
  - Plan strategies and conduct investigations in response to complaints, reportable incident reports, or observations;
  - Assess information, identify contraventions to the legislation, prepare reports, and work with facilities as they develop appropriate corrective action plans.
- Enforcement
  - Apply progressive enforcement strategies using positive enforcement techniques as a first step, e.g., consultation, training, and assistance in developing corrective action plans; and
  - Use negative enforcement when required, e.g., official warning letters, conditions on the licence, suspension of license, or injunctions through the court system.
- Reconsideration/appeal mechanisms
  - Reconsider regulatory decisions on a local level when requested, based on due process and principles of administration law and administrative fairness; and
  - Support a fair and open appeal process when a request is made to the Appeals Board for review of a decision.

**NOTE:** Health authorities also play a role in providing community care facilities themselves, either through contractual arrangements or in some cases, direct funding and management of facilities. In these cases, the management role is separate from the regulatory oversight role. Where health authorities are service providers they are also responsible for complying with regulatory requirements and provision of quality services and continuous quality enhancement.

### 5.1.2 Assisted Living Residences

The role of the provincial Office of the Assisted Living Registrar is:

- Registration
  - Review all supporting documents (e.g., permits, reference checks, plans to implement health and safety standards, draft personal service plans, etc.);
  - Conduct a risk assessment and follow-up as necessary (e.g., investigate risks, advise operators on rectifying deficiencies, etc.);
  - Approve registration where regulatory requirements have been met.
- Information
  - Provide information on policies and guidelines that must be applied on an ongoing basis by resident operators.

- Complaint Investigation
  - Apply an incremental remedial approach as a first step in investigating complaints, including reviewing the operators policies and procedures, and educating the complainant and the operator about requirements and standards;
  - Apply progressive enforcement techniques in cases where concerns continue and the risk is deemed high, ranging from changing the conditions of an operator's registration, and in more dangerous situations, the use of fines, suspension or cancellation of a registration.

The role of health authorities with respect to Assisted Living Residences is to:

- Determine eligibility of individuals for assisted living subsidies;
- Set performance objectives for assisted living residences as part of contract management arrangements for subsidized residents;
- Consult with and provide information to the Office of the Assisted Living Registrar on new registration requests;
- Monitor contractual performance in assisted living residences, including reviewing statistics, visiting residences, conducting resident satisfaction surveys, etc.;
- Investigate problems and issues related to contractual performance;
- Collaborate and share information with the Office of the Assisted Living Registrar on regulatory compliance complaints and issues related to health and safety.

### 5.1.3 Summary of Supporting Evidence

For the most part, exemplary practices in this field are the result of consensus views of regulatory experts, based on experience developed over many years. Policies and procedures that ensure thorough, fair, responsive, consistent, and accountable risk assessment, inspection, complaint investigation, and enforcement, are acknowledged to contribute to effective licensing and registration processes. Many experts recommend implementation of “a formalized risk-assessment approach for inspections that concentrate on facilities with a history of non-compliance, and prioritize inspection procedures”.<sup>35</sup> Risk assessment tools recognize that the regulatory threshold is set at the minimum acceptable level and that most violations pose a degree of risk for persons in care, and moreover, that some violations pose significantly more risk than others.<sup>36</sup>

With respect to assisted living, residents are able to make the range of decisions that allow them to live safely in a supportive, semi-independent environment. It is recognized that housing and services need to adapt to meet the needs of each resident by embracing the concepts of resident choice, privacy, independence, individuality, dignity and respect. Residents, with the support of their families and case managers (where involved), determine with the operator the type of

accommodation and services they require, all of which is confirmed in a tenancy agreement (in BC).<sup>37</sup>

Overall, researchers and experts<sup>38</sup> in the field agree on the following characteristics of effective regulation in health care: a focus on improvement; responsiveness to individual organizations depending on their response and behavior; 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; sufficient flexibility to allow discretion in responding, while also ensuring an appropriate level of consistency; cost and benefits are taken into account, both for the regulatory agency, and the regulated organizations; information on the regulatory process, and on findings, is readily available to stakeholders and the public; a wide range of incentives and sanctions are available; mechanisms are in place for holding the regulator accountable for actions, while also ensuring independent decision-making; systems are in place to monitor and evaluate the impact of regulations and regulation systems.

## **5.2 Promoting Health**

Health authorities, the Office of the Assisted Living Registrar and other provincial ministries/agencies, as appropriate, work to enhance understanding, awareness and support for community care facilities and assisted living residences among both health professionals and the public. (Health authority licensing officers and/or other public health professionals in the health authority may be responsible for these activities).

- Healthy public policies
  - Advocate for policies that reflect and integrate the above principles into all aspects of the regulatory process;
- Increase public awareness
  - Provide public information resources and materials to educate the public about the value, importance and characteristics of quality child care, quality assisted living and quality community care to assist them in making knowledgeable decisions and in providing well-informed input;
  - Ensure public accessibility to assessment information on each facility/residence;
- Strengthen community action/community collaboration
  - Provide planning, development, funding, contract management and performance monitoring of long-term care, mental health and substance use, and assisted living residential facilities (with the exception of privately operated sites);
  - Facilitate community development and community capacity building in partnership with health care professionals, community care facilities, assisted living residences and community service agencies / organizations to build

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- knowledge, commitment and support for coordinated community planning and ongoing quality improvement;
- Encourage community engagement in provision of services, assistance, support, input and feedback to enhance support for clients/residents.
- Develop skills
  - Implement appropriate training for licensing officers to strengthen their knowledge, skills and abilities (**see requirement below**);
  - Provide and/or facilitate the delivery of education and training for public health professionals, community service workers, and staff of community care facilities/assisted living residences, to enhance knowledge and skills related to regulatory requirements and implementation of best practices;
  - Provide a range of information, resources and technical assistance to encourage and educate care providers to comply with regulations and to enhance the quality of services and relationships with families and communities.

**NOTE:** The Working Group noted that an important requirement in providing this core program and enhancing the effectiveness of the health authority regulatory oversight function for community care, is a coordinated provincial training program for licensing officers, including:

- A province-wide certificate-based training program that includes training components as follows:
  - Competencies identified through an occupational analysis described in *Licensing Officer Occupational Profile*<sup>39</sup>;
  - Regulatory requirements based on the *CCALA*;
  - Skills required to respond effectively to the complexity of each stage of the regulatory oversight process;
  - Knowledge and understanding of the specific population groups that receive care, along with key elements and best practices required for effective quality care;
  - Skills in communicating effectively;
  - Skills in collaborative practice development.
- Training opportunities that encompass not only the learning needs of new or aspiring licensing officers, but also the ongoing developmental needs of existing licensing officers across the province.

### 5.2.1 Summary of Supporting Evidence

The World Health Organization Ottawa Charter notes that health promotion should encompass a number of strategies including: building healthy policies, creating supportive environments; strengthening communication; developing personal skills, and reorienting health services (this

latter point is discussed under ‘Enhancing Quality’). Some of these relate to strengthening overarching values, goals and activities that enhance effectiveness of the health care system, while others relate to the care of clients, support of residents, or to awareness and involvement by families, communities and the public.

With respect to the training and education of licensing officers, the Working Group highlighted that a centralized, thorough training program is fundamental to enhancing and advancing the quality and effectiveness of the licensing function across the province, as well as to reducing the duplication and inconsistencies that occurs through the wide range of in-house orientation and training measures provided by each health authority. The Working Group places a priority on a provincial certified training program to achieve the goals of the model core program.

The National Association of Regulatory Administration recommends<sup>40</sup> that monitoring/licensing agencies assist in education and training of care providers by addressing new training requirements and building up training resources. Activities could include: promotion and support of in-service training for care providers; the development of tools, curricula and materials that help providers to orient and training their personnel; provision of quality train-the-trainer sessions; collaboration with the formal education systems to respond to the educational needs of providers and their staff; orientation sessions on legislation; and provision of topical training related to recognized competencies for particular occupations.

Evidence on best practices in community development and community capacity building notes the importance of: intersectoral collaboration and open communication, the value of process as well as outcome, accessible and transparent decision-making structures, the need to build on existing structures of community representation, and skills development and education for all stakeholders involved.<sup>41</sup>

### **5.3 Preventing Harm**

Key prevention measures to reduce and/or eliminate common sources of harm in licensed care facilities and assisted living residences include (in addition to measures noted in 5.1) the following:

- Advocate with providers of community care facilities and assisted living residences to prevent and/or reduce infections and communicable diseases by:
  - Encouraging facilities/residences to promote compliance with immunization schedules for children admitted to programs;
  - Implementing, in long term care facilities, infection control policies and procedures, immunization policies based on BCCDC recommendations for vulnerable individuals, a risk management plan, health emergency management plan, quality management processes, and staff education on infection control practices.
- Promote and support implementation of injury prevention strategies, including:

- Strategies to reduce the risk of injuries from poor quality supervision and care, falls, wandering, etc. For example, adult fall risk screening and assessment, or assessment of wandering, and where necessary, adopt personalized multifactorial risk management strategies;
  - Promotion and support for prevention policies and procedures focused on reducing the risk of physical, emotional, sexual, financial abuse, neglect and maltreatment;
  - For child care, implement injury prevention strategies such as active and positive supervision, safe space arrangement, developmentally appropriate programming, and preventive strategies to reduce developmental harm;
  - Implement best practices for safe and stimulating outdoor environments including use of the natural environment and creative design of outdoor spaces.
- Advocate with service providers for use of best practices in preventing/reducing medication errors in nursing homes, working with the College of Pharmacists where there are concerns, interdisciplinary case management, medication reviews, practice feedback and benchmarking, and educational outreach to health care providers.
  - Work with other public health officers in supporting the implementation of other key prevention strategies that may be necessary, such as food safety, quality drinking water, tobacco cessation, wound care practices, etc., as well as positive preventive measures such as physical exercise, good nutrition, life skills development as appropriate, etc.

### 5.3.1 Summary of Supporting Evidence

The BC Auditor General recommended that health authority contracts with providers of residential care services identify requirements 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.<sup>42</sup> 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.<sup>43</sup>

There is strong evidence for success in falls prevention based on fall risk screening and assessment followed by the development and implementation of tailored interventions.<sup>44</sup> There is overall consensus among a number of literature reviews on long-term care facilities 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 this approach should be implemented as part of an overall, comprehensive falls prevention program.<sup>45</sup>

Following analysis of risk factors and injury rates, the British Columbia Injury Research and Prevention Unit have recommended protective initiatives to reduce playground injuries in child

care centres. These are summarized above and discussed in detail in *Reported Injuries in Child Care Services* (2006)<sup>46</sup>.

## **5.4 Enhancing Quality**

As regulatory requirements are the minimum level of acceptable care, it is incumbent on health authorities (licensing officers and/or other public health professionals in the health authority) to promote, encourage and support providers in exceeding these minimum standards and enhancing the quality services and quality of life for clients/residents beyond the minimum legislative requirements. This includes the need to:

- Seek agreement and support from health authority leadership to promote / encourage / advocate ongoing quality improvement in community care facilities;
- Raise awareness, understanding and support among public health and other health care professionals about the value of continuous quality improvement and the need to encourage, guide and motivate facility operators in implementing this approach;
- Encourage positive leadership and effective organizational management including clear mission statements, positive environments, connectivity and trust among staff, and continuity in care; and
- Advocate for the involvement of clients/residents, their families and the surrounding community in providing increased input and participation in decision-making processes.

### 5.4.1 Summary of Supporting Evidence

A study comparing high-performing and low-performing nursing homes<sup>47</sup> highlighted key differences. Leaders in the high-performing homes behaved congruently with the nursing home's stated and lived mission by exhibiting a genuine interest in the well-being of residents, fostering connectivity among staff, ensuring ample information flow, and using 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.<sup>48</sup>

There is a quality continuum that generally determines the purpose, roles, and activities of licensing professionals. For example, licensing officers ensure that children are safe in facilities in the low to mid range of the quality continuum and thus focus on enforcing regulations to ensure compliance; however, for those facilities in the higher end of the quality continuum, licensing officers focus on consultation and support to enhance services<sup>49</sup>.

Staff education and training has been found to be a key indicator of quality care in all care settings.<sup>50 51</sup> There is also evidence demonstrating a linkage between certain standards and the level of quality care. For example, in child care, the staff to child ratio, and small group sizes are important indicators of quality.<sup>52</sup>

*Commitment to Care: A Plan for Long-Term Care in Ontario* (2004)<sup>53</sup> recommends enhancing the quality of life for long-term care residents by engaging families, volunteers and by better

integrating long-term care into the vibrancy of the surrounding community. Proposed initiatives include: more education to increase awareness of 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, and sharing of best practices. Similarly *A Review on the Quality of Care Homes in Scotland, 2004*<sup>54</sup> noted "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."

## **5.5 Program Evaluation and Continuous Improvement**

Ongoing assessment and evaluation (in combination with Monitoring and Surveillance in 5.6), in partnership with appropriate Ministries/agencies, other health authorities and/or academic researchers, can assist in identifying measures for continuous quality improvement in enhancing the effectiveness of program delivery and program outcomes, including:

- Establish assessment processes, including program evaluation frameworks and appropriate outcome indicators;
- Conduct program evaluations, program audits and research studies, particularly to determine the value of new initiatives (in partnership with other health authorities, appropriate Ministries/agencies, and/or academic institutions);
- Conduct periodic evidence reviews of the literature to track emerging research in order to identify proven and/or best practices in the field (with appropriate partners); and
- Apply research and evaluation results to ongoing program planning and decision-making processes.

**NOTE:** The Working Group emphasized the need for continuous improvement processes in light of the lack of evidence, particularly BC evidence, in this program area. They consider a systematic approach essential, involving a wide range of partners across the continuum of care, to identify gaps and shortcomings as well as strengths and effective practices.

### 5.5.1 Summary of Supporting Evidence

The Auditor General of Alberta recommended that health "authorities should have systems to periodically measure, evaluate and report on the effectiveness of services provided in long-term care facilities". (Although this recommendation was developed specifically for long-term care facilities, it could apply to other residential facilities as well as to child day care programs.) It was proposed that health authorities should: define the purpose and objectives of services provided in long-term care facilities; establish methods to measure whether the objectives are being met; have information systems to obtain reliable cost and results information promptly; analyze performance information and use it to recommend changes to the services provided in long-term care facilities; and report performance information to their respective Ministers.<sup>55</sup>

It is recognized that although public health, and prevention programs in particular, are difficult to measure, it is nonetheless likely that we will be able to manage, and improve, core functions in public health if we can measure performance.<sup>56</sup> An information system capable of measuring

success is necessary for this purpose. The public has a right to expect that the public health sector, along with the rest of the health care system is paying attention to the quality and effectiveness of the interventions it undertakes, and is working to improve that quality.<sup>57</sup>

## **5.6 Monitoring and Surveillance**

Partnerships with appropriate Ministries/agencies, other health authorities and academic researchers can enhance monitoring and surveillance of healthy community care facilities and assisted living, to clarify trends and patterns in risk levels as well as to assist in measuring ongoing program outcomes:

- Identify and collect key statistical information/indicators on the level of legislative compliance, complaints (a commitment has been made to the Ombudsman to monitor complaints), as well as the quality of care beyond minimum requirements provided by community care facilities and services provided by subsidized assisted living residences, throughout the region;
- Encourage partners to collaborate in the collection of statistical data, data sharing and data management processes, including the use of appropriate information technology systems that will facilitate consistent data collection and information sharing;
- Analyse and interpret data to identify local and regional trends, major issues, key risk factors, vulnerable groups and populations and programs outcomes, to support effective planning and decision-making.

### 5.6.1 Summary of Supporting Evidence

The Allen Report<sup>58</sup> on BC community care facilities discussed the importance of a comprehensive information system on all aspects of community care licensing for health regions and the province as a whole.

Overall, monitoring and surveillance of both regulatory oversight processes and community care outcomes is accepted by experts as necessary for responsible and effective program management. In addition, the literature stresses the need for organizational commitment to a thorough analysis of safety issues, the development of actions to reduce harms, verification of their implementation and effectiveness, and identification of any unanticipated secondary effects. Leadership involvement in, and coordination of, all these activities is deemed necessary for an effective process.<sup>59</sup>

## **6.0 BEST PRACTICES**

Often, there are no “best practices” that are agreed upon; rather, there are practices that may have been successful in other settings and should be considered by health authorities. The terms “leading practices”, “better practices”, or “promising practices” are often preferred to reflect the evolving and developmental nature of performance improvement.

Healthy community care facilities and assisted living residences cover many different types of care services and a wide variety of client groups. This wide range of functions makes it difficult to provide an overview of best or promising practices that can be applied to all projects. Thus a list of key references is included to provide a detailed discussion of effective practices for further guidance and advice:

- *Review of the Evidence and Best Practices on Healthy Community Care and Assisted Living Residences* (2010), prepared by the Ministry of Healthy Living and Sport, Victoria, BC.
- *A Guide to Community Care Facility Licensing in British Columbia* (2009 draft), prepared by Ministry of Healthy Living and Sport Victoria, BC.
- *Manual for Risk Based Inspection* (2009 draft), by the Ministry of Healthy Living and Sport, Victoria, BC.
- *A Best Practices Approach to Regulated Child Care within a Framework that Supports Good Outcomes for Children* (2003), by E.E. Ferguson et al., and Child Care Connection Nova Scotia with the Provincial/Territorial Director of Child Care/Early Childhood Development Services.
- *A Review of the Literature on Best Practices in Falls Prevention for Residents of Long-Term Care Facilities* (2003), by V. Scott, M. Donaldson, and E. Gallagher.

With respect to mental health and substance use treatment and rehabilitation programs:

- The BC Ministry of Health Services developed *Best Practices in Mental Health and Addictions*, prepared by Working Group on 7 different topics including:
  - Housing (2000)  
[http://www.health.gov.bc.ca/library/publications/year/2000/MHABestPractices/bp\\_housing.pdf](http://www.health.gov.bc.ca/library/publications/year/2000/MHABestPractices/bp_housing.pdf).
  - Psychosocial Rehabilitation and Recovery (2000)  
[http://www.health.gov.bc.ca/library/publication/year/2000/MHABestPractices/bp\\_psychosocial\\_rehab.pdf](http://www.health.gov.bc.ca/library/publication/year/2000/MHABestPractices/bp_psychosocial_rehab.pdf).
- *Planning Guidelines for mental health and addictions services for children, youth and adults with developmental disabilities* (2003), by the BC Ministry of Health Services.
- *Service Model, Standards and Guidelines for Adult Residential Substance use Services and Supports* (draft), by the BC Ministry of Health Services.

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In addition, there are a number of documents that provide best practices related to effective substance use treatment and rehabilitation listed on the website of the Centre of Addictions Research BC website ([www.carbc.ca](http://www.carbc.ca)). (As noted earlier clinical and therapeutic practices were not within the scope of the paper.)

## **7.0 INDICATORS, BENCHMARKS AND PERFORMANCE TARGETS**

### **7.1 Introduction**

It is important to define what one means by the terms *indicators*, *benchmarks* and *performance targets*. An indicator is a representation (usually numerical) of something that is seen to constitute an important reflection of some aspect of a given program or service. Indicators need to be standardized in some manner so that they can be compared across different organizational entities such as health regions. Benchmarks are usually numerical representations. However, they are reflective of “best” practices. They represent performance that health authorities should strive to emulate. Benchmarks are determined by: reviewing the literature; reviewing the best practice experience in other jurisdictions; or by determining “consensus” opinion of leading experts and practitioners in the field. Performance targets are locally determined targets that represent a realistic and achievable improvement in performance for a local health authority.

One can develop indicators related to the inputs, activities, outputs and outcomes (immediate, intermediate or final) of each of the respective healthy community programs. Thus, it is not necessary to only have outcome-related indicators and benchmarks. Furthermore, indicators need to be understood within a broader context. For example, a low per-capita cost for a specific program could reflect the efficiency and effectiveness of the function, or it could reflect a function that is under-resourced. In general, it is best to consider a number of indicators, taken together, before formulating a view on the performance of a given program. Indicators and benchmarks work best as flags to indicate a variance from accepted norms and standards. Further investigation is usually required to determine the causes of any given variance from such norms or standards.

A health authority could determine its performance target by assessing its current (and perhaps historical) level of performance; then, based on a consideration of local factors (e.g., capacity, resources, new technology, staff training etc.), it could establish a realistic performance target. This performance target would be consistent with the goal of performance improvement, but would be “doable” within a reasonable period of time. Initially, health authorities will set performance targets for a number of indicators. However, over time and particularly if consistent data collection methods and definitions are applied, it would be realistic for health authorities to share information related to their performance targets and then develop a consensus with other health authorities to determine provincial benchmarks for these indicators. In other words, locally developed performance targets, over time, could lead to the development of additional provincial benchmarks.

### **7.2 Indicators for Healthy Community Care Facilities and Assisted Living Residences**

Indicators prepared by the Working Group are presented in the Appendix. It is recognized that in some instances, the health authorities may have relatively little influence or control over the indicators, but these can nevertheless, provide important information on trends, patterns and emerging issues which are necessary for planning purposes. The indicators and benchmarks which are under the control and influence of health authorities provide a basis for ongoing

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performance review and evaluation. It is recognized that health authorities are at different stages of development and that they may wish to choose those indicators which are most relevant to their circumstances or to identify others that reflect their unique needs.

In many cases, baseline data may need to be established to provide a basis for comparative analysis in future years. Benchmarks will be determined over time between the Ministry of Healthy Living and Sport and the health authorities, and as well through the involvement of Ministry of Children and Family Development with regard to data on child care. In addition, health authorities may wish to establish local or regional benchmarks and performance targets.

## **8.0 EXTERNAL CAPACITY AND SUPPORT REQUIREMENTS**

### **8.1 Key Success Factors/System Strategies**

The previous sections outlined the main components and best practices that health authorities could include in their healthy community care and assisted living program. Successful implementation of effective programs in this field will also depend on having in place overall system strategies/key success factors. These include:

- Strong support from the Board and management of the health authorities regarding the importance of all aspects of the program on healthy community care facilities and assisted living residences in their region, and the role it plays in protecting the health of the population.
- Allocation by the province and the health authorities of sufficient resources to provide continuous improvement and high quality programs.
- Well-trained and competent staff with the necessary policies, information and equipment to carry out their work efficiently and effectively.
- An information system that provides staff with appropriate support, the public with access to information, and management with the information it needs to drive good policy and decisions.
- Clear mechanisms of reporting and accountability to the health authority, to the Ministry of Healthy Living and Sport, to other ministries of government (as appropriate) and to external bodies.

### **8.2 Information Management for Healthy Community Care Facilities and Assisted Living Residences**

It will be important for health authorities to review their existing information and monitoring systems with respect to their ability to measure and monitor performance indicators. This should include:

- Establishing new policies and procedures for some activities to ensure that the necessary data are gathered;
- Facilitating the process of recording and monitoring data; and
- Establishing baseline levels for new data sets as a foundation to compare and assess trends and differences over time.

Health authorities will also need to consider the impact of program monitoring and evaluation on their staffing resources. Expertise will be needed in the fields of program monitoring, program analysis and program evaluation to ensure effective implementation and assessment of the core functions improvement process.

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## GLOSSARY

The following definitions, unless otherwise noted, are from the *BC Community Care and Assisted Living Act*:

**"adult"** means a person 19 years of age or older;

**"assisted living residence"** means 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;

**"board"** means the Community Care and Assisted Living Appeal Board continued under section 29;

**"care"** means supervision that is provided to

(a) a child through a prescribed program,

(b) a child or youth through a prescribed residential program, or

(c) an adult who is

(i) vulnerable because of family circumstances, age, disability, illness or frailty, and

(ii) dependent on caregivers for continuing assistance or direction in the form of 3 or more prescribed services;

**"child"** means a person under the age of 13 years;

**"community care facility"** means a premises or part of a premises

(a) in which a person provides care to 3 or more persons who are not related by blood or marriage to the person and includes any other premises or part of a premises that, in the opinion of the medical health officer, is used in conjunction with the community care facility for the purpose of providing care, or

(b) designated by the Lieutenant Governor in Council to be a community care facility;

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**"director of licensing"** means the director of licensing designated under section 3 and includes, for the purposes of a delegation made under section 3 (2), the person to whom the delegation is made;

**"employee"** includes

- (a) a volunteer,
- (b) a person providing services under contract or other person ordinarily present at a community care facility but does not include a person in care, or
- (c) a person providing services under a contract or other person ordinarily present at an assisted living residence but does not include a resident;

**"health authority"** means a body designated under section 4 of the *Health Authorities Act*;

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

**"licence"** means a licence issued under section 11;

**"licensee"** means a person, including an aboriginal governing body however organized and established by aboriginal people within their traditional territory in British Columbia, that holds a licence;

**"manager"** means an individual whom the licensee has authorized to manage the operation of the community care facility;

**"medical health officer"** means a medical health officer designated under the *Public Health Act*;

**"minister"** includes a person designated in writing by the minister;

**"municipality"** includes

- (a) a regional district, and
- (b) a local trust committee as defined in the *Islands Trust Act*;

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

**"premises"** means a building or structure and includes outside areas adjacent to the building or structure ordinarily used in the course of providing services;

**"prescribed services"** means services prescribed under section 34 to be prescribed services;

**"registrant"** means an operator of an assisted living residence registered under section 25;

**"registration"** means a registration under section 25 (1);

**"registrar"** means the assisted living registrar designated under section 24 and includes, for the purposes of a delegation under section 24 (2), the person to whom the delegation is made;

**"resident"** means a person who resides at an assisted living residence;

**"sibling group"** means a group of 3 or more children

(a) who reside in the same household if they are in the care of a person who is, with respect to each child,

(i) a parent of the child,

(ii) a person with whom the child is placed under the *Child, Family and Community Service Act*,

(iii) a person who has custody or guardianship of the child under an order of a court, or

(iv) the spouse of a person referred to in subparagraph (i) or (iii) if that person resides in the household, or

(b) who are recognized by the director of licensing as a sibling group;

**"youth"** means a person who is neither a child nor an adult for the purposes of this Act.

## **APPENDIX 1: THE EVIDENCE BASE FOR A MODEL CORE PROGRAM FOR HEALTHY COMMUNITY CARE FACILITIES AND ASSISTED LIVING RESIDENCES**

**Taken from:** *An Evidence Review on Healthy Community Care Facilities and Assisted Living Residences, Prepared by Hollander Analytical Services for the Ministry of Healthy Living and Sport, 2010.*

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.

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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 Appendix includes 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

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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

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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 wellbeing.

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 be 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 wellbeing. Social support "prevents and/or mediates the effect of disease and promotes health and wellbeing". 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 behavior, 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.

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- 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

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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

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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;

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- 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.

**APPENDIX 2: MATRIX OF KEY LINKAGES FOR HEALTHY COMMUNITY CARE FACILITIES/ASSISTED LIVING RESIDENCES**

	<b>Core Public Health Programs</b>	<b>Other Health Programs/Providers</b>	<b>Local, Regional and Provincial</b>
<b>Child Care</b> (residential facilities and child care centers)	<ul style="list-style-type: none"> <li>• Healthy Infant and Child Development</li> <li>• Healthy Child and Youth Development</li> <li>• Promotion of Healthy Living</li> <li>• Food Safety</li> <li>• Prevention of Unintentional Injuries</li> <li>• Promotion of Dental Health Prevention of Communicable Disease</li> <li>• Prevention of Violence, Abuse and Neglect</li> <li>• Healthy Communities</li> <li>• Mental Health Promotion and Prevention of Mental Disorders</li> <li>• Health Emergency Management</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care providers</li> <li>• Counsellors/mental health professionals</li> </ul>	<ul style="list-style-type: none"> <li>• Ministries of Child and Family Development, Education and Advanced Ed</li> <li>• Local, regional and provincial parent groups</li> <li>• Local, regional and provincial child care associations</li> <li>• Community children’s service agencies</li> <li>• Local recreational services/programs</li> <li>• Local fire protection / regulation, zoning, business permits, water quality, etc.</li> <li>• Regional and local Aboriginal groups</li> <li>• Regional and local cultural organizations</li> </ul>
<b>Community Care</b> (aged adult care, mental health, and detox residences)	<ul style="list-style-type: none"> <li>• Promotion of Healthy Living</li> <li>• Food Safety</li> <li>• Prevention of Harm from Substances</li> <li>• Prevention of Unintentional Injuries</li> <li>• Prevention of Communicable Disease</li> <li>• Prevention of Violence, Abuse and Neglect</li> <li>• Healthy Communities</li> <li>• Mental Health Promotion and Prevention of Mental Disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Primary care and acute care providers</li> <li>• Counsellors/mental health/ substance use professionals</li> <li>• Dental health care providers</li> <li>• Rehabilitation service providers</li> <li>• Hospice service providers</li> </ul>	<ul style="list-style-type: none"> <li>• Ministry of Healthy Living and Sport</li> <li>• Ministry of Health Services, Home and Community Care</li> <li>• Local governments (zoning, permits, fire regulations, etc.)</li> <li>• Family councils or family groups</li> <li>• Local, regional and provincial community care associations</li> <li>• Community social services</li> <li>• Community service groups</li> <li>• Regional and local Aboriginal groups</li> <li>• Regional and local cultural organizations</li> </ul>
<b>Assisted Living</b> (adult residences for people who are aging, those with developmental disabilities, mental illness, problematic substance use, or others with assistance needs)	<ul style="list-style-type: none"> <li>• Promotion of Healthy Living</li> <li>• Food Safety</li> <li>• Prevention of Unintentional Injuries</li> <li>• Prevention of Communicable Disease</li> <li>• Prevention of Violence, Abuse and Neglect</li> <li>• Healthy Communities</li> <li>• Mental Health Promotion and Prevention of Mental Disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Primary and acute care providers</li> <li>• Counsellors/mental health / substance use professionals</li> <li>• Dental health care providers</li> <li>• Rehabilitation service providers</li> </ul>	<ul style="list-style-type: none"> <li>• Office of the Assisted Living Registrar</li> <li>• Ministry of Health Services, Home and Community Care</li> <li>• Local governments (zoning, permits, fire regulations, etc.)</li> <li>• Local, regional and provincial community living assoc.</li> <li>• Community social services</li> <li>• Local service groups</li> <li>• Local recreation programs</li> <li>• Regional and local Aboriginal groups</li> <li>• Regional and local cultural organizations</li> </ul>

### APPENDIX 3: LOGIC MODEL - CORE PROGRAM FOR HEALTHY COMMUNITY CARE FACILITIES AND ASSISTED LIVING RESIDENCES

**Goal:** To provide regulatory oversight that will promote, protect and enhance the health, safety and dignity of person in community care facilities and promote optimal development and quality of life for adults and children who receive care, and for assisted living, to support service delivery for those who require assistance with daily activities.

Components	Activities	Outputs (Examples)	Short & Intermediate Outcomes (Examples)	Long-term Outcomes	Ultimate Outcomes
Protecting Health	<ul style="list-style-type: none"> <li>Adult and child community care facilities:</li> <li>Oversight to ensure compliance with legislative requirements through license issuance, compliance monitoring and inspection, investigation management, enforcement and reconsideration / appeal mechanisms;</li> <li>Assisted living residences:</li> <li>Development of performance objectives for service providers, including compliance with relevant legislation, as part of contract management for subsidized services, as well as monitoring contract compliance and related collaboration with the Assisted Living Registrar</li> </ul>	<ul style="list-style-type: none"> <li>Community care facilities:</li> <li>Formal risk assessments</li> <li>Inspection visits</li> <li>Investigation reports</li> <li>Enforcement (warnings, etc).</li> <li>Assisted Living residences:</li> <li>Contract performance objectives</li> <li>Subsidy eligibility decisions</li> <li>Monitoring visits / reports</li> </ul>	<ul style="list-style-type: none"> <li>Community care facilities:</li> <li>Appropriate, effective and fair regulatory oversight</li> <li>Flexible application of regulations</li> <li>Continuous quality improvement</li> <li>Assisted living residences:</li> <li>Effective contract management</li> </ul>	<ul style="list-style-type: none"> <li>Increased safety of clients and residents</li> <li>Increased compliance with statutory requirements and quality assurance processes</li> </ul>	<p>Improved health and wellness for British Columbians</p> <p>Enhanced systemic support for community care facilities and assisted living residences</p> <p>Reduced burden on the health care system</p>
Promoting Health	<ul style="list-style-type: none"> <li>Advocate for healthy policies for care facilities/residences</li> <li>Enhance public awareness of the value, importance and characteristics of quality child care, quality assisted living, and quality residential care</li> <li>Strengthen community development, capacity building and collaboration to encourage local engagement in enhancing services, support, input and decision-making</li> <li>Provide educational opportunities for public health professionals and staff of care facilities/residences</li> </ul>	<ul style="list-style-type: none"> <li>Public information resources</li> <li>Coordinated community plans</li> <li>Community engagement in service and support for clients</li> <li>Assessment information on facilities/residences</li> <li>Education resources and training opportunities</li> </ul>	<ul style="list-style-type: none"> <li>Increased community coordination and capacity</li> <li>Enhanced awareness and knowledge of families about quality services</li> <li>Increased involvement of the community in providing services, assistance and input</li> </ul>	<ul style="list-style-type: none"> <li>Increased public knowledge, participation in, and support for community care facilities and assisted living residences</li> </ul>	
Preventing Harm	<ul style="list-style-type: none"> <li>Promote policies and practices to reduce infections and communicable diseases</li> <li>Promote and support fall prevention strategies in community care facilities, assisted living residences, and child care centres</li> <li>Coordinate with other public health prevention programs for healthy drinking water, food safety, tobacco cessation, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Information on best practices</li> <li>Meetings</li> <li>Educational sessions</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened policies</li> <li>Reduced rate of infection and communicable diseases</li> <li>Reduced harm from falls, medication errors, etc.</li> </ul>	<ul style="list-style-type: none"> <li>Prevention or reduction of risk factors in facilities/residences</li> </ul>	

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Components	Activities	Outputs (Examples)	Short & Intermediate Outcomes (Examples)	Long-term Outcomes	Ultimate Outcomes
Enhancing Quality	<ul style="list-style-type: none"> <li>Seek agreement from health authority senior management to actively promote ongoing quality improvement</li> <li>Raise awareness and understanding about the value and characteristics of high quality care</li> <li>Encourage positive leadership and effective organizational management of community care facilities/residences</li> </ul>	<ul style="list-style-type: none"> <li>Briefing notes</li> <li>Public information materials</li> <li>Resources on best practices for quality care including effective management</li> <li>Training opportunities</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced organizational management of child day care, care homes and assisted living residences</li> <li>Enhanced knowledge and support for quality care</li> </ul>	<ul style="list-style-type: none"> <li>Increased systemic support for quality service</li> <li>Enhanced development of children in child day care</li> </ul>	Enhanced quality of life and quality of services for clients/residents
Program Evaluation and Continuous Improvement	<ul style="list-style-type: none"> <li>A systematic approach involving the participation of a wide range of partners across the continuum of support/care to:</li> <li>Conduct program evaluations, program audits and research studies to determine the value of initiatives</li> <li>Conduct periodic evidence reviews of the literature to track emerging research to identify proven and/or best practices in the field</li> <li>Apply research and evaluation results to ongoing program planning and decision-making processes</li> </ul>	<ul style="list-style-type: none"> <li>Baseline data</li> <li>Evaluation frameworks</li> <li>Program evaluation reports</li> <li>Evidence review</li> <li>Program planning and redesign</li> </ul>	<ul style="list-style-type: none"> <li>Improved decision-making to enhance program effectiveness</li> <li>Enhanced ability to establish key program priorities</li> </ul>	<ul style="list-style-type: none"> <li>Continuous program improvement</li> <li>Increased ability to provide advice and support to providers</li> </ul>	
Surveillance, Monitoring and Evaluation	<ul style="list-style-type: none"> <li>Identify and collect key statistical information on the level of legislative compliance and quality of care provided by community care facilities, and on the services provided by assisted living residences</li> <li>Encourage partners to collaborate in the collection of consistent statistical data, data sharing and data management processes</li> <li>Analyze and interpret data to identify local and regional trends, issues and risk factors.</li> </ul>	<ul style="list-style-type: none"> <li>Statistical reports</li> <li>Trends analysis</li> </ul>	<ul style="list-style-type: none"> <li>Improved reporting systems on the status of services (level and quality of services)</li> </ul>	<ul style="list-style-type: none"> <li>Enhanced ability to identify emerging challenges and issues</li> </ul>	

## APPENDIX 4: SUGGESTED INDICATORS

### Suggested Indicators by Source for Community Care Facilities Core Function

<b>Suggested Indicator</b>	<b>Source</b>	<b>Comment</b>
Report on the number of inspections by HA, inspection type (initial, follow-up, routine, routine follow up, complaint, complaint follow up) by facility and service type	HACCLS	
Report on the number of “reportable incidents” by incident type, facility and service type, and HA	HACCLS	As defined in the Child Care Licensing Regulation and the Residential Care Regulation
Report on the number of confirmed “reportable incidents” by incident type, facility and service type, and HA	HACCLS	As defined in the Child Care Licensing Regulation and the Residential Care Regulation
Report on the number of facilities by HA and service type with a low risk rating	HACCLS	
Report on the number of facilities by HA and service type with a moderate risk rating	HACCLS	
Report on the number of facilities by HA and service type with a high-risk rating	HACCLS	
Report on the number of facilities with a high hazard rating, medium hazard rating and a low hazard rating by HA and service type	HACCLS	
Report on the number of critical hazards in facilities by service type and HA	HACCLS	
Report on the number of critical hazards corrected by date of follow-up inspection of facility, by service type and HA	HACCLS	
Report on the number of investigations by service type and HA	HACCLS	
Report on the number of new and denied applications by service type and HA	HACCLS	
Number of substantiated complaints leading to corrective action by service type and HA	To be determined	
Description or plan of how inspection information will be posted and kept current, and how utilization of inspection reports by the public will be monitored.	HA summary report	