Introduction

In March of 2021 an application was made to the Seniors Embracing Technology (SET) program to host a webinar over Zoom. This virtual event would explore the delivery of Long Term Care in the province of BC.

During the Covid 19 Pandemic it became tragically clear that the current system was ill equipped to manage with an outbreak of this nature. In fact it became clear that the system was already insufficient. As a result it was determined that we the public could respond by inviting knowledgeable panelists to speak about their experiences and that the public be invited to listen and respond.

Therefore, with funding from the United Way of the Lower Mainland, and support from the City of New Westminster and the Century House Association, an organizing committee was struck and the planning began. We named the event Long Term Care – Time for Change.

The first task was to establish the makeup of the panel. To that end we were most fortunate in obtaining the participation of four stellar people. Andre Picard, Health Columnist of the Toronto Globe and Mail and author of his newly published book "Neglected No More". Gloria Gutman, Professor Emerita from Simon Fraser University and member of the Order of Canada, Isobel Mackenzie the Seniors Advocate for the Province of British Columbia and Jim Sinclair Chair of the Fraser Health Authority Board of Directors. These individuals all volunteered their time and expertise which was greatly appreciated.

All of the panelists were available for Wednesday, September 22, 2021 from 1:30 pm to 3:30 pm. So the date was set.

Planning and Implementation

Next, came promoting the event. As this project was being supported by Century House in New Westminster the event was included in its hallmark publication the Clarion and, we had access to the mailing list for the Association membership. Posters were made and distributed around the Lower Mainland and word of mouth began to travel. Promotion was successful and seventy six people participated in the event.

Each panelist would be provided two questions to respond to for their ten minute presentations. They would then be available in a twenty minute breakout room for a Q&A. Members of the organizing committee would assist as moderators. Following the breakout rooms the panelists reported back to the plenary with their findings.

We planned this event with a major outcome in mind, that the public find its voice to impact change. Although we had heard and learned much about the inadequacies of Long Term Care during Covid 19, and Government did immediately implement some necessary improvements, the public has not used its voice to draw attention to this matter. Therefore, right from the start of planning it was agreed that we would prepare a follow up report of the event. This report, including Recommendations and Actions to improve care for the elderly will be widely circulated.

The Main Event

The following are the summaries of the four presentations including feedback from the breakout rooms.

Dr. Gloria Gutman, Professor Emirata, SFU

Moderator P.A. McDonald

Questions

1. **From the vast body of work you have produced could you share with us some research you have done in long term care settings that has had some impact on the care and support of residents and more generally on government policy.**
2. **Could you speak about prevention of elder abuse and neglect in institutional settings – including resident to resident aggression.**

LTC Research Examples

- Stark-Gutman series of studies that described and tracked health service utilization of a 100% sample of clients of the BC Long term care program in two health units (one urban and one semi-rural) over a 10 year period.
- Canadian Study of Health and Aging, a 3 wave 15 year longitudinal study of 10,000 Canadians aged 65+
- Studies on design for dementia in LTC.
- Research on needs of younger adults in LTC.
- Most recently, how to increase access & uptick of advance care planning by minority elderly in LTC (e.g. LGBT, Chinese, South Asian).
- Study of MindfulGarden, a digital health technology designed to de-escalate anxiety and agitation in Long Term Care residents and Intensive Ccare Unit patients.

Key lessons learned

1. Need to maximize person-environment fit – the right person in the right place at the right time. Including all possible options.
2. To improve quality of life of people requiring LTC. We need to train, support and better value those who support them – formal and informal care-givers.
3. We need to recognize the important influence on health/service utilization of the social determinants of health and in particular the two cross-cutting variables – gender and culture.

Dementia cannot be ignored

- In Canada, over half a million people live with dementia and the number is expected to double in the coming ten years.
- Approximately 76,000 new cases of dementia are diagnosed in Canada every year.
- As a major cause of dependency and disability, dementia not only impacts the elderly but also their families, care providers and communities.

Key lessons learned

1. It is widely recommended that non-pharmacologic interventions be the first line of management of persons with dementia, as psychotropic medications increase the risk of unfavorable and lethal outcomes.
2. Dementia is a risk factor for elder abuse and neglect in LTC and other Settings.
3. Resident aggression is an under-addressed form of abuse in LTC.

Conclusion

- It is important that the COVID-19 epidemic raised awareness of the short-falls of LTC. No more "Crash Cart Approach" solutions. The long term systemic issues of under-staffing, inadequate infection control, under-preparation for disasters and emergencies and under-regulating and monitoring must be addressed.

- The first iteration of MindfulGarden application in Intensive Care Unit (ICU) and High Acuity Unit (HAU) patients will test its effectiveness in reducing use of anti-psychotic or sedative medications and restraints for management of hyperactive delirium.
- Study participants will be exposed to MindfulGarden for 4 hours in conjunction with standard care and compared to controls who receive standard care only.
- In a long term care home setting, MindfulGarden offers a gentle non pharmaceutical solution to managing hyperactive dementia, improving the QOL of residents and the staff who work with them.
- Testing about to start in an ICU will indicate whether it is also effective in preventing/treating delirium, as reflected in reduced use of anti-psychotic/sedative medication and physical restraints.

See appendices for references for this presentation

Breakout Room discussion

- Long Term Care should be included in the Act. This requires legislative changes which is complicated, suggest trying additional/or changes to the provincial regulations.
- Province: Inspections, standards (Ratio of staff to client ie - how many staff per person. Exclude counting "support" staff such as maintenance, laundry, cleaners, cooks, administrative support: need more inspectors, regulators, and staff for enforcement. Dollars designated for Long Term Care should go directly to patient care.
- A change of attitude – LTC facilities are based on prison model. For example: eat at same time every day, wake up and bed at the same time every day, and staff are "in charge" (i.e. the boss). Example locking everyone out during Covid 19 = visitors, friends, family, etc. The effects of that.

- How to change attitudes? So that the patient is able to eat, sleep, go to the bathroom, etc. at times that is comfortable for them.
- You cannot expect changes from any level of government if there are no statistics/data to back up the request for change – anecdotal stories don't work. If you can't count it, then it doesn't exist.
- Profit motives: contracting out, lots of foreign ownership (profit), how can we "police" the operators of the facilities: standards, and inspectors.
- Third party corporations supply staff to these facilities: few, if any Registered Nurses in these facilities. Care aides are the usual patient carers/staff. These care aides/ staff may be hired from a corporate employment agency that pays the staff and in turn invoices the facility. This means that the Care aides are paid only a portion of the money allotted to patient care. For example, a care aide earns $16.00 per hour but the corporation bills the facility $24.00 per hour.
- Agreement with changes in regulations, inspections and "a new vision". Look for good examples here (in BC)? (Some facilities had no Covid 19 outbreaks).
- Same type of care should be available for everyone whether at a private or non-profit facility.
- Comments about paying staff for the work they do, better education for Care aides, give them an 8-hour day, so they don't have to go to various facilities to secure a living income.

Commonalities:

- Stop contracting out and pay employee directly.
- Money for patient care should go to patient care not corporate profits.
- Change of attitude towards elders, get away from the prison model.
- Legislative changes at both levels of government, rules, regulations, inspections, enforcement etc.

Isobel MacKenzie, BC Seniors Advocate

Moderator Ginger Brown

Questions

1. **Impact of Seniors Advocate's Office (SAO) on the development/implementation of polices and quality standards of care for the elderly.**
2. **Your vision for how to improve the quality of care for the elderly over the next 5 years.**

- The Seniors Advocate has some impact (wished it has more), and its efficacy is based on: Raising awareness in the general public regarding seniors' issues/needs in order to "harness the good will of the public"; and, enhancing the power/importance of, and by producing/disseminating, data that influences and can be used by decision makers.
- Government/decision makers review the broader base underlying issues (data/numbers, themes, who impacted, causes, linkages etc), and the SAO provides data to the government and the public that is "unvarnished" versus having a government and/or academic lens.
- The SAO talks to the government in a language they understand in order to move forward with addressing needs of seniors. "At the end of the day, the government is the people and if the people want it badly enough, the government. will deliver it".
- The SAO informs the public and raises the profile of seniors. The public has a great capacity to understand numbers and make informed decisions.
- Some successful changes have included: increasing funded hours of care; changes to the Community Assisted Living Act; increased Housing Grants; changes to the Admissions to Care Act.
- Isobel wished there were SAOs in all provinces in order to enhance planning for quality seniors' care, at both the provincial and federal levels.

- Vision would include "Increasing supports and capacity for seniors to live at home for as long as they are able and want to live at home"; we fall "short of all that we could do to support them".
- 15% of those currently in LTC facilities could be living in the community due in part to financial issues, but also in part due to overly bureaucratic and complex systems.
- What is the key: "getting the right person, at right time, to right place"; and, having a "lynch pin" person who is supporting seniors through the continuum of care.
- All admissions to LTC facilities should occur only when, that is where seniors really need to be, and all other options to allow them to stay at home have been exhausted.

How to make LTC better:

a) "Really listen to people who live there and what they are saying" versus rationalizing what can't be done (i.e. balancing financial sheets, appeasing all interests groups, etc.).
b) Health care professionals need to refocus from "fixing it" to understanding what seniors want and making their last few years "comfortable and giving them what they want".
c) Family visitation procedures during COVID although well intentioned, were guided by underlying paternalism.
d) Re-evaluate the concept of risk, and who has the capacity to assess and make decisions about risk. There is an underlying issue regarding persons rights to exert capability for free will over the totality of their years, and their inability to make every day decisions should be far along the continuum of care (i.e. due to dementia).
e) Need more staff who listen to residents, and understand/provide what they want regarding activities of daily living (sleeping, activity, eating, bathing etc.); need more staff who are truly interested in what seniors say and their life stories; and, need "enough people, enough time, and enough empathy" in LTC facilities.

f) "It will never be perfect" as it is not always feasible/appropriate to provide what the clients/seniors want: personal choice(s) has limits. However, what is important is to validate the seniors' feelings/wants/wishes in order to show them respect that they know their own mind and wishes, which however valid, may not be possible to actualize.

Breakout Room Discussion

Home Support (HS):

a) 65% of LTC admissions had not received HS prior to admission.
b) HS is charged to BC clients/families per a sliding scale (not in all provinces) so finances can become an impediment to access the required services/programs and possibly lead to premature admissions to LTC.
c) HS is restricted and underfunded for clients requiring more intensive longer-term care at home. Need more funding for housekeeping, meal prep, bathing frequency; CSIL and client/family oversite of their care funding allocations; live-in care support (24x7) for shorter term situations (i.e. Acute Care discharges; health exacerbations etc).
d) There is a need for increased awareness about what HS services are available.
e) Need more qualified home care workers, with more oversight, and more continuity of assignment.

Respite Care:

a) The most difficult seniors to manage at home often have dementia.Need more funding and access to various options for caregiver support/respite: increase short-term in-home HS; Adult Day Care; overnight respite care beds.

Assisted Living:

a) Need more subsidized assistance when clients care needs increase (i.e. palliative care) in order to allow clients to "age in place" versus eviction (per Residential Tenancy Act) and/or premature admission to LTC facilities.

LTC Funding:

a) Need more funding for staff in LTC facilities, not just working smarter, as there is no short-cut to "Human Care".
b) Need more funding generally for all aspects of LTC operational and capital management in addition to increased staffing. Funding comes from one source and you "either raise taxes or provide better health care....we must choose....but everyone wants to go to heaven and no one wants to die".
c) 66+% approx. of LTC facilities are contracted (versus owned/operated by Health Authorities) of which there is a 50/50 split between for profit vs not for profit facilities.
d) Contracted facilities need more oversight and enforcement (public ownership "needs teeth") of care standards/expectations by Health Authorities. There should be clear/concrete consequences and financial penalties applied for poor performance, and rewards for those who excel. Current regulatory standards (i.e. licensing, requirements for accreditation) needs to be reviewed/enhanced in order to ensure comprehensive standards of care are identified, monitored and followed-up.
e) Outsourcing should be discouraged, and all funding should be directed to quality care & operations not to dividends/shareholders.

Resident & Family Councils:

- Need to support formation and active participation of effective Resident & Family Councils regarding site-based services/programs/issues which directly affect the care and quality of life of residents.

Other:

- Facility limitations, need more security and Special Care beds and specially trained staff.
- Avoid "Inappropriate" early discharges from Acute Care. Need to ensure adequate care planning and that pathways have been identified with clients/family, and resources have been put into place, prior to discharge.

- "Inappropriate" utilization of Emergency Rooms and admissions to hospital due to lack of adequate Primary Care and Home Supports in the community.
- Alternatives to LTC noted in "Reimaging Care for Older Adult Focus Group Consultations" by Health Excellence Canada at:

  www.healthcareexcellence.ca/en/what-do/what-we-do-together/shapingthefuture-of-care-closer-to-home-for-older-adults

- Perhaps open the Canada Health Act (and/or similar legislation) for review/revision.
- Increase number of Gerontologists and provide more specialty geriatric education and support for GPs in Primary Care.
- Increase early Advanced Care Planning and "kitchen table discussions" regarding senior's wishes/plans for end of life and promote/enhance a palliative approach to care for seniors.
- Need to address "ageism" in our facilities and society.

Andre Picard, Health Journalist, Toronto Globe and Mail

Moderator Anne Ladouceur

Questions

1) **What prompted you to write your book 'Neglected No More'?**

2) **From research and writing your book, do you have a vision as to how affordable comprehensive care can be provided to the elderly?**

- Was shocked by the carnage of COVID in Long Term Care homes – of 27,500 COVID deaths, 18,000+ were in congregate settings. The impact of COVID was the impetus to getting the book done. As a result of his own experiences with his parents, Picard realized that this was a reflection of the systemic ageism in our systems and politics re the elderly. Scandal is that most of these deaths were preventable – many countries had none or lower rate of deaths in LTC; Canada has a percentage of deaths unseen in the rest of the world.
- The book is really about the fundamental failings in elder care, questions we should be asking and how we can ensure that each individual Canadian gets the right care, in the right place and at the right time. No one magic formula – services need to be adapted to the needs of each individual.
- Need to prioritize quality of life rather than quantity of care – the things we do, to and for, people are not necessarily what they want. Elderly with whom he has spoken are not afraid of dying; they are afraid of living a miserable life.
- The starting point is something we don't talk about – we need a fundamental change in individual and collective attitudes.
- Not enough to just say we value our elders and want them to remain active members of our community – deeds and policies and not just words needed. The final line in 'Neglected No More' is "...give life to our values."
- Going into an institution should not be the default setting when one's health is failing. It should be the absolute last resort.

- These last resort homes should look like a home and not a prison. They should not have regimented mealtimes, uniforms, etc. (LTC homes came up through the penal system not health care).
- Need to shift resources from institutional care to the community – home care, supportive housing, services like Meals on Wheels, respite care, etc. Difficulty buying groceries should not be the reason for sending people to institutions – keeping people in the community is a simple fix.
- Not necessary to get rid of homes – quality is what needs to be addressed.
- To address quality, we need to start where the biggest problems exist – staffing – including numbers (need 50,000 personal support workers), salaries, and training (especially in dealing with people with dementia).
- 4-hour care standards need to be adequately funded – 4-hour standard cannot be met if paid only 2 hours.
- Having nurses provide care in nursing homes results in better care as demonstrated by Sunnybrook Veterans Center.
- Nursing homes need to be more like homes and should be located in town centers, as opposed to hidden out in the country, so that seniors, including those with dementia, are visible to the community and not an abstract concept. Such a policy would help reduce ageism.
- Care must be patient centered, emotion focused, personal and responsive as opposed to warehousing.
- Nobody disagrees in theory with treating seniors well but there is no follow-through in practice – often a question of cost although we find money for corporate welfare but not for seniors who have paid into the system via taxes, for years.
- In so many instances, health authorities overrule doctors. This needs to change.

Breakout Room Discussion

Whole range of questions on issues that overlap a little with the previous group report (Jim Sinclair with Fraser Health Authority) including lack of training and oversight, standards of care, ensuring caregivers know how to do important tasks such as bathing someone with dementia, protection against abuse, money.

- Discussion of money. Currently government spends 13.7 billion but needs to spend double that amount.
- Money not the only solution – we need fundamental change. It would be worse to put more money in the system while continuing to do more of the same.
- Seniors do not need mediocre care; they need different kinds of care.
- Discussion re whether LTC should be included in Canada Health Act. In his view, opening up the CHA would be more trouble than it's worth. Federal government can meet its obligation with parallel legislation that would have strings attached to the funds – money must go to LTC.
- Question about why not more gerontologists. In his view, part of the issue lies in the low esteem attached to that specialty – Canada trains more pediatricians than gerontologists. Family doctors are in essence gerontologist since the bulk of their patients are often seniors and so we should change how we train them.
- Advance Planning is very important so that seniors can express their wishes when they are healthy and of sound mind and body. Helpful for families to not have to make these decisions in a time of crisis.

Most important discussions we can have about all of these issues are around the kitchen table – making our desires known to our loved ones, figuring out our finances so that follow-through can happen.

Jim Sinclair, Chair Person, Fraser Health Authority

Moderator Lois Brassart

Questions

1. **What is the role and responsibility of the Fraser Health Authority as it relates to seniors?**
2. **Long Term Care is the residential side of care for the elderly. Could you talk about the community care side available to allow people to age in their own homes?**

"No solution without the public and without public being involved in this debate for sure"

- Largest health authority, 1.8 million people.
- Deliver hospital and community-based services-home health, home support, respite care, dietitian services, long term support in many areas and community work.
- Very diverse population with 32 indigenous communities, 330,000 seniors,
- Number of seniors will increase by 46% in the next 10 years. Whatever we build today will not be adequate going forward. Long term care is one piece of a much bigger picture.
- About 14,000 people get these services in the system. Long term care facilities in Fraser Health – 82 long term care facilities. 41 privately run, 25 run by nonprofits, 16 run directly by Fraser Health (FH). 10,000 people call these places home.
- FH is responsible for day-to-day operations for care homes, financial oversight when there are major issues, quality of care, expansion and building of new care homes and making sure on track.

Covid19 and Long Term Care

- 15,000 residents died in Canada about 55% of all deaths, in FH almost 1,000 died or 45% of deaths. Lots of lessons learned. Had 2 lines of defense:
    1. Stopping infection and virus from getting into homes and
    2. Trying to prevent it from spreading within the home itself once it got there.
- If the system was failing before Covid then the system and infrastructure inside the homes failed during Covid.
- Had to go in and provide a large amount of support to try fix the situations and stop infections from spreading.
- At peak had over 150 people on support teams doing nothing but providing support to try and keep control of the situation.
- Faced lot of challenges because of old facilities, number of facilities had 4 people to a room or 3 or 2 to a room, 14% share room and 17% share with 3 or more, a good chunk of rooms are double occupancy which isn't comfortable in normal times, during Covid was particularly troublesome.

How we treat health care workers

- If you pay bad wages and treat people badly you are going to get bad care. Labour shortages, inherited government policies from 2003 which allowed LTC facilities to fire all the staff in the home and replace them with contract labour.
- What we have now is great disparity of wages in the system and that creates a whole lot of dynamics as well as difficulty getting people to come to work, that shortage became accentuated during Covid and caused a larger crisis.
- Ended up creating a pool of 500 people to assist in other areas, to help in home support as we had a critical shortage.
- This may have helped prevent what happened back east, where you had in some cases, people not being fed or supported, we got over some of that.
- Some of the changes were single site policy about 3000 people that tried to make a living going from long term care facility to long term care facility.

That was large group of people and fear was they'd take the disease with them as they went to the different homes.

- In the end we stopped that by only allowing people to work in one site. But it didn't stop there and this is one lesson to keep learning, from.
- All the wages went up to the highest union level, so for some people 1000s of people about $6-7 wage increase, care aid could be $16/hour and union wage was $24. That made big difference.
- Other labour problem on some sites there were 4 employers, so FH had to deal with different companies employing the housekeepers, the food workers, the care aids, the nurses, plus had to deal with 4 sets of management plus the management over top of that. This was a result of those 2003 decisions and created a lot of problems for FH.
- Around the disease the biggest problems was the large number of people in the community who got Covid and then the virus went to the care homes
- Biggest contributing factor; wide spread in community meant wide spread in care homes as they are interlinked.
- 87% of viruses were brought in by long term care workers themselves people that lived in the community.

Other learning – all the decisions made to clamp down on the virus made people's lives difficult, people were isolated, visitations were cut off, homes set up more like hospitals, isolated people in rooms at end of day really affected the mental health and wellbeing of residents.

Thoughts TO TAKE AWAY

- Human resource policy - need to raise wages to a solid level working with government and unions. Must ensure staff doesn't go to a private care facility and earn $16 - $18 and then go to public facility and earn $24. We need to say wherever you work you are a valuable employee and the person you are taking care of is just as important in a private or public facility and staff are just as important.
- Training, we are way behind, way behind, need to do a lot more.

- Don't want to build more institutions than we have to, it depends on what we do in home support and all those other areas like home support, presently it appears we need 4000 new beds in 10 years. That will cost lots of money, need to rebuild that support at home, then create homes instead of institutions.
- Will we continue to allow private sector to continue to build and run the homes or actually focus money on public operations? Jim, feels strongly should be under public administration.
- If we don't have a team working in the community it won't work. FH is committed to team approach; have brought back in-the-home-support workers from private sector.
- Have created teams so can work together with nurses, doctors, physiotherapists, community support workers and linking those services together. It is a big challenge. Important to link them to the community. Bring people into the community, linking with exercise programs, dietitians, meals-on-wheels and getting volunteer drivers. Need to socialize the experience as much as possible.
- There is a lot of work to do. Many have to step up to the plate. It's important the lessons from Covid are not lost they can't just be headlines during the crisis, can't lose interest in these issues.
- Use these issues as the fuel for the urgency for continued action to meet the needs of an aging population. To live in dignity and independence.
- On the economic front long term care homes Budgetary Office from Federal Government suggested we need to spend about $14 billion dollars per year over next 5 years to really deal with long term care issues, home support, pay people properly and build facilities. The present government has committed 9 million over the same period. We have a long way to go. Thanks for listening to me.

Breakout Room Discussion

- What does stay at home really mean and what are the challenges?
- Mixture of good and bad experiences with home care.
- Concern the public doesn't know what is available, what they can expect and how do they access home support.
- Bureaucracies of programs, how to figure them out especially when exhausted as a care giver.
- One person was finding it difficult to figure out how to utilize the 'hire your own' people program. It seems to simply add additional work for the caregiver.
- Programs for frail elderly – this is a positive program, connects people with physician, community care nurse, housekeeping etc, works well in keeping people in their homes.
- Concern about different number of people who enter the home
- High turnover probably due to low wages, difficult for people to continually bring outside care workers up to speed on person's needs, lack of solid support.
- We all realize without public pressure and public support it's not going to change.
- Concern the deaths in the long-term care facilities are starting to retreat.
- Training was considered important, however if people have complex medical issues or dementia training is not adequate, need a provincial education standard.
- Private care has its own issues, need to make public system work.
- Home support is challenged – one of real drawbacks is lack of consistency of care worker. About 45% of care is from different people coming in daily to assist.
- FH is working on a system whereby areas will be broken into neighborhoods and staff will 'work' a neighborhood. May not get the same person every day, however will get to know the care people as a small group will support one neighborhood.

- Should know how to navigate the system, waited over a year for spouse assessment; system has to be more efficient. (Jim Sinclair cared for his wife for 2 years at home, he is well aware of the shortcomings of the home care portion of the system.)

Recommendations

To identify issues and make recommendations we acknowledge and understand that the definition of Long-Term Care varies in lexicon from Province to Province, and from region to region, across the country. As well, legislation and regulation vary from Province to Province. There needs to be legislative and regulatory systems that make sense to users and providers (operators). As well, it is understood that care for the elderly includes a continuum of choices. These choices go from living at home with home help to full care in a facility. "Independence" and aging in place are overarching themes for seniors in determining their preferences for housing and care options as they age.

Aging in place refers to having the health care, social supports, and services available to live safely and independently in your home.

For the purposes of these recommendations, whenever "housing and care" is used, it implies: accessibility, adaptability, person centered care and coordinated services. As well, adopting a philosophy of aging in place needs to be combined with a choice in housing and care.

There was a wealth of information generated from the presentations and discussions during the webinar. It became apparent that the subject of care for seniors is complex, complicated and cumbersome; from language, terminology, legislation and regulation and philosophy, to the cost of care and shortage of staff. These recommendations are an attempt to be as inclusive as possible.

Federal Government

1. That the Federal government adopt legislation that addresses the need for comprehensive and compassionate care for the elderly that ensures the right to choose, regardless of income, ethnicity and gender. This legislation would be intended to drive the work of the Minister of Seniors Canada.

2. That funding from the federal government be tied to and match the need for delivering care to the elderly and frail in a manner that ensures choice and provides for aging in place.

Provincial Government

1. That no new care settings be added until there is a full investigation and report into the delivery of Residential and Home Health Care in the province of British Columbia. The report will inform future program development.

2. That Assisted Living is reviewed to assess its efficacy.

3. Ensure that any new residences be developed with the focus on a home like environment preserving quality of life and dignity.

4. That evidence based funding is increased to improve the delivery of home care programs that promote aging in place.

5. That a system be developed to ensure that seniors, in the process of planning for their housing and care needs have access to clear and comprehensive information that encompasses the right to choose.

6. That the regulatory environment for profit and non-profit settings be standardized and equal.

7. That wages for care support workers be a living wage. And that wages for employees in the private sector match those in the non-profit sector.

8. Disallow staff from working in more than one facility. With proper remuneration this will be unnecessary.

9. That education and training levels for all employees be reviewed and modified to reflect increased complexity of care and the need for higher standards of care.

10. That funding and hours of direct care given in residential settings not include ancillary staff such as cleaning and food services hours.

11. That contracting out to third parties is eliminated.

Health Authorities

1. That there be a review of the current licensing procedures in residential and community care and that the outcomes of that review include enforcement and repercussions to ensure the highest level of care possible.

2. That Health Authorities promote and support a non-medical, community based approach to providing services to support independent living. And that they value and support informal care givers, (whom the system is dependent upon), such as family, friends .

3. That Health Authorities enhance and increase Home Support services and promote access to a range of Respite Care services including beds; and, increased access to Adult Day Care Programs.

4. That for the delivery of accessible and affordable Home Care, the concept of "neighbourhoods" be created to allow for a team approach to provide greater consistency between client and caregiver.

5. That at the time of discharge, Health Authorities ensure optimal planning, coordination and communication between Acute Care and other sectors such as community care, in order to ensure a smooth transition. And that they look to existing programs, such as the Patient Oriented Discharge Summary, PODS program offered by Providence Health Care.

6. That there is a timely, responsive, and easily accessible complaint system for users of Health Authority services.

7. That first time inquiries to Health Authority, Home Health Care Services be responded to and followed up in a timely and manner. And that the caller has been told, and therefore understands the process for accessing services. The current system is fractured.

8. That the Health Authority provides public awareness, and promotes and support ongoing education to the public on the benefits of Advanced Care Planning and Representation Agreements using existing available resources such as Nidus Personal Planning Resource Centre.

Infectious Diseases and Disasters

1. That due to the regrettable loss of life in residential care settings from Covid 19, that protocols and practises be established to prevent the transmission of infectious diseases.

2. That protocols and procedures necessary to manage infectious diseases be up to date and that staff be trained and provided regular in-service.

3. That resident isolation during an infectious disease outbreak be avoided at all costs and that where isolation is mandatory that extra staffing be put in place to protect against deteriorating health and happiness and quality of life.

Municipal Government

1. That the City of New Westminster entrench in the official community plan that housing and care for seniors be adequate and accessible according to need and the ability to pay.

2. That the City promotes the development of seniors housing in naturally occurring retirement communities close to transit, and amenities at a walkable distance.

3. That the City of New Westminster be advocates ensuring that senior's needs are being met to support healthy active aging.

4. That in light of **Climate Change**, which included the heat dome of June 2021 an emergency response plan be put in place to prevent loss of life amongst the elderly and the frail.

Actions

1. That a public education program including print, radio and social media is developed to educate the public of the importance of reform in care for the elderly.

2. That organizations and individuals unite to organize and implement a day of action across Canada on Seniors Day, to draw attention to the fractured nature of the current system of care for the elderly in this country. The Right Person, the Right Time, the Right Place.

3. That seniors, seniors organizations and the general public advocate for needed reform to care for the elderly. Spread this report widely and encourage implementation of its contents. Send to local Members of Parliament and Members of Legislated Assemblies.

Appendices

Panelist Bios

Gloria Gutman

Gloria, founded SFU's Gerontology Research Centre and Gerontology Department. Currently, she's Vice-President of the International Longevity Centre-Canada, Immediate Past-President International Network for Prevention of Elder Abuse, member Research Management Committee Canadian Frailty Network, Board Member International Society for Gerontechnology. Her research/publications address elder abuse, seniors housing, long term care, health promotion, disaster preparedness, gerontechnology.
In December 2016, Gloria was named a Member of the Order of Canada.

Jim Sinclair

Jim's appointments and roles include: Director, Canada Post Board, Adjunct Professor of Labour Studies at Simon Fraser University. He has previously served on the BC Hydro Board and the Vancouver/Richmond Health Board. Jim was the president of the BC Federation of Labour from 1999 – 2015 and vice-president of the United Fisherman and Allied Workers' Union from 1982 to 1999.
Jim Sinclair holds an honorary doctor of laws from Kwantlen Polytechnic University.
Jim is currently the Chair of the Fraser Health Authority.

Isobel Mackenzie

Isobel Mackenzie has over 20 years' experience working with seniors in home care, licensed care, community services and volunteer services. Isobel led B.C.'s largest not-for-profit agency, serving over 6,000 seniors annually. In this work, Isobel led the implementation of a new model of dementia care that has become a national best practice, and led the first safety accreditation for homecare workers, among many other accomplishments. Isobel has been widely recognized for her work and was named B.C. CEO of the Year for the not-for-profit sector and nominated as a Provincial Health Care Hero. Isobel received both her undergraduate and graduate degrees from the University of Victoria and has a Certificate in Health Care Leadership from the University of Toronto.

André Picard

Andre Picard is a health reporter and columnist for the Globe and Mail, where he has been a staff member since 1987. He is also the author of five bestselling books. André is an eight-time nominee for the National Newspaper Awards, Canada's top journalism prize, and past winner of a prestigious Michener Award for Meritorious Public Service Journalism. He was named Canada's first "Public Health Hero" by the Canadian Public Health Association, and a "Champion of Mental Health" by the Canadian Alliance on Mental Illness and Mental Health, and received the Queen Elizabeth II Diamond Jubilee Medal for his dedication to improving health care. Andre is a graduate of the University of Ottawa and Carleton University, and has received honorary doctorates from six Universities, including UBC and the University of Toronto.

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Reference from Isobel MacKenzie

Alternatives to LTC noted in "Reimaging Care for Older Adult Focus Group Consultations" by Health Excellence Canada at:

www.healthcareexcellence.ca/en/what-do/what-we-do-together/shapingthefuture-of-care-closer-to-home-for-older-adults

References from Chat rooms

Hi I want to share these emergency preparedness guidelines for LTC and community settings shared from Dr. Samir Sinha at the National Institute on Aging

file:///C:/Users/ritam/Documents/Desktop/main/Canadian%20Centre%20for%20Healthcare%20Facilities/2021/Webinar%201/2021-01-26%20CCHF%20-%20LTC%20&%20EmergencyPreparedness.pdf

- Closing the Gaps:
    - Advancing Emergency Preparedness, Response and Recovery for Older Adults (2020 report) https://caep.ca/wp-content/uploads/2020/12/CRC_WhitePaper_EN-5.pdf
- LTC Standards are being discussed on October 7 www.cchf.net if you can join.
- Alternatives to LTC: Re-Imagining Care for Older Adults
  Focus Group Consultations: October 12th / 14th / 15th, 2021 by Health Excellence Canada. I'll try and find a link for sign-up. Here is the link to sign up for the focus groups mentioned above:
  https://www.healthcareexcellence.ca/en/what-we-do/what-we-do-together/shaping-the-future-of-care-closer-to-home-for-older-adults/

A Lived Experience

My Mother is 92 and suffers from Alzheimer's. My family and I have been navigating the Health Authority's very confusing, opaque processes and policies for quite some time now.

Certainly, the model for LTC is in need of an overhaul, but I believe that Community Care and Acute Care also do not serve our Elders well. I don't believe a meaningful conversation about Long term care can be held in isolation from Community care and Acute care.

We are currently reaping the benefits of the Federal cuts in health transfers beginning in the 90's.This has manifested throughout the Health Care system. Over the past 10 years, I have had firsthand experience with the decline in the level of care for complex elderly patients in hospital. Typically, admission has been through the ER in a crisis situation. It's clear that there has been a shift in philosophy from 'providing care' to 'gate keeping'. As soon as an elder is admitted to the ER, treatment is guided less by their complex care needs and more by their trajectory to release from hospital. An example of this callous attitude was evident when my elderly Mother was transferred alone, confused and afraid, from RCH to Eagle Ridge with no notice to the family beforehand despite repeated requests that family accompany her.
On 2 occasions, my Mother was released from Royal Columbian with a serious pressure sore on her heel which in the first case, took months to heal, and in the second case, has yet to resolve, 4 months later. This is a direct result of a lack of staff in acute care to provide complex care. I want to make it clear here that none of this is the fault of front line Health care workers' have encountered many wonderful nurses and care aids who do their very best to provide compassionate care in the most trying of circumstances. Chronic underfunding has made their working conditions extremely difficult.

Communication between the three agencies providing care for Elders is fractured at best.. Families are left to navigate a byzantine system on their own, as their loved ones require increasing support from Acute Care, Community Care and Long Term Care. Case managers in Community care are meant to provide guidance to families, however I have often found that they can be difficult to

reach, are not able to clearly articulate policy, and certainly don't act as advocates for vulnerable seniors who need support.
In Fraser Health my experience has been that records are not shared between regions (Burnaby and Tri Cities for example) this is an inefficient way to operate and makes accessing services more difficult for families.

I am providing this account of our experience with Emergency/ Acute care, and Community Care because in many cases, these precede Long Term Care, and sadly our family's experience is not unique.

With regard to Long Term Care, questions as follows -

Wait lists
Why are wait lists not transparent?
It is unreasonable for families to plan in the absence of this crucial information.

Aging Infrastructure
Older Care homes are 'Grandfathered' from standards requiring individual rooms for residents. It is shameful that Elders find themselves sharing a room with strangers in the final years of their lives. What is the duration of these exemptions?
The heat waves this summer created serious risk in Care homes. I'm not aware of a requirement for Care homes to be equipped with AC. What plans are being made to address this issue? It is appalling that Fragile seniors are being put to bed in 33 degree heat.

Third Party Operators
What can be done to insure all resources allocated by the Health Authority actually go to patient care? In the case of Kiwanis, here in New Westminster, a third party operator,(Provita) holds the Contract for care aids and keeps a percentage of funds intended to Care for vulnerable Seniors. They have done this by cutting the wages of staff.

Hours of Care
How are facilities monitored for staffing levels?

My Mother's home is regularly short staffed. This manifests in significant hardship for residents, who can't get help going to the toilet, getting in and out of bed and other activities of daily living.

I would also add that accessing support from Fraser Health with regard to my Mothers case and our experience with Long Term Care has been a frustrating, time consuming undertaking.

Nancy Whiteside

Planning Committee:

Long Term Care: A Time for Change

PANEL DISCUSSION

Wednesday • 1:30 - 3:30 pm • September 22
(Pacific Time)

Register in advance:
newwestcity.ca/longtermcare

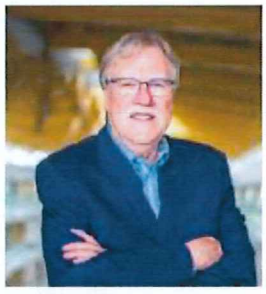
The City of New Westminster and Century House Association invite you to spend two hours of discussion and brainstorming with our distinguished panel. Join us to help form the best approach for the care and support of the frail and elderly population currently residing in British Columbia.

Panelists are:

Gloria Gutman, PhD
Professor Emerita,
Department of
Gerontology, SFU

Isobel Mackenzie
Seniors Advocate,
Government of British
Columbia

Andre Picard
Staff Columnist,
the Globe and Mail



Jim Sinclair
Board Chair,
Fraser Health Authority

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