ALBERTA CONTINUING CARE ASSOCIATION

Continuing Care Act Engagement

howegroup

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EXECUTIVE SUMMARY

BACKGROUND & SCOPE

Alberta's current continuing care system is guided and regulated by multiple pieces of legislation, some dating back to 1985. With six Acts, each with its associated set of regulations, and three sets of standards, the current continuing care legislative framework is seen to be complex, fragmented, and cumbersome particularly for operators providing multiple levels of care and services within the continuing care sector. In March 2022, the Government of Alberta introduced *Bill 11: The Continuing Care Act* (the *Act*) with the intention of maintaining what works well, consistently applying it across services and settings, and addressing gaps highlighted during the pandemic. The new legislation also significantly expands the scope of who will be regulated and defined as falling within the continuing care sector.

Alberta Continuing Care Association (ACCA), supported by Alberta Health, undertook a comprehensive province-wide consultation to gather feedback to inform the development of new regulations associated with the *Act*. ACCA retained the Howegroup team in September 2022 to understand the impact on the sector and to inform the development of the regulations and standards

The Howegroup engagement included:

- A facilitated panel at the ACCA Conference in Red Deer (approximately 200 attendees).
- Facilitated sessions with the ACCA Board of Directors (n=8).
- One-on-one interviews with a mix of operators from across the province (n=31).
- Discussions with resident and family council representatives (n=38).
- An online survey with operators (n=32).
- Participation in Continuing Care Alliance and Alberta Health Continuing Care Regulations/Standards Working Team sessions.
- A presentation at the ACCA AGM (approximately 40 attendees).
- Participation in multiple regulation content review sessions.
- A public survey hosted on a dedicated website (haveyoursayacca.ca) and promoted through social and traditional media (n=1156).

Limitations of the engagement include a condensed timeframe, knowledge gaps of the *Act* within specific areas of the sector, lack of awareness of the *Act* among residents and family members, absence of union participation, and limited health zone representation in the engagement.

FINDINGS

Concerns and Opportunities with The *Act*

The engagement uncovered general areas of concern and opportunity with the development of regulations and standards

The most notable concerns include:

- Lack of details which leaves room for interpretation when implemented.
- The introduction of punitive penalties which will detract from the culture of trust that currently exists between operators, Alberta Health, and Alberta Health Services.
- The need for funding to accompany any changes to support implementation.

Areas of opportunity include:

- The potential for increased efficiencies for operators by aligning and streamlining regulations and audits, and reducing duplications (i.e., Labour, Jobs, Economy and Occupational Health and Safety).
- Opportunity for workers to benefit through increased scope of practice, additional career opportunities, and streamlined regulatory requirements.
- Residents and clients may benefit through an easier to understand system (both access and navigation).
- There is potential for improved outcomes (i.e., more timely response).

Participants were hopeful the *Act* may transform the system with regulations that are not overly restrictive, leaving room for demonstration and innovation.

Licensing

As part of the *Act*, Alberta Health will be establishing an updated licensing regime which will, for the first time, apply to all continuing care operators. As many operators within the continuum do not fall under 'care', the requirement to be licensed is considered significant 'overreach' that may impact delivery, or even offering, of services. Additionally, operators feel licensing will shift significant resources away from bedside care in order to deal with an unnecessary 'bureaucratic burden' and many expressed concerns how the term on a license may impact their ability to secure financing for new developments and obtain insurance in an already challenging market.

Operators requested the current licensing process and requirements remain as is as the system is working and operators are familiar with requirements. The non-renewal of a license is considered one of the most serious consequences for continuing care operators and therefore should be considered an 'action of last resort'; instead, operators should have the opportunity to remediate non-emergency issues, and the subsequent impacts to residents' physical and mental wellbeing should also be considered.

Operators would like to see a fair and equitable regulatory environment related to the government's takeover of an operation, if necessary. In such cases, it was recommended that the government would be required to use fair market value, determined by an independent body, and agreed upon by operators and government.

Inspections and audits

As the *Act* sets out to update and expand the inspection system in Alberta, consistency remains the primary concern. To support consistency, current and future inspectors should receive consistent training across the province with the curriculum including emotional intelligence, administrative fairness, care and building management, and that the accreditation survey model may be emulated (i.e., appropriate qualification and skill expectations in accreditation surveyors). Operators were in general agreement that it was critical not to 'over qualify' the position. Operators felt that three to five years of sector experience should be required for inspectors. There was an interest in gathering and publicly publishing anonymized data regarding the types of fines, penalties and enforcement measures imposed by individual inspectors across the province. Almost all operators identified a need for tracking and reporting infractions by each inspector to ensure consistency. The majority of operators reported that a reasonable notice period to prepare for an audit was four to six weeks.

Appeals

Operators felt the time frame for an appeal should correlate with the level of seriousness of the issue being appealed, and clarification is needed on what happens to residents and staff during the appeals process. Operators provided significant feedback regarding the appeal process and the need for it to be fair, fast, and free of any bias and demonstrated interest. Operators recommended a three-person panel including a government-approved representative, a sector-approved representative, and an independent Chair. When it comes to processing times for appeals, it was suggested operators be provided with 15 business days to file an appeal, with the expectation that paperwork be minimized. In terms of the scope of what should be eligible for appeal, operators requested it should include anything that may result in a significant financial impact and would like the right to appeal items related to not meeting regulation criteria. Once the *Act* is enforced, operators have requested the ability to recover legal and administrative costs for all successful appeals.

Penalties

As drafted, the *Act* would facilitate a dramatic increase in the scope and scale of penalties for operators who are in contravention of the law. In terms of this consultation, this issue generated the most significant amount of feedback and concern from a broad spectrum of operators. The proposed $100,000 per day penalties was considered highly unacceptable. This would have the potential to put operators out of business and create a barrier for not-for-profit operators to attract and retain volunteer board members. Lack of clarity as to whether 'an individual' could be held accountable and fined for either their own actions, or that of their employees, was another reason cited for the government to reconsider or postpone indefinitely this new fine structure.

A shift to an enforcement model would fundamentally change the relationship between operators, Alberta Health, and Alberta Health Services. The issuance of fines, increased enforcement, and a system no longer built on trust, runs the risk of further eroding the relationship between government and the continuing care sector. Operators are supportive of Alberta Health implementing enforcement measures on operators who cannot adhere or meet reasonable standards and regulatory requirements that are within their control. However, there was overwhelming need for an enforcement system that would provide some flexibility and allow for the operator to remediate any identified problems.

Resident and family councils

Resident and family councils offer site-specific communication conduits between continuing care operators and those they serve. Participation in resident and family councils continues to pose as a primary challenge. There was consensus that the councils serve as forums of information sharing, allows for "on the ground" focus on residents' concerns such as meals and recreation,

opportunities for educational/informative speakers, as well as reliable occasions when follow-ups are provided. Overall, there was a lack of knowledge regarding the *Act*, the process undertaken by Alberta Health, and the potential implications for residents and families. None of the residents or families were aware of the new legislation. There was consensus that better communications about regulatory changes related to the *Act* would be needed to inform residents and their families with considerations for multi-channel messaging, diversity and language barriers, and highlighting 'how' and 'what' would be impacted for residents, clients, and families.

Concerns around formalizing roles and relationships within The *Act* included:

- Misalignment of resident and family expectations with systemic capacity.
- Limited volunteer capacity within smaller organizations.
- The ability to recruit and fill roles may be daunting or overwhelming for residents and family members.
- Resident and family councils may be best left out of the regulations to allow flexibility for each continuing care home to determine its unique needs (i.e. separate councils, joint councils etc.).

Health Human Resources

Several systemic issues were identified with respect to health human resources (HHR). Alberta Health Services' dual roles – itself as the regulatory body while also competing for human resources was a significant concern considering the shortage of registered nurses and health care aides across the province, particularly in rural and remote Alberta. Other HHR concerns include ongoing impact (burnout) from COVID, regulatory changes to have disproportionate impact on smaller providers, and the increasing reliance on internationally trained workers who cannot be included in the HCA Directory.

Solutions for mitigating the impact on HHR include a collaborative system-wide approach to recruitment and retention, increased scope of practice, more resources for on-the-job training, and positive messaging from the Ministry of Health that supports workers and leaders in the sector. Ninety-three percent of respondents to the Operator survey agreed that Alberta Health should designate certain parts of the province as "HHR Shortage Zones" to recognise the limited access to health human resources for key specialized in-demand occupations.

Operators are looking for recognition of the different staffing needs for urban versus rural operations, reflecting the diversity across the province. Operators had mixed feelings about providing staffing ratios in the regulations, with the majority feeling ratios are too restrictive and preferred minimum standards or a framework to allow for more flexibility. Operators were concerned setting specific hours and ratios may not support the unique resident needs of individual sites given the diversity across the province.

Culturally appropriate care

Regulations should support culturally appropriate care on and off Indigenous Reserves and Metis Settlements by creating a special advisory group to advise on priorities and approach that is parallel and synchronized with the rest of the system. Additionally, there is support for a requirement that every operator deliver training that is culturally specific (reflecting the diversity within Alberta overall) and includes Indigenous culture.

Public survey findings

In collaboration with ACCA's communication's team a public engagement survey was launched on ACCA's microsite (www.haveyoursayacca.ca) to capture feedback from members of the public relating to the *Act*, With a total of 1,156 responses, only 4% considered themselves "very familiar" with the *Act*. The majority were "not at all familiar" (52%) or "somewhat familiar" (43%) with the *Act*. Only 16% of respondents believed the legislative changes will result in improved quality of care and services for Alberta seniors (39% responded 'no' and 45% responded 'I don't know'). Seventy percent (70%) of respondents found it "very important" for regulatory changes/reform to occur within the continuing care sector in order to provide better care for Albertans. An overwhelming majority of respondents (88%) indicated that it is important for Alberta's continuing care providers to have their feedback considered by the provincial government regarding potential changes to the current regulatory framework. Eighty-five percent of respondents found it to be "very important" that a continuing care setting is licensed and 87% of respondents found it to be "very important" that infractions of standards are publicly reported.

Implementation needs

All stakeholders engaged were most interested in the implementation of the *Act* through its regulations, and the "on the ground" changes that will materialize for residents, clients, families, workers within the industry, and operators. There is a strong desire for the collaborative approach taken to date to continue along with streamlining and aligning licensing with accreditation; recognition of the immense HHR challenges across the system; commitment to deliver a flexible compliance environment; enforcement of minimum standards and reward for overachievement; and that accountability and reporting are regional and topic-specific (i.e., infractions and commendations). Awareness and communications will continue to play a significant role in the implementation of the *Act* and, as such, the sector is looking for: clear and realistic expectations, plain language messaging, communications tailored for each stakeholder group (i.e., public, residents, families, workers, operators, and positive messaging. ACCA can support implementation through continued representation of members, leading and collaborating with Alberta Health, and educating members on the ongoing development and implementation process as well as leading education and awareness among the public around the *Act*, its implications and continuing care in general.

INTRODUCTION

BACKGROUND

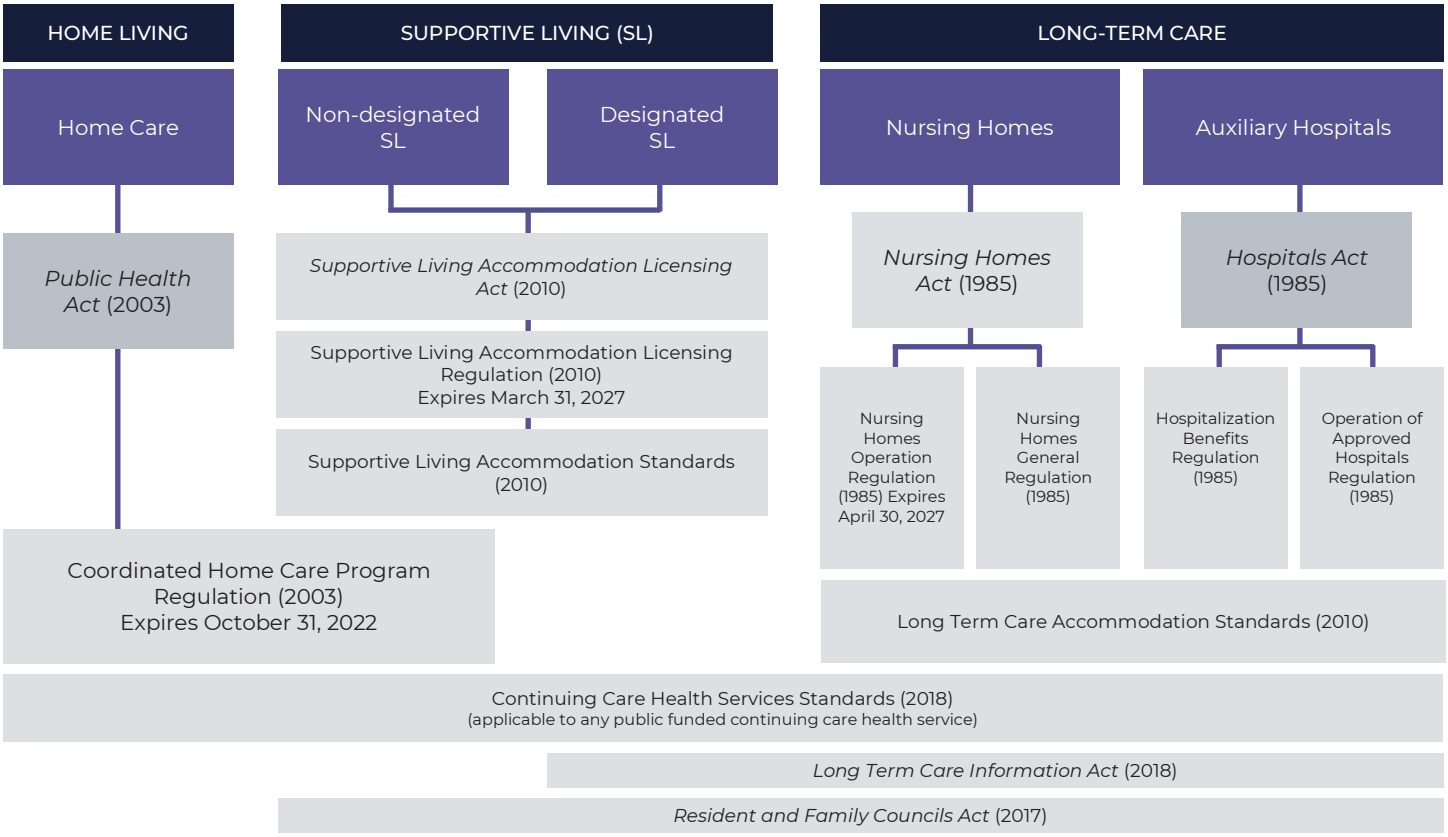
About the Alberta Continuing Care Association (ACCA)

The Alberta Continuing Care Association (ACCA) represents providers of continuing care services in Alberta. ACCA supports a diverse group of not-for-profit and private operators who represent the broad spectrum of the sector as well as providers of products and services that support the continuing care sector. Through member engagement, government relations and advocacy, ACCA strives to be the leading voice in continuing care in Alberta. Collectively ACCA's members provide care and services for over 13,000 long-term care (LTC) and designated supportive living (DSL) individuals and over 5.7 million hours of Home Care to Albertans.

About the *Continuing Care Act* (Bill 11)

Alberta's current continuing care system is guided and regulated by multiple pieces of legislation, some dating back to 1985. With six Acts, each with its set of regulations, and three sets of standards, the current continuing care legislative framework is seen to be complex, fragmented, and cumbersome particularly for operators providing multiple levels of care and services within the continuing care sector (Figure 1).

FIGURE 1. CURRENT CONTINUING CARE LEGISLATIVE FRAMEWORK



On March 28, 2022, the Government of Alberta introduced *Bill 11: Continuing Care Act* (the *Act)*. The *Act* will 'maintain what works well and apply it consistently across services and settings, while addressing gaps identified by stakeholders and highlighted during the COVID-19 pandemic.' Alberta Health has communicated that the intention of the new *Act* includes:

Alberta Health has communicated that the intention of the new *Act* includes:

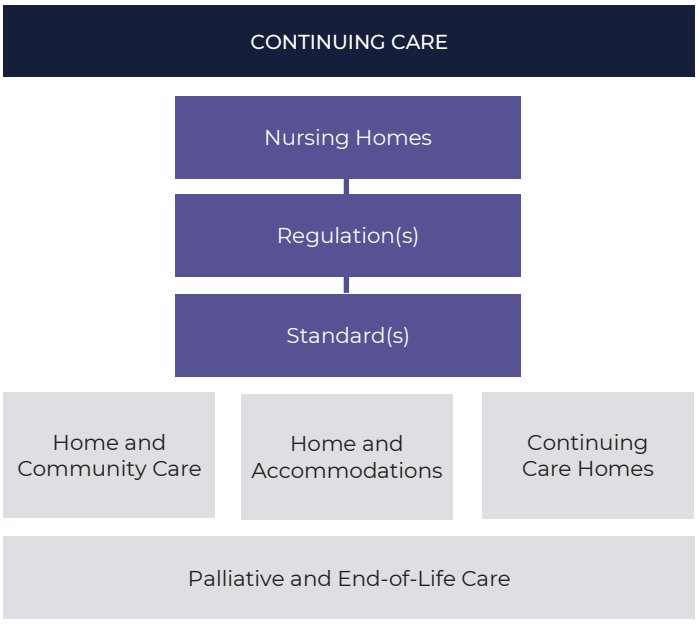
- Replacing multiple acts with one piece of streamlined legislation for continuing care (Figure 2).
- Improving transparency and accountability to Albertans regarding how the continuing care system is governed.
- Establishing a consistent approach and alignment of legislated requirements and services across the continuing care system for home and community care, supportive living accommodations, palliative and end-of-life
- care and long-term care and designated supportive living.
- Addressing gaps in current legislation to give Alberta Health greater authority to effectively monitor and enforce compliance to legislated requirements, including standards.
- Enabling a person-centred, flexible and innovative system of care.

At the time of writing this report, the full legislative framework is being developed, inclusive of regulations and standards which will provide additional context and specific details for operators. While the *Act* received Royal Assent on May 31, 2022, the regulations and standards pertaining to the *Act* have yet to be approved by Cabinet.

It is intended that implementation of the *Act* will commence in Spring 2023. At this time *the Act* will come into force and existing continuing care legislation will then be repealed.

This legislative framework is considered to be foundational by Alberta Health as the first step on the path to the broader system change that will transform the continuing care system. Other initiatives included within the Continuing Care System Transformation include examining workforce needs, expanding home and community care, increasing continuing care home capacity, and enhancing palliative and end-of-life care.

FIGURE 2. NEW CONTINUING CARE LEGISLATIVE FRAMEWORK



Purpose and Scope

The Government of Alberta did not adequately consult with ACCA prior to the introduction of the *Act*. ACCA initially responded with a letter from its Board in which ACCA's stance was that it agreed with the shift away from institutional care language and a progression towards a regulatory environment that prioritizes resident and client quality of life, but expressed concern for the over-regulation and administrative burden, and the need for the development of a collaborative framework that treats operators as partners in planning and decision-making and one that provides clear regulations and standards.

ACCA, supported by Alberta Health, undertook a comprehensive province-wide consultation to gather feedback to inform the development of new regulations. ACCA retained the Howegroup team in September 2022 to understand the impact on the sector and to inform the development of the regulations and standards. In consultation with ACCA and Alberta Health, Howegroup developed a comprehensive stakeholder engagement plan to assess the impact on long-term care, designated supportive living, home and community care, and palliative and end-of-life care operators.

APPROACH

Considerable time was spent developing a robust engagement approach that was feasible within the tight timelines of October to December 2022. Following a review of relevant documents (including existing and new legislation and ACCA communications), and in collaboration with ACCA and Alberta Health, the following approach was designed.

TABLE 1. ENGAGEMENT APPROACH

Engagement approach	Details and sample
Facilitated panel discussion at the ACCA Conference	• Target audience: ACCA Board and members, Alberta Health • Approximately 200 attendees
Board facilitated sessions and interviews	• Facilitated in-person session in Edmonton (n=5) • Facilitated in-person session for Board members in Vancouver (n=2) • Individual interview for Board members unable to attend facilitated sessions
Interviews (in-person and via Zoom)	• 31 operators representing long-term care, designated supportive living, home care, and palliative and end-of-life care; from urban, rural and remote locations throughout the province, with a mix of for-profit and not-for-profit models • 4 associations • 1 Alberta Health Services Zone
Resident Family Council sessions and interviews	• 9 sites were engaged with a total of 14 residents, 11 family members, and 13 staff

Engagement approach	Details and sample
Operator survey	• n=32 **Provider Type** • Private: 36% • Not-for-profit: 36% • Faith based, not-for-profit: 28% **Services Provided** • Facility-based care including designated supportive living and long-term care: 39% • Palliative and end-of-life care: 28% • Supportive living: 17% • Home and community care: 17% **Health zone** • North: 10% • Edmonton: 22% • Central: 22% • Calgary: 31% • South: 14%
Participation in Alliance meetings	• Bi-weekly meetings (n=5)
Participation in Alberta Health Continuing Care Regulations/Standards Working Group sessions	• Licensing and compliance monitoring • Ministerial regulations • Supportive living services • Staffing
Presentation at the AGM	• Presentation on preliminary findings at the November 17, 2022 AGM (n=40 attendees)
Regulation content review	• Participation in the confidential development of regulations via inclusion in small group invited by Alberta Health.
Real time collaborative information sharing	• Weekly briefing meetings (N=7) with Alberta Health to review engagement findings to inform regulations
Communication and promotion campaign to capture feedback from members of the public relating to the *Act*	• Development of ACCA's microsite (www.haveyoursayacca.ca) • 7,300+ link clicks from 432,600+ viewers reached via ACCA's Facebook and Instagram • News release distribution to media outlet throughout Alberta
Public survey	• n=1156 **Health Zone** • North: 14% • Edmonton: 25% • Central: 26% • Calgary: 16% • South: 13% • Don't know: 4%

Limitations

There were several limitations during the engagement process:

- The condensed timeframe, which may have impacted participation in the operator survey and interviews.
- Knowledge gaps within specific areas of the continuing care sector (home care in particular).
- Lack of awareness among residents, families
- and the public.
- Lack of union involvement in the engagement process, and a general lack of union interest in the impact of the *Act* overall.
- Limited health zone participation.

ABOUT THIS REPORT

What follows is the engagement methodology; findings including: overall areas of concern and opportunity, specific findings aligned with the sections of *the Act* (licensing, inspections, appeals, compliance and enforcement, resident and family councils), impact on HHR, support for culturally appropriate care, communication and public perception, implementation needs, and a summary of key observations and areas for consideration. Due to the collaborative nature of the engagement with Alberta Health, areas for consideration are presented in lieu of recommendations.

ENGAGEMENT FINDINGS

Findings are presented collectively from all participants groups. What follows are salient points regarding the following topics:

- Areas of concern
- Areas of opportunity
- Licensing*
- Inspections and audits*
- Appeals*
- Penalties and escalating enforcement
- Resident and family councils
- Health human resources (HHR)
- Culturally appropriate care
- Communication and public perception
- Implementation needs and roles

* The Board primarily informed these topics, and as such, findings are based on a more focused subset of the engagement participants.

Areas of greatest concern

Operators identified a number of concerns with the *Act*, most notably the absence of detail of the content of the regulations, leaving room for interpretation with implementation. Operators shared a very high level of concern over the introduction of financial penalties (detailed in the 'Penalties' section of this report) and negatively impacting the trust that exists between operators and Alberta Health / Alberta Health Services. Additionally, operators were concerned about the impact to resources (financial and human) of the regulations and stressed that funding must accompany any changes to the continuing care system.

Additional concerns shared by operators include:

- Auditors: lack of uniform training and lack of uniform application of regulations.
- Blurred lines: palliative and end-of-life care 'lumped in' with long-term care, an assumption that acute care workers are trained for long-term care, class 1 and 2 licencing creating unnecessary division within sector, home care 'lumped' in with facility-based care (or overlooked/ignored), regulating private-pay non-government funded sites may deter individuals from choosing this option. Please refer to Appendix A for an overview of the concerns that exist with hospice being included with long-term care.
- Burden: not aligning occupational health and safety regulations with new continuing care regulations creating confusion and bureaucracy, additional staffing requirements, additional 'paperwork', not enough time to implement the changes, restriction may stifle innovation.
- Conflict of interest: Alberta Health Services creates many of the labour challenges faced by operators.
- Safety: over-emphasizing safety at the expense of resident quality of life.

> **"It feels very punitive. I have concerns about how we will be impacted regarding situations that are beyond our control. It feels very heavy handed and it standards to cause a rift between government and providers. Why would government want to create a contentious relationship? We are held to a standard that the government operators aren't."**
>
> - HOME CARE OPERATOR

"The challenge is the potential loss of trust when it comes to the government and the operators. Things are written with good intentions, but the interpretation is where the trouble occurs."

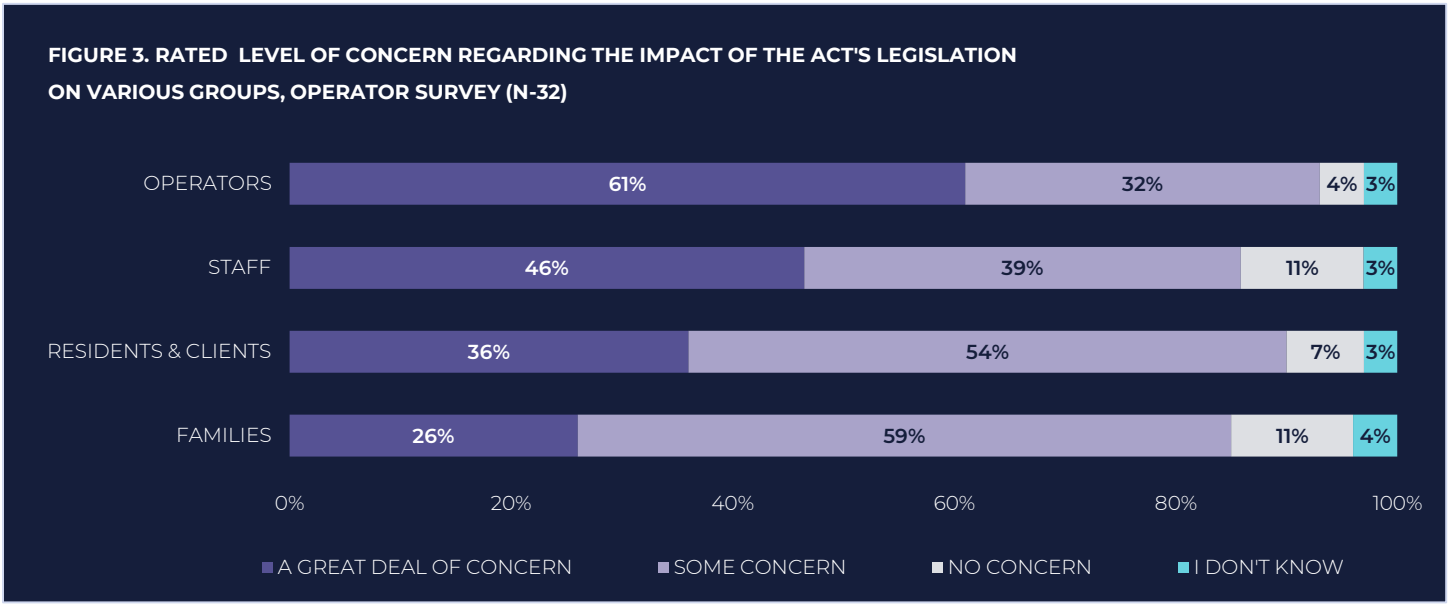
- LONG TERM CARE OPERATOR

"With a patient-centred funding model, it is not timely enough to provide good care. We can't foot the bill and wait to be paid back for enhanced services. Our experience to date has been horrific."

- DSL OPERATOR

Operators believe the greatest impact will be to operators, followed by staff, residents and clients and families (Figure 3).

FIGURE 3. RATED LEVEL OF CONCERN REGARDING THE IMPACT OF THE ACT'S LEGISLATION ON VARIOUS GROUPS, OPERATOR SURVEY (N-32)



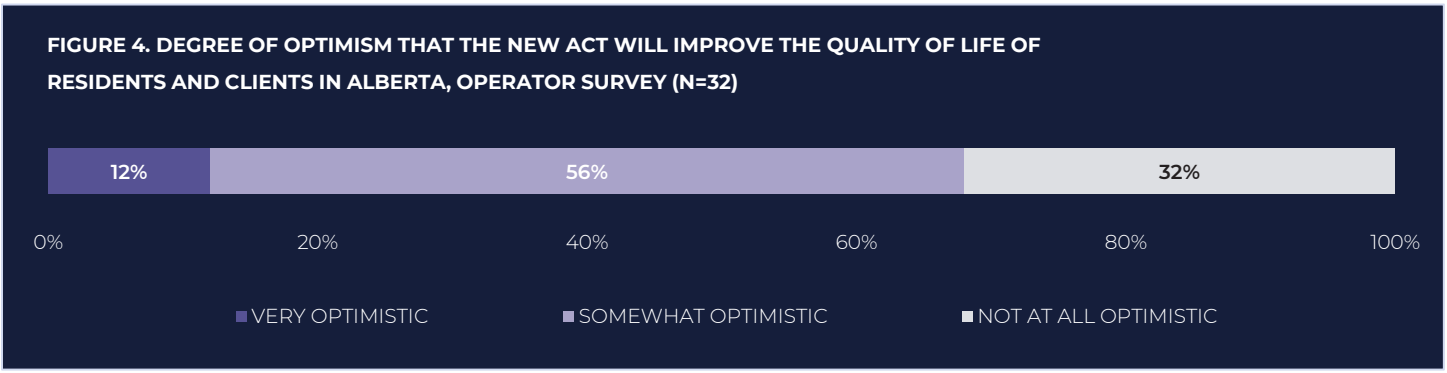
"We need to make sure we're creating a sustainable system. It feels like we rushed this. We have vague legislation that is relying on specific regulations to be interpreted and this may be happening under different governments (and therefore different political ideology) that may impact providers differently. 'Taking profit out of care translates into an access issue."

- HOME CARE OPERATOR

AREAS OF OPPORTUNITY

The engagement uncovered areas of opportunity for operators, workers, residents and families, and the continuing care system. Operators, in particular, were very optimistic (12%) or somewhat optimistic (56%) that the *Act* will improve the quality of life of residents and clients in Alberta (Figure 4).

FIGURE 4. DEGREE OF OPTIMISM THAT THE NEW ACT WILL IMPROVE THE QUALITY OF LIFE OF RESIDENTS AND CLIENTS IN ALBERTA, OPERATOR SURVEY (N=32)



Areas of opportunity - for operators

Interviewees saw the greatest opportunity with the *Act* in building efficiencies through aligning regulations and streamlining audits, reducing duplication and in some instances 'triplication' (i.e., Labour, Jobs, Economy and Occupational Health and Safety). Streamlining has the potential to improve communications with residents, clients, and families and provide one go-to source for the public. Interviewees felt operators, in general, may be held to a higher standard of care and home care may become more prevalent within the supportive living environment. There is optimism among some operators that the interaction with Alberta Health and Alberta Health Services could shift toward greater collaboration such as with operators and the Ministry of Housing and Community.

> **"As operators, we respond to too many of the same inquiries, same information is repeated over and over again and this is unaccounted for, unfunded management hours."**
>
> - DSL OPERATOR

> **"For operators with numerous services ranging from retirement living to long-term care we won't be subject to four Acts and four sets of rules. It modernizes the system."**
>
> - HOME CARE OPERATOR

Areas of opportunity - for workers

Interviewees saw opportunity within the new *Act* to recognize workers in a positive uplifting way that acknowledges their contribution to the care of Albertans. Additionally, opportunity exists to provide workers increased career opportunities to 'ladder up' and practice to their full potential. Workers may also feel safer knowing standards are higher, and changes in regulation give workers one regulatory 'house'.

Areas of opportunity - for residents and clients

Interviewees identified the following opportunities for residents and clients within the *Act*:

- Streamlined legislation mitigates risk of miscommunication and makes system more understandable, as well as easier to navigate.
- Residents' and clients' outcomes are met as they arise.
- Potential for individuals to remain at home longer while receiving high quality care, supports aging in place.
- Health dollars to follow the resident.

> **"People know there are lots of differences within the continuum, and if we are committed to aging in place, very least should be able to create standard benefits, and ways of moving through the system. Allow people to have services around them and coming to them, rather than people having to move to fit the service."**
>
> - ASSOCIATION

> **"There will be one standard that workers have to obtain, and they can more easily move across the system."**
>
> - HOME CARE OPERATOR

Areas of opportunity - for the system

Interviewees saw the potential for the *Act* to transform the system, with room for demonstration and innovation if the regulations are not too restrictive. Streamlining may lead to simpler information and easier access to continuing care for all. Interviewees also saw opportunity for better case managers and improved navigational tools for residents and families.

> **"We are watching to see if the regulations help people remain in the community if that is their choice. There has to be easy access to all services – reducing costs, improving access, and increasing knowledge of what services exist – and this needs to be ongoing. It all relates to quality of life and bringing services to the person or family."**
>
> - ASSOCIATION

> **"I believe the new *Continuing Care Act* is founded on principles that could be transformative but I hope it doesn't get lost in the regulations. There is a potential win-win for Alberta seniors."**
>
> - LONG-TERM CARE OPERATOR

> **"All the work around the transformation is an opportunity to look differently at our clients to ensure the system is working and client outcomes are met. The intent is a 'win' going forward – how it lands it yet to be seen."**
>
> - INDEPENDENT LIVING OPERATOR

> **"If we get this right there is an opportunity to introduce innovation into care delivery (i.e. flexibility in providing services and sharing learnings with other operators)."**
>
> - LONG-TERM CARE OPERATOR

> **"The government can and should provide a vision of hope and goodness that occurs within the sector."**
>
> - DSL OPERATOR

LICENSING

As part of the *Act*, Alberta Health will be establishing an updated licensing regime which will, for the first time, apply to all continuing care operators. Once the new system is fully operational, each site will be required to obtain and renew their operator license. The *Act* states that a license may be issued for up to four years and is subject to a renewal application process. Operators that do not meet minimum requirements, as set out by Alberta Health, will have their licenses revoked.

Requiring non-government private-pay operators in licensing regime

There was concern that requiring non-government, private-pay independent and supportive living sites to obtain a license and fall under the jurisdiction of the *Act* was considered a significant 'overreach.' As many of these operators don't normally fall under a 'care model', the new licensing regime could potentially impact the delivery of existing services.

For example, some sites may choose to stop providing a group of services so as to not be captured by the new regulations – notwithstanding the fact their residents have really appreciated and valued these service offerings over the years.

> **"My concern with licensing is that it depends entirely on the inspector at one moment in time. Our independent living may look different at different points in time depending on what clients need. We have seen this in the past."**
>
> - INDEPENDENT LIVING OPERATOR

> **"The licensing of long-term care is not really much of an issue for me. If you can show your financiers you have a contract for 25 years then there is no problem."**
>
> - LONG-TERM CARE OPERATOR

Term and scope of licenses

The majority of long-term care operators expressed serious concerns about being incorporated into a reformed licensing application and renewal regime. Some stated it will require them to shift significant resources away from the bedside in order to deal with an unnecessary 'bureaucratic burden'.

The requirement for long-term care home operators to obtain and renew a license every four years was deemed highly problematic. They indicated this would have serious negative impacts regarding their ability to secure financing for new developments and as well as obtain and/or renew insurance in an already challenging market.

A much smaller group of operators did indicate they were not concerned about the impact of the licensing reform as their lenders were more focused on whether they had a secure long-term contract with Alberta Health Services – not whether they had to renew a license over a set period of four years.

Initial license application process and requirements

There was significant agreement that every effort should be made to keep the process of the initial and renewal license application as simple as possible. Many operators expressed an interest in not changing the current process and requirements - as it generally has worked well in the past and operators are familiar with it.

There was a great deal of interest in having Alberta Health quantify and report out how the future state will be 'streamlined' and will 'reduce red tape' for not only the regulator, but also for operators, residents and their families.

A number of operators felt it was best to focus the license application and renewal process in three key areas that would benefit government, the operators and the seniors they serve. These included a high-level of standards for the delivery of care, financial accounting and accommodation.

Non-renewal of a license

The non-renewal of a license is considered one of the most serious acts that can be imposed on continuing care operators. As such, there was much discussion and feedback regarding how to best manage this process and what criteria should be established through the new regulations to trigger a non-renewal.

Several broad themes emerged:

- Most operators considered the renewal of licence process to be unnecessary as there are regular care audits performed by the health authority.
- Revocation or non-renewal of a license should be considered by government as an 'action of last resort.'

LICENCE RENEWAL KEY THEMES

- Action of last resort
- Opportunity to remediate
- Cost and clarity
- Impacts to residents, family members
- Impacts on health and continuing care system

- Operators should have the opportunity and time required to remediate any (non-emergency) issues of concern that may materially affect the status of their license.
- Impacts to the physical and mental wellbeing of residents and their families should be major factors considered prior to any final decision made regarding the removal of an operator license.
- A clear set of criteria should be established and properly communicated to operators outlining what it would take for them to lose their license or not have it renewed.
- Negative impacts to the overall health care system should be anticipated.
- Cost to both the operator and government will be significant.
- Non-renewals and closures will create mistrust and a reduction of faith in the health and continuing care system overall.

In addition, there were specific concerns expressed by a number of long-term care operators regarding what may happen when a license is not renewed:

- Significant stress, unemployment, job insecurity, financial insecurity, loss of pension/benefits/seniority, need for staff relocation to new work sites.

- Lack of bed capacity within a particular region – most notably in rural Alberta.
- Impact to health (physical and mental) of residents forced to decant.
- Additional disruption to an 'already chaotic and stressed workforce.'
- Outstanding on-site support service provider contracts in jeopardy.
- Increased litigation.

Lastly, operators would like to see a fair and equitable regulatory environment which speaks to the government takeover of a site. It was recommended that regulations dictate facilities taken over by government are done so using fair market value as determined by an independent body agreed upon by operators and government.

Impact on health human resources

In reference to the 'health human resources ecosystem,' it was stated the non-renewal of licenses would serve to further exacerbate the current hiring crisis. Operators believe the sector is already facing significant difficulties in hiring staff due to 'job insecurity' and this will only be amplified if staff are under the impression they are working in a sector where job losses are likely to occur every four years.

> **"A four-year limit on licenses and having to reapply and reinspect? This is a very big concern. What happens if the Minister simply decides they do not want to renew our license?"**
>
> - LONG-TERM CARE OPERATOR

Renewing a license – process and procedures

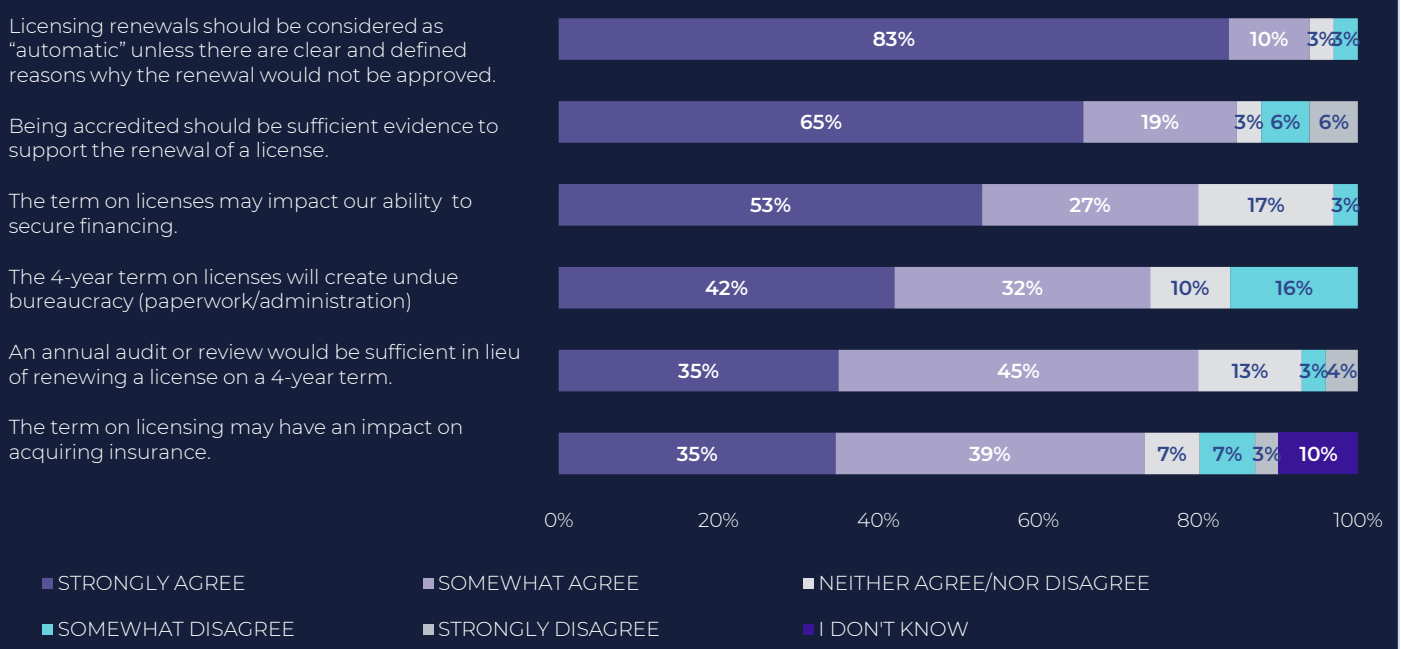
Operators are looking for consistent and predictable language and processes to build trust in the system (Figure 5). They provided a number of recommendations regarding how the license renewal system should be managed in future state:

- Similar to the process in several other provinces, consider having an evergreen licence with the ability of the health authority to place conditions on the licence where there are serious concerns.
- Provide automatic renewals - unless the operator has a track record of serious breaches related to the delivery of care services, financial improprieties, or sub-standard living accommodations.
- Factor into the license renewal process whether the accreditation of an operator remains valid.
- Consider providing automatic license renewal for operators who have been fully accredited.
- Place a greater focus on education for site leadership for the purpose of reviewing the interpretation of regulations.
- Provide six-month advance notice for renewals, with an additional three-month reminder, and a final renewal notification reminder at 30 days.
- Furthermore, an operator could have conditions placed on their license if they fail to maintain their accreditation (Alberta Health Services should consider providing direct funding to cover the ongoing cost of accreditation similar to the Quality Attainment Premium provided by the Ontario Ministry of Long-Term Care).
- Ensure that the 'offer to remediate' is always on the table to operators prior to a license being revoked or not renewed. This would include providing sufficient notice if a license is not being renewed.
- In reference to the requirement for a licensee to wait 24 months before re-applying for a license that has been revoked, some operators indicated this was overly punitive and heavy-handed. It was put forward that once a licensee demonstrates they have addressed all the conditions which led to the removal of their license, they should be able to re-apply.

It was noted that 'restarting operations' after a loss of license, would place onerous burdens on staff and administration, as well as ensuing system inefficiencies.

> **"Having standards is important however that being said, licenses are a system assurance to the public that operators are meeting requirements. Continuing care licensing is a relatively young intervention. It would be interesting to know if the desired impact of their implementation actually was realized. Having continuity and audits in place should be sufficient to determine licensure compliance without having to renew on a cycle."**
>
> - OPERATOR SURVEY

FIGURE 5. LICENSING AND LICENSE RENEWALS, OPERATOR SURVEY (N=32)



> **"Given the high bar of accreditation, what else could be required to secure a licence?"**
>
> - LONG-TERM CARE OPERATOR

> **"There is no additional capacity in the system therefore cancelling a license would likely lead to Alberta Health Services assuming operation of the site."**
>
> - OPERATOR SURVEY

INSPECTIONS & AUDITS

The *Act* sets out to update and expand the inspection system in Alberta. In the future state the *Act* will facilitate inspectors to oversee the Activities of operators across the continuum.

Training and qualifications for inspectors

There was a great interest in how Alberta Health and Alberta Health Services will approach the issue of training inspectors. A number of operators expressed interest in making sure that all current and future inspectors be provided with consistent training across the province. It was felt that without consistent training, there is a greater risk that operators may be treated differently based on the level of training of each inspector received. Operators felt that a regimented, robust and thorough training program should be developed and that all inspectors should be made to undergo this training before they are placed (or remain) on the frontline.

Operators felt it was critical to ensure the curriculum used to train inspectors included the subject areas of emotional intelligence as well as administrative fairness. In addition, it was recommended that any new regulations developed should try to avoid subjectivity where possible and keep things very clear for inspectors.

In terms of qualifications for the hiring of new inspectors, operators were in general agreement that it was critical not to 'over qualify' the position. One operator cited a recent example whereby it was a requirement in a job posting that candidates be trained as engineers. It was felt this was too high a bar to set for qualifications and would not result in the right type of people getting hired. From the operator survey, 66% of respondents identified that five or more years of sector experience should be required for inspectors whereas 34% of respondents felt three years of sector experience would be sufficient.

> **"The intersection will be with between inspections done under occupational health and safety and those through the legislative framework. Will there be confusion with operators on which to comply with?"**
>
> - ASSOCIATION

> **"It would be helpful to learn on an aggregate basis about the types of infractions. We would need a trending analysis and outcomes from that. What is trending in terms of results and consequence? That would help to alleviate the risk of overreach and provide oversight."**
>
> - LONG-TERM CARE OPERATOR

Operators felt it should be made clear what the approved qualifications are to become an inspector. Preferably it is someone who has a good understanding of the sector including 'real world' issues that take place on the front-line. There is also a strong desire for consistency and objectivity between inspectors.

> **"Inspectors need to understand operations and have had experience managing an operation. In too many situations this is not the case and they focus on non-material issues."**
>
> - OPERATOR SURVEY

There was great deal of interest in having the accreditation surveyor model emulated. Oversight bodies such as Accreditation Canada and CARF send the appropriate people to conduct visits (i.e., qualification and experience). Operators also expressed an interest in ensuring inspectors, where practicable, have experience and understanding of both clinical and building envelope issues.

> **"Many inspectors who carry out audits are not nurses. Audits must be carried out in a clinically competent manner by experienced nurses with relevant training. Operators are tired of having to "educate" investigators carrying out audits."**
>
> - OPERATOR SURVEY

Applying the law equally and equitably

In addition to a more robust and consistent training regime, operators felt it was important approved policies, rules and regulations be applied equally and equitably across the sector. There was interest in gathering and publicly publishing anonymized data regarding the types of fines, penalties and enforcement measures imposed by individual inspectors across the province. A majority of operator survey respondents (96%) identified a need for tracking and reporting infractions by each inspector to ensure consistency.

97%

OF OPERATOR SURVEY RESPONDENTS STRONGLY AGREED THAT THERE NEEDS TO BE CONSISTENCY IN THE WAY INSPECTIONS ARE PERFORMED ACROSS SECTOR WITHIN THE PROVINCE, REGARDLESS OF OWNERSHIP AND OPERATOR

It was felt that providing more data regarding the type of activities undertaken by inspectors each year would help to dispel myths regarding what enforcement measures are actually being applied. Furthermore, it would help to potentially identify any anomalies or trends as they pertain to individual inspectors or regions of the province. There was a fairly even split of operators who would like to see trends on inspectors to be reported either quarterly or annually. As well, operators expressed a reasonable time to prepare for an audit was four weeks (33%), or six weeks (30%) (Operator survey).

Reducing red tape and streamlining the system

A number of operators believe the *Act* can also provide an excellent opportunity, if properly managed, to reduce red tape, duplication and help to streamline the system. This was referenced on several occasions when it came to the processes related to inspections and audits. There was a general belief the *Act* could lead to fewer unnecessary audits and facilitate better alignment between the various individuals working with the future state regulatory environment. Some operators stated they believe the newly designed system could reduce what they refer to as the 'duplication and triplication' of inspection and audit activities.

> **"For operators with numerous services ranging from retirement living to long-term care we won't be subject to four Acts and four sets of rules. It modernizes the system."**
>
> - HOME CARE OPERATOR

> **"As operators, we respond to too many of the same inquiries, same information is repeated over and over again and this is unaccounted for, unfunded management hours."**
>
> - DSL OPERATOR

While the *Act* does offer the opportunity to significantly streamline the audit and inspection system, it is critical the benefits of this activity are also felt directly by operators, residents and families – and not simply the regulators themselves. It should be noted that not all operators were convinced the *Act* would result in a more streamlined system. They expressed deep reservations it may prove more cumbersome and costly to manage for both government and operators. Operators believe it will take a significant amount of vigilance on the part of government to ensure that there are downstream benefits that will flow out of the full implementation of the *Act*. Operators are concerned that too many audits are already occurring and that this approach is not contributing to a collaborative environment. As well, operators are concerned that the focus of audits is often on what operators are doing wrong and what's missing as opposed to acknowledging what is in place and working well.

> **"Again, in the spirit of quality improvement, visit can occur at any time and an operator should be ready. The amount of documentation is outstanding and the length of time to prepare is large in addition to taking leadership away from the day to day during the visits."**
>
> - OPERATOR SURVEY

APPEALS

Continuing care operators are afforded in the *Act* the ability to appeal a range of decisions made by Alberta Health or Alberta Health Services staff. They include items such as the non-renewal of a license or an administrative penalty. While the *Act* spells out the ability for an operator to appeal, it is the newly developed regulations that will provide further detail as to how and when this can take place.

Operators felt the time frame for an appeal should correlate with the level of seriousness of the issue being appealed (100% of Operator survey respondents strongly agreed or agreed), and clarification is needed on what happens to residents and staff during the appeals process (97% of Operator survey respondent strongly agreed or agreed).

100%

OF OPERATOR SURVEY RESPONDENT STRONGLY AGREED OR AGREED THAT THE TIME FRAME FOR AN APPEAL SHOULD CORRELATE WITH THE LEVEL OF SERIOUSNESS OF THE ISSUE BEING APPEALED.

Natural justice

Operators provided significant feedback regarding the appeal process and the need for it to be fair, fast, and free of any bias. In that regard, there was a great deal of interest in the idea of creating a unique appeal process that met the needs of both operators and government. There were a number of suggestions put forward including the creation of a three-person panel that would include a government-approved representative, a sector-approved representative, and an independent chair. This model is successfully utilized in several other similar provincial and federal appeal panels whereby subject-matter experts are required as part of this quasi-judicial process.

When it comes to processing times for appeals, it was suggested operators be provided with 15 business days to file an appeal. There is also a general expectation the amount of paperwork required will be kept to a minimum. The majority of Operator survey respondents identified that 30 days (47%) or 60 days (27%) would be a reasonable time period for an appeals panel to provide a decision, following the filing of an appeal.

Scope of appeals

In terms of the scope of what should be eligible for appeal, operators requested it should include anything that may result in a significant financial impact. They felt this would allow for a wider breadth of items to be included than simply a fine or penalty imposed. In addition to items that will have significant financial implications, some operators wanted the right to appeal items related to why they don't meet certain criteria as set out by regulation. Lastly, operators believe they should be able to file and successfully win an appeal if it can be determined the original ruling against them was related to something 'completely outside the control and influence' of the operator.

Impacts of an appeal on imposed fines and penalties

As it pertains to the issuance of fines and penalties, operators spoke passionately about the need to ensure once an appeal is filed – any fine or penalty issued related to said appeal shall be set aside until such time as the appeal has been heard and a final decision rendered.

Given the size and scope of potential new administrative penalties, it was stated that unless the fines are set aside during an appeal process, they may have the unintended consequence of unnecessarily putting an operator into serious financial jeopardy. This is particularly true if the appeal process is delayed or if takes a longer time to be heard.

Cost Recovery for Appeals

An appeal, regardless of the nature, results in unexpected administrative and legal costs for the operator. It was noted these costs can be significant in size and are considered as non-recoverable in terms of funding provided by Alberta Health Services.

There may be situations whereby operators are issued a fine, but it is eventually overturned by the appeal panel. In cases such as these, there are currently no opportunities for the operator to recover costs which can often be very significant if they require the assistance of legal counsel. Once the *Act* is enforced, operators have requested the ability to recover identified costs for all successful appeals. These would include both legal and administrative costs that can be quantified by the operator.

PENALTIES AND ESCALATING ENFORCEMENTS

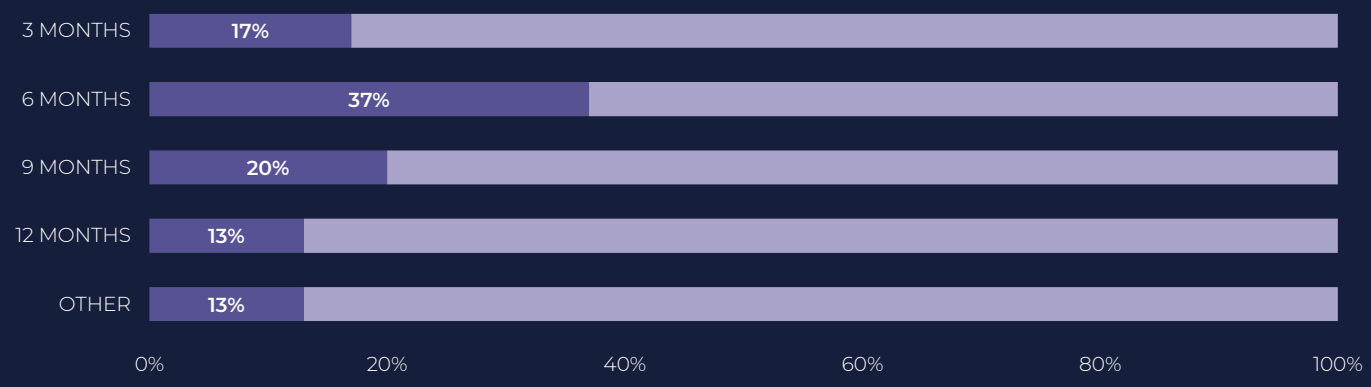
As drafted, the *Act* would facilitate a dramatic increase in the scope and scale of penalties for operators who are in contravention of the law. In terms of this consultation, this topic generated the most significant amount of feedback and concern from a broad spectrum of operators.

Penalty structure

An overwhelming majority of operators surveyed and who participated in our workshop expressed that the proposed $100,000 per day penalties was simply unacceptable. It was reported that even the issuance of a single fine to an operator would be enough to put some for-profit and non-profit operators out of business. In terms of non-profits, there was a particular concern over the impact this may have in attracting and retaining a qualified volunteer board of directors from within the community.

Operators stated the best approach for Alberta Health to take is to refrain from moving forward with this new increased penalty regime - until such time as there can be more meaningful consultation with the sector. Furthermore, the lack of clarity as to whether 'an individual' could be held accountable and fined for either their own actions, or that of their employees, was another reason cited for the government to reconsider or post-pone indefinitely this new fine structure. Should Alberta Health move forward with the current plan for a new penalty framework, operators were concerned that enough advance notice be provided prior to it coming into effect (Figure 6).

FIGURE 6. PREFERRED TIMEFRAME FOR ADVANCE NOTICE THAT A NEW PENALTY REGIME WILL BE FULLY IMPLEMENTED



"Penalties will change the culture of long-term care in Alberta. When Justice Eileen Gillese was investigating the Wettlaufer cases, she chose not to assign any blame as the LTC system had so many systemic vulnerabilities. Justice Gillese instead asked that we implement an ethos of a "just culture" in LTC. With so many systemic vulnerabilities (shortage of staff, underfunding of LTC, limited training, limited support from health authorities), it is grotesquely unfair to impose penalties on one single player."

- OPERATOR SURVEY

Education as a tool for changing behaviour and operating procedures

The continuing care sector has a long track-record of utilizing education as a tool which can help change behaviour and deal with implementing positive changes into the operations of each site. There was significant feedback that the *Act* and subsequent regulations will 'tip the scales' and shift the focus away from the current education model to more of an enforcement model.

A shift to an enforcement model would fundamentally change the relationship between operators, Alberta Health and Alberta Health Services. The issuance of $100K per day fines, increased enforcement and a system no longer built on trust, runs the risk of further eroding the relationship between government and the continuing care sector.

"A clear understanding of the roles and responsibilities of the director and the role of the individuals at the site level. On one hand the system has put just culture initiatives in place such as the HQCA Just Culture work and Accreditation Canada standards for just culture and then on the other hand the system speaks to severe penalties and non-compliance. Enforcement strategies and penalties would be considered contrary to a just culture unless the circumstances around the penalties were well defined and just. It would appear to be contrary in subject matter especially if the circumstances were beyond the operator's control."

- OPERATOR SURVEY

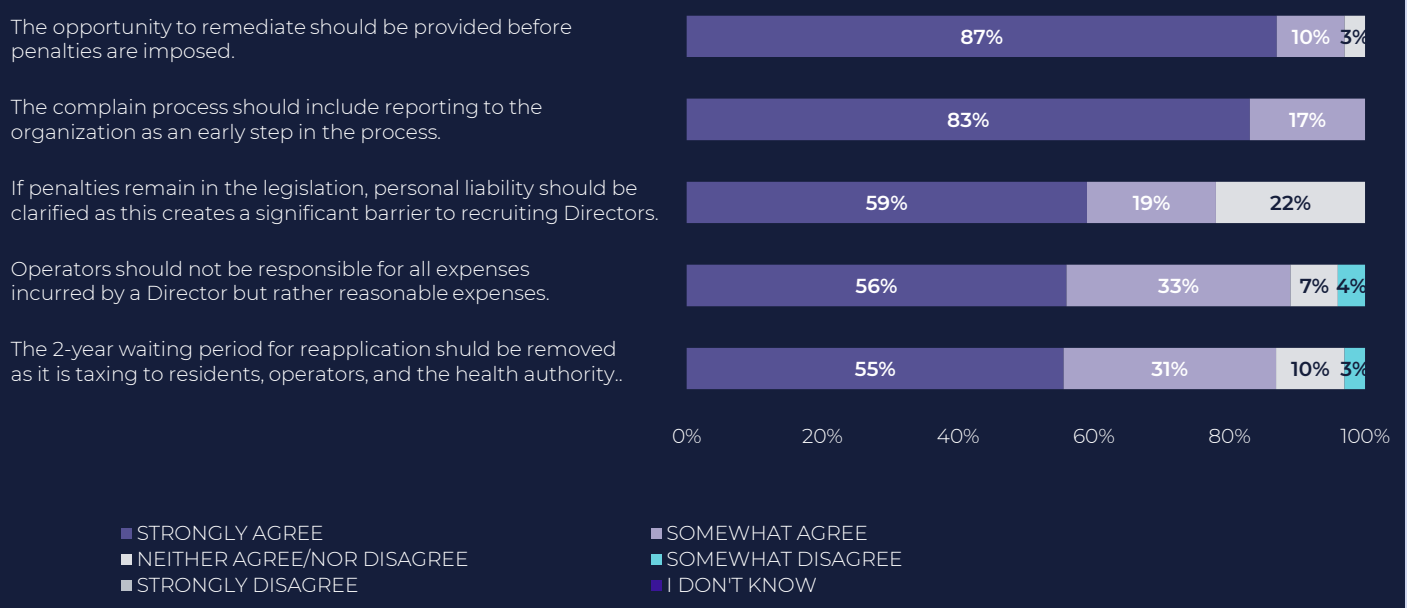
Escalating enforcement

Operators are supportive of Alberta Health implementing enforcement measures on operators who cannot adhere or meet reasonable standards and regulatory requirements that are within their control. However, there was overwhelming feedback that the enforcement system must have some flexibility and allow for the operator to remediate any identified problems.

There was widespread concern if operators were unable to meet certain standards, a model of 'progressive discipline' would not be applied equitably across the sector. It was hoped that a new regulatory environment would clearly spell out the critical need for escalated enforcement – including an opportunity to remediate.

Operators preferred a regulatory model that considers a number of factors prior to the implementation of enforcement measures. These could include the longevity of the business, track record of remediation and a genuine interest in wanting to fix the problem (Figure 7).

FIGURE 7. PENALTIES AND OTHER ENFORCEMENT MECHANISMS: RATED AGREEMENT WITH CHANGES REQUIRED TO THE ACT, OPERATOR SURVEY (N=32)



RESIDENT AND FAMILY COUNCILS

Resident and family councils offer site-specific communication conduits between Continuing Care operators and those they serve. Our engagement with residents, family members, and staff explored what currently works well and areas for improvement with existing councils, possible alternative mechanisms where councils do not exist, their knowledge and awareness of the *Act* and subsequent regulations, licensing, and reporting of infractions.

"State of the Councils"

In general, those interviewed acknowledged that their respective councils are functioning well, where administrations provide the clerical support, are generally responsive to items raised by councils, and some offer the flexibility of online meetings to include remote attendees. There was consensus that the councils serve as forums of information sharing, allows for "on the ground" focus on residents' concerns such as meals and recreation, opportunities for educational/informative speakers, as well as reliable occasions when follow-ups are provided. All interviewees acknowledged that valuable connections and relationships are built through these regular gatherings. The toolkit offered through the Alberta Resident and *Family Councils Act* (2018) was often cited as helpful to council members and administrators.

> **"The Toolkit is very helpful. It is something we are able to do because of the (previous) legislation and it is great. I thought it was just me against the world, but there are things we can do."**
>
> - FAMILY MEMBER

> **"I put more faith in reading the council meeting minutes as a barometer of how the facility performs than on Yelp reviews."**
>
> - FAMILY MEMBER

Participation in resident and family councils continues to pose a primary challenge. The median length of stay for residents of care homes continues to shrink which limits the engagement of residents and their family members in their participation in councils. The COVID-19 pandemic and its associated safety mandates also presented an additional barrier of participation for some family members. In addition, the perception of resident and family councils being formal structures and associated roles and responsibilities creates unintentional barriers for residents and family participation. Those councils who had embraced technology for remote attendance were able to mitigate some of the negative effects on attendance – the addition of online feedback mechanisms may also offer family members another avenue of anonymous engagement.

While some interviewees were concerned that a low participation rate by residents and their family members could potentially lead to councils being dominated by the concerns of a few, many also acknowledged that anyone with concerns are always welcomed to attend while broader distribution of minutes and information through multi-channels (notice boards, email, hard copy delivery & etc.) would ensure any resident's concern can be addressed. Some participants noted that councils could be a forum to contribute to site-specific quality improvements (within contract perimeters), and potential inclusion of third-party subject matter experts could add value and strengthen accountability. It was also noted that many residents with cognitive or memory challenges rely on family members and peers to speak for them, and the various barriers of participation pose an outsized impact for those who may not be able to advocate for themselves.

> **"Many of our residents have memory challenges and asking them to give their opinions is pushing it."**
>
> - RESIDENT

> **"There is huge room for improvement with resident and family councils, but it has to be reinvented. It can't have the same parameters. They need a shared purpose, some independent members such as community members."**
>
> - FAMILY MEMBER

Potential alternative mechanisms to Councils

For those interviewed, the absence of resident and family councils was difficult to imagine and therefore few ideas for an alternative/replacement of resident and family councils were explored. Participants valued the councils as the reliable channels of communication for site-specific concerns. Various centralized concepts and changes in process were suggested as possible alternatives to resident and family councils, these include:

- Formalizing feedback and escalation systems with regulations.
- Having Alberta Health Services case managers acting as conduits.
- Codifying a resident/family feedback mechanism within the accreditation and audit processes.

> **"As part of the audit I am able to send in some personal things that I don't want the group to know. I can send it via email attachment."**
>
> - FAMILY MEMBER

> **"If I have significant concerns, I put it in writing for the management."**
>
> - FAMILY MEMBER

Knowledge of the *Act*

Overall, we found a lack of knowledge regarding the *Act*, the process undertaken by Alberta Health, and the potential implications for residents and families. None of the residents or families were aware of the new legislation. Several indicated they only researched about it after receiving the notice of our engagement and we heard comments that it 'looks like it's all done'. None of the residents or families understood how the legislation may affect residents and families. Residents and family members are mostly anxious to find out the "on the ground" changes that may come from the *Act*. Some are concerned that not enough consultation was done before the *Act* was passed. Without more specific information on the impact, participants exhibited some skepticism about the intents of the new legislation.

Communicating changes to the Resident and Family Council regulations

There was consensus that better communications about regulatory changes related to the *Act* would be needed to inform residents and their families. Several ideas were offered by interviewees:

- Every resident should receive communications in hard copy..
- Concise communications.
- Must consider diversity of residents and language barriers.
- Specifics of "how" the changes will impact the "what" would be impacted – person-centred definition.
- Multi-channel availability including:
  - Mail paper packages to Council president (or representative).
  - Digital – email/website/social media.
  - Direct engagement, i.e., presenting at council meetings.
  - Include printed communications within regular mailings i.e., monthly financial statements from sites.

Defined roles within the council (formality)

There were mixed responses with respect to creating defined roles and responsibilities for councils. Some felt the formality provided accountability and supported councils, while most others indicated the formality would create additional barriers to participation. Sixty-four percent (64%) of respondents agreed that the regulations should define roles, relationships and responsibilities of a resident and family council.

Concerns around formalizing roles and relationships within the *Act* included misalignment of resident and family expectations with systemic capacity, limited volunteer capacity within smaller organizations, and the ability to recruit and fill roles may be daunting or overwhelming for residents and family members. It is possible that resident and family councils may be best left out of the regulations, to allow flexibility for each continuing care home to determine its unique needs (i.e. whether councils are jointly family and resident or separate).

"Operators should do everything they can to support and encourage councils but if there is no interest that is not on the operator if they have made the effort."

- OPERATOR SURVEY

"Many residents and families are uncomfortable taking the lead/responsibility for organizing and chairing the councils and request operator support in this regard. It puts the operator at a disadvantage if residents and families do not want to assume these formal roles and/or full conduct the stated responsibilities associated with the same. Let's focus on what is important - there is offer of a regular forum to all those who are interested to receive updates, provide input and the operators demonstrates follow-up on concerns expressed in a timely manner."

- OPERATOR SURVEY

The existing toolkit was cited as a great resource and the expansion of the toolkit may offer an additional level of support for resident and family councils. Members of councils are generally overtasked with their individual daily demands – many of them were candid to express that they would not attend or participate if there were any requirements to structure councils with formally defined executive roles. However, they acknowledged that an expanded toolkit with suggestions of executive roles and terms of references may help forming of councils where there is currently none. A guideline or framework of roles and responsibilities is welcomed but should not be limiting by being prescriptive.

Residents and family members were also appreciative and grateful for site management's ongoing support in taking on the administrative burden of councils relating to distributing agendas, and the recording/distribution of minutes.

"A structured guide would be an effective alternative to help small, young councils grow in strength and numbers."

- STAFF MEMBER

"If you tell me you are looking for 'officers' to be executives on the council, I would not make eye contact. I just want to stay in my own lane. I am here for my mom."

- FAMILY MEMBER

Resident and Family thoughts around licensing

When asked about licensed facilities there was clear consensus that standards of care should be achieved, but there were mixed feelings regarding licensing of sites. Some felt they should be licenced, some felt licensing was not very important considering sites must meet accreditation standards (standards were seen as more important), and a few indicated that if sites are accredited, a license should just follow.

Residents and families were also interested to know how the licensing will be defined and how it will bring real improved care or additional funding for care. There may be opportunities for additional council participation such as preparing for accreditation, designing programs, selection of some staff roles – which contributes to the determination of standards and licensing. Participants also raised the question about 'consequence' – how it could be a mechanism for accountability.

"If a facility is accredited, just rubber stamp them for a licence, don't add more paperwork."

- FAMILY MEMBER

"In order to get a licence, you should have to meet those (accreditation) standards."

- FAMILY MEMBER

"Other than bureaucracy, what does a licence do? Let's not just add another layer and that cost (of licensing) will just be handed down to families. This won't give me any more protection, but it costs more. If you get accredited the licence should follow without extra bureaucracy."

- FAMILY MEMBER

Resident and Family thoughts around reporting of infractions

With respect to the reporting of infractions, full disclosure and honesty is important for residents and families. We heard that residents and families need to be notified before the media and there should be considerations regarding timing and frequency of reporting infractions (i.e., single, minor infractions do not need to be publicly reported, sites should be given opportunity to remediate).

There was consensus that reporting infractions would provide a measure of accountability as well as opportunity to improve care and service. There was also consensus that publication of infractions should be based on severity and/or frequency of infractions/occurrence.

"Infractions should be available if I wanted to go and look for it, but not available in the news, etc. unless it is a repeated problem. If I wanted to look at a government website and see no infraction for a place I was interested in, that would be helpful."

- FAMILY MEMBER

"I think it is important to report infractions, but we have to be careful, when does it happen? Are we going to make it too difficult for facilities to operate safely and effectively? Let's not throw more obstacles at them."

- FAMILY MEMBER

HEALTH HUMAN RESOURCES

Staffing challenges

A number of systemic issues were identified with respect to health human resources (HHR) including the role of Alberta Health Services as the regulator while also competing for human resources while there exists a critical shortage of registered nurses and health care aides across the province, particularly in rural and remote Alberta. This competition became apparent during the pandemic when Alberta Health Services failed to send staff to care homes which were in crisis mode. In contrast, other health authorities across Canada recognized the emergency and sent additional staff to care homes in crisis.

The HHR staff shortage has also created a suppliers-market whereby some staff are choosing to work casual rather than full-time, in favour of work-life balance, as casual shifts are readily available. Interviewees expressed concern that burnout from the pressures of COVID are still relevant and additional mandates stemming from changes in the regulations may further impact the mental well-being of workers. Concerns were raised that additional barriers and pressures stemming from changes in the mandate may have a greater impact on smaller providers with less capacity to shift resources.

Finally, there stands to be negative impacts regarding the HCA Directory as internationally trained staff cannot be on the Directory. An additional concern is that when new HCA standards were introduced, existing HCAs were not grandfathered and they were not placed in the Directory. Instead, many HCAs were required to take additional education courses to maintain certification. Many HCAs who have worked in care homes for decades find this requirement unfair. There is a risk of loss of this experienced HHR resource if this issue is not addressed.

> **"Right now 70% of operators are under contract with Alberta Health Services. They regulate and discipline long-term care. There is a lack of trust around should Alberta Health Services be the contractor or should it be Alberta Health? If I had staff shortages, I wouldn't rely on either Alberta Health or Alberta Health Services to staff us. We need to build synergies within the sector."**
>
> - LONG-TERM CARE OPERATOR

> **"Alberta has done a really bad job of recruiting to rural Alberta. We are hiring and training our own staff for rural sites – how can there then be punitive measures?"**
>
> - LONG-TERM CARE OPERATOR

Mitigating the impact

Interviewees are looking for a collaborative approach to recruitment and retention within the sector, with resources available for providers to protect staff, share resources, and train staff in a common way to build capacity within the entire sector. Providers identified the need for flexibility in staffing, particularly to accommodate for resident acuity, to allow for increased scopes of practice. A solution may be more resources for the on-the-job training, "earn as you learn" approaches, expanded talent pipelines, and recognition of new-Canadians' training and experience. Providers would also like to see positive messaging from Alberta Health as the sector is recovering from the impact of the pandemic.

"There is a focus on the negative, and there is not a lot of effort put in the positives of care. New regulations have to be given a positive essence – it cannot be about exposing, humiliating and destroying demoralized morale, this impacts front line workers. There is not enough gratitude already."

- DSL OPERATOR

"We want to promote a collaborative approach to recruitment and retention, right now everyone is in the same boat. If institutional continuing care homes have more advantages, higher wages, benefits – it not great for the continuum as a whole and will encourage people to a higher level of care than may be necessary."

- ASSOCIATION

"It will be important to look at the *Act* from a labour strategy; it must be congruent with other initiatives in the province to improve the labour conditions we have. For example, new immigrants will come to wherever in Canada is the easiest place is to get employment."

- HOME CARE OPERATOR

93%

OF OPERATORS AGREE THAT ALBERTA HEALTH SHOULD DESIGNATE CERTAIN PARTS OF THE PROVINCE AS BEING IN AN HHR 'SHORTAGE ZONE' TO RECOGNIZE THAT ACCESS TO HR MAY NOT ALWAYS BE POSSIBLE..

HHR shortage zone

When asked if the province should designate certain parts of the province as being in an "HHR Shortage Zone" to recognize that access to human resources may not always be possible (hence this would be considered when applying possible fines) we heard considerable support for designated shortage zones, specifically the need for the recognition of different staffing needs and labour market availability for urban versus rural operations, reflecting the diversity across the province.

"This would work, the government is aware of where the problems exist. They have closed parts of hospitals in Red Deer. Everyday in our rural site it is hard to fill positions."

- LONG-TERM CARE OPERATOR

"We are at a disadvantage due to our location and competing with Alberta Health Services for staff. Designating us as hard to recruit would help. What's needed in legislation is flexibility regarding penalties in areas where you can't hire staff."

- LONG-TERM CARE OPERATOR

If the Province should designate certain parts of the province as "HHR Shortage Zones", the majority of operators surveyed identified Alberta Health as the group that should be responsible for this. Other respondents identified alternate involved players could include Alberta Health Services, the Alberta government, the federal government, Alberta Continuing Care Association, Continuing Care Safety Alliance, Provincial Labour Ministry or a combination of these parties. Several respondents identified the need for operators to be involved in this process collaboratively with other groups. There was also discussion around the formation of 'working groups' or 'independent groups' with representation from operators and designated agencies.

Other comments or concerns from the operator survey include:

- Several respondents were outspoken around concerns that 24/7 RN legislation is 'crippling the health care system by tying up RN's in LTC facilities', they also identified LPNs are not being used to their full scope of practice to alleviate burdens, where possible.
- Respondents identified designates should be familiar with issues in rural and northern recruitment practice and needs.

"We need a national plan for this and certainly a coordinated approach at the provincial level. The state of HHR at the moment is frightening and with no coordinated approach, operators are working at cross purposes at times."

- OPERATOR SURVEY

"This is a provincial and national issue exacerbated by the impact of the pandemic- operators should not be penalized if they have done their best to try to recruit staff."

- OPERATOR SURVEY

Optimizing scope of practice

There is tremendous support for optimizing scope of practice among care staff, health care aides, licenced practical nurses, and registered nurses by creating resident-centred culture and defining roles within this context. It is also seen as an opportunity to support recruitment and retention as individuals look for challenge within their current roles and the opportunity to use their full scope of practice. Providers recognize the need to work closely with unions to support staff working to their full scope. Providers are looking for flexibility within the regulations to maximize scope and create an environment that supports innovation.

"There is a risk if the regulations are too restrictive. 'More of the same' could result in less innovation in the sector."

- ASSOCIATION

"HCAs are trained to do a lot more than they are. There is a lot of work that can be done. Each site needs the ability to optimize scope of practice based on each site. We consider individual skills, critical thinking skills, these are very valuable."

- LONG-TERM CARE OPERATOR

"Staff leave because they aren't being challenged; they want to work to their full scope and to do more."

- LONG-TERM CARE OPERATOR

"With the shortage of workers, we are forced to contact a staffing agency to provide an RN but what would be better is having an LPN working to full scope. Some operators are using agency staff when they have never used them before and it's causing problems with quality of care."

- LONG-TERM CARE OPERATOR

"Enhancing the role of RNs to do IVs (antibiotics and palliative care meds) would alleviate hospital admissions."

- LONG-TERM CARE OPERATOR

"Regulations can state working to full scope, but the issue is with unions about changing job descriptions. Whatever we come up with in terms of regulations there must be recognition of an underlying source obstacles if unions aren't on board."

- LONG-TERM CARE OPERATOR

Evidence to support changes in staffing models

Operators are seeking flexibility to create staffing models for their sites to support resident needs. Evidence that could be used to determine that staffing is resident-centred, safe, and improving quality of life begins with understanding what resident-centred means to residents themselves and may be aligned with

- Experiential data from residents, family, staff,
- and managers
- Staffing ratios
- Clinical indicators/ metrics
- Clinical (nursing) assessments, particularly by staff working to full scope with the appropriate tools to monitor residents

"Quality of life is hard to standardize and measure. We need a collaborative idea around what quality of life means and create a framework around this. Operators should be able to modify their staffing within this framework."

- LONG-TERM CARE OPERATOR

Operators did not feel residents and families could participate in developing staffing models given the lack of understanding around funding envelopes, acute needs of residents, and staff roles – suggesting a great deal of education would be necessary before meaningful conversations could occur.

"If you asked the average resident, what made their day good, it would be their personal interactions, the taste of the food, who is helping them. The problem is the medical model versus the social model."

- LONG-TERM CARE OPERATOR

Including staffing ratios in regulations

Operators had mixed feelings about providing staffing ratios in the regulations, with the majority feeling ratios are too restrictive and preferred minimum standards or a framework to allow for more flexibility. Operators were concerned setting specific hours and ratios may not support the unique resident needs of individual sites given the diversity across the province and felt that a resident case mix index is a more appropriate indicator. Operators were in favour of outcome-based and resident-need based HHR regulations in lieu of strict hours and set ratios.

"Standardizing staffing levels could prove unsafe. Acuity levels differ across facilities. Don't pigeonhole operators with a set number of hours."

- LONG-TERM CARE OPERATOR

HHR implementation approach

Operators would like to see a streamlined approach when it comes to the implementation of new regulations to minimize administrative burdens that would take resources away from care, combined with flexibility and focus on solution-finding rather than "fines and enforcement", combined with an outcomes-based approach, to put care first. Additionally, operators would like recognition that the contract manager is operating with conflict when they are competing for the same talent in the area while in a position to levy fines for operators struggling to staff their operations.

When asked what role Alberta Health and/or Alberta Health Services needs to play to support operators if HR issues arise that are out of operator control, but may subject them to a financial penalty, we heard the need for staffing contingency, more funding to hire staff, mitigating competition with Alberta Health Services for staffing, and focusing on systemic issues such as recruiting internationally educated workers.

> **"Standardizing staffing levels could prove unsafe. Acuity levels differ across facilities. Don't pigeonhole operators with a set number of hours."**
>
> - LONG-TERM CARE OPERATOR

> **"What happens on the ground is so drastically different than what is planned, does government even know this? Even the design of a building impacts staff roles."**
>
> - DSL OPERATOR

> **"[Alberta Health Services] steal my staff, give me more work and say we'll penalize you if you don't fill the shifts."**
>
> - HOME CARE OPERATOR

> **"Having a publicly funded organization competing for the same staffing pool is a problem."**
>
> - HOME CARE OPERATOR

CULTURALLY APPROPRIATE CARE

Interviewees were asked for ways in which the new regulations could support culturally appropriate care on and off Indigenous reserves and Metis settlements. Indigenous people must be able to control their own destiny and determine what type of priorities they have for the delivery of care that is 'parallel and synchronized' with the rest of the system.

There is a need for a special advisory group to help the industry respond to how to implement the regulations within this context and the need to include a requirement that every operator deliver culturally specific training to all staff on an annual basis that includes Indigenous culture, provided by, and with, Indigenous Peoples. With respect to providing culturally appropriately care more broadly, there is a need for a multicultural lens reflecting Alberta's diversity across populations.

> **"Standards should provide minimum requirements and not inadvertently exclude and one group. It needs to be possible for groups to build culturally appropriate care and make sure that practices and information in culture-centred care is shared."**
>
> - ASSOCIATION

> **"There is room across the entire continuum to improve training around providing culturally appropriate palliative care."**
>
> - PALLIATIVE AND END-OF-LIFE CARE OPERATOR

PUBLIC PERCEPTIONS AND PERSPECTIVES REGARDING THE *ACT*

Howegroup, with communications and promotion support from ACCA, published a public engagement survey on ACCA's engagement portal haveyoursayacca.ca to capture feedback from members of the public relating to the *Act*. ACCA's Facebook and Instagram advertising campaign reached 432,600+ viewers with 7,300+ link clicks. Between November 10, 2022, and November 25, 2022, a total of 1,156 responses to the public engagement survey were submitted. Below is a summary of the feedback.

Demographics

Almost 90% of the respondents (1,039) identified as 50+. The largest age group is "66 to 80" with 532 responses, followed by 443 in the "51 to 65" age group, and 64 individuals over the age of 80 responded to the survey. Sixteen responses were provided by individuals "20 to 25", and 94 responses from the age group "36 to 50". As shown in Figure 8 the majority of respondents were from the central and Edmonton regions, followed by Calgary and the northern and southern regions.

FIGURE 8. DISTRIBUTION OF RESPONDENTS BY HEALTH ZONE (N=1145)

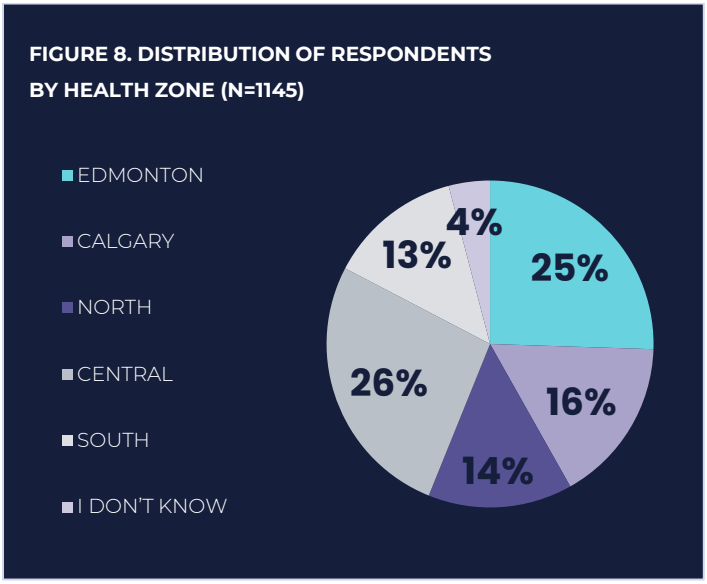
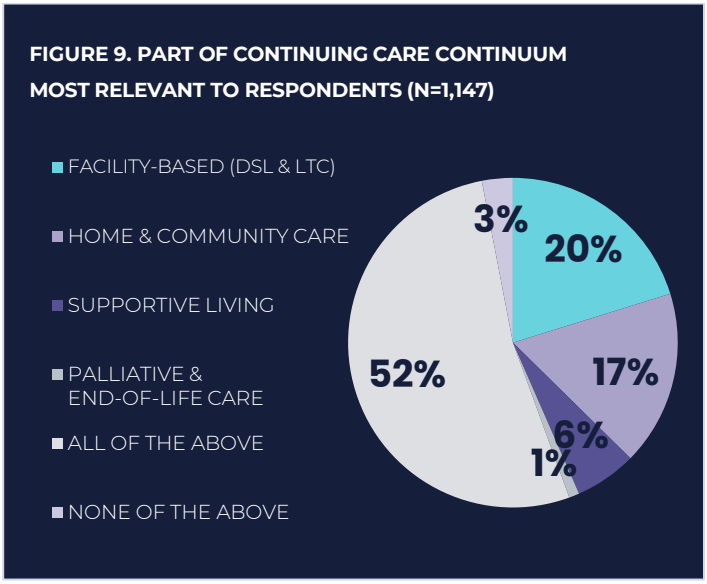


FIGURE 9. PART OF CONTINUING CARE CONTINUUM MOST RELEVANT TO RESPONDENTS (N=1,147)



Half (52%) of respondents report the entire continuum of care being relevant to them (Figure 9), followed by facility-based (20%) and then home and community care (17%).

Awareness

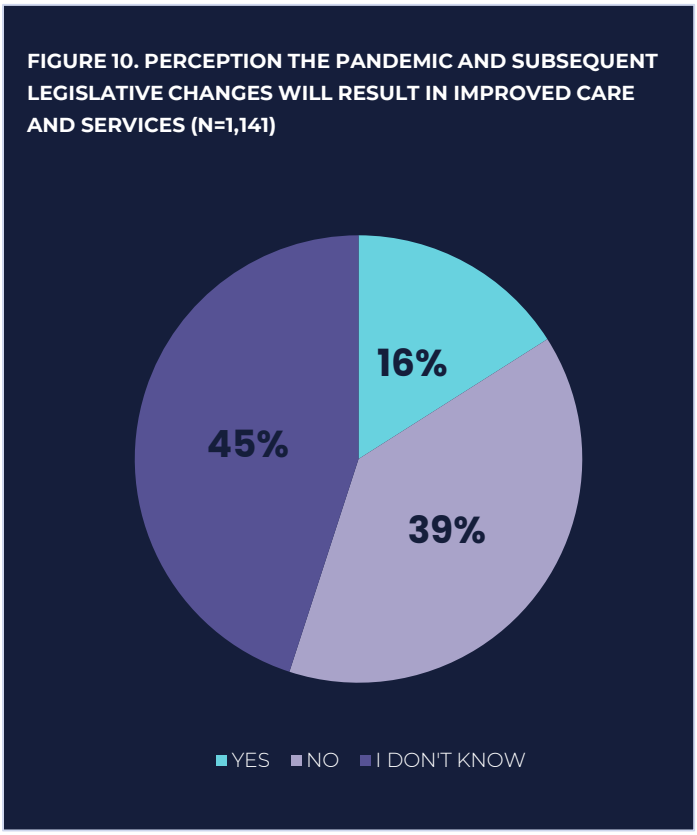
Only 4% of those surveyed considered themselves "very familiar" with the *Act*. Half (52%) considered themselves "not at all familiar" and 43% considered themselves "somewhat familiar".

COVID-19 pandemic and subsequent legislative reform

When asked if respondents believed the COVID pandemic and subsequent legislative changes

coming out of it would result in improved care and services for Alberta seniors the minority reported positively (Figure 10).

FIGURE 10. PERCEPTION THE PANDEMIC AND SUBSEQUENT LEGISLATIVE CHANGES WILL RESULT IN IMPROVED CARE AND SERVICES (N=1,141)



The *Act* brought with it key changes to Alberta's then existing legislation. The respondents found the following to be the top three most important changes:

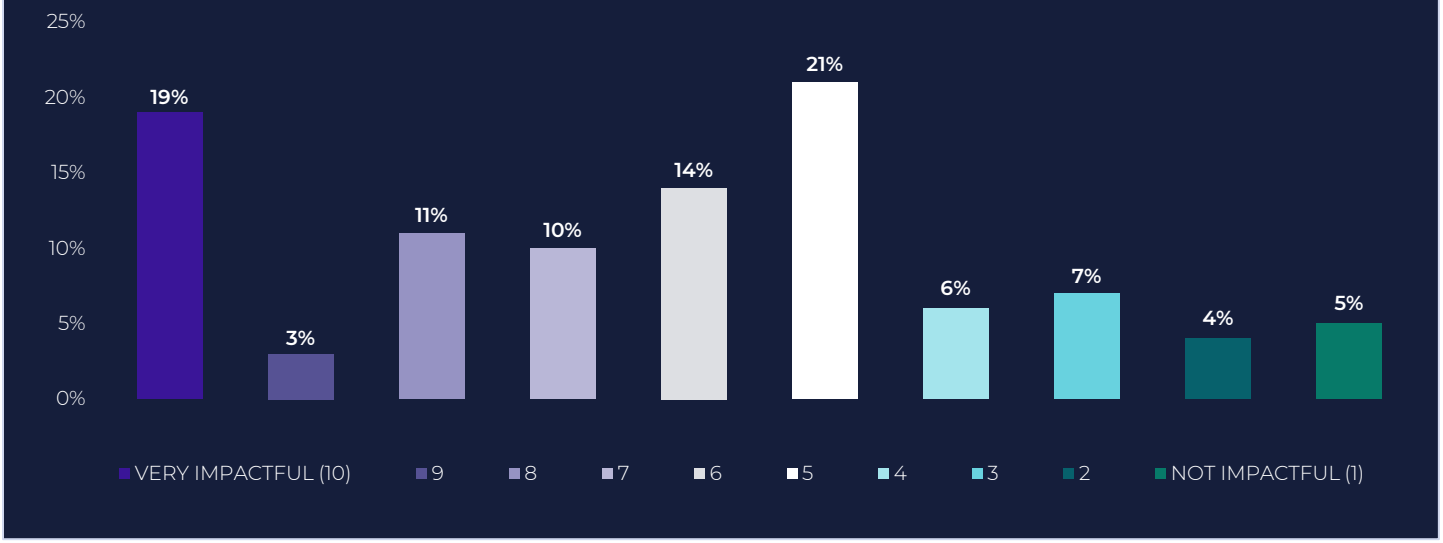
- Establishes a consistent approach and alignment of legislated requirements and services across the continuing care system for home and community care, supportive living accommodations, palliative and end-of-life care and long-term care and designated supportive living.
- Improves transparency and accountability to Albertans regarding how the continuing care system is governed.
- Enables a person-centred, flexible and innovative system of care.

Seventy percent (70%) of respondents found it "very important" for regulatory changes/reform to occur within the continuing care sector in order to provide better care for Albertans.

Engagement and impact

An overwhelming majority of respondents (88%) indicated that it is important for Alberta's continuing care providers to have their feedback considered by the provincial government regarding potential changes to the current regulatory framework. Feedback on standards and regulations from residents and clients, family members, and care providers/operators were considered important by majority of the respondents. In addition, while there was a wide distribution in perception of how impactful the changes associated with the *Act* will have on Albertans living in LTC/DSL settings and receiving hoe and community care (Figure 11), the majority lean toward a minimal or moderate impact.

FIGURE 11. IMPACT OF CHANGES ASSOCIATED WITH THE ACT ON ALBERTANS LIVING IN LTC/DSL SETTINGS AND RECEIVING HOME & COMMUNITY CARE (N=1,087)



Licensing and infractions reporting

When asked about the importance of a continuing care setting being licensed and public reporting of infractions of standards 85% of respondents found it to be 'very important' that a continuing care setting is licensed and 87% of respondents found it to be 'very important' that infractions of standards are publicly reported.

IMPLEMENTATION NEEDS

ROLES FOR ACCA, ALBERTA HEALTH AND ALBERTA HEALTH SERVICES

All stakeholders engaged were most interested in the implementation of the *Act* through its regulations, and the 'on the ground' changes that will materialize for residents, clients, families, workers within the industry, and operators. We heard from participants that there are collaborative and individual roles to play by Alberta Health, and the ACCA.

Interviewees confirmed they expect collaborative engagement between Alberta Health and ACCA to continue, and to ensure the original intents of the *Act* are achieved while:

- Streamlining and alignment in accreditations with licensing while minimizing duplications and overlap of processes.
- Recognizing the immense HHR challenge, regulations would be drafted with full consideration in supporting the talent pipeline.
- Commitments to working collaboratively to deliver a flexible compliance environment that prioritize person-centred care while addressing regional factors such as HHR shortages (i.e., single-site mandate adds to the demand for talent, so corresponding resources for talent development must be available to balance the scales).
- Minimum standards are enforced while overachievement is encouraged and rewarded.
- Accountability and reporting are regional and topic-specific (i.e., infractions and commendations).

Awareness and communications will continue to play a significant role in the implementation of the *Act*. Participants are looking for Alberta Health to provide a comprehensive "roll-out" plan, that would feature:

- Clear and realistic expectations in delivery and timeline.
- Plain language.
- Communications tailored for each stakeholder group, i.e., general public, residents, families, workers.
- A responsive Q&A mechanism.
- Information that is current and accurate.
- Recognizing that changes require both time and resources – both need to be budgeted accordingly.
- Positive messages.

While there were signs of "engagement fatigue" due to the recent spotlight on healthcare mostly brought on by the COVID-19 pandemic, participants overwhelmingly appreciated this engagement process by the ACCA. They expected ACCA to continue:

- Representing the interests of its members within the sector.
- Playing a leadership and valued partner role in the information sharing from Alberta Health about the *Act* and its associated implementation plan to residents, families, workers, and the general public.
- Educating members and sector stakeholders in the ongoing development and implementation processes associated with the *Act*.

> **How much time is this going to take? What resources will we have to dedicate to this? We have no idea what to expect."**
>
> - PALLIATIVE AND END-OF-LIFE CARE OPERATOR

> **We need funded hours, clear expectations, clear roles, and clear timelines for implementation."**
>
> - DSL OPERATOR

> **Alberta Health needs simple roll-out plans for the public. We need information that is tailored to residents and families plus an education session if it is quite different. What does it mean? How is it rolled out? ACCA can play a role here too."**
>
> - ASSOCIATION

> **It would be wonderful if there were awards, not just enforcements, penalties, and reporting of infractions."**
>
> - DSL OPERATOR

> **We need training modules and online learning. It is going to fall to organizations to get the messages across to the people they serve."**
>
> - LONG-TERM CARE OPERATOR

SUMMARY AND CONSIDERATIONS

This large-scale, province-wide, engagement on the *Act* was conducted with a broad sampling of stakeholders within the continuing care sector. Findings reflect the diversity across the sector. The collaborative nature with ACCA and Alberta Health was foundational in executing the engagement within a compressed timeline.

We learned that there still exists a general lack of awareness of the *Act,* particularly when the stakeholders are further removed from potential regulatory and enforcement impacts (i.e. home care operators, residents and families, and the public. Findings from residents, families, and the public highlighted the gap in awareness and knowledge of the *Act*, flagging this as a significant area of focus for Alberta Health with the roll out of regulations.

THERE IS HEALTHY SKEPTICISM SURROUNDING THE *ACT*'S ANTICIPATED BENEFITS TO THE SECTOR AND CONCERN REGARDING CONGRUENCY BETWEEN THE INTENTION OF REGULATIONS AND THE RESULTS FROM IMPLEMENTATION. MANY STAKEHOLDERS STRESSED THE NEED FOR FLEXIBILITY TO SUPPORT INNOVATION AS A WAY OF MITIGATING THE PRESSURE REGULATORY CHANGES WILL HAVE ON THE SECTOR AND POTENTIALLY ON THE QUALITY OF CARE AND SERVICE DELIVERY.

Recognizing this consultative engagement was required to be completed within a compressed timeframe, with the support of ACCA, we took a collaborative approach through "just-in-time" engagement and reporting with Alberta Health. Several interim briefings were shared with ACCA and Alberta Health and were used by Alberta Health to inform the development of materials to support regulations and inform Cabinet briefings. We also had the opportunity to participate in a privileged and confidential process with Alberta Health to begin the development of new regulations. Ongoing collaboration with government throughout the process supported the real time development of the new continuing care regulatory framework.

The insights and findings gathered through this expansive consultation have been designed to support ACCA's ongoing engagement and collaboration with the sector and collaboration and advocacy with Alberta Health. As Alberta Health develops the regulations, and the associated comprehensive implementation plan, ACCA members will continue to rely on ACCA for ongoing member communications and engagement (including the development of a revised resident

and family council toolkit). The collaborative relationships established through this engagement process and the momentum gathered put ACCA in good stead with Alberta Health not only to have an authoritative voice in advocacy across regulatory content but also to provide regular feedback to Alberta Health on the implementation of the *Act*.

In addition to the current engagement on the legislative framework, ACCA is well positioned to strengthen collaboration with other continuing care associations to provide a voice for the continuing care sector in the broader system change that will transform the continuing care system. ACCA's leadership could have significant influence on other initiatives within the Continuing Care System Transformation, including examining workforce needs, expanding home and community care, increasing continuing care home capacity, and enhancing palliative and end-of-life care. Furthermore, ACCA may be a leader in knowledge sharing with other provincial associations, as well as nationally with the Canadian Association for Long Term Care (CALTC). Both of these leadership opportunities may require enhancement in ACCA's systemic capacity to support future legislative review.

APPENDIX A: PALLIATIVE AND END-OF-LIFE CARE OPERATIONS

Hesitancy exists with hospice being 'included' with long-term care for the following reasons, which provides the opportunity for operators to work with Alberta Health and Alberta Health Services to better position operators to provide this level of care to residents.

Instruments: The palliative approach would benefit anyone with a life limiting disease or prognosis. However, once residents enter into the hospice setting, they are typically at end stage of their illness (a 3–4-month prognosis) going into multi-system failure and are often experiencing complex symptom issues such as hypo or hyper delirium, pain, shortness of breath or clusters of symptoms. Consequently, the nursing staff in hospice need to be skilled in common validated palliative assessment tools such as the Edmonton symptom assessment scale, the palliative performance scale, confusion assessment method, etc. They need to use tools designed for end of life, use the tools more frequently, determine what interventions need to be implemented, evaluate the outcome, and conserve resident's energy. It would not be helpful to use the InterRai instrument or other long-term care standard assessments which are comprehensive but lack a focused approach to hospice residents at end of life.

Frequency of the assessments: Hospice residents' health status can change so rapidly and the nursing staff must be diligent about assessments in order to effectively manage complex symptoms (maybe daily). Additionally, the palliative care plan needs to be updated frequently to address the residents' end-of-life and symptoms changes. Annual care planning as in the Continuing Care standards would not align with complex needs of hospice residents at end-of-life and experiencing clusters of symptoms. The focus of care in the continuing care health service standards is person-centred and hospice care tends to be family centred.

Bathing and mouth care: Due to symptom issues, palliative wounds, and limited ability to ambulate, each hospice resident needs to be assessed for the most appropriate way to bath and the frequency. If death is imminent, a bed bath may be planned. For example, if the resident has significant pain, several drains and complex dressings, the nurses will individualize the bath schedule for this resident. Due to the quick changes in status of hospice residents, the nurses must plan the bath schedules daily. Although, two showers are available in this setting, most of the hospice residents' functional status is too low to safely shower. Furthermore, mouth care standards in continuing care are also not as agile as needed in hospice settings. For example the twice a day mouthcare standard would be suboptimal for residents at end of life. Mouth care has to be much more frequent for hospice residents.

Dietary: Hospice residents are often too ill to dine in the public dining area and will eat or be fed in their rooms. Their dietary needs are discussed weekly at interdisciplinary rounds. Since the residents have a short length of stay in hospice due to their prognosis, their ability to swallow or eat changes frequently so the nursing team must be diligent in assessing the resident's need for thickened diets or other modifications. This information is communicated with the dietary team and nursing team, documented in the nursing notes and ideally in the care plan.

Documentation: Often daily since the hospice residents' symptoms change frequently and the nurse needs to describe the outcome of each intervention.

Skills: Since there are several palliative emergencies, hospice nurses have to be skilled and educated in managing such as exsanguinations, palliative sedation, superior vena cava obstructions, etc. These issues can cause a lot of stress for stress, and some ethical conversations with families and residents. Therefore, interdisciplinary family meetings, grief counseling session, and debriefing sessions are frequently planned in hospice environments.

ABOUT THE AUTHORS

This engagement was completed through a collaboration of three entitles: Howegroup, Michifco, and The Diag Group.

Jennifer Hystad, MSc, CE, Howegroup, is a consultant living and working in the Lower Mainland of beautiful BC where she moved after growing up in Edmonton, AB. Her areas of focus are strategy, evaluation, and organizational development. Her work is rooted in the social determinants of health, and she has spent much of her career supporting organizations that champion healthy aging and quality care for older adults. Jennifer brings expert advice and counsel along with proven methods to ensure high quality products that align with project purpose and organizational strategy, goals and objectives. Jennifer partners with clients to apply best practices supporting organizational change and learning. Jennifer holds a Master's degree in Health Promotion Studies and a bachelor's degree in Science, from the University of Alberta. Jennifer is a Credentialed Evaluator (CE) with the Canadian Evaluation Society

Jason Chan, BA, The Diag Group, brings a broad spectrum of experience across the public, private, and non-for-profit sectors. His passion for relationship building and advocacy weaves through his career in governments, major projects, and multi-national organizations. Jason's commitment to collaboration and the solution-based approach to engagement has been demonstrated through key achievements in his career. As a senior executive for a major Indigenous government delivering education and skills training, he has leveraged his vast government and stakeholder engagement experience into unprecedented funding and associated programming results. Having spent time in Ottawa and overseen the stakeholder engagement of several major projects, Jason brings with him the strategic vision along with the attention to detail that is required for proper campaign execution. Jason holds a B.A. from the University of Michigan and a Social Media Marketing Certificate from Northwestern University. He resides in East Vancouver and volunteers his time for several social and affordable housing initiatives. .

Wynona Giannasi, MPA, CE, Howegroup, is a consultant based in Vancouver BC. She co-founded Howegroup in 2006 with a vision of supporting organizations to lead social change. Wynona is particularly passionate about improving care and enhancing support services. Wynona utilizes a unique style to bring together differing perspectives to drive organizations forward. Wynona works with senior leaders, industry partners, staff, and the public to leverage organizations' strengths and facilitate the development of effective strategic priorities. Wynona holds a Master's in Public Administration, with a specialization in performance management and a Bachelor of Science, both from the University of Victoria. Wynona is a Credentialed Evaluator (CE) with the Canadian Evaluation Society.

Daniel Fontaine, BA, Michifco, has worked in the private and not-for-profit sectors as well as government. Fontaine is the currently the principal at Michifco Consulting Inc. He previously served as the Deputy Minister and Chief Executive Officer for Métis Nation BC. Fontaine also worked as the CEO for the BC Care Providers Association. He was appointed to the Board of Directors for Douglas College and served on the BC College of Psychologists from 2004-2010. He formerly served as the President for the Canadian Association for Long-Term Care (CALTC). In May 2018 the national Minister of Health appointed Fontaine to the Federal Advisory Panel on Dementia. The Panel worked to support the implementation of Canada's National Dementia Strategy. In March 2022 Fontaine was inducted into Canada's Marketing, PR, Advertising and Communications Hall of Fame. In 2012 Fontaine was awarded the Queen's Diamond Jubilee Medal for public service. Fontaine is married with one son, and the family has lived in historic New Westminster for over two decades.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