Maximizing Resident Care and Safety

OANHSS Submission to the Ontario Standing Committee on Finance and Economic Affairs

JANUARY 2014

OANHSS | Ontario Association of Non-Profit Homes and Services for Seniors

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Table of Contents

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Summary of Recommendations

In light of the growth in overall resident acuity, the associated growth in labour intensive services, and increases in input costs, OANHSS recommends:

Rec. 1. Given the 1.1% increase in year over year acuity and the ongoing input cost pressures (averaging approximately 1.5%[1]), OANHSS recommends a maintenance increase of 1.5% to the NPC and PSS envelopes.

ESTIMATED COST = $27.772M

Aggressive behaviours have become a critical issue directly affecting the safety and well-being of residents and staff within the long term care system. In recognition of that fact, this submission focuses on aggressive behaviour and the steps needed immediately to maximize safety and quality of life for all long term care residents, now and in the future. The following recommendations call for actions that include: regulation change, designated units, staffing needs, staff training, and research.

With respect to the moderate risk residents we propose the following:

Rec. 2. The Ministry increase NPC and PSS funding, based on Behaviour Supports Ontario (BSO) in-home expertise models, to ensure a core level of behaviour care expertise in all homes and to offset the behaviour-related funding deficit inherent in the RUGs methodology.

[1] OANHSS Collective Agreement Trends Report. October 2013.

ESTIMATED COST = $92.430M

Rec. 3. Although effective training and education programs exist, (PIECES, U-First, Montessori, etc.), access to these resources needs to be improved. OANHSS recommends that the Ministry facilitate access to the appropriate training and education programs for all care staff on a regular and recurring basis.

ESTIMATED COST = $15.302M

With respect to the high risk residents, those that would fall into the ABS 5 plus category, we propose the following:

Rec. 4. The Ministry must revise the applicable regulations to enable homes, based on reasonable criteria, to redirect admission of residents, and the right to transfer existing residents, deemed to pose a significant risk to other residents and staff due to aggressive behaviour to a designated behaviour unit.

ESTIMATED COST = NO COST

Rec. 5. In order to ensure the safety of all residents and staff, OANHSS recommends that the Ministry expand the number of designated units for extremely aggressive residents and that homes without designated units be permitted to transfer, or refer, residents to such specialized units or other appropriate settings within the mental health system as appropriate.

ESTIMATED COST = TBD

Rec. 6. That the Ministry, based on the BSO designated unit staffing model, fund all existing and new designated units across the province and that designated unit funding be separate from level of care funding.

ESTIMATED COST = TBD

Rec. 7. In concert with the foregoing recommendations, the province needs to facilitate a research project that will investigate, in detail, the characteristics of residents and potential residents at risk of aggressive behaviours with the objective of identifying various levels of risk within that population. That research should also assess the care needs of the various risk-levels in order to determine their fit within the scope of practice within LTC.

ESTIMATED COST = $0.250M

Total estimated cost of costed recommendations = $135.754M

For assumptions and data supporting these cost estimates please see Appendix 1.

1.0 Introduction

OANHSS is the provincial association representing not-for-profit providers of long term care, services and housing for seniors. Members include municipal and charitable long term care homes, non-profit nursing homes, seniors' housing projects and community service agencies. Member organizations operate over 27,000 long term care beds and over 8,100 seniors' housing units across the province.

This submission provides input from the non-profit long term care (LTC) provider's perspective on how the system can be improved through public investments and policy changes and enhancements; changes that the Ministry may wish to include in its 2014-15 budget planning process.

As of May 2013 the Ministry of Health and Long-Term Care (MOHLTC) reported approximately 21,000 seniors were awaiting placement in one of the 77,600 LTC beds in Ontario's 630 LTC homes[2]. The occupancy rate in the province averages 99.0%.

The people behind these numbers represent the most vulnerable of all societal groups; the frail elderly. Not all seniors need LTC and all stakeholders are working hard to enable seniors to remain in their communities. The result of this policy direction, coupled with the facts of the demographics of aging, is that those with the greatest need are the ones being admitted to LTC homes. Acuity in the LTC population is increasing accordingly.

Historically, the primary reasons for relying on LTC were due to physical health issues. Over time, mental health issues, dementias in particular, have grown in prevalence and are expected to continue to grow with the aging "baby boomers". Along with the increase in mental health conditions has grown the risk to the safety and well-being of residents and

[2] Ministry of Health and Long-Term Care. Long-Term Care Home System Report, August, 2013.

staff of LTC homes. The risk stems often from individuals suffering from mental health afflictions without the necessary level of care and expertise.

Individual homes have made efforts to deal with the care and safety demands created by the growing mental health issues in LTC. Unfortunately, there are limited or no additional resources made available on a system-wide basis. Although many homes have "secure behaviour units" these receive no additional funding over the standard level of care funding.

There are some exceptions on the horizon. LHINs have developed exploratory approaches to the provision of care around mental health, with an emphasis on aggressive behaviours, most notably, Behaviour Supports Ontario (BSO). One of the BSO models that OANHSS members support is the "embedded model" of care where expertise and increased staffing is made available to enable individual homes to properly care for residents with manageable behaviours. We also strongly support the BSO model of enhanced supports within a "designated" and transitional behaviour unit which provides intensive therapy for residents with very difficult to manage behaviours. These approaches have been shown to work and it is time to implement them on a system-wide basis in order to minimize the risk of the incidents resulting from aggressive behaviours that periodically occur within homes. This will involve a financial commitment on the part of the MOHLTC.

We do not profess to have an answer that will totally eliminate critical incidents resulting from aggressive behaviour. These are often totally unpredictable and unpreventable, however, the actions recommended in this Budget submission will go far to diminish the risk of injuries and maximize the safety and well-being of all residents in LTC.

The nature of the LTC population has changed and the LTC system needs to respond appropriately. In our submission we make the point that overall acuity measures, although very useful for some purposes, do not provide enough information to properly understand the resident population.

2.0 Challenging Needs

In this section we provide an overview of high growth areas of physical and mental health needs with a detailed view of dementias. We also look at the prevalence and change in aggressive behaviours over time and the relationship between key areas of mental health and aggressive behaviours. Our recommendations are informed by our analysis of these relationships, prevalence and growth data found in the Ontario RAI-MDS data set for January 1, 2010 to March 31, 2013.[3]

2.1 Physical Acuity Demands

Year over year, overall acuity has increased by 1.1%. However, this overall trend hides some larger growth areas both in physical and mental health. On average 40.1% of LTC residents have six or more formal diagnoses and that group is growing at 7.9% each year. At any given time, 38.5% of residents are experiencing a flare up of a medical condition and 8.0% of residents' conditions are unstable.

There has been an increase in the growth of moderately prevalent chronic diseases within the LTC population. For example, emphysema/COPD is increasing at 3.1%, arteriosclerotic heart disease at 5.2% and renal failure at 6.4%.

[3] Dr. Jeff Poss of the University of Waterloo provided OANHSS with an analysis of Ontario Minimum Data Set (MDS) items and scale results for each quarter from January 1, 2010 to March 31, 2013 and a more in depth analysis focuses on aggressive behaviour within the quarters January 1 to March 31, 2012 and 2013. The results of his analysis have been drawn upon for the purpose of this submission.

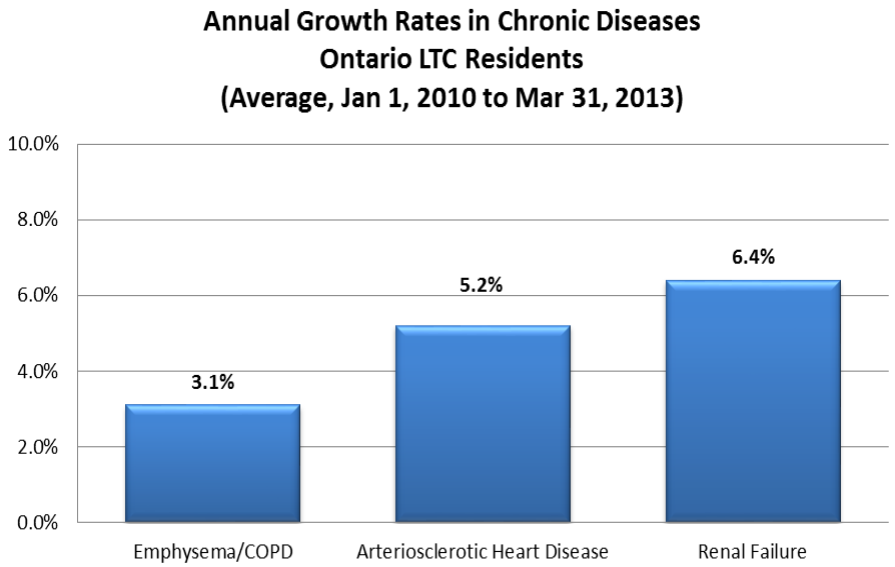

Figure 1: Growth in Chronic Diseases - Ontario LTC

Although less than 5.0% of the resident population suffers from end-stage disease at any point, that number is increasing at a rate of 13.2% per annum. In addition, antibiotic resistant infections, while relatively rare, are experienced by an average of 3% of the resident population, and are increasing at 20.3% per annum.

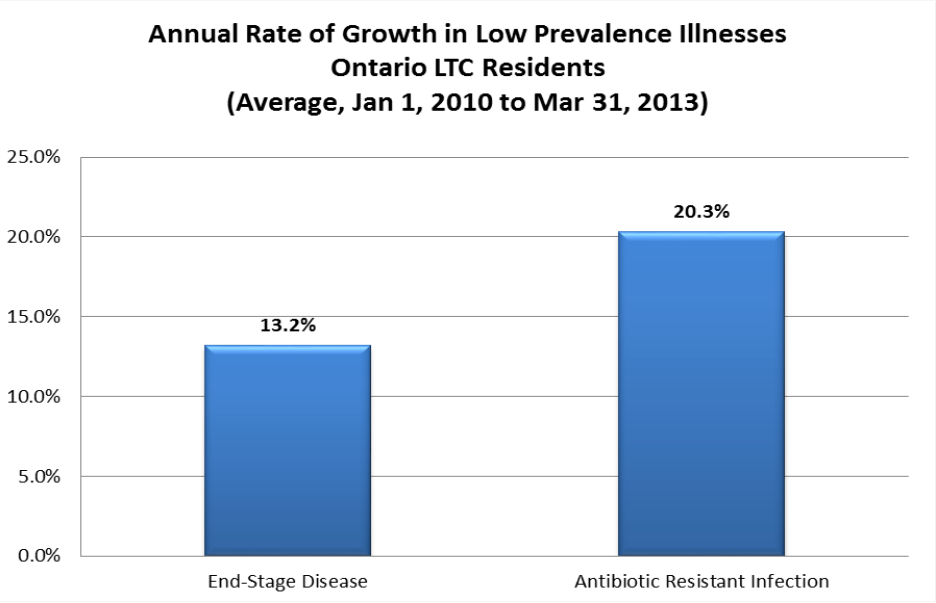

Figure 2: Growth in Low Prevalence / High Care Intensity Illnesses - Ontario LTC

It is not a surprise that these and other increases in physical health problems give rise to increased need for care. A broad range of treatments, many highly labour intensive, reflect this increased need. Figure 3, below, illustrates the average growth rates for a selection of key care services provided in LTC homes. The need for the provision of oxygen therapy, monitoring acute conditions, administering IV medications, and monitoring intake/output are increasing at 5.9%, 6.1%, 10.2% and 11.8%, respectively.

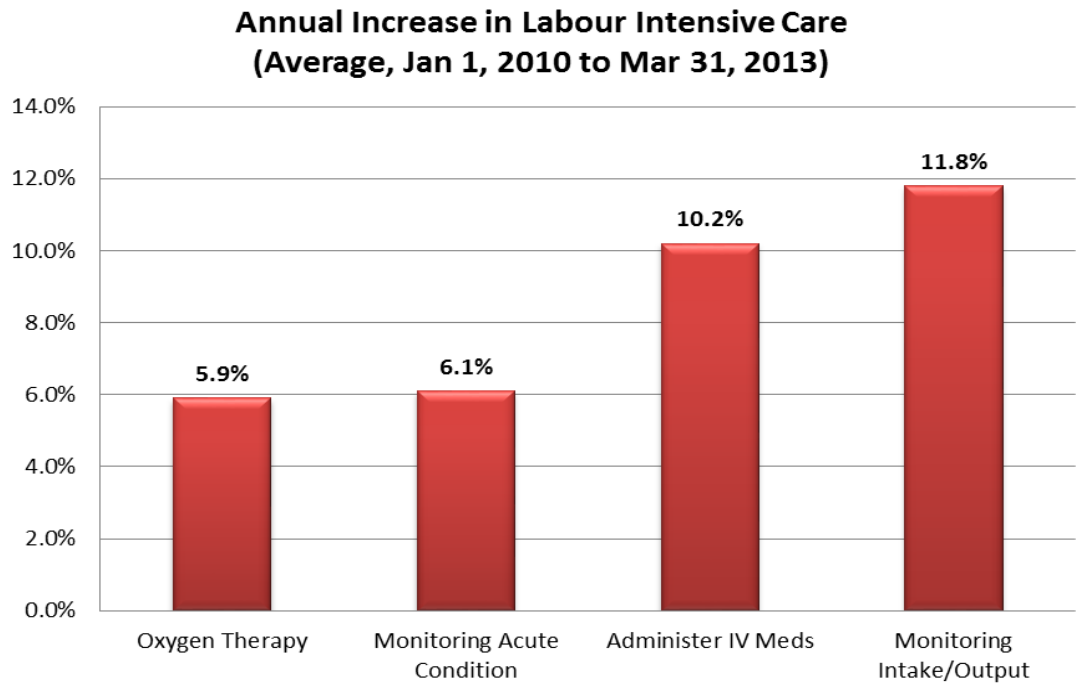

Figure 3: Growth in Labour Intensive Care - Ontario LTC

Recommendation on overall acuity:

Rec. 1. Given the 1.1% increase in year over year acuity and the ongoing input cost pressures (averaging approximately 1.5%[4]), OANHSS recommends a maintenance increase of 1.5% to the NPC and PSS envelopes.

[4] OANHSS Collective Agreement Trends Report. October 2013.

2.2 Prevalence and Growth in Mental Health Diagnoses

Although the LTC resident population suffers from a broad range of physical health issues of which only a small number are profiled above, it is also afflicted with a broad range of mental health issues. Many of these issues affect a large and ever increasing number of residents. Table 1, below, shows the prevalence and rate of growth of some of the mental health issues for LTC home residents, the most common of which are dementias, which affect, on average, six out of 10 residents (59.7%); a number that is growing at an estimated 2.9% per annum. In terms of straight numbers this equates to over 46,000 people across all homes, or, on average, 74 out of 119 people in each home. This is a huge and growing group of people in need.

Table 1: Prevalence and Growth in Mental Health Issues

Impairment	Average Prevalence	Average Annual Rate of Growth
Dementia – all	59.7%	2.9%
Depressed Mood (Depression Rating Scale score 3 plus)	32.5%	1.2%
Cognitive Impairment (Cognitive Performance Scale score 4 plus)	27.9%	**-2.1%**
Any Psychological Disorder	38.8%	4.8%
Anxiety Disorder	8.6%	9.8%
Schizophrenia	3.4%	1.9%
Bipolar	2.3%	3.0%

Source: CCRS, RAI-MDS Quarterly, January 1, 2010 to March 31, 2012.
All CCRS data courtesy of Dr. J. Poss, University of Waterloo

Cognitive impairment, defined as a score of 4 or more on the Cognitive Performance Scale, and depressed mood, defined as a score of 3 or more on the Depression Rating Scale[5], are experienced by a good number of residents as well; roughly 3 in 10 (27.9% and 32.5%,

[5] The Depression Rating Scale does not equate to a formal diagnosis of depression rather it identifies depressed mood or possible signs of depression.

respectively). However, cognitive impairment is decreasing by an estimated 2.1% per annum.

Anxiety disorders, with a prevalence of 8.6%, are increasing at a rate of almost 10% per annum. Other less common psychiatric diagnoses, such as schizophrenia and bipolar disorder, 3.4% and 2.3% prevalence respectively, are also growing at more modest rates of 1.9% and 3.0%, respectively. Although these more familiar psychiatric diagnoses are of lower prevalence, 38.8% of residents have a psychiatric diagnosis of one sort or another and that overall group is growing at 4.8% per annum.

It must be kept in mind when interpreting these statistics that they do not capture the complexity of acuity at the individual level, as one person may have multiple impairments. So of the 59.7% of the population with a dementia diagnosis there will be individuals with cognitive impairment, depressed mood and a psychiatric diagnosis, not to mention any number of physical health, functional, and/or behavioural impairments.

2.3 Aggressive Behaviours and Mental Health

Aggressive behaviours are identified through the RAI-MDS assessments using a number of individual items and scales. Here we will focus on the Aggressive Behaviour Scale[6] (ABS) and its component measures. See Appendix 2 for ABS rating details.

On average, 46% of residents engage in aggressive behaviours as measured by the Aggressive Behaviour Scale (ABS). As illustrated in Figure 4, below, 35% of all residents have moderate levels of aggressive behaviour, scoring 1 to 4 on the ABS, and 11% are considered to show severe to very severe levels of aggressive behaviour with ABS scores of five or more.

[6] Perlman, C.M and Hirdes, J.P. The Aggressive Behaviour Scale: A New Scale to Measure Aggression Based on the Minimum Data Set. Journal of the American Geriatrics Society. Vol. 56 (12), Dec. 2008.

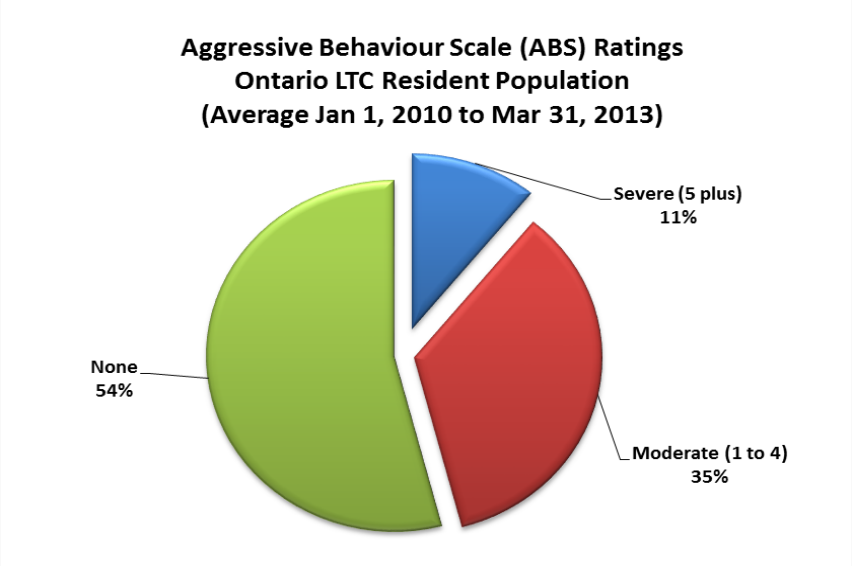

Figure 4: Prevalence of Moderate and Severe Aggressive Behaviours

As described earlier, the most common mental health issues in the LTC resident population are dementia, depressed mood, cognitive impairment, and, collectively, a broad range of formal psychiatric disorders. The relatively less common conditions include anxiety disorders, schizophrenia and bipolar disease. Residents affected with many of these mental health problems are over-represented in the groups with moderate and severe aggressive behaviours.

Currently, it is not possible to assess risk to safety posed by individuals displaying aggressive behaviours with any degree of precision. The following analysis relies on the assessed magnitude of aggressive behaviour exhibited as measured by the ABS. We split the affected population into low to moderate and severe to very severe. Although useful for our purpose of informing policy recommendations, a more detailed and rigorous study would be required to gain a more accurate picture of risk and specific care requirements (see recommendation #7).

It is the view of the care providers that the Resource Utilization Group (RUGs) funding allocation methodology is not adequately sensitive to the resource demands currently

associated with aggressive behaviours, let alone the resource requirement to approximate the actual need.

We would like to take this opportunity to put into some context the potential magnitude of the RUGs insensitivity problem in dollar terms. Estimates of the additional resource requirements of residents with various behavioural issues range from about $9.00 to $14.00 PRD. In Ontario this would translate into about 36,000 residents at any given point in time. Taking the low end estimate of additional (currently unrecognized) costs of $9.00 PRD the burden on homes is over $117.9M per annum. Applying the higher, $14.00 PRD, the estimate grows to $183.3M. These are rough estimates of the prevalence of the various behaviours and the associated resource demands. However the potential dollar magnitude highlights the need for serious and immediate programmatic response.

Mental health is typically what comes to mind when the issue of aggressive behaviour in LTC is discussed. In the next section we profile the prevalence of various mental health conditions within groups identified as displaying aggressive behaviours.

2.3.1 Moderate Aggressive Behaviour and Mental Health

Figure 5, below, details the time series over the 2010 to 2013 period. As of quarter 4 of the 2012-13 fiscal year, residents displaying moderate aggressive behaviours accounted for 37.1% of the resident population (over 27,500 people, or 44 people per 119 in each home) and that group is estimated to be increasing 4.2% per annum (over 1,150 people each year).

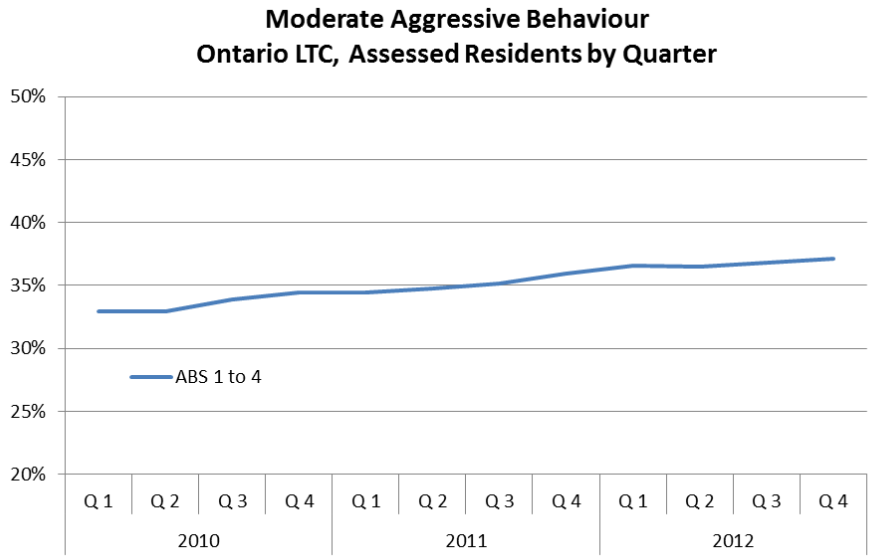

Figure 5: Moderate Aggressive Behaviours in Ontario LTC Homes (2010 to 2012)

Table 2, below, compares the prevalence of residents with mental health conditions to their prevalence within the group of residents with moderate aggressive behaviours in the last quarter of fiscal year 2012-13. Residents with a dementia, depressed mood and/or cognitive impairment are highly over-represented in the moderate aggressive behaviour group. While 61.9% of residents suffer from some form of dementia, 72.1% of residents with ABS 1 to 4 have a dementia. About 32.5% of the overall resident population are assessed with depressed mood, but they represent 41.8% of those with moderate behaviours. Similarly, 27.4% of the overall population has a cognitive impairment but they represent 35.2% of those with moderate aggressive behaviours. Residents with anxiety disorder, schizophrenia and bipolar disease are not at all, or just slightly, over-represented. When all psychiatric diagnoses are considered as a group (i.e. any psychiatric diagnosis) there is only minor over-representation within the moderately aggressive resident group.

Table 2: Prevalence of Mental Health Conditions with Moderate Aggressive Behaviour (Q4, FY 2012-13)

Impairment	Prevalence within All Residents	Prevalence within ABS 1 to 4
Dementia – all	61.9%	72.1%
Depressed Mood (Depression Rating Scale score 3 plus)	32.5%	41.8%
Cognitive Impairment (Cognitive Performance Scale score 4 plus)	27.4%	35.2%
Any Psychological Disorder	38.8%	42.8%
Anxiety Disorder	9.7%	9.9%
Schizophrenia	3.6%	3.8%
Bipolar	2.4%	2.4%

Source: CCRS, RAI-MDS, Jan 1, January 1, 2013 to March 31, 2013.
All CCRS data courtesy of Dr. J. Poss, University of Waterloo

The groups most at risk of aggressive behaviour then are not necessarily those with psychiatric conditions, but those suffering from dementia, depressed mood, and cognitive impairment. Again, it must be kept in mind when interpreting these statistics that they do not capture the complexity of acuity at the individual level as one person may have far more than one impairment and combinations of mental health issues may influence the expression of aggressive behaviours.

Residents with moderate aggressive behaviours, while generally not posing a high level of risk to the physical safety of other residents and staff, do require more attention and that attention draws staff time away from the needs of the general resident population and lowers the overall quality of life in the home. Specifically, increases in interventions related to behaviours such as evaluations by mental health specialists increased by 6.4%; implementing changes to residents' environment to influence their mood or behaviour increased by 20.8%; and re-orientation/cueing increased by 10.1%. Similar increases in the use of these interventions were seen for newly admitted residents as well. All of these

services reflect increased care demand. If staff do not have the time and expertise to provide the proper care to individuals at risk of displaying aggressive behaviours, then the risk of aggressive behaviours can escalate to very dangerous or even fatal levels.

Long term care homes, the MOHLTC, LHINs, CCACs and other partners have worked to ensure the safety and well-being of all LTC residents generally and with respect to the risks associated with the large and growing problem of aggressive behaviours. Psychogeriatric Outreach Teams (POTs) and, more recently, Behaviour Supports Ontario (BSO) are just a couple of initiatives intended to help protect residents and staff and ensure proper care is provided to all residents. Homes, in addition to working with BSO and POTs, have created dementia units of varying capacity and sophistication. Homes also try to ensure staff have access to training and retraining opportunities, such as PIECES, Montessori, Gentle Care, etc.

Notwithstanding these efforts and largely due to current staffing levels, staff are forced to either provide the needed time and deny attention to the needs of the general resident population or do not provide the needed time and potentially increase the level and intensity of aggressive behaviours. An unacceptable middle-ground is an increased reliance on physical and/or chemical restraint. In the last quarter of the 2012-13 fiscal year, 40% to 45% of aggressive residents with a dementia were prescribed antipsychotic drugs in the week before their assessment, compared to 32% of the general resident population. Residents with aggressive behaviours are also much more likely to experience restraints than the general resident population. Although there is no quality target for use of chemical restraints, HQO has set an aspirational target of 3.0% for daily restraint use. Clearly we are nowhere near that target.

Many of these interventions have been implemented on a "project" basis or, in the case of training, on a scale that limits their effectiveness. OANHSS members agree that the time has arrived for a province-wide and permanent approach to dealing with the issues of aggressive behaviours. Homes need adequate staffing, expertise and properly funded

training and staff development opportunities to maximize the well-being and safety of residents and staff in long term care homes. Improved depth and breadth of such training will not only improve care standards, allowing for a reduction in reliance on chemical and physical restraints, but also positively impact the care culture around the needs of residents with behaviours.

There is no magic number of staff that will totally ensure the safety and well-being of residents, particularly when aggressive behaviours are involved. However, the BSO embedded model is supported by OANHSS and its member homes. Although not uniform in their staff mix, the additional resources usually include: an additional PSW, a PSW Behaviour Lead, and a Behaviour Therapist, or equivalent, for each home. In our costing we have included provision for 1 PSW FTE per 100 beds, 1 PSW Behaviour Lead per 200 beds, and 1 Behaviour Therapist, or equivalent, per home (see cost estimates in Appendix 1). The allocation model would remain to be developed around these parameters in order to accommodate small homes.

With respect to the **moderate risk residents**, those that would fall into the ABS 1 to 4 category, we propose the following:

Rec. 2. The Ministry increase NPC and PSS funding, based on Behaviour Supports Ontario (BSO) embedded (in-home) expertise models, to ensure a core level of behaviour care expertise in all homes and to offset the behaviour-related funding deficit inherent in the RUGs methodology.

Rec. 3. Although effective training and education programs exist, (PIECES, U-First, Montessori, etc.), access to these resources needs to be improved. OANHSS recommends that the Ministry facilitate access to the appropriate training and education programs for all care staff on a regular and recurring basis.

2.3.2 Severe Aggressive Behaviour and Mental Health

Figure 6, below, shows the average proportion of individuals scoring 5 or greater on the ABS over the period 2010 to 2013. Although, fairly stable, the prevalence of severe aggressive behaviour (i.e. ABS 5+) may be trending down at an estimated rate of 5.1% per annum[7]. It is unknown what is driving the decline, but it could be a result of staffing increases over the past 3 years, improved management of these cases and/or the effect of BSO.

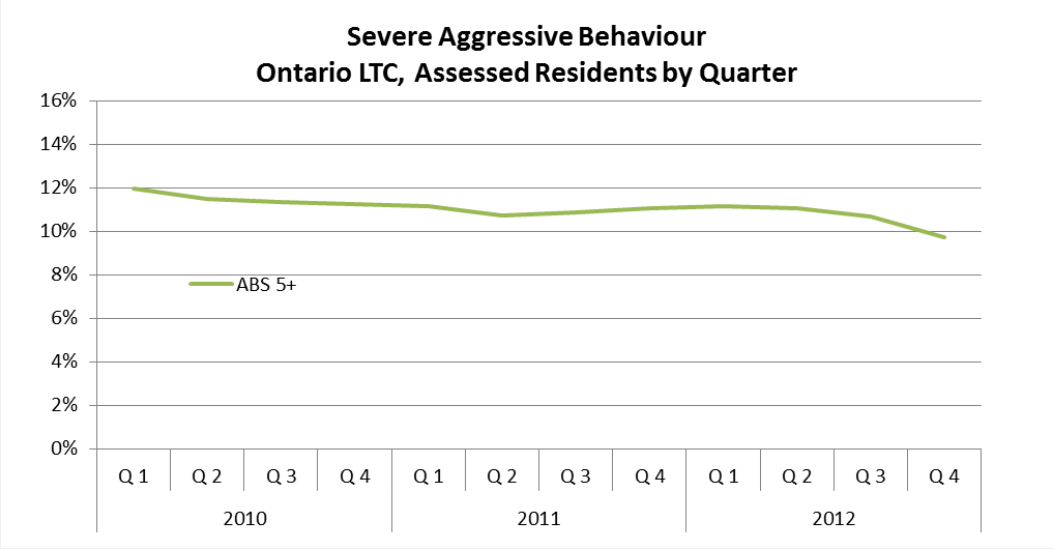

Figure 6: Severe Aggressive Behaviours in Ontario LTC Homes (2010 to 2012)

Table 3 compares the prevalence of mental health conditions to their prevalence within the group of residents with severe aggressive behaviours in the last quarter of fiscal year 2012-13. The characteristics of the severe aggressive behaviour group are the same as with the moderate behaviour group however there is a far greater concentration of residents with the most prevalent mental health challenges within the severe aggressive behaviour group. Residents with a dementia, depressed mood and/or cognitive impairment are highly over-represented in the severe aggressive behaviour group. While 61.9% of residents suffer from some form of dementia, 83.5% of residents with ABS 5 plus have a dementia. About 32.5% of the overall resident population are assessed with

[7] Note that this is a relative decrease in prevalence and not an absolute decline.

depressed mood, but they represent two thirds (66.5%) of those with severe behaviours. Similarly, 27.4% of the overall population has a cognitive impairment, but they represent over half (52.6%) of those with severe aggressive behaviours.

Also similar to the moderate aggressive behaviour group, residents with anxiety disorder, schizophrenia and bipolar disease are not at all, or just slightly, over-represented. When all psychiatric diagnoses are considered as a group (i.e., any psychiatric diagnosis) there is still only modest over-representation within the moderately aggressive resident group.

The highest risk groups then are not the psychiatric conditions alone, but those suffering from dementia, cognitive impairment and depressed mood. Again, however, the combinations of mental health issues, likely combined with environmental factors will help pinpoint the most at risk groups.

Table 3: Prevalence of Mental Health Conditions with Severe Aggressive Behaviour (Q4, FY 2012-13)

Impairment	Prevalence within All Residents	Prevalence within ABS 5 plus
Dementia – all	61.9%	83.5%
Depressed Mood (Depression Rating Scale score 3 plus)	32.5%	66.5%
Cognitive Impairment (Cognitive Performance Scale score 4 plus)	27.4%	52.6%
Any Psychological Disorder	38.8%	44.0%
Anxiety Disorder	9.7%	11.0%
Schizophrenia	3.6%	3.7%
Bipolar	2.4%	2.6%

Source: CCRS, RAI-MDS, Jan 1, January 1, 2013 to March 31, 2013.
All CCRS data courtesy of Dr. J. Poss, University of Waterloo

Much of what was said above about efforts to deal with moderate aggressive behaviours applies to severe aggressive behaviours as well. The BSO includes a range of service models targeting various segments of the LTC population. Where, for the moderate group, homes have expressed their preference for the embedded model with enhanced care levels and specialized (and permanent) in-house supports. Care to residents with severe behaviour issues require specialized behaviour units; both transitional and long term.

The transitional designated behaviour unit model, although applauded by homes, suffers from an alternate level of care (ALC) problem in that many residents, when ready to return to a general unit, find no open beds and end up staying in the behaviour unit at the expense of those waiting to get in. A solution to this LTC ALC problem will be a major challenge that must be solved going forward. The number and geographic distribution of specialized units should be determined to ensure access for direct referrals and for those deemed inappropriate for placement into homes with such resources. In both cases the right level and mix of staff, with properly funded training and development opportunities, are required.

Currently, some homes provide dementia units serving 17.7% of the resident population, or just over 13,000 people, at any given time. These units receive no additional funding. Unlike formally sanctioned “designated” or “specialized” behaviour units, dementia units have varying levels of care and special programming. The more formal behaviour units, of which there are 6 in the province with a total of 117 beds, often receive funding through their LHIN either from Aging at Home funds or as BSO projects. Otherwise homes wishing to open a designated behaviour unit must demonstrate that they can afford to do so.

With respect to those with severe aggressive behaviours we propose the following:

Rec. 4. The Ministry must revise the applicable regulations to enable homes, based on reasonable criteria, to redirect admission of residents, and the right to transfer existing residents, deemed to pose a significant risk to other residents and staff due to aggressive behaviour to a designated behaviour unit.

Rec. 5. In order to ensure the safety of all residents and staff, OANHSS recommends that the Ministry expand the number of designated units for extremely aggressive residents and that homes without designated units be permitted to transfer or refer residents to such specialized units or other appropriate settings within the mental health system as appropriate.

Rec. 6. That the Ministry, based on BSO designated unit staffing models, fund all existing and new designated units across the province and that designated unit funding be separate from level of care funding.

Our main concern in this submission is that the people affected by aggressive behaviours be provided with a higher level of care by properly trained staff in order to maximize the safety and well-being of all LTC residents and staff. It is time for a province-wide implementation of strategies that homes know to be effective on a project basis. Throughout this submission we also have highlighted the need to gain a better understanding of the characteristics of the resident population displaying aggressive and related behaviours. In that regard, we further recommend that:

Rec. 7. In concert with the foregoing recommendations, the province needs to facilitate a research project that will investigate, in detail, the characteristics of residents and potential residents at risk of aggressive behaviours, with the objective of identifying various levels of risk within that population. That research should also assess the care needs of the various risk-levels in order to determine their fit within the scope of practice within LTC.

3.0 Conclusion

If implemented, our recommendations will improve the safety and well-being of all LTC residents and staff. In addition, over time, the proposed changes may dampen the magnitude of aggressive behaviours as a result of improved levels and quality of care.

Along with the improved approach to behaviours we expect to see decreases in the use of chemical and physical restraints, along with a broader positive evolution in the care culture within homes.

To achieve these benefits it is imperative that the government act quickly to implement these improvements, province-wide, in order to deal with the risks associated with the growing issue of dementias, and associated mental health issues that compound the risk of aggressive behaviours.

The proposed measures will enable LTC homes to maximize safety and well-being for all concerned.

Appendices

APPENDIX 1: Costing Detail

Recommendation 1: 1.5% Maintenance Increase to NPC and PSS Envelopes.

	Current Per Dia	*Increase PRD (1.5%)*	*Incremental Increase (rec cost)*
NPC	88.93	0.89	**25,253,452**
PSS	8.87	0.09	**2,518,814**
Total	97.80	0.98	**27,772,266**

Estimated Cost = $27.772M

Recommendation 2: Behaviour staffing increment for moderate behaviours - consistent with current estimates of RUGs shortfall.

	FTE Increase	**Annualized**
PSW	780	32,760,000
PSW - Behaviour Lead	360	18,720,000
Behaviour Therapist	630	40,950,000
Total	1,770	92,430,000

The costing assumes:

1 PSW FTE per 100 beds
1 PSW Behaviour Lead per 200 beds
1 Behaviour Therapist per home.

Estimated Cost = $92.430M

Recommendation 3: Regular Behaviour-related Training

Training	Training Days per annum	FTE Estimate	Estimated Tuition/Fees	Backfill Cost	Total Annual Cost
Registered Staff	2 day	11,873	2,255,899	5,801,334	8,057,233
PSW/HCA/Other Aids	1 day	29,364	2,202,337	4,681,890	6,884,226
Other Staff (NPC and PSS)	1 day	1,375	103,155	257,400	360,556
Total		**42,613**	**4,561,391**	**7,839,957**	**15,302,015**
Tuition Costs based on PIECES and U-FIRST, FTE based on MOHLTC Staffing Report Data for 2012					

The costing assumes:

2 day training per Registered staff member (e.g. RNs, RPNs, OT, PT, Social Workers)
1 day training per PSW/HCA and Other Aids
1 day training for Other NPC and PSS staff

Course costs are based on PIECES and U-First cost, backfill costs are based on average hourly wage based on MOHLTC Staffing Report data for 2012.

Estimated Cost = $15.302M

Recommendation 4: Regulation changes to enable redirection and referrals directly to Behaviour Units.

NO Cost

Recommendation 5: Increase Number of Designated Behaviour Units using the BSO staffing.

Estimated Cost = TBD

Recommendation 6: Ministry Funding for New and Existing BSO-modeled Designated Behaviour Units.

Estimated Cost = TBD

Recommendation 7: Behaviours Research

Estimated Cost = $0.250M

Based on discussions with researchers in the field.

Total Cost (costed items only)

Recommendation 1	$27.772M
Recommendation 2	$15.302M
Recommendation 3	$92.430M
Recommendation 7	$0.250
Total Costed Recommendations	**$135.754M**

APPENDIX 2: Aggressive Behaviour Scale (ABS) Scoring

ABS[8] is a four item summary scale measuring verbal and physical abuse, socially inappropriate behaviour, and resisting care. The frequency of items is coded for the 7 days prior to assessment. Frequency of each behaviour is scored as:

0 – Behaviour not exhibited

1 – Behaviour occurred 1 to 3 days in the past 7 days

2 – Behaviour occurred 4 to 6 days of the previous 7, but less than daily

3 – Behaviour occurred daily

The frequency measure rating for each of the individual behaviours is summed to determine an individual's ABS score. Scores can range for 0 to 12. A score of 5 or greater is considered severe.

[8] Perlman, C.M and Hirdes, J.P. The Aggressive Behaviour Scale: A New Scale to Measure Aggression Based on the Minimum Data Set. Journal of the American Geriatrics Society. Vol. 56 (12), Dec. 2008.