

The Staffing Crisis

The 2001 report from FAIRE¹, the Background Brief in support of the 2003 Citizen Watch request to the Auditor General for an audit of long term care facilities², and the subsequent 2003 Creating Protections for Better Lives of Vulnerable Seniors in Care³ both document the list of problems directly attributable to inadequate staffing levels and staff competencies. In 2006, Citizen Watch reported the same problems.⁴

The staffing crisis is apparent in both home care⁵ and in assisted living facilities⁶ as well. The history of home care through the 1990s is that as home care was made available to a larger number of people (largely as a consequence of the closure of hospital beds and the reduced admissions to extended care facilities), the range and level of services were reduced⁷, admission criteria were increased, and wait lists developed. This issue got some attention in May 2006⁸, when the province removed the \$3,000 funding cap on services in response to a series of public complaints⁹ about services to young disabled adults. Users of the maximum services reported that even when the increased care had been approved, it wasn't available because there was no staff to provide the care – and there was no additional funding provided by the province to the health regions to expand the home care programs. In order to reduce the use of ambulance responses to seniors' falls in lodges and other supportive living settings, Capital Health and EMS have initiated a pilot project which involves a "first response" assessment team to determine if an emergency room visit is necessary.¹⁰ This reduces the need to have these settings staffed sufficiently to prevent falls injuries, or to assess harm caused by falls.

Facility Staffing

Today, 80% of care is provided by personal care aides¹¹, many of whom have no formal training.

Increasingly, the professional nursing staff is occupied with administrative duties and crisis response, leaving little if any time for supervision or coaching of the unregulated care staff and ongoing observation, monitoring, and unscheduled interventions for individual residents.

The shift of daily care responsibilities and "nursing care" to persons other than professional nursing staff has not been supported by the training and certification necessary to provide the hands-on care staff with the knowledge and skills necessary for effective monitoring or to identify intervention needs or care – and in any event, there aren't enough bodies available for individual care other than the basics.¹²

While the attending and consulting doctors and mental health professionals rely almost entirely on the resident logs and other records, these too are often incomplete and inaccurate because staff do not have sufficient skills or time for the necessary observation and recording of information which, taken collectively, could identify significant emerging issues.

Both the care facility operators and the Alberta Senior Citizens Housing Association acknowledge difficulties because of staffing shortages.¹³

Temporary bed closures in care centres because of staffing shortages and care concerns are a reality; they simply are not publicly reported. Families report that Capital Health has assumed management of the Rivercrest Lodge Care Centre in Ft. Saskatchewan, and that the Jubilee Lodge has frequent "temporary closures" because of long-standing care concerns. (Both are owned by Qualicare Health Service Corporation.¹⁴)

The oversight bodies, and in particular the Health Facilities Review Committee, do not do a competent job of monitoring quality of care, or adequacy of staffing. In fact, they simply don't even try to do either.

Alberta has never done a review or study of the care services needed and available. A 2001 study by PriceWaterhouseCoopers of the Ontario Long Term Care Facilities found that residents were receiving inadequate nursing, aide and therapy care.¹⁵

Staffing requirements

There are no specific requirements for the staffing levels or the clinical quality of care services. The Health Care Service Standards simply require health regions to develop policies about care, including the skill levels of staffing. The Health Care Service Standards apply only to publicly funded care, and not to care or supplemental services for which the resident pays privately.

The requirements to increase the "hours of care" were a Department of Health and Wellness directive; there was \$38.2 million extra funding provided in 2005 and 2006 for this purpose, and the Minister at the time promised an accounting of the resulting staffing increases¹⁶. That has not yet been provided.

The Minister was not talking about the actual care time being provided to residents. "Hours of care", in this context, means "paid hours of work"; it's an accounting number. It includes time spent on vacation, sick leave, paid breaks, staff meetings, administrative work, housekeeping, planning, and a myriad of other activities. Facilities are not even required to record time actually spent providing hands-on care to a resident or residents, which residents and their families consider being "care time".

Defining care responsibilities

The shift to “blended jobs” which occurred several years ago is another way the care facility operators attempted to increase care: previous non-care positions (mostly “facility services”, like daily housekeeping, food service, recreation planning and activity, unit clerk, but also therapy staff positions) are reduced, and replaced by care staff positions.

The shift was achieved under the guise of the “Eden Alternative”¹⁷, an operational model of care developed in the U.S. and marketed as improving the quality of lives of care facility residents.

This has not, in fact, increased care time, because the duties from the abolished positions are simply reassigned to the care staff. (As even the Health Facilities Review Committee noted, in one report¹⁸, another consequence was to decrease the level of the daily housekeeping; another is to reduce the level of recreation and therapy services available to the residents).

One of the effects of this is likely to put expenses which previously were (for accounting purposes) accommodation expenses, into the “care services” category. Shared resident cost for “personal care services” was one of the Broda recommendations.¹⁹

The care jobs have been redefined: care aides now routinely perform duties previously considered skilled nursing services²⁰. The Government Organization Act and the Health Professions Act define “restricted services”, which can only be performed by regulated health care professions except under certain circumstances.²¹

Training

The 2006 Health Care Service Standards required that health care aides employed in care facilities either have formal training or meet the competency equivalency assessment by March 2008. The 2007 revised Standards modified that to include commencing a training program within 6 months of being employed, and completing the program within 2 years.

The Minister had previously announced resources to provide training opportunities for health care aides. However, in April 2007, the Central Alberta Council on Aging sent a letter to the Minister of Advanced Education and Technology (and others) reporting that the in 2006 there had been 7 students enrolled in the Personal Care Attendant Program at Red Deer College; the program was cancelled in 2007 for lack of registration.²²

(note: apparently Lethbridge College has now closed its program.)

The Government’s 2007 Health Workforce plans²³ include some funding for health care aide employers for costs associated with training and upgrading skills. The basic problems of low wages, part-time or casual jobs, and minimal employment benefits remain.

Assessing Care Needs

The care that is provided is what the health region and/or the operator has determined is necessary to meet “unmet assessed needs”.²⁴

Care needs are identified according to specific criteria²⁵, which have been changed over the years as the services provided and the need for care has increased. The services provided are those considered necessary for “unmet care needs” – those which cannot be met from other source (e.g. family, or in the community). Often, reference is made to “medically necessary services”; “. . . *Currently, publicly insured medically necessary services, has by implication been limited to hospital-based services under the direction of a physician.*”²⁶ Continuing care centres are still technically registered (by Alberta Health) as either nursing homes or auxiliary hospitals, but are operating under the “continuing care system” without the range or level of services provided in hospitals.

Staff Injuries

*In 2004 the Workers’ Compensation Board of Alberta accepted 3,493 lost-time claims from health service workers. Long-term care facilities had the highest lost-time claim rate of all the health service areas, at a cost of \$2.9 million in 2004.*²⁷

Carol Wodak, October 2007

- ¹ The Shame of Canada's Nursing Homes: A testimony of the experiences of older persons in care facilities in Canada. Cochrane, Alberta: Families Allied to Influence Responsible Eldercare. (author's files)
- ² BACKGROUND BRIEF IN SUPPORT OF LETTER OF REQUEST FOR AUDIT OF LONG TERM CARE FACILITIES IN ALBERTA, RESPECTFULLY SUBMITTED TO THE AUDITOR GENERAL OF ALBERTA, MR. FRED J. DUNN, FCA, BY 12 CONCERNED CITIZENS, SEPTEMBER 5TH, 2003; <http://www.continuingcarewatch.com/Submission.pdf>
- ³ Creating Protections for Better Lives of Vulnerable Seniors in Care Today and in The Future, Presentation to the Standing Policy Committee on Health and Community Living, June 17, 2003; by Families Allied to Influence Responsible Eldercare (FAIRE); <http://www.continuingcarewatch.com/Creating%20Protections%20pdf.pdf>
- ⁴ An Inside Look at the Continuing Care Experience in Alberta, An analysis of Family Feedback 2006 <http://www.continuingcarewatch.com/AnalysisFamilyFeedback.pdf>
Union survey paints a bleak picture of seniors' care October 23, 2006 http://cupe.ca/elderly/Union_survey_paints_#
- ⁵ Missing Pieces of the Shift to Home and Community Care: A Case Study of the Conversion of an Alberta Nursing Home to a Designated Assisted Living Program (Armstrong & Deber), M-THAC Research Program, 2006 <http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-THAC%20Projects/All%20info/Hinton/Publications/p401090.pdf>
Many Canadian seniors are at risk of injury because they are not receiving any form of home care, suggests a new Statistics Canada report, October 17, 2006 CBC News
Family of stroke victim calls home care 'sorely inadequate' September 5, 2006 CBC News
- ⁶ Disabled care review promised Calgary Herald Dec 22, 2006 *An estimated 910 disabled Albertans under age 65 reside in nursing homes because they are too sick to care for themselves. . . Organizations representing the disabled say a dire shortage of group home spaces and other housing options, coupled with a **15-year freeze on home-care funding**, is forcing some young patients into nursing homes.*
Residents protest conversion to 'assisted living' Loss of long-term care in Hinton a 'slap in the face' Mike Sadava, The Edmonton Journal May 15, 2007
Disabled residents pawn in staffing shortage *Forced to leave homes because assisted-living facility can't cover overnight shift* Friday, June 23, 2006 The Edmonton Journal
- ⁷ The possibilities and the realities of home care Wilson et al Can J Public Health 2005;96(5):385-89; Wilson et al (Faculty of Nursing, University of Alberta) http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=Retrieve&db=PubMed&list_uids=16238160&dopt=AbstractPlus
- ⁸ Alberta News Release May 16, 2007; *"Removal of home care ceiling strengthens clients' independence; Change supports government's effort to ensure policies reflect the needs of persons with disabilities"*
- ⁹ Old before her time Calgary Herald Dec 17, 2006; Disabled care review promised Calgary Herald Dec 22, 2006; June 23, 2006 The Edmonton Journal Forced to leave homes because assisted-living facility can't cover overnight shift
- ¹⁰ September 2007 MD Scope Alberta Medical Association [http://www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDoc/2DE6232B25B774B787257344004D719D/\\$File/mdscope_sept07.pdf](http://www.albertadoctors.org/bcm/ama/ama-website.nsf/AllDoc/2DE6232B25B774B787257344004D719D/$File/mdscope_sept07.pdf)
In late September, Edmonton Paramedics will pilot a falls-referral system for Capital Health seniors who have fallen or are at risk of a fall.
For patients who do not require hospital transport, paramedics will utilize fall risk-screening tools to assess and categorize patients into a "low-," "moderate-" or "high-" risk ranking.

The patient will then be referred to falls-prevention programs or services specific to their fall-risk ranking. For example, a “high-risk” senior may be referred to a geriatric assessment clinic for further follow-up. One of the goals of the one-year pilot, starting in September, is to connect patients to existing resources and programs in the community and increase the communication between health care providers specific to client-focused interventions.

Paramedics will inform family physicians and home care services (via letter) about their patients who have suffered falls and the recommended referral options. By providing this information to a patient’s primary physician, Edmonton Medical Services (EMS) hope to provide valuable patient updates that may not have been reported by the patient or family otherwise.

Falls are the second-most-frequent type of call that Edmonton EMS responds to annually. A recent data analysis of Edmonton EMS Patient Care Reports indicated that falls-related calls are on the rise yearly, accounting for more than 6,000 calls last year alone.

For more information, contact Jennifer Fernandes, Community Educator, City of Edmonton EMS, at jennifer.fernandes@edmonton.ca.

<http://www.acicr.ualberta.ca/pages/news/pdfs/5-ICA%20January%202003.pdf>

Innovation and leadership tops the day By Craig Muncaster, ACICR Injury Control Coordinator - Acute Care/Trauma. Case in point is the innovative program created through the partnership between the City of Edmonton's Emergency Response Department (ERD), EMS and its Prevention and Public Education (PPE) Section.

The PPE Section reviews and analyzes emergency data and the top emergency call responses are carefully analyzed. In the final analysis, **falls-related calls, second only to breathing problems, represent a significant and escalating proportion of the City of Edmonton's EMS calls and repeat visits. Further scrutiny reveals that about 50 per cent of these fall-related calls were responses to older adults aged 65 and older, living independently in the community.**

Armed with statistical data the PPE Section and front-line staff, with the support of administrators, endeavour to address falls affecting independent-living seniors through the STOP (Seniors Training on Preventing) Falls Program. . . 'Point-of-injury' data is collected and is providing the older adult community and key stakeholders with valuable information, detailing the many risk-related factors associated with falls. **This prevalent injury claims the lives of more than 50 Alberta seniors annually and results in about 39 emergency department visits and 14 inpatient hospitalizations daily**

¹¹ “The majority of hands-on care is provided by non-professional staff under the supervision of Registered Nurses, or Licensed Practical Nurses. These care staff are called Health Care Aides (HCAs) or Nursing Attendants, or Personal Care Aides. HCAs provide up to 80 per cent of the hands-on care that a resident receives.” Alberta Long Term Care Association Newsletter, June 2007
<http://www.longtermcare.ab.ca/publication/newsletters.aspx>

In 1986, the care staffing in nursing homes and auxiliary hospitals (now merged into “continuing care centres”) was 30% Registered Nurses, 19% Licensed Practical Nurses, and 51% nursing attendants. (A New Vision of Long Term Care 1988, Long Term Care Committee)

Care funding to facilities in the mid-90s reduced the front-line staffing to half the previous levels¹¹, and also reduced the training for health care workers. But as facilities struggled to maintain care services with decreasing funding, Registered Nurses were replaced by Licensed Practical Nurses, who in turn were replaced by unregulated personal care aides.

Despite a 1996 Alberta Health-funded study in a Leduc nursing home showing that regular physical therapy services not only improved residents’ health but also reduced care costs more than enough to pay for the staffing, these services have largely vanished from the facilities. (A study of the outcomes of Enhanced Physical Therapy and Occupational Therapy Hours of Service Long Term Care Residents in a Nursing Home Setting, conducted at Salem Manor Nursing Home, Leduc, Alberta and funded through LTC, Alberta Health, Sept 1993, B. Purzyblyski, et al)

¹² In a 2000 newsletter, the Bethany Care Society published a basic care schedule:
24 hour care schedule for a dependent resident (total, 205 minutes, 3.42 hours)

Long Term Care Staffing Background

30 minutes –morning: toilet, mouth care, wash, dressing	15 minutes – help with lunch (again, 3 - 4 people)	5 minutes – medication administration
5 minutes – medications, 10 minutes – 2-person transfer into chair	15 minutes – 2-person continence care or toilet, transfer /lift to bed for nap	15 minutes – lift onto bed, 2-person continence care or toilet
15 minutes –breakfast (each caregiver assisting at least 3 residents)	10 minutes – check on resident several times; provide fluids, snacks	15 minutes – bedtime mouth care, wash, make comfortable in bed
15 minutes – assist with toileting (2-person transfer)	10 minutes – 2-person transfer/lift to wheelchair	10 minutes – late evening check and care
10 minutes – help finish off getting ready for the day	15 minutes –assistance with dinner	10 minutes – nighttime care and comfort

The article noted that a great many every-day needs (portering to a church service, going outside for a while, talking about family) weren't included; and the 3 hours of funded care were expected to include: care management (physicians' medication orders, care conferences, care assessment and planning, calling family to update them on changes, charting, organizing appointments and transportation, etc.); clinical care and therapies (wound care, insulin, swallowing assessment, exercise/rehabilitation, recreation activity, social work support, pain; control, palliation and address unpredictable changes in clinical status); staff vacations, sick time, holidays and other leave.

The Auditor General's 2005 Report on Seniors Care acknowledged "*challenges in meeting human resources and continuing staff education needs*", the use of Licensed Practical Nurses instead of Registered Nurses, reporting hours for administrative, payroll and housekeeping personnel as nursing and personal care hours, the housekeeping duties assigned to care aides, the increasing use of professional care staff for administrative duties, and failures of inservice training programs.

¹³ "*Changing medical technology also means that persons who previously would have been kept in active treatment hospitals are being sent to long term care facilities instead. The savings to the health care system are immense (\$125 per day for long term care compared to about \$1,000 per day for acute care). An increase of about \$16 a day per resident would increase staffing levels to where all residents would receive the care they require daily,*" stated Ms Nielsen.

News Release May 09, 2005 Long Term Care Association Welcomes Auditor General's Report

"The emphasis on aging in place in one's home community is a strategy supported by both the Broda Report and Alberta for All Ages. The Auditor General's Report notes that this strategy has resulted in individuals entering the long term care system today with "more complex health conditions, behavioral issues and higher functional needs." At the same time, care funding has not kept pace with rising acuity or inflation. In contrast to the increasing functional needs, behavioral issues and complex care needs of residents, funding directions over the past five years have resulted in a continuing deprofessionalization of the workforce. This not only impacts the quality of clinical care provided, but also limits the availability of professional supervision for personal care aide staff. This move also directly impacts quality improvement initiatives, monitoring of services, updating of care plans and monitoring the implementation of care plans – areas that all require skilled knowledge of professional nursing and management staff. Continued deprofessionalization of the workforce is an area of concern expressed by the Auditor General and one that will, in fact, inhibit the ability of operators to implement and manage many of the Draft Standards as proposed. . . Attention must be paid to maintaining the level of clinical education and expertise required in order to respond appropriately to the unstable, complex care needs of this clientele. . funding processes must recognize the full and actual costs of staffing, and not some predetermined average or "selection of level 'x'" from a union contract that bears little relationship to issues of benefits, non-productive costs, seniority, retention, etc. . . Staff costs consume almost 75% of revenues in long term care, and modest funding increases last year were surpassed by wage and benefit increases of up to 3.5%. . . In an environment of year-on-year fiscal constraint, and in a highly competitive recruitment marketplace for both corporate sector and other health care workers, employers in long term care are disadvantaged in attracting and retaining staff in terms of the compensation and working environments able to be offered."

Response to The MLA Task Force on Continuing Care Health Service and Accommodation Standards
Bethany Care Society September 2005

*“Residents are **not** responsible for the cost of care. That is the government's responsibility. In the survey we conducted last year, many of you made comments about the need to increase the amount of time care-staff spend with each resident. Our association agrees with you. Care staffing levels have not kept pace with residents' needs which have steadily increased. In addition, labour contracts have provided more benefits for staff vacation, statutory holidays, illness, etc. which has reduced available staff time. **Since 1990 the gap between what is provided and what is needed is 24.2%. . . Based on 2003 wages and benefits the government needs to add another \$85 million to the system.**”*
(emphasis added)

ALTCA Newsletter March/April 2004.

ALTCA research has demonstrated that staffing levels and the corresponding care hours per resident per day are currently inadequate in Alberta. This inadequacy is further exacerbated by increasing numbers of high needs residents. In the Wilson study, there is further illustration that staffing ratios and mix are important factors in positive resident outcomes. . . It has been found that care-aides with 10 or more residents to care for cannot provide adequate care unless the majority of residents are in the minimal needs category. . . With budgets eroded by inflation, the trend has been to replace RNs with lesser-qualified and lower wage LPNs. The loss of RNs means a loss in skills, care planning and resident health status communication capabilities. In addition, the RN must spend more time training and supervising a larger staff of LPNs. These lead to poorer resident health outcomes and safety concerns regarding the monitoring of medications and patient response to medications. The role of RNs in adopting InterRAI/MDS is also a key factor that will reduce the time RNs can devote to patient care and LPN training. In addition, the decreasing number of RNs makes InterRAI/MDS implementation more difficult. . . The loss of RNs in long term care also impacts physicians. An ALTCA forum revealed that without the support that the RN role provides in care, physicians are reluctant to enter long term care practice. . . A problem associated with inadequate staff levels is higher turnover. Research shows that high turnover among RNs corresponded with higher rates of infection and hospitalization among care center residents. . . When there is appropriate staffing, it has been demonstrated that use of restraints declines. In fact, one study shows that low staffing levels was the only factor in higher restraint usage. . . Overall, the practices that retain staff result in improved outcomes including fewer behavioral problems, less use of restraints, and better cognition among residents.

ALTCA Response to MLA Task Force, September 2005

“Our surveys of long term care facilities show that operators are forced to use care funding to make up for inflationary erosion of the accommodation rate. It's been three years since the last accommodation rate adjustment. We need to index the accommodation rate to ensure care levels can be maintained.”
Dianne Nielsen ALTCA Executive Director

“We are very concerned that operating and maintaining the MDS/RAI system will divert staff from care delivery at the bedside. Furthermore, the time and resources devoted to operating the system at less than optimal performance compromises the output of the system and the benefits it may hold for resident's health outcomes.”

Information Update for Alberta MLAs April, 2006

“Many housing operators throughout the seniors housing sector have indicated that their organizations are experiencing serious difficulties as a result of staffing shortages. . . Although the issues around recruitment and retention are widespread and not unique to our industry, the greatest impact appears to be within operations where 24 - hour staffing is essential. ” <http://www.ascha.com/News/news/enews-July-Aug-06/19.htm>

“Staff Recruitment and Retention as set out in Recommendation No. 5 is an issue for more than just personal care aides. Supportive Living operators are experiencing tremendous difficulty in recruiting and retaining appropriate 24 hour staffing that include housekeeping, laundry and foodservice employees. This Recommendation needs to recognize this reality and include housing operators as part of the problem solving team. It is currently an employee's market in Alberta and remaining competitive in wages while maintaining economical operations is becoming an increasingly arduous task. . . For six years now we have been advocating for appropriate operational funding based on the level of services available to residents. Many services such as special diets, enhanced cleaning (more

than weekly), increased monitoring, etc. are being provided by housing operators without adequate funding. In the private sector some residents can afford to pay for the additional services but in the public setting it is the contributing municipalities that are paying for these services (many of which are health/wellness related) as the residents are primarily low income seniors and the rents are regulated.” Re: Seniors Report, What We Heard & Draft Recommendations, Alberta Senior Citizens’ Housing Association, September 2005

- ¹⁴ Qualicare is owned by Greg Ulveland, who also operates the Citadel Care Centre in St. Albert and the Northcott Lodge Nursing Home in Ponoka. Northcott, Jubilee, and Rivercrest received over \$2 million from 2003 -2006 in General Revenue Grants, over and above their operating grants from the health regions. (The Jubilee Lodge in Edmonton, where Jennie Nelson was scalded in 2004, is reputed to have had several “temporary closure” orders since.) The capital costs of the Citadel Care Centre was funded in part with public funds.
http://www.capitalhealth.ca/NewsAndEvents/NewsReleases/2003/Five_new_ong_term_care_facilities_added.htm

- ¹⁵ Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators January 11, 2001
http://www.oanhss.org/staticcontent/staticpages/about/Level_of_Service_Study/Level%20of%20Service%20Report%20FINAL%20version.pdf

- ¹⁶ Hansard, March 1, 2006, Ms. Evans:” *We will provide an analysis of how many staff were added, but I want to make clear that I will define it in two ways: the number of staff that we believe were added not so much as a result of the move to 3.4 hours of care per patient but equivalents so that we’re comparing apples with apples and not just looking at the numbers that have been inflated because people have moved into long-term or continuing care residence. The other part, though, I should tell you is that in some cases dollars that were provided for long-term care were provided to increase the salary levels of people who were advanced either by merit or by some other agreement with their institution, so it not only provided more dollars for increasing the number of hours of staff care on that patient ratio but increased the number of dollars that individual providers received for the work they did interfacing on the front lines.*”

In Ontario, following a similar increase in care facility funding levels in 2002, an independent audit was ordered to account for the changes resulting from the additional funding: Nursing and Personal Care: Funding Increase Survey Sigma-3 Policy Research Inc., 2003
http://www.health.gov.on.ca/english/public/pub/ministry_reports/nursing_person_care/npc_funding_survey.pdf

- ¹⁷ The Eden Alternative Background paper prepared for the CUPE Health Care Council, 2000
http://cupe.ca/saskatchewan/The_Eden_Alternative
http://cupe.ca/updir/The_Eden_Alternative_-_Final_%28Web%29.pdf
“*The Eden Alternative is an operational model of nursing home care developed in the United States in the early 1990s. Eden’s goal is to transform long-term care facilities into “human habitats” in order to combat the loneliness, helplessness and boredom of frail, institutionalized elders. Eden’s human habitat involves the introduction of animals, birds, plants, gardens and visiting children into the long-term care facility. Eden also restructures the delivery of care in order to personalize it and endeavors to create a less institutionalized, more relaxed environment . . . In Eden Alternative facilities, jobs in nursing, laundry, recreation and food services can be reduced or eliminated as aide’s jobs are expanded to include some or all of their duties.*”

The report concludes that the approach has negative consequences when a facility is understaffed.

- ¹⁸ Health Facilities Review Committee report of a routine inspection of the Strathcona Care Centre, March 29 & 30, 2005. Also, personal stories and submissions to the MLA Task Force, August 2005; in my own experience, the staffing was reduced in 2001, and “staffing resources were reallocated” to increase the number of care aide positions by decreasing housekeeping and other support positions; however, the housekeeping, some food service and most recreation duties went to the care aide staff, while professional therapy services were significantly reduced.

¹⁹ Broda, Long Term Care Policy Advisory Committee Final Report Healthy Aging, New Directions for Care LISTING OF RECOMMENDATIONS November 1999

Who is responsible for the costs of continuing care?			
Cost components	Home care	Supportive living	Long term care facility
Professional care, e.g. health and medical treatments, visits, tests, etc.	Government – 100%	Government – 100%	Government – 100%
Activities of daily living, e.g. personal care and homemaking services	Government/individual share costs	Government/individual share costs	Government/individual share costs
Accommodation, e.g. food, cleaning, utilities, etc.	Individual – 100%	Individual – 100%	Individual – 100%
Capital, e.g. construction, renovations and upgrading	Individual – 100%	Individual, with income support where needed	Shared responsibility: Individual – 33% (through rental payments) Owner – 33% Government – 33%

²⁰ Continuing Care Health Service Standards 2007: “**Personal care services** includes assistance with the activities of daily living (i.e. bathing, personal hygiene, grooming, dressing, toileting, incontinence management), assistance with therapeutic regimes (i.e. range of motion, medication assistance and reminders, simple wound care, respiratory equipment, ostomy care), simple bedside care (i.e. mouth care, turning, application of lotions), therapeutic interventions for behaviour management and maintenance of health records.”

²¹ Decision-making Standards for Nurses in the Supervision of Health Care Aides; 2003.
http://www.clpna.com/doc_restrictedactivities.pdf Discussion of previous restricted duties which can now be assigned to health care aides.
Restricted Activities, Activities of Daily Living and Unregulated Workers: Supervised by Nurses 2005;
 briefing paper following stakeholder consultations re: revised HCA curriculum.
Health Care Aide Definition 2006 http://www.health.gov.ab.ca/key/HCA_Definition.pdf

²² One reason suggested for this was the cost of the program fee (\$3,000 - \$4,000) and the absence of financial support for living costs during the training period; another was the low wages for subsequent employment.

²³ http://www.health.gov.ab.ca/key/Health_Workforce.html

²⁴ Continuing Care Health Service Standards 2007: “**Assessed health service needs** are the unmet health service needs of clients, as assessed through the continuing care health service assessment and care plan processes as described within.”

²⁵ The Alberta Assessment and Placement Instrument for Long Term Care (1989) was introduced to standardize and control access to continuing care facilities and services. It was subsequently modified (reducing number of indicators of care needs)*, and further modified by the Health Regions; it has recently been replaced by the interRAI MDS-HC and MDS 2.0. Use of a standardized assessment instrument does not, of course, ensure consistency of needs assessments, and the subsequent development of care plans relies heavily on the services and staff available.
Quality and Accountability Canadian Style; A Comparative Look at Accreditation and Resident Classification Systems between Canada and Australia 1999
<http://www.ncbaron.com/htmlfiles/documents.htm>

Eldercare—On the Auction Block 2002; Wendy Armstrong, Alberta Consumers Association
 “Another concept from the early 1990s was that access to all publicly funded LTC beds or in-home care would be based on “assessed need” (i.e., assessed by a health professional from the health

region, using a formal criteria). Most people don't realize that "assessed need" isn't what a person actually needs but refers only to the particular and often narrow range of supplies and services available through the regional health authority (RHA). In other words, an individual's assessed need is limited by what the regional home care program, for example, offers."

<http://www.albertaconsurers.org/>

²⁶ Primary Health Care: Six Dimensions of Inquiry Alberta Health & Wellness, October 2000

Accountability – Achieving Accountability in Alberta's Health Care System November 2001

http://www.health.gov.ab.ca/resources/publications/Accountability_2001.pdf

Decision-making for health care systems: a legal perspective, Almond G A; Edmonton: Alberta Heritage Foundation for Medical Research (AHFMR) 2003 ISBN1896956653.

²⁷ Hansard March 1, 2006; Hon Iris Evans, Minister of Health and Wellness

Further reading:

Citizen Watch: Informative Papers, Reports and Web-sites, at

<http://www.continuingcarewatch.com/links.htm#informative>

Ethical Choices in Long-Term Care: What Does Justice Require?, (World Health Organization),

http://www.who.int/mediacentre/news/notes/ethical_choices.pdf

Reading the Fine Print: Focus on Long Term Care Insurance (Armstrong & Deber) M-THAC, 2006

[http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-](http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-THAC%20Projects/All%20info/Reading%20The%20Fine%20Print/Publications/p401089.pdf)

[THAC%20Projects/All%20info/Reading%20The%20Fine%20Print/Publications/p401089.pdf](http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-THAC%20Projects/All%20info/Reading%20The%20Fine%20Print/Publications/p401089.pdf)

[http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-](http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-THAC%20Symposium%20Materials/Presentations/Raisa%20Deber%20Presentation.pdf)

[THAC%20Symposium%20Materials/Presentations/Raisa%20Deber%20Presentation.pdf](http://www.teamgrant.ca/M-THAC%20Greatest%20Hits/M-THAC%20Symposium%20Materials/Presentations/Raisa%20Deber%20Presentation.pdf)

Jumping on the Alberta Bandwagon: Does B.C. need this kind of Assisted Living? (Armstrong) 2002

<http://www.albertaconsurers.org/>, Investigative Reports