OFFICE OF THE
SENIORS ADVOCATE
BRITISH COLUMBIA

Every Voice Counts

Office of the Seniors Advocate Residential Care Survey Provincial Results

September 2017

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BRITISH COLUMBIA

September 15, 2017

Over 27,000 seniors in B.C. live in a residential care facility. Often times called the "care" or "nursing" home, it is a place that keeps our most frail and vulnerable seniors safe and secure. The vast majority of seniors will live their entire life in the comfort of their own home and will never directly experience residential care. This fact, however, does not diminish the commitment seniors, their family members and indeed most British Columbians have to ensuring that the final years of life spent in a care home in B.C. are as dignified, meaningful and enjoyable as possible.

As the Seniors Advocate, I meet with many seniors and their families who have both inspiring and heartbreaking stories about residential care. In my travels to many care homes in all parts of the province, I see a significant diversity of facilities in terms of design, staffing, approaches to care and, without exception, some very dedicated staff. I see residents who are joyful and engaged and some who are struggling to find meaning and happiness. The range of care needs is vast, from some residents with whom I have very spirited discussions (sliding into debate at times) while walking down the hallway, to others who are unable to communicate with anyone and are completely dependent on others for all of their physical care needs.

Residential care is a licensed facility that provides safety and security for residents and peace of mind for family members. We enforce robust regulations and track a wide range of indicators such as falls, infection rates, staffing levels, complaints, and use of certain medications to name but a few. We in the system have looked to these indicators as a measure of quality-too many falls or citations from licensing equates to lower quality for example. While it is important to monitor these activities, what about other aspects of life? Do residents have friends, how do the staff treat them, are meals enjoyable, are there meaningful things to do—these are all important aspects of daily life for residents. How are we measuring success in achieving quality in these areas?

In the consumer world, when assessing quality, we look for feedback from people who have actually used the product. The discerning traveller is going to want to read the feedback from the people who have actually stayed in the hotel versus the official website with the professional photos and marketing department descriptions. Customer feedback is obviously important as we are constantly requested to complete satisfaction surveys. In residential care, we have been slower to adopt this approach as a means to improving quality.

The Office of the Seniors Advocate has a statutory obligation to monitor services to seniors and to report to the public on issues of concern. These duties combined to produce the decision that my office would undertake a survey of all residents in all publicly funded care facilities, to ask their opinion about how well we are doing in meeting their needs and we would also ask the opinion of their family members.

The support and co-operation received for this undertaking was nothing short of phenomenal. From the Ministry of Health who has funded this initiative, to the health authorities who provided critical data, to the care operators who welcomed the surveyors into their facilities with open arms. However, the most inspiring support, without a doubt, is the incredible contribution of over 800 volunteers across this province who dedicated over 25,000 hours of their time sitting down with almost 10,000 residents to hear their stories, ask their opinions, and engage with them as equals in a conversation about what life is like in the place where they live.

The stories, the feedback and the results paint a picture of a rich and diverse group of men and women who, through circumstances beyond their control, have found themselves: living with folks many of them don’t really know; eating food that some like more than others; waiting for help that is sometimes too long in coming; and lacking the freedom to go and do what they want when they want. Despite all of these challenges however, most describe themselves as happy and many would recommend that others come and live with them. We should all be humbled by the grace and equanimity demonstrated by seniors in residential care in this province and recognize how deserving they are of our care and attention.

This report is not the “voice” but the “voices” of residential care as the diversity of opinions is apparent in the results. Together, these voices are telling us that our residential care system has some good aspects—even very good for some—but, taken as a whole, we need to do better and, in some cases, much better. You will read in the report of residents who are waiting too long to get the help they need, who are frustrated by the rigidity of fixed schedules and who want to have more to do and people they can talk to. In a number of different ways, the message that prevails is “more staff“, “more freedom” and “engage with me.”

The first step in fixing a problem is diagnosing the problem, and this survey is an instrument that probes what residents think about a number of activities in their care home. The survey allows us to hear from the users of our service, how we are, or are not, meeting their needs. There is a proverb: not to know is bad, not to want to know is worse. The support for this survey from so many, tells us that we want to know; now we need to learn from the results and develop a plan for improvement.

Sincerely,

Isobel Mackenzie
Seniors Advocate
Province of British Columbia

Acknowledgements

The OSA Residential Care Survey was a mammoth undertaking on a scale not seen before in Canada. To be effective the survey needed rigorous oversight of testing, implementation and protocols. It needed co-ordination across a vast geography with five health authorities, over a hundred different operators and many residents who spoke a language other than English.

The success of the survey is the result of the efforts of almost 1,000 people and to name them all would not be possible, but there are some key acknowledgements to make.

First and foremost are the over 800 volunteers. Their willingness to engage directly with the residents was, without a doubt, one of the main reasons for such a high response rate. A survey where every resident was asked for their opinion simply would not have been possible without the dedication of these volunteers.

Secondly, the consultation group which grew at one point to include over 25 people. Your voices were important to ensure we asked the right questions the right way. The diversity of perspectives from front line staff to policy makers to administrators, funders and family members was critical to ensure we had a result that would allow us to turn the thoughts of the residents into action.

The Ministry of Health, Health Authorities and Providence Health Care invested significant time in securing the funding for this project, ensuring we meet all regulatory requirements and provided us with needed data and information.

Facility Operators were key to the success of this undertaking. All facilities ensured that volunteers were welcomed and supported and that the paperwork was handled properly.

The Regional Engagement Leads in each health authority undertook the task of recruiting, screening, training, deploying and monitoring the 800 volunteers this project engaged. The results speak to the success of their work.

A team of consultants and academics from across Canada were involved to ensure that we were adhering to protocols and that data results were processed quickly and accurately.

The staff of the OSA were engaged in the project since inception and have shepherded the project over the past two plus years ensuring we stayed focused on our main mission.

The ability to successfully complete this project at all, never mind the fact it came in under budget and on time was without a doubt only possible because of the leadership of Lena Cuthbertson, Provincial Executive Director of the Office of Patient-Centred Management & Improvement. Without Lena’s tenacious oversight of every segment in the process of taking the audacious idea of asking every resident in every facility to tell us what they think and bringing it to reality, we would not have given voice to the almost 10,000 seniors we have heard from.

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Report Summary

Background

This survey is the first time that any jurisdiction in Canada has undertaken a survey of all residents in all care facilities at the same time, using the same survey. The survey has been led by the Office of the Seniors Advocate of BC (OSA), an independent office of the provincial government with the statutory duty to monitor seniors services. This report is in partial fulfillment of Section 3(1)(a) and (2)(d) and Section 4(2) of the *Seniors Advocate Act*, Province of British Columbia.

Highlights of this report include:

- The survey was planned over a 14-month consultative process that included academics and research experts in survey design, community groups, front line staff, care providers, union representatives, health authority funders and operators, and family members. The consultative group chose to work with the interRAI *Self-Reported Resident Quality of Life Survey for Long Term Care Facilities* for this project as it is the most widely used survey instrument in Canada to understand the experience of seniors living in residential care. An additional 20 custom questions on a range of topics including medication use, quality of physician care and handwashing were added to the survey. All custom questions were developed by the consultation group and the OSA, and were field tested prior to implementation.
- To understand the perspectives of family or friends who are a resident's most frequent visitor, we chose to work with the interRAI *Family Survey for Long Term Care*, a rigorously developed and tested companion to the resident survey tool. A set of 40 custom questions was added to the family survey. As with the resident survey, all custom questions were field tested.
- To conduct the survey, the consultative group chose the model of one-to-one interviews conducted by volunteers. In support of this, over 800 volunteers were recruited, screened and trained to conduct the survey. These volunteers logged over 25,000 hours of service.
- Over 22,000 residents in 292 facilities were asked to participate in the survey, with 9,605 completing the survey, resulting in a 43% response rate.
- The survey asked 103 questions including two questions on overall quality. Questions were grouped into the following categories:
    - Personal Control
    - Social Life
    - Staff Responsiveness Caring Staff
    - Food
    - Physician Care
    - Medications
    - Hand Washing
    - Family Councils
    - Resident Views of Their Health and Well-Being

- Residents' most frequent visitors or MFV (usually but not always a family member) were also surveyed with 104 questions and their responses were matched to the responses of their loved one, allowing comparisons. Family members could respond to the survey on paper and mail it in or respond on-line. There were 19,906 surveys delivered to family members through postal mail, from which 9,604 responses were received, for a 48% response rate.
- The surveys completed by the residents are linked to their health assessment (interRAI RAI MDS 2.0; assessments are conducted on a quarterly basis in residential care) allowing analysis of patterns of health characteristics that exist relative to survey results. We are also able to determine the health profiles of those who responded to the survey relative to those who did not.
- The survey was piloted in May and June 2016 and rolled out throughout the rest of the province from September 2016 to May 2017.
- Every resident was approached up to three times to determine if they could/would complete the survey. The only exclusions were for residents who were deceased, discharged, palliative, or whose behavioural challenges could place the surveyor at risk. These criteria excluded 2,154 residents, leaving 22,162 residents invited to participate.
- Results of the survey are tabulated at the provincial, health authority and facility levels. This report is focused on the provincial level results. Health Authority level results are available in an addendum document available online at www.seniorsadvocatebc.ca Facility level results will be available later in 2017 and they will be posted online and linked to the individual facility through the OSA's *British Columbia Residential Care Quick Facts Directory*.

Results

The full report provides answers to all questions asked of residents and family members. This section provides some highlights that help to demonstrate the balance between those areas where we are doing well, areas where we might be okay but could improve, and still other areas where we clearly need to improve.

Most questions had the possible answers framed on a five point scale. The top two answers were taken as positive and the bottom two as negative. The middle answer, often expressed as "sometimes," could be taken as positive, negative or neutral depending on the question. For example, "sometimes" getting one's favourite foods is much different from "sometimes" being taken to the toilet when needed.

If 80% or more of respondents gave a positive answer, it was considered that we are doing fairly well; otherwise, it was considered an area for improvement. How much improvement is needed, and how quickly, is a combination of the specific issue and the spread of responses over the entire five point scale.

What residents are telling us about the overall experience of living in their care home:

- **4 out of 10** residents living in residential care **do not want to be there**, yet 77% would likely recommend the facility to others;
- **50%** of residents rated the overall quality of the care home as **very good or excellent**; and
- **65% of family members** rated the facility **8 or higher** when 10 was the highest possible score.

Where are specific areas where we are **doing well**:

- **88%** of residents **feel safe** in the care home, although this dips to 77% who feel their possessions are safe;
- **80%** say they can **decide for themselves** what clothes they can wear and what they will spend their time doing;
- **90%** of residents report **family can visit whenever they want** and **86%** of family members report they **can find a place to visit** that is private and appropriate;
- **86%** of residents report that the staff treat them with **respect**;
- **83%** of residents believe the **staff know what they are doing**;
- **80%** of residents indicate they **get the services they need**;
- **88%** of family members who have witnessed aggressive residents report that **staff handled the matter appropriately**;
- **88%** of family members report being **involved in decisions** about the care of their loved one;
- **89%** of family members report **knowing who to talk to** for information;
- **88%** of families report that facility staff **address concerns of family/MFV** always or most of the time; and
- **93%** of family members think the care home is **clean** and **82%** think it **smells good**.

Where are the **areas for Improvement**:

- Well over half (**62%**) of residents say they **do not get to bathe or shower** as often as they want, with a full **50% saying it rarely or never happens as often as they want**;
- **One in four** residents only **sometimes, rarely or never get help to the toilet** when needed;
- **25%** of residents report staff tries to **relieve physical discomfort** only sometimes (16%), rarely (5%) or never (4%);
- Over **a third** of residents **do not usually decide for themselves** when they can get up in the morning with a full 24% saying they rarely or never get to decide;
- Over **a third** of residents (38%) report that there is **rarely or never** enjoyable **things to do** in the **evening** and this holds true for **weekends** as well, with 36% reporting there is nothing to do on Saturdays and Sundays;

- **51%** report that they are **rarely** or **never asked** for their help/advice;
- Almost half, **46%** of residents report that there is **no one** living in the facility that they consider a **close friend** and 45% report there is no one for them to do things with;
- Just over half (**57%**) report that the care facility "**feels like home**," 18% say "sometimes" with **one out of four** saying it **rarely or never** feels like home;
- Just over half (**58%**) have a **staff member** they consider **a friend** always or most of the time;
- **34%** of residents report staff only **sometimes, rarely or never have enough time** for them;
- **24%** of residents **don't tell** staff **when** they are **not happy** about something, yet 74% report feeling safe in expressing their opinion without fear of reprisal;
- **49%** of residents only sometimes, rarely or never have the **same care aide on most weekdays**;
- Less than half (**46%**) of staff regularly **make time for friendly conversation** with the resident;
- **52%** of residents report that they **don't** really **get to eat when they want**, 21% say it happens only sometimes while 14% say it is a rare occurrence and 17% report they never get to eat when they want;
- 4 out of 10 (**41%**) say there is **not enough variety** in their **food**; while one-third believe we could do a better job at making sure meals are served at the correct temperature;
- More than **one-third** of residents are only sometimes (20%), rarely (7%) or never (11%) **getting the help they need** at mealtimes to eat and this perception is reinforced with similar observations by family members;
- Less than half (**43%**) of residents report that the **doctor visits** them when they are sick and **only 44% rate** the overall quality of their **physician care as excellent or very good**. Family members share similar views;
- **42%** of residents report they **do not know** what **medications they are taking** and 38% report they are not consulted about their medications while 65% of family members report being consulted about medication changes;
- Only **25%** of family members report being instructed on **where to wash their hands** with only 16% actually shown proper handwashing. Seventy-nine percent of family members have seen staff washing their hands; and
- **26%** of family members report they are **not aware of Family Councils**, while of those who are aware, 38% never attend meetings.

Recommendations

1. Increase staffing levels in care facilities.

While many residents felt that staff were competent and respectful, a common theme throughout the survey was that there were not enough staff to fully meet their needs. This observation is reinforced by survey results from family members and is one of the more frequently referenced issues in the comments section.

Maintaining a commitment made in March 2017 by the B.C. Ministry of Health to ensure a minimum of 3.36 funded care hours per resident per day, resulting in almost 3 million additional care hours a year, is a critical first step and staffing levels must be carefully monitored and enforced. More staff will inevitably mean improvements in the consistency of staff and response times for basic care needs such as using the toilet, more responsive bathing times and help eating meals. Increased staffing also allows for important interpersonal relationships to develop between staff and residents such as time for conversation and companionship, a key component in an individual's quality of life, and one that is currently lacking for many residents.

2. Increase flexibility around when and how care, services and activities are delivered.

It is clear from many residents' responses that the personal freedom of when and how to engage in many of the basic activities of daily living is lacking for some. While some restrictions are the inevitable outcome of communal living, results would indicate we can still do better than our current state. Accommodating personal preferences of when an individual wants to bathe, eat or get up in the morning are examples of areas where we have implemented policies that are constructed to maximize ease on staffing. We need to look at these activities through the lens of first asking residents what they want and then determining how we can best make that happen.

3. Increase activities for weekends and evenings and create more meaningful experiences overall.

Lack of engagement can lead to social isolation even when living in a facility with dozens or even hundreds of other people. Social isolation has long been recognized as a negative influence on health and a potential trigger for accelerating dementia. In the survey many residents have told us there are not enough activities on weekends and in the evening and that, during the week, activities are not as meaningful for them as they could be. We need to examine how we approach activities, and recognize the different ability levels of residents who are living in the same facility. An activity that is engaging for someone with high cognitive but low physical function will not likely be appropriate for someone who has low cognitive and physical function. Yet, we often create "the activity" for the morning or afternoon and expect all residents to find it fulfilling. Clearly some do, but many are being left behind and we can do better.

Ensuring appropriate and engaging activities are available is only half the equation in ensuring the outcome of higher social engagement. Creating an environment and culture that encourages residents to participate in the life of the care home through engaging with other residents and staff is equally important. The relatively low scores for social engagement indicate this is an area where improvement is necessary.

4. Provide better physician care either through GPs and/or explore further increasing the role of nurse practitioners to improve care.

Only 44% of residents found the quality of care from doctors excellent or very good. In addition, less than half of residents' most frequent visitors say they are usually given information by the resident's doctor. The physician can play a significant role in determining the quality of life for residents. Medication regimes, decisions on transfer to the hospital, determining the appropriate tests and diagnostics are all significant issues that are ultimately decided by the physician. The majority of residents and their family members are ambivalent at best about the quality of this service.

Given this, within the context of the resource challenges in the physician sector, this may be the catalyst to explore and more fully embrace the potential of the nurse practitioner to provide primary care to those in residential care, with physician care as the exception.

5. Examine opportunities to improve the meal time experience.

Most people in the general public have the impression that one of the worst things about residential care is the quality of the food. In this survey we found that one third of residents are not regularly enjoying mealtimes. The top complaint about the food was related to timing; residents were not able to eat when they wanted. While we can also do better with the variety of the food and ensure that it is hot enough, a big improvement would be to allow people more freedom in choosing when they want to eat. We also must ensure that those who need assistance to eat, receive that assistance. This last point links to the first recommendation on increasing staff.

6. Provide on-going education for all care staff on the importance of resident emotional well-being and focus on developing staff skills in supporting this important aspect of care.

While care staff are trained in the fundamentals of care such as bathing, transferring, lifting, etc., there is often not formalized training in how to support residents emotionally. The survey results indicate we are doing a good job in training staff to be competent in undertaking the tasks of care, but we may be falling short in ensuring care staff are equipped at understanding how to meet the emotional and social needs of residents. While some of this is undoubtedly related to staffing levels (care staff triage the important physical care needs first, leaving little or no time for the other needs), we know training also places heavy emphasis on the physical care needs, potentially at the expense of emotional care.

How to support a resident who is depressed, how to draw out a resident's personal background and life story, how to help connect residents with other like-minded residents—these are all important pieces of the totality of care and are often overlooked. Focused training on these aspects of care will reinforce their importance.

The OSA, in response to low scores in the social engagement parts of the survey will begin to track and report the interRAI MDS 2.0 index on social engagement (ISE) and if possible the revised index (RISE) for facilities and look at year over year progress.

7. Health Authorities to require facilities to administer the interRAI *Self-Reported Quality of Life Survey for Long Term Care Facilities* and the interRAI *Family Survey for Long Term Care* in two years and publish the results.

We must build on the work of this survey and measure progress. The key is ensuring that all facilities use the same survey questions and methodology and that full results are published. It will take time to determine how to make improvements and then we must allow for improvements to be implemented and residents to appreciate the difference before we will reasonably know if we have made progress.

Fairness and accuracy requires that all care facilities use the same survey and we must be able to measure results against the baseline results of this survey to measure progress. Therefore, we recommend the Ministry of Health require all Health Authorities to survey all publicly funded residents in long term care in 2019/2020 using the interRAI *Self-Reported Resident Quality of Life Survey for Long Term Care Facilities* as well as family members using the companion *Family Survey for Long Term Care* and to publish the results. This will be followed by another OSA province-wide survey in 2021/2022.

8. Foster greater engagement with family members in two key areas.

Responses from family members show that in many areas there is good to excellent communication with families. Two areas that require attention, however, are in the promotion of family councils and hand washing. Currently 24% of those who answered the survey were unaware of family councils. The fact the family members answered the survey indicates they want to be engaged and part of making sure the care home can be as good as possible for their loved one, yet one in four did not know about family councils.

While family members gave a high rating to facilities' cleanliness, which is important for infection control, they gave low marks on promoting hand washing for visitors. Research is very clear that frequent and proper hand washing is the single biggest improvement we can make to lower infection rates and given the physical frailty of many who reside in care homes, it is a critical area to improve.

About Residential Care in B.C.

There are almost 28,000 seniors in British Columbia who live in licensed residential care. This is approximately 4% of the seniors population. Residential care is defined as a setting where three or more unrelated individuals live in an environment that is regulated through the *Community Care and Assisted Living Act* or the *Hospital Act* and enforced through the medical health officers of each health authority. Residential care provides 24-hour professional supervision and care in a secure environment for people who have complex care needs and who can no longer safely live on their own. People eligible for long-term care include those with severe behavioral problems, those who are cognitively impaired, physically dependent, or have multiple disabilities and require professional nursing care. Individuals in residential care live in private or shared rooms. They receive meals, assistance with medication, and personal assistance with daily activities including bathing and dressing, as well as social and recreational activities.

British Columbia provides subsidized, licensed residential care services through both facilities owned and operated by health authorities, and facilities owned and operated by either a not-for-profit society or a private company who have a contract with the health authority for the delivery of residential care services to health authority referred residents. One-third of B.C.'s facilities are owned and operated by the health authorities, while the other two-thirds are owned and operated, either by not-for-profit societies or private companies. The amount the resident pays, and the regulations governing their care and safety, is the same regardless of ownership or subsidy. In addition to publicly subsidized residential care, there are facilities that offer some or all of their beds on a completely private (non-subsidized) basis, where the resident pays the full costs, which can be over $10,000 per month in some facilities but generally ranges from $6,500-$8,500 per month. There are approximately 4,000 of these private beds in British Columbia.

Currently, in B.C., there are approximately 28,000 subsidized residential care beds in 338 regulated facilities. Of the 338 facilities, the OSA identified 292 as providing long term care primarily to seniors and these are currently listed in the OSA's *British Columbia Residential Care Quick Facts Directory*.

Accessing Residential Care

All British Columbians are entitled to access subsidized licensed residential care based on a standardized assessment that determines their level of care need. Provincial guidelines take into account the person's care needs, to what extent these needs are currently being met, and whether the person is able to remain in their current living arrangement with available supports. Often, a move to residential care is precipitated by a sudden decline in functional ability or a change in a person's support network—such as the death of a spouse—that makes living at home no longer sustainable.

The assessment to qualify for licensed residential care is carried out by a clinician employed by the regional health authority. This person may be a registered nurse, occupational therapist or physiotherapist. The main tool for assessment, developed by an international research organization called interRAI, is the Resident Assessment Instrument – Home Care (RAI-HC). This is a standardized assessment of an individual's physical and cognitive function, communication, pain, medical instability, and suitability of the home environment. It is conducted in the hospital or at home.

Once a person has been assessed as requiring the level of care provided in a licensed facility, they are offered the first bed that becomes available in a facility within a certain geographic area of where the person currently resides. After settling into this facility, a resident can put their name on a transfer list for consideration to move to the facility of their choice when a bed becomes available.

All subsidized licensed care facilities are designated as "complex care" and are expected to care for anyone who is assessed as requiring care. Some facilities have specialized units within the care facility that care for unique populations such as those with advanced dementia or behavioural issues; however, this is not a requirement and many facilities do not segregate their residents.

Paying for Residential Care

Licensed residential care is provided to all qualified[1] British Columbians, regardless of their ability to pay. The cost to residents for care is 80% of their after-tax income, up to a maximum of $3,240 per month[2]. Notwithstanding the 80% rule, all residents are guaranteed to be left with a minimum of $325 per month. Currently, 34% of residents pay $1,200 or less, and over 50% pay $1,600 or less. Just 13% of residents pay the maximum rate.

The health authority funds the difference between what the resident is paying and the actual cost, which varies depending on the size and location of the facility, but on average is estimated to be $6,400 per month for the total cost, of which the government subsidizes around $4,900, on average. Regardless of whether a resident is placed in a private room or is required to share with one or up to three other people, the rate they pay is the same. Currently in B.C., 75% of care beds are in single occupancy rooms.

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[1] Eligibility requirements include: being a Canadian citizen or permanent resident, being at least 19 years of age, and having resided in B.C. for at least 3 months.

[2] Adjusted annually, on January 1, to reflect changes in the consumer price index.

Who is Living in Residential Care

The average age of a resident in B.C.'s residential care facilities is 85, and over one-third are 90 or older. There is a wide range of abilities and disabilities amongst the long term care population. Some residents may be completely capable physically and require no assistance for any activities but they suffer memory loss (cognitive impairment) that impacts their ability to live independently while other residents may have full cognitive function but rendered a quadriplegic from stroke or accident and are fully dependent on staff for all activities. A summary of resident characteristics illustrates this diversity:

- Approximately one third of residents are married, and of these, the majority have a spouse living in the community;
- Over one third of residents do not have dementia;
- 34% of residents exhibit aggressive behaviours, including physical and verbal aggressions;
- Almost one third of residents have a diagnosed psychiatric or mood disorder, with the most common (24% of all residents) being depression;
- 48% of residents are prescribed antidepressants;
- 30% are prescribed antipsychotics;
- Over half of residents (53%) use a wheelchair as their primary mode of locomotion;
- Almost two thirds of residents (60%) are usually or always incontinent;
- 38% of residents have a relatively high level of cognitive function (CPS 2 or less); and
- 30% have a relatively high level of physical function (ADL 2 or less).

These statistics paint a picture of residential care communities with a wide diversity of residents. Aside from all residents each coming from a wide variety of social, economic, and ethnic backgrounds, the needs of residents are also very different. While just over half of residents need a wheelchair to navigate their facility, just under half do not need a wheelchair to get around. A major focus in residential care is addressing the needs of clients with dementia, as the majority of residents do, in fact, have dementia. However, a substantial minority—34%—do not, and have very different social and emotional needs.

Measuring Quality in Residential Care

People who come to live in residential care do so because of limitations that could be physical, cognitive, financial, or some combination that impedes their ability to live independently. They need and/or want the safety and security that a provincially licensed and regulated facility offers.

While safety and security are important, there is growing recognition of the importance of quality of life as an indicator of success in providing the best possible environment for those no longer able to live independently.

We have many objective measures of safety and security that are tracked by health authorities for each facility, such as the number of falls, medication errors, missing or wandering residents, disease outbreaks, and incidents of aggression between residents. Licensing inspections and violations are also monitored, as are the number of complaints. In addition, the Canadian Institute for Health Information (CIHI) collects information from facilities on key indicators derived from the interRAI RAI MDS 2.0 health assessments conducted on a quarterly basis. Each year, the Office of the Seniors Advocate publishes the *British Columbia Residential Care Facilities Quick Facts Directory*, a centralized resource for residential care information in the province that reports on these indicators.

These objective measurements that we use and report on, however, do not capture the opinion of the people living in the facility. When determining the quality of the facility and whether or not programs and services are successful, we should first and foremost be asking the people who experience life on a day-to-day basis in the care home how satisfied they are. Arguably, the most important measurement of quality is the opinion of the person for whom we build, staff, and run the care home.

The OSA Residential Care Survey

In October 2014, the Office of the Seniors Advocate made a public commitment to conduct in-person interviews with residents in publicly funded residential care homes in British Columbia. Each resident's most frequent visitor, usually a family member, would also be mailed a survey. This commitment was endorsed by the B.C. Ministry of Health. The OSA partnered with the B.C. Patient-Centered Measurement Working Group to engage their expertise with large, province-wide surveys. Between May 2016 and May 2017, more than 22,000 individuals were approached to participate in the survey in 292 care facilities across the province. More than 800 volunteers were trained to conduct one-on-one, face-to-face interviews with residents and they ultimately logged over 25,000 hours sitting with seniors and listening to their care experiences.

The results of the survey identify opportunities for improvement, as well as areas of excellence, and will serve as an important baseline to measure the quality of care residents are receiving in the future. Recommendations within this report outline some broad directions and first steps that health authorities and facility operators can take to improve the quality of care in B.C.'s facilities based on the perceptions of residents.

Development of the Survey

The survey and its methodology were designed through a 14-month consultative process involving a diverse group of key stakeholders including: care providers; health authorities; family members; union representatives; community groups; and academic experts from across Canada. With additional input from national and international survey research experts. The key stakeholders selected the surveys that would be used: the interRAI *Self-Reported Quality of Life Survey for Long-Term Care Facilities* and the interRAI *Family Survey for Long-Term Care*.

These surveys have been used in other jurisdictions in Canada, are endorsed by the Canadian Institute for Health Information, and the survey methodology and privacy and information security protocols put in place in B.C. were reviewed by the Health Information, Privacy and Security Operations Committee of B.C. and the B.C. Information and Privacy Commissioner; the survey has been accepted by Accreditation Canada as fulfilling their mandatory client experience survey requirements.

A significant benefit of this survey tool is that it can be linked to resident assessments that are conducted regularly, giving a clear picture of the physical and cognitive attributes of respondents. Residents in publicly-subsidized beds are assessed quarterly, as well as within 14 days of admission, using interRAI's RAI-MDS 2.0 assessment tool. De-identified data about an individual's physical and cognitive state are logged and collected for the B.C. Ministry of Health.

Both the resident survey and most frequent visitor survey included over 100 questions in ten different areas: personal autonomy; staff responsiveness; medications; food; caring of staff; physician care; social life; family councils; hand washing; and residents' view of their own health and well-being. The OSA worked with the stakeholder group to add questions unique to B.C.

Questions were field tested and refined with input from residents and family members, clinicians, community stakeholder groups, and academics. Significant effort was required to ensure privacy requirements set out under the B.C. *Freedom of Information and Protection of Privacy Act* were met. Privacy Impact Assessments were conducted for each stage of the project with input and guidance from the B.C. Health Information, Privacy and Security Operations Committee of British Columbia.

Due to logistical challenges a decision was made to exclude any facility where all of the residents were private pay. While these facilities are still subject to licensing standards, the availability of some of the other standardized data were not available. It is estimated there may be up to 20 completely private licensed long term care facilities in B.C. There are private paying residents who co-reside in the same facility as publicly subsidized residents and these residents formed part of the survey. There are 94 facilities in B.C. where there are both private and publicly subsidized clients. The publicly subsidized clients are the majority in all of these facilities and most facilities have less than 15 residents who pay privately.

Data collection and collation of the responses was conducted by NRC Health (formerly National Research Corporation Canada), a leader in the field of patient experience surveys. NRC worked with Dr. Walter Wodchis, a health services researcher at the University of Toronto with internationally recognized expertise in long term residential care, to conduct analysis of the results and linkage with RAI MDS assessment data.

Methodology

The magnitude of the survey, both in terms of the number of facilities and residents, as well as the diverse geography of where facilities are located in the province, presented unique challenges in terms of how in-person surveys would be conducted. A volunteer management model was chosen as a way of not only accommodating the volume of in-person interviews, it was also an opportunity to engage a community of individuals with both personal and professional interest in seniors in residential care.

Volunteer Recruitment Process

In order to facilitate the volunteer recruitment process, a Regional Engagement Lead (REL) was hired for each of the province's five regional health authorities. The REL was responsible for recruiting, selecting and supporting the volunteers who would, in turn, be responsible for conducting resident interviews. The RELs also maintained the centralized provincial volunteer human resources database and scheduling system. RELs placed and supervised all volunteer interviewers, ensuring data collection reliability and that proper protocols were followed.

Volunteers were recruited in a variety of ways: via the media and social media; through community centres and educational programs; distribution lists; and word of mouth. Ultimately, more than 800 volunteers were recruited and rigorously screened and trained through a process including interviews, criminal record checks, and a full-day training session. Training sessions were held across the province and were conducted by Regional Training Coordinators contracted from NRC Health.

In addition, training sessions provided volunteers with further information regarding the background of the project, comprehensive training in how to conduct a structured interview, guidelines and considerations when engaging with residents, and an opportunity to role-play and conduct mock interviews. The mandatory training modules volunteers were required to complete included addressing topics, such as: communicating with persons with dementia; hand hygiene; infection prevention and control protocols; and privacy and confidentiality training. Volunteers' abilities were assessed during training and throughout their engagement.

Conducting the Survey

The guiding principle of the OSA's Residential Care Survey was that "every voice counts." To this end, nearly all residents were approached to participate and provide their views regarding their own experience. To ensure maximum participation, the survey was translated into languages most commonly spoken in B.C.'s facilities, and volunteers who were native speakers in those languages were recruited. Survey volunteers approached every resident up to three times to attempt the survey.

Overall, volunteers conducted surveys in 292 facilities, approaching 22,162 residents to participate in the survey. Of those approached, 9,605 completed the survey, for a response rate of 43%.

Approximately 15% of residents declined to participate, while 21% were unable to complete the evaluative sections of the survey, which were intended to assess a resident's cognitive ability to understand and provide meaningful answers to survey questions.

Most Frequent Visitor Survey

Along with the resident survey, a parallel survey designed to be answered by a resident's most frequent visitor (MFV) was also distributed. This survey mirrored questions asked of the resident and shifted the perspective so that the MFV was asked what they thought about the resident's experiences in care. Some additional questions were also added to the MFV survey that addressed the MFV's experience in visiting the facility and how involved they were with the resident's care planning. The MFV survey comprised 104 questions. The interRAI *Family Survey for Long Term Care* comprised the majority of the questions, with the remainder being custom questions developed and tested by the OSA and the B.C. Patient-Centered Measurement Working Group.

In most cases, the MFV was a family member, although this was not a requirement to receive the survey. Facility staff were asked to identify each resident's MFV. The MFV surveys were mailed out to recipients following completion of the resident surveying at a given facility. Surveys could be filled out and mailed back, or could be completed via a secure website. Each survey had a code that enabled it to be linked to the corresponding resident survey. To date, 19,906 MFV surveys have been mailed out, and 9,604 were returned for processing, for a response rate of 48%.

Respondent Characteristics

For any survey, it is important to understand how people who respond to the survey differ from those who do not respond, as well as whether the respondents are representative of the overall population that was surveyed. Although the intent of this survey was to conduct a census rather than a random sampling survey, it was never expected that all residents would be able to respond. It was expected that some residents would be unable to respond to the survey because of cognitive impairment or other limitations.

In many areas, the survey respondents were reflective of the resident population. We found that the average age of respondents was 83 years compared to 85 years for the overall population. Respondents were slightly less likely to be female (64%) than the overall population (66%). For the MFV survey, respondents represented residents with an average age of 85, of whom 68% were female. Measures of medical stability, pain levels, and depression differed little between the resident respondents, MFV respondents, and the overall population.

As expected, an area where the resident survey was not as reflective of the overall population within residential care is cognitive function. Cognitive functioning is measured with the Cognitive Performance Scale (CPS), which is a 7 point scale running from 0 (no impairment) to 6 (very severe impairment). While **30% of the overall population had severe to very severe cognitive impairment**, just over **10% of respondents** had severe to very severe cognitive impairment. However, although the resident survey is less likely to have responses from residents with a high degree of cognitive impairment, we see that the MFV survey represents residents along the continuum of cognitive performance much closer to what is in the overall population.

Among residents with high degrees of impairments for Activities of Daily Living (ADL), we also found that residents were less likely to respond compared to their overall representation. Like CPS, impairment in ADL is measured on a 7 point scale running from 0 (no impairment) to 6 (very severe impairment). Among all residents in B.C.'s residential care system, **40% had severe to very severe impairment** in their ability to perform ADL tasks, such as bathing, dressing, toileting, and shifting from sitting to standing. Among survey **respondents, 28%** had a similar level of impairment, while 39% of residents represented by an MFV survey had a similar level of impairment.

In addition to having their basic needs met, people aspire to engage socially with those around them. Residential care is a communal living environment, so to a certain extent, a resident's experiences and perception will be shaped by their ability to adapt to this environment; similarly, a facility that helps residents to engage socially with other residents and staff can allow residents to feel more at ease. The Index of Social Engagement is a 7 point scale, with higher numbers indicating greater social engagement. Residents who responded to the survey tended to be more socially engaged than residents who did not respond. Residents represented by an MFV survey were more likely to represent residents with lower levels of social engagement compared to the resident survey respondents. It is reasonable to think that residents who are more socially engaged would be more likely to feel comfortable participating in the in-person survey.

Overall Results

This survey asked over 100 questions on a variety of functions and experiences that happen on a day-to-day basis in care homes. In addition to questions about specific activities and practices, the survey also asked two questions related to the overall function of the care facility. We asked residents to rate the overall quality of the care home on a five point scale ranging from excellent to poor. We also asked residents to indicate whether or not they would recommend the facility to others.

In addition to the specific quality related questions, we asked two further questions to allow us to understand the lens through which a resident might view their experiences in the care home. First, we asked residents if they wanted to be living in the care home and secondly we asked whether they saw themselves as someone who was generally a happier person than most people. If a person is happy and wants to be living in the care home their overall views may prove to be more positive. Conversely, if a person does not want to be living in the care facility this may result in less positive experiences.

Family members or MFV were asked two of the same questions and their responses are expressed in the (brackets).

1. Overall quality of care and services rating in this care home

Excellent	Very good	Good	Fair	Poor
15% (MFV: 28%)	**35%** (MFV: 39%)	**35%** (MFV: 22%)	**12%** (MFV: 9%)	**3%** (MFV: 2%)

2. Would recommend this care home to others

Always	Most of the time	Sometimes	Rarely	Never
43% (MFV: 57%)	**34%** (MFV: 27%)	**13%** (MFV: 10%)	**4%** (MFV: 3%)	**6%** (MFV: 3%)

3. Want to live in this care home

Yes	No
61%	**39%**

4. Happier than most other people

Always	Most of the time	Sometimes	Rarely	Never
20%	**47%**	**22%**	**7%**	**4%**

Most Frequent Visitor-only Questions

5. Want resident to live in this care home

Yes	No
91%	9%

6. Think resident wants to live in this care home

Yes	No
68%	32%

7. Care home is clean

Always	Most of the time	Sometimes	Rarely	Never
54%	39%	6%	1%	0%

8. Care home smells good

Always	Most of the time	Sometimes	Rarely	Never
35%	47%	12%	5%	1%

9. Overall rating of this care home

10	8–9	5–7	2–4	0–1
22%	44%	29%	5%	1%

Observations

These answers reflect the trend we see throughout the survey results: residents do not speak with one voice but with many different voices that express different opinions. The results also tell us that most frequent visitors, usually a family member, may hold different opinions and perceptions from their loved one.

Fully half (50%) of residents rate the overall quality as good, fair or poor, while the other 50% rate it as very good or excellent, demonstrating that many residents appear very satisfied, some are very dissatisfied, while still others are somewhere in between.

While only half of residents rate their facility as very good or excellent 77% would recommend the facility to others all, or most of the time. This seeming contradiction is explained in part by the issue of loyalty that one might feel to their care home irrespective of one's views on its quality, and/or reflect the fact that while the quality could be better, they don't think their particular care home is any worse than other care homes.

Well over half of the respondents see themselves as generally happier than most people. Within this context, however, more than a third of residents do not want to live in their care home. It is important to recognize that care homes are the appropriate place for many people given their health challenges. Many residents recognize this and acknowledge it is where they want to be, given the circumstances. However, we also must be aware of the fact that a not insignificant number of people would actually prefer to live elsewhere and it is understood that this overwhelmingly means in the community. For this reason, it is vital to ensure all possible community supports are exhausted before placing someone in a care home who does not wish to be there.

We can see that 32% of family members don't think their loved one wants to live in the care home, but only 9% of family members don't want their loved one in the care facility. This speaks to the continuing tension in some families where a senior wants to continue living at home, but they can only do so with help from family members who are increasingly shouldering the burden of care and are increasingly overwhelmed.

Family members appear to have slightly higher opinions about the quality of the care homes than residents, with cleanliness and smell getting high marks.

Personal Control

This group of questions are designed to test the sense of personal control or autonomy residents feel they have over their day to day life in the facility. Being able to do what we want when we want is important to everyone regardless of age or where we live. However we may take for granted the many individual day to day decisions we make for ourselves that, in the regulated care setting, are dictated by policy, regulation and resource allocation decisions made by other people.

10. Bathe or shower as often as they want

Always	Most of the time	Sometimes	Rarely	Never
15% (MFV: 6%)	**22%** (MFV: 12%)	**12%** (MFV: 13%)	**13%** (MFV: 21%)	**37%** (MFV: 48%)

11. Bothered by noise

Always	Most of the time	Sometimes	Rarely	Never
4% (MFV: 2%)	**8%** (MFV: 4%)	**25%** (MFV: 36%)	**24%** (MFV: 37%)	**38%** (MFV: 20%)

12 Can be alone when they wish

Always	Most of the time	Sometimes	Rarely	Never
28% (MFV: 36%)	**39%** (MFV: 42%)	**24%** (MFV: 13%)	**5%** (MFV: 5%)	**3%** (MFV: 5%)

13. Can easily go outdoors

Always	Most of the time	Sometimes	Rarely	Never
34% (MFV: 25%)	**29%** (MFV: 23%)	**16%** (MFV: 18%)	**9%** (MFV: 13%)	**13%** (MFV: 21%)

14. Can go out on spur of the moment

Always	Most of the time	Sometimes	Rarely	Never
23% (MFV: 15%)	**29%** (MFV: 28%)	**17%** (MFV: 16%)	**14%** (MFV: 15%)	**18%** (MFV: 25%)

15. Control who comes into own room

Always	Most of the time	Sometimes	Rarely	Never
30% (MFV: 13%)	**35%** (MFV: 28%)	**15%** (MFV: 14%)	**9%** (MFV: 16%)	**12%** (MFV: 29%)

16. Decide how to spend time

Always	Most of the time	Sometimes	Rarely	Never
34% (MFV: 26%)	**46%** (MFV: 47%)	**14%** (MFV: 13%)	**4%** (MFV: 7%)	**2%** (MFV: 7%)

17. Decide when to get up

Always	Most of the time	Sometimes	Rarely	Never
31% (MFV: 15%)	**33%** (MFV: 40%)	**13%** (MFV: 19%)	**10%** (MFV: 12%)	**14%** (MFV: 13%)

18. Decide when to go to bed

Always	Most of the time	Sometimes	Rarely	Never
42% (MFV: 20%)	**35%** (MFV: 41%)	**11%** (MFV: 17%)	**5%** (MFV: 11%)	**7%** (MFV: 11%)

19. Decide which clothes to wear

Always	Most of the time	Sometimes	Rarely	Never
52% (MFV: 20%)	**28%** (MFV: 28%)	**11%** (MFV: 21%)	**5%** (MFV: 14%)	**4%** (MFV: 18%)

20. Feel possessions are safe

Always	Most of the time	Sometimes	Rarely	Never
38% (MFV: 30%)	**39%** (MFV: 47%)	**12%** (MFV: 13%)	**6%** (MFV: 6%)	**5%** (MFV: 4%)

21. Feel safe alone

Always	Most of the time	Sometimes	Rarely	Never
52% (MFV: 42%)	**36%** (MFV: 47%)	**8%** (MFV: 9%)	**2%** (MFV: 1%)	**2%** (MFV: 1%)

22. Privacy is respected during care

Always	Most of the time	Sometimes	Rarely	Never
36% (MFV: 54%)	**42%** (MFV: 40%)	**16%** (MFV: 5%)	**4%** (MFV: 1%)	**2%** (MFV: 0%)

Most Frequent Visitor-only Questions

23. Can find place to visit with my family member

Always	Most of the time	Sometimes	Rarely	Never
59%	27%	8%	4%	2%

Observations

This section produced one of the highest negative scores of the survey with 37% of respondents stating that they "never" get a bath or shower as often as they want and a further 13% stating they "rarely" get a bath or shower as often as they want for a total of 50% never or rarely getting bathed as often as they want, and this increases to 62% when we add those who only "sometimes" get to bathe or shower as often as they want.

Some residents feel access to the outdoors and spontaneous outings are limited which could be attributed to building design and potential limitations of the individual resident.

Residents feel more freedom about when they can go to bed versus when they can get up. This may link to the morning routines which are based on common waking times tied to a common breakfast time, which are both tied to higher staffing levels in the morning than at other times of the day.

On a more positive note, residents feel overwhelmingly that they and their possessions are safe. The majority feel they get to choose what to wear, when to go to bed and can be alone when they wish.

Again as in the previous section we see some significant differences in the perceptions of the most frequent visitor and their loved one. Generally speaking, for this section, MFVs expressed lower ratings than the resident, while in the quality section, they generally expressed higher ratings.

Social Life

Social engagement is increasingly being recognized as a significant predictor of health status in later years. Being connected to other people and feeling valued is a goal everyone hopes to achieve regardless of their age. How well we achieve this in a care setting has not been fully explored. In the survey we asked 14 questions designed to give an overall sense of the social connectedness of residents and insight into specific areas where that connection was better or worse.

24. Another resident is a close friend

Always	Most of the time	Sometimes	Rarely	Never
15% (MFV: 6%)	**18%** (MFV: 12%)	**21%** (MFV: 21%)	**16%** (MFV: 24%)	**30%** (MFV: 37%)

25. Can explore new skills/interests

Always	Most of the time	Sometimes	Rarely	Never
13% (MFV: 14%)	**20%** (MFV: 22%)	**27%** (MFV: 29%)	**19%** (MFV: 21%)	**21%** (MFV: 14%)

26. Can participate in religious activities

Always	Most of the time	Sometimes	Rarely	Never
32% (MFV: 40%)	**25%** (MFV: 26%)	**20%** (MFV: 16%)	**8%** (MFV: 7%)	**15%** (MFV: 11%)

27. Can spend time with like-minded residents

Always	Most of the time	Sometimes	Rarely	Never
18% (MFV: 24%)	**27%** (MFV: 32%)	**28%** (MFV: 24%)	**15%** (MFV: 13%)	**12%** (MFV: 7%)

28. Care home feels like home

Always	Most of the time	Sometimes	Rarely	Never
24% (MFV: 30%)	**33%** (MFV: 38%)	**18%** (MFV: 17%)	**8%** (MFV: 8%)	**16%** (MFV: 7%)

29. Easy to make friends in care home

Always	Most of the time	Sometimes	Rarely	Never
18% (MFV: 8%)	**32%** (MFV: 22%)	**25%** (MFV: 29%)	**15%** (MFV: 24%)	**11%** (MFV: 16%)

30. Enjoyable things to do in the evening in this care home

Always	Most of the time	Sometimes	Rarely	Never
11% (MFV: 7%)	**23%** (MFV: 20%)	**28%** (MFV: 31%)	**20%** (MFV: 28%)	**18%** (MFV: 14%)

31. Enjoyable things to do on weekends in this care home

Always	Most of the time	Sometimes	Rarely	Never
11% (MFV: 10%)	**25%** (MFV: 29%)	**28%** (MFV: 31%)	**18%** (MFV: 20%)	**18%** (MFV: 10%)

32. Friends/family can visit when they choose

Always	Most of the time	Sometimes	Rarely	Never
66%	**24%**	**6%**	**2%**	**2%**

33. Have opportunities for affection/romance

Always	Most of the time	Sometimes	Rarely	Never
7% (MFV: 3%)	**8%** (MFV: 7%)	**14%** (MFV: 15%)	**15%** (MFV: 21%)	**57%** (MFV: 54%)

34. Participated in meaningful activities in the past week

Always	Most of the time	Sometimes	Rarely	Never
12% (MFV: 12%)	**24%** (MFV: 25%)	**28%** (MFV: 31%)	**16%** (MFV: 19%)	**20%** (MFV: 13%)

35. People ask resident for help/advice

Always	Most of the time	Sometimes	Rarely	Never
6% (MFV: 2%)	**11%** (MFV: 3%)	**33%** (MFV: 21%)	**21%** (MFV: 28%)	**30%** (MFV: 46%)

36. People to do things with

Always	Most of the time	Sometimes	Rarely	Never
10% (MFV: 5%)	**17%** (MFV: 12%)	**28%** (MFV: 30%)	**19%** (MFV: 28%)	**26%** (MFV: 25%)

37. Treated with respect by other residents in care home

Always	Most of the time	Sometimes	Rarely	Never
34%	**43%**	**16%**	**4%**	**3%**

Observations

Almost all the questions in this section failed to produce a majority of residents providing the positive answer of "always" or "most of the time."

While some residents clearly do feel engaged, the majority appear to feel they don't have many friends and like-minded people they can enjoy activities with and they don't see themselves as engaging with the care home community. There appears to be a lack of activities in the evenings and on the weekends, and not all the activities offered during the week are meaningful.

Part of the reason for lower positive ratings in this section could be attributed to the challenges of our current complex care system where we combine residents of very different physical and cognitive abilities, backgrounds and languages into one facility. The 43% of residents who responded to the survey generally have higher levels of physical and cognitive functioning than the 57% who did not answer the survey, yet many of them dine together and have the same calendar of activities.

With just over half (57%) of residents stating that the facility felt like home all or most of the time, combined with the overall lower scores in this section, there is an indication that this is an area that needs improvement.

On a positive note, residents feel overwhelmingly positive that the facility creates an environment where friends and relatives are welcome to visit at any time. Residents also strongly feel they are treated with respect by the other residents.

As with the previous sections there were sometimes significant discrepancies between the perceptions of the resident and the family member but it was more evenly distributed in terms of negative and positive response differences.

Staff Responsiveness

There is a diversity of physical needs in care homes. Some residents require little or no physical assistance to undertake any activity and the function of staff is mainly to monitor for wandering while others require total care and staff are required to assist them with all of their activities of daily living including intimate personal care. The availability of staff to respond when needed, their technical and emotional skills play a large part in how residents experience day to day life. This set of questions is designed to test residents and MFV perceptions on the responsiveness of staff in meeting residents' needs.

38. Can express opinions

Always	Most of the time	Sometimes	Rarely	Never
39% (MFV: 53%)	**35%** (MFV: 30%)	**15%** (MFV: 9%)	**6%** (MFV: 4%)	**5%** (MFV: 4%)

39. Can get health services needed

Always	Most of the time	Sometimes	Rarely	Never
37% (MFV: 49%)	**42%** (MFV: 39%)	**14%** (MFV: 10%)	**5%** (MFV: 2%)	**2%** (MFV: 0%)

40. Get help to toilet when needed

Always	Most of the time	Sometimes	Rarely	Never
42%	**33%**	**14%**	**5%**	**6%**

41. Get services needed

Always	Most of the time	Sometimes	Rarely	Never
32% (MFV: 36%)	**48%** (MFV: 51%)	**15%** (MFV: 11%)	**4%** (MFV: 2%)	**2%** (MFV: 0%)

42. If needed can get help right away

Always	Most of the time	Sometimes	Rarely	Never
31% (MFV: 28%)	**42%** (MFV: 46%)	**18%** (MFV: 19%)	**6%** (MFV: 6%)	**2%** (MFV: 1%)

43. Staff act on resident suggestions

Always	Most of the time	Sometimes	Rarely	Never
17% (MFV: 21%)	**36%** (MFV: 45%)	**32%** (MFV: 25%)	**9%** (MFV: 6%)	**6%** (MFV: 3%)

44. Staff know what they are doing

Always	Most of the time	Sometimes	Rarely	Never
37% (MFV: 43%)	**46%** (MFV: 45%)	**13%** (MFV: 10%)	**3%** (MFV: 1%)	**1%** (MFV: 0%)

45. Staff pay attention to residents

Always	Most of the time	Sometimes	Rarely	Never
30% (MFV: 39%)	**47%** (MFV: 48%)	**18%** (MFV: 12%)	**4%** (MFV: 1%)	**2%** (MFV: 0%)

46. Staff respect likes/dislikes of residents

Always	Most of the time	Sometimes	Rarely	Never
32% (MFV: 43%)	**46%** (MFV: 46%)	**17%** (MFV: 10%)	**4%** (MFV: 1%)	**2%** (MFV: 0%)

47. Staff respond quickly

Always	Most of the time	Sometimes	Rarely	Never
28% (MFV: 29%)	**44%** (MFV: 51%)	**21%** (MFV: 16%)	**5%** (MFV: 4%)	**2%** (MFV: 1%)

48. Treated with respect by staff

Always	Most of the time	Sometimes	Rarely	Never
48% (MFV: 61%)	**38%** (MFV: 33%)	**10%** (MFV: 5%)	**2%** (MFV: 1%)	**1%** (MFV: 0%)

Most Frequent Visitor-only Questions

49. Family member/MFV can express opinions without fear

Always	Most of the time	Sometimes	Rarely	Never
70%	21%	6%	2%	1%

50. Have seen residents behave aggressively in the home

No	Yes
54%	46%

51. Staff handle aggressive behaviour appropriately

Always	Most of the time	Sometimes	Rarely	Never
52%	36%	10%	1%	0%

Observations

Overwhelmingly, residents feel that staff treat them with respect and for the most part they have the necessary skills for the job. There are areas however where the timeliness of the staff to respond could be improved. While it may sound high to say that 75% of residents can get helped to the toilet in time, 25% or 1 in 4 are not reliably helped to the toilet on time. This same sentiment is expressed through a series of other questions dealing with the issue of timeliness and there is a fairly consistent response from over 20% - 25% of residents that they are made to wait too long for a variety of their needs to be met.

It was reassuring to see the very strong feeling that residents can express their opinions freely, however elsewhere in the survey we find that they actually do not let staff know when they are unhappy about things as much as they could/should.

Again in this section we see a divergence between the resident and the most frequent visitor, but here the MFV is generally skewing to more positive results. While 46% of visitors reported seeing a resident act aggressively, it is reassuring to see that 88% believe the staff responded appropriately all or most of the time.

Caring Staff

In addition to the skills and responsiveness of staff it is important for residents to believe that staff actually care about their health, well-being and happiness. Developing relationships with staff builds the foundation upon which critical connections can be made that will create the engagement between staff and residents that is necessary to have a positive impact on residents. These questions are designed to help give an overall picture of the level of engagement between residents and staff.

52. Care helps residents live life as wanted

Always	Most of the time	Sometimes	Rarely	Never
29% (MFV: 31%)	**45%** (MFV: 46%)	**15%** (MFV: 15%)	**6%** (MFV: 5%)	**5%** (MFV: 3%)

53. Have same care aide most weekdays

Always	Most of the time	Sometimes	Rarely	Never
13% (MFV: 9%)	**38%** (MFV: 44%)	**24%** (MFV: 31%)	**16%** (MFV: 12%)	**9%** (MFV: 4%)

54. Have special relationship with staff

Always	Most of the time	Sometimes	Rarely	Never
15% (MFV: 18%)	**22%** (MFV: 29%)	**20%** (MFV: 30%)	**15%** (MFV: 14%)	**28%** (MFV: 8%)

55. Residents have a staff member they consider a friend

Always	Most of the time	Sometimes	Rarely	Never
26% (MFV: 25%)	**32%** (MFV: 37%)	**22%** (MFV: 25%)	**9%** (MFV: 9%)	**11%** (MFV: 5%)

56. Staff ask how they can meet resident needs

Always	Most of the time	Sometimes	Rarely	Never
17% (MFV: 20%)	**31%** (MFV: 41%)	**27%** (MFV: 26%)	**13%** (MFV: 10%)	**13%** (MFV: 3%)

57. Staff have enough time for residents

Always	Most of the time	Sometimes	Rarely	Never
23% (MFV: 15%)	**43%** (MFV: 46%)	**21%** (MFV: 25%)	**9%** (MFV: 11%)	**4%** (MFV: 3%)

58. Staff know life story of resident

Always	Most of the time	Sometimes	Rarely	Never
10% (MFV: 11%)	**23%** (MFV: 38%)	**27%** (MFV: 34%)	**18%** (MFV: 13%)	**22%** (MFV: 4%)

59. Staff make time for friendly conversation with resident

Always	Most of the time	Sometimes	Rarely	Never
17% (MFV: 25%)	**29%** (MFV: 41%)	**32%** (MFV: 26%)	**14%** (MFV: 7%)	**9%** (MFV: 1%)

60. Problem gets solved when tell staff not happy

Always	Most of the time	Sometimes	Rarely	Never
21%	39%	27%	9%	4%

61. Staff explains what they are doing when giving care

Always	Most of the time	Sometimes	Rarely	Never
34%	37%	18%	6%	5%

62. Staff tries to relieve physical discomfort

Always	Most of the time	Sometimes	Rarely	Never
35%	40%	16%	5%	4%

63. Staff tries to understand feelings

Always	Most of the time	Sometimes	Rarely	Never
18%	38%	26%	10%	8%

64. Tell staff when not happy about something

Always	Most of the time	Sometimes	Rarely	Never
26%	28%	22%	11%	13%

Most Frequent Visitor-only Questions

65. Consulted when care plan changes

Always	Most of the time	Sometimes	Rarely	Never
49%	27%	12%	7%	5%

66. Family/MFVs involved in care plan development

Always	Most of the time	Sometimes	Rarely	Never
43%	31%	15%	7%	4%

67. Family/MFVs involved in decisions about care

Always	Most of the time	Sometimes	Rarely	Never
58%	30%	8%	3%	1%

68. Family/MFVs kept up to date by staff

Always	Most of the time	Sometimes	Rarely	Never
44%	35%	13%	6%	2%

69. Family/MFVs know who to talk to for information

Always	Most of the time	Sometimes	Rarely	Never
57%	32%	9%	3%	1%

70. Staff address concerns of family/MFVs

Always	Most of the time	Sometimes	Rarely	Never
54%	34%	10%	2%	0%

Observations

The overarching context for most of the questions related to engagement between residents and care staff is continuity of staffing. If staff are to bond with the resident to the degree necessary for true engagement there needs to be the familiarity that develops through consistent interaction.

Almost half of the residents (49%) report that they only sometimes, rarely or never have the same care aide most weekdays. With this lack of continuity it will be more difficult to achieve some of the desired outcomes that reflect a caring staff and we see this reflected in the answers to other questions in this section.

We do see that just over half (58%) have a staff member they consider a friend but only one-third (33%) think the staff know their life story. We also see reflected in the answer to some questions the underlying issue of care staff having enough time. This observation by both residents and MFVs is echoed in other sections of the survey. For example, less than half of the residents (46%) report that staff routinely make time for friendly conversation.

Of some concern should be the observation by 25% of residents that staff only sometimes, rarely or never try to relieve physical discomfort. This is undoubtedly related to having sufficient time for observation and conversation that could alert care aides to residents who are experiencing discomfort.

There is also a clear opportunity for improvement in encouraging residents to be more forthcoming when they are not happy about something, as almost half (46%) reported that they only sometimes, rarely or never tell staff when they are not happy about something.

The MFV responses reflected, on average, a fair degree of satisfaction among MFVs that they are sufficiently involved in the care issues of their loved one. Indeed, there is potentially an underlying issue that we are doing a better job of talking to families about the resident than we are doing talking directly to the residents. This is also reflected in the section on medications.

Food

Food is a very important part of daily life in a care facility. All licensed care facilities are required to serve breakfast, lunch and dinner and all facilities are required to have professional oversight of the food to ensure menus are healthy and balanced and special dietary requirements are met.

One of the biggest adjustments some people make when they come to live in a care facility is that choices around food are much more limited compared to when one lives in their own home, and that dining with a group of people for all meals creates a social environment that some will embrace and others will resent. For some, the relief from cooking is most welcome, while others found great joy in the creative aspect of preparing meals for themselves and their families. It is within this complicated context that the following questions were asked to determine what elements of the eating experience residents most enjoyed and/or were most troubled by.

71. Can eat when they want

Always	Most of the time	Sometimes	Rarely	Never
16% (MFV: 14%)	**32%** (MFV: 33%)	**21%** (MFV: 24%)	**14%** (MFV: 16%)	**17%** (MFV: 13%)

72. Enjoy mealtimes

Always	Most of the time	Sometimes	Rarely	Never
25% (MFV: 18%)	**42%** (MFV: 48%)	**22%** (MFV: 24%)	**8%** (MFV: 9%)	**4%** (MFV: 2%)

73. Enough variety in meals

Always	Most of the time	Sometimes	Rarely	Never
18% (MFV: 22%)	**41%** (MFV: 45%)	**23%** (MFV: 20%)	**11%** (MFV: 10%)	**6%** (MFV: 3%)

74. Food is the right temperature

Always	Most of the time	Sometimes	Rarely	Never
23% (MFV: 24%)	**45%** (MFV: 51%)	**21%** (MFV: 17%)	**8%** (MFV: 6%)	**4%** (MFV: 2%)

75. Get favourite foods

Always	Most of the time	Sometimes	Rarely	Never
11% (MFV: 7%)	**29%** (MFV: 29%)	**33%** (MFV: 37%)	**16%** (MFV: 20%)	**11%** (MFV: 8%)

76. Get help to eat when needed				
Always	**Most of the time**	**Sometimes**	**Rarely**	**Never**
30% (MFV: 48%)	**32%** (MFV: 26%)	**20%** (MFV: 19%)	**7%** (MFV: 4%)	**11%** (MFV: 3%)

Most Frequent Visitor-only Questions

77. Staff take the time needed to feed my family member				
Always	**Most of the time**	**Sometimes**	**Rarely**	**Never**
36%	**27%**	**21%**	**8%**	**8%**

Observations

Less than half of the residents report that they were generally able to eat when they want. Despite the 67% who report that they enjoy meal times, there are fully one-third of residents who say they generally do not enjoy their meal time. Some of this links to the variety of food and the timing; however, we should be very concerned that 38% of residents report that they sometimes, rarely or never get help to eat when needed. This is supported by the MFV survey reporting that 37% of respondents don't believe their loved one is getting sufficient help to eat when needed.

While differences in food preference make complete satisfaction by all residents difficult, improving the percentage of people who enjoy their mealtimes by offering more flexible timing, ensuring food is the right temperature and assisting those who need help eating would potentially offer some immediate improvement. Licensing regulations outline that facility staff must ensure that breakfast, lunch and dinner are made available between certain time windows at minimum but do not restrict mealtimes to only those hours. Should the resident be unable to attend during meal time, a meal must be provided and taken to them without cost.

Physician Care

Physicians are self-employed individuals who provide care at a residential care site. It is the physician who is responsible for decisions to transfer a resident to hospital and for communicating with the resident and family about medical care decisions and medications. Given the health conditions of seniors living in residential care, the attentiveness of physicians when required is critical.

The current role that physicians play in determining medication regimes, hospital transfers and diagnostics ensures their actions link not just to the quality of life and care for residents but to resource utilization in the system. The survey asked residents to rate the overall quality of care and services from a physician. These questions were customized for the B.C. survey and are intended to gauge how satisfied residents and their families are with the role the physician plays in their care, which links to their quality of life.

78. Doctor visits when NOT sick

Always	Most of the time	Sometimes	Rarely	Never
8% (MFV: 8%)	**9%** (MFV: 15%)	**21%** (MFV: 32%)	**16%** (MFV: 25%)	**46%** (MFV: 20%)

79. Doctor visits when sick

Always	Most of the time	Sometimes	Rarely	Never
22% (MFV: 34%)	**21%** (MFV: 32%)	**19%** (MFV: 20%)	**16%** (MFV: 9%)	**22%** (MFV: 5%)

80. Overall quality of care and services from doctor

Excellent	Very good	Good	Fair	Poor
15% (MFV: 21%)	**29%** (MFV: 28%)	**35%** (MFV: 27%)	**15%** (MFV: 18%)	**8%** (MFV: 7%)

Most Frequent Visitor-only Questions

81. Doctor provides individualized care

Excellent	Very good	Good	Fair	Poor
21%	27%	26%	18%	8%

82. Doctor washes/cleans hands

Always	Usually	Sometimes	Never
55%	23%	8%	14%

83. Family/MFVs given information from doctor

Always	Most of the time	Sometimes	Rarely	Never
25%	23%	17%	18%	17%

Observations

There is obvious room for improvement in how residents perceive their medical care with only 44% of residents rating the care of their physician as very good or excellent. Some residents are required to change physicians when they are admitted to residential care and the ambivalence about the quality of care being received could be related to the fact they no longer enjoy the care from someone they may have known for 40 years or more. These results also raise larger health care policy questions about the allocation of physician resources. For example, could residential care adopt an expanded role for nurse practitioners who would form the physician-like attachment with residents?

Low physician engagement manifests itself in many things, too frequent or infrequent referrals to emergency departments and orders to treat, in addition to over-prescription and mismanagement of medications. Finding a new model of primary care delivery to the long term care sector may be the only way to achieve improvements given the doctor shortage and the demographics of seniors indicating an increase in demand for services and a relative decrease in supply.

Medications

Use and potential over use of medications is a focus for quality improvement in residential care. For example, the Canadian Institute for Health Information (CIHI) has chosen to highlight the misuse of one medication group known as antipsychotics to serve as a quality indicator for facilities. This increased focus is showing some encouraging results and reinforces that measuring and reporting are important first steps in achieving change.

Empowering all citizens, but particularly seniors with the knowledge to ask about medications and the requirement of physicians to seek consent from either the patient/resident or their designated decision maker is acknowledged as the first line of defence in reducing both medication errors and over medication. Therefore, measuring and reporting on medication awareness and consent in residential care was deemed sufficiently important to add these customized questions to the B.C. survey.

84. Consulted about taking medications

No	**Yes**
38%	**62%**

85. Know what medications taking

No	**Yes**
42% (MFV: 15%)	**58%** (MFV: 85%)

86. If yes to above, know what taking medications for

No	**Yes**
14% (MFV: 2%)	**86%** (MFV: 98%)

Most Frequent Visitor-only Questions

87. Family/MFVs consulted about medications changes

No, and don't wish to be	No, but wish to be	Yes
7%	28%	65%

Observations

With 42% of residents stating they do not know what medications they are taking and 38% reporting they are not consulted, this is a key area for improvement. The outcome of increasing the consultation with residents and obtaining explicit consent is that it will force the conversation about not only what the medications are for, but outline the benefits versus the risks of medications and side effects. With complete information, residents will be empowered to make their own benefit and risk assessment before taking medication(s).

Undoubtedly the challenges in relation to medication link to some of the challenges around physician care which may require that we think of different ways of engaging residents in the decision making around their medications.

Hand Washing

Seniors in residential care are more susceptible to infections and the risk of complications from these infections is also increased in the senior population. Hand hygiene is the most significant improvement that can be made to reduce infections, followed by keeping a clean environment. Visitors to care facilities need to be educated and supported in the importance of hand washing and directed on how and where to wash their hands when visiting the facility. These questions were designed for most frequent visitors only.

Most Frequent Visitor-only Questions

88. Care staff instruct where to get handwashing products

Always	Usually	Sometimes	Never
17%	8%	8%	67%

89. Care staff showed MFV proper handwashing

Always	Usually	Sometimes	Never
10%	6%	5%	80%

90. Care staff told MFV about importance of handwashing

Completely	Quite a bit	Partly	Not at all
28%	14%	12%	47%

91. Comfortable asking if staff wash/clean their hands

Always	Usually	Sometimes	Never
30%	16%	10%	44%

92. Other staff wash/clean hands

Always	Usually	Sometimes	Never
48%	31%	13%	8%

Observations

These results indicate a need for better protocols to ensure visitors are instructed on how to properly handwash, and where to get handwashing products in the facility.

Family Council

A family council is a group of individuals who are the contact person, representative or relatives of care facility residents, and who meet regularly for a common purpose related to the care facility. One of the key roles that a family and/or resident council can play is to promote improved communication and collaboration between family members and facility staff, and management. This may involve working collaboratively on projects that enrich the lives of residents, making recommendations to decision makers, and communicating common concerns and ideas for improvements. Most frequent visitors were asked in the survey whether they attended family council meetings and whether they were informed about family councils.

Most Frequent Visitor-only Questions

93. MFV informed about family council (multiple answers allowed)

No, not aware of	Yes, saw on poster/ brochure	Yes, by family of another resident	Yes, by staff
26%	20%	5%	56%

94. If aware, MFV attends family council

Always	Most of the time	Sometimes	Rarely	Never
21%	11%	15%	15%	38%

Observations

Family councils can provide an excellent mechanism to stay informed of the day to day activities of residential care and how decisions impact loved ones. The survey results show facilities could do a better job of ensuring family members are both aware and encouraged to participate.

How Residents View Their Health and Well-Being

The survey asked a number of questions to both residents and their most frequent visitors about the general physical and emotional health of the resident. These questions provide an important picture of overall perceptions of well-being over time. These questions were separate from the main survey.

95. General health is

Poor	Fair	Good	Very good	Excellent
6% (MFV: 16%)	**20%** (MFV: 37%)	**39%** (MFV: 34%)	**27%** (MFV: 12%)	**9%** (MFV: 2%)

96. Health limits moderate activity e.g. walking a block

No, not limited at all	Yes, limited a little	Yes, limited a lot
29% (MFV: 9%)	**29%** (MFV: 19%)	**42%** (MFV: 72%)

97. Health now limits ability to bathe/dress self

No, not limited at all	Yes, limited a little	Yes, limited a lot
41% (MFV: 7%)	**28%** (MFV: 20%)	**31%** (MFV: 73%)

98. Accomplished less due to physical health

Yes, all of the time	Yes, most of the time	Yes, some of the time	Yes, a little of the time	No, none of the time
9% (MFV: 27%)	**18%** (MFV: 21%)	**20%** (MFV: 20%)	**16%** (MFV: 13%)	**35%** (MFV: 18%)

99. Physical health in past week limited daily activity

Yes, all of the time	Yes, most of the time	Yes, some of the time	Yes, a little of the time	No, none of the time
11% (MFV: 30%)	**18%** (MFV: 23%)	**18%** (MFV: 19%)	**15%** (MFV: 13%)	**38%** (MFV: 15%)

100. Accomplished less past week due to emotional problems

Yes, all of the time	Yes, most of the time	Yes, some of the time	Yes, a little of the time	No, none of the time
3% (MFV: 10%)	**8%** (MFV: 12%)	**15%** (MFV: 22%)	**14%** (MFV: 19%)	**60%** (MFV: 37%)

101. Emotional problems in past week impacted activities

Yes, all of the time	Yes, most of the time	Yes, some of the time	Yes, a little of the time	No, none of the time
3% (MFV: 12%)	**6%** (MFV: 12%)	**12%** (MFV: 20%)	**12%** (MFV: 17%)	**67%** (MFV: 40%)

102. Pain interfered with normal activities in past week

Extremely	Quite a bit	Moderately	A little bit	Not at all
4% (MFV: 5%)	**12%** (MFV: 14%)	**15%** (MFV: 19%)	**21%** (MFV: 28%)	**48%** (MFV: 34%)

103. Amount of time feeling calm/peaceful in past week

No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
4% (MFV: 2%)	**8%** (MFV: 8%)	**16%** (MFV: 22%)	**52%** (MFV: 60%)	**19%** (MFV: 8%)

104. Amount of time having a lot of energy in past week

No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
14% (MFV: 27%)	**19%** (MFV: 31%)	**23%** (MFV: 22%)	**35%** (MFV: 18%)	**9%** (MFV: 2%)

105. Amount of time feeling downhearted in past week

No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
37% (MFV: 16%)	**26%** (MFV: 29%)	**20%** (MFV: 31%)	**14%** (MFV: 21%)	**3%** (MFV: 3%)

106. Physical/emotional problems impacted social activity

No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
51% (MFV: 29%)	**18%** (MFV: 21%)	**18%** (MFV: 22%)	**8%** (MFV: 15%)	**5%** (MFV: 14%)

107. Rating of physical health compared to one year ago

Much worse	Slightly worse	About the same	Slightly better	Much better
8% (MFV: 25%)	**15%** (MFV: 38%)	**54%** (MFV: 26%)	**13%** (MFV: 6%)	**10%** (MFV: 5%)

108. Rating of emotional problems compared to one year ago

Much worse	Slightly worse	About the same	Slightly better	Much better
5% (MFV: 11%)	**12%** (MFV: 24%)	**61%** (MFV: 47%)	**12%** (MFV: 11%)	**10%** (MFV: 7%)

Observations

It is encouraging to see feedback from both residents and most frequent visitors underscoring that, overall most rate their general and emotional health as satisfactory even though mobility, pain and emotional issues are very prevalent among the residential care population.

Conclusion

The survey results contained in this report represent the voices of British Columbians that are rarely heard and send strong messages about where residential care for seniors is working well, and where improvements are most needed. When considering these results, it is critical to remember that as in any community, the individuals for whom residential care is their home, have the same breadth of opinions as a group of people who live on a cul-de-sac in the suburbs or a highrise in the west end of Vancouver. At any dinner table in a facility, there will be residents who are very satisfied with the care they receive and others who feel the complete opposite. The results of the survey do not show a residential care system that is failing overall. The results do show that it is failing some people some of the time and that overall it is a system with room for improvement, and in some areas, much improvement is needed.

It is clear that staffing levels are a major concern for residents and their families. While staff overall are caring and respectful, consistent feedback is that there simply are not enough staff to ensure residents' needs are taken care of when they need to be. Inadequate staffing levels lead to inconsistency among care aides and ultimately an erosion of important interpersonal interactions between staff and residents. Insufficient staffing also hampers the ability for flexibility in care delivery such as bathing and eating times, as well as reduces the ability for care providers to offer diverse and engaging social and leisure activities for residents.

In addition to more staff, residents want more freedom. While communal living brings some loss of complete individualism, the results clearly speak to a need to re-examine some of our policies and procedures such as our approach to bathing and meal times for example.

Residents are also telling us they need to feel more engaged. There is an overall sense of loneliness that many, although not all residents express. They may be living with many other people and having meals with them, but they still feel alone. A better connection with staff on a personal level and the ability to spend time with residents they might have more in common with is a clear need that comes from the survey responses.

Our seniors deserve the best possible experience of living. Many British Columbians are deeply committed to this as evidenced by over 800 people volunteering over 25,000 hours to ensure residents' voices were heard. Furthermore, facility operators want to provide the best possible care. The open embrace from operators for this survey tells us they want to know how residents feel and where improvements can be made. Health Authorities and the provincial government have shown they too want to know through both their support and funding of this survey.

Finally, residents want to see improvements. Almost 10,000 residents took the time to answer over 100 questions in this survey. This required significant stamina and commitment. When we asked residents for their opinion and engaged with them as equals we were repaid with an outpouring of information that will be invaluable. Planning for seniors can only be effective if it involves seniors and that is what this survey allows. It is our hope moving forward that initial recommendations based on these collective voices are carefully considered so that together we can be very proud of a truly exemplary piece of our health care system.

The recommendations highlighted below outline where residents and their family members indicate action is needed to improve quality of life in our long term care sector in British Columbia.

These are the first set of recommendations that come from our first analysis of the survey. Over the next year we will continue to analyze the findings and we may produce additional recommendations in the future.

Recommendations

1. Increase staffing levels in care facilities.

While many residents felt that staff were competent and respectful, a common theme throughout the survey was that there were not enough staff to fully meet their needs. This observation is reinforced by survey results from family members and is one of the more frequently referenced issues in the comments section.

Maintaining a commitment made in March 2017 by the B.C. Ministry of Health to ensure a minimum of 3.36 funded care hours per resident per day, resulting in almost 3 million additional care hours a year, is a critical first step and staffing levels must be carefully monitored and enforced. More staff will inevitably mean improvements in the consistency of staff and response times for basic care needs such as using the toilet, more responsive bathing times and help eating meals. Increased staffing also allows for important interpersonal relationships to develop between staff and residents such as time for conversation and companionship, a key component in an individual's quality of life, and one that is currently lacking for many residents.

2. Increase flexibility around when and how care, services and activities are delivered.

It is clear from many residents' responses that the personal freedom of when and how to engage in many of the basic activities of daily living is lacking for some. While some restrictions are the inevitable outcome of communal living, results would indicate we can still do better than our current state. Accommodating personal preferences of when an individual wants to bathe, eat or get up in the morning are examples of areas where we have implemented policies that are constructed to maximize ease on staffing. We need to look at these activities through the lens of first asking residents what they want and then determining how we can best make that happen.

3. Increase activities for weekends and evenings and create more meaningful experiences overall.

Lack of engagement can lead to social isolation even when living in a facility with dozens or even hundreds of other people. Social isolation has long been recognized as a negative influence on health and a potential trigger for accelerating dementia. In the survey many residents have told us there are not enough activities on weekends and in the evening and that, during the week, activities are not as meaningful for them as they could be. We need to examine how we approach activities, and recognize the different ability levels of residents who are living in the same facility. An activity that is engaging for someone with high cognitive but low physical function will not likely be appropriate for someone who has low cognitive and physical function. Yet, we often create "the activity" for the morning or afternoon and expect all residents to find it fulfilling. Clearly some do, but many are being left behind and we can do better.

Ensuring appropriate and engaging activities are available is only half the equation in ensuring the outcome of higher social engagement. Creating an environment and culture that encourages residents to participate in the life of the care home through engaging with other residents and staff is equally important. The relatively low scores for social engagement indicate this is an area where improvement is necessary.

4. Provide better physician care either through GPs and/or explore further increasing the role of nurse practitioners to improve care.

Only 44% of residents found the quality of care from doctors excellent or very good. In addition, less than half of residents' most frequent visitors say they are usually given information by the resident's doctor. The physician can play a significant role in determining the quality of life for residents. Medication regimes, decisions on transfer to the hospital, determining the appropriate tests and diagnostics are all significant issues that are ultimately decided by the physician. The majority of residents and their family members are ambivalent at best about the quality of this service.

Given this, within the context of the resource challenges in the physician sector, this may be the catalyst to explore and more fully embrace the potential of the nurse practitioner to provide primary care to those in residential care, with physician care as the exception.

5. Examine opportunities to improve the meal time experience.

Most people in the general public have the impression that one of the worst things about residential care is the quality of the food. In this survey we found that one third of residents are not regularly enjoying mealtimes. The top complaint about the food was related to timing; residents were not able to eat when they wanted. While we can also do better with the variety of the food and ensure that it is hot enough, a big improvement would be to allow people more freedom in choosing when they want to eat. We also must ensure that those who need assistance to eat, receive that assistance. This last point links to the first recommendation on increasing staff.

6. Provide on-going education for all care staff on the importance of resident emotional well-being and focus on developing staff skills in supporting this important aspect of care.

While care staff are trained in the fundamentals of care such as bathing, transferring, lifting, etc., there is often not formalized training in how to support residents emotionally. The survey results indicate we are doing a good job in training staff to be competent in undertaking the tasks of care, but we may be falling short in ensuring care staff are equipped at understanding how to meet the emotional and social needs of residents. While some of this is undoubtedly related to staffing levels (care staff triage the important physical care needs first, leaving little or no time for the other needs), we know training also places heavy emphasis on the physical care needs, potentially at the expense of emotional care.

How to support a resident who is depressed, how to draw out a resident's personal background and life story, how to help connect residents with other like-minded residents—these are all important pieces of the totality of care and are often overlooked. Focused training on these aspects of care will reinforce their importance.

The OSA, in response to low scores in the social engagement parts of the survey will begin to track and report the interRAI MDS 2.0 index on social engagement (ISE) and if possible the revised index (RISE) for facilities and look at year over year progress.

7. Health Authorities to require facilities to administer the interRAI *Self-Reported Quality of Life Survey for Long Term Care Facilities* and the interRAI *Family Survey for Long Term Care* in two years and publish the results.

We must build on the work of this survey and measure progress. The key is ensuring that all facilities use the same survey questions and methodology and that full results are published. It will take time to determine how to make improvements and then we must allow for improvements to be implemented and residents to appreciate the difference before we will reasonably know if we have made progress.

Fairness and accuracy requires that all care facilities use the same survey and we must be able to measure results against the baseline results of this survey to measure progress. Therefore, we recommend the Ministry of Health require all Health Authorities to survey all publicly funded residents in long term care in 2019/2020 using the interRAI *Self-Reported Resident Quality of Life Survey for Long Term Care Facilities* as well as family members using the companion *Family Survey for Long Term Care* and to publish the results. This will be followed by another OSA province-wide survey in 2021/2022.

8. Foster greater engagement with family members in two key areas.

Responses from family members show that in many areas there is good to excellent communication with families. Two areas that require attention, however, are in the promotion of family councils and hand washing. Currently 24% of those who answered the survey were unaware of family councils. The fact the family members answered the survey indicates they want to be engaged and part of making sure the care home can be as good as possible for their loved one, yet one in four did not know about family councils.

While family members gave a high rating to facilities' cleanliness, which is important for infection control, they gave low marks on promoting hand washing for visitors. Research is very clear that frequent and proper hand washing is the single biggest improvement we can make to lower infection rates and given the physical frailty of many who reside in care homes, it is a critical area to improve.

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