Focus on the Future:

Long-Term Care Initiative

A Report to the Honourable Don McMorris, Minister of Health

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Long-Term Care Initiative

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Executive Summary

Background

The seniors population in Saskatchewan falls along a continuum of care, starting at point where a healthy, active senior is living independently and in their home all the way to those seniors living in institutional settings such as a special-care home. It is not unreasonable to conclude that the majority of Saskatchewan's seniors are continuing to live healthier lives and remaining independent in their community. This is supported by the clear message from the public consultations that seniors want to age-in-place and remain in their homes and communities for as long as possible.

As we look for ways to address the sustainability of the health system – including the continuum of care – there may be some merit in considering how resources might be allocated to ensure seniors remain independent, and living in their homes and communities for as long as possible. Saskatchewan has one of the highest bed ratios in special-care homes, yet on the other hand, Saskatchewan has one of the lowest per capita spending on home care services per person age 75 +. This suggests there may be some cost-efficiencies to realize along continuum of care. This combined with exploring opportunities for how other community-based services can be maximized to their full potential will ensure the continuum of care is sustainable for our future seniors.

Public Consultations

After hearing from many seniors, employees of Regional Health Authorities and other interested stakeholders about the five areas of investigation, it became very apparent that many of our Saskatchewan seniors are vibrant, healthy, active and contribute greatly to our society. They want to remain living in their community for as long as possible with the option to age-in-place. Saskatchewan seniors are also prudent in how they would like to see public funds spent and strongly supported government 'stretching' the taxpayers dollars to achieve maximum outcomes.

It was quite obvious after the consultations were complete that two areas of utmost priority were: accessibility to personal care homes and home care supports.

Regarding *accessibility to personal care homes*, there was a clear message that a subsidy is needed for residents of personal care homes with an assessed care and income need. There is also a strong desire for more frequent inspections of personal care homes to ensure quality of care. In addition, the public would like more information about personal care homes to be publicly available to assist individuals with selecting an appropriate personal care home.

During the discussions about *home care supports*, there was a general feeling that there are inadequate levels of homemaking and home maintenance services available through the home care program. In addition, home care clients frequently felt they did not have a consistent care provider.

While the remaining three areas of investigation did not appear to rank as high in priority as that of accessibility to personal care homes and home care supports, they still generated some clear messages.

With respect to the *feasibility of establishing a seniors' secretariat*, there was general agreement that there is a need for two functions within government – a general inquiry line dedicated to seniors and a seniors' (or vulnerable adults) advocate. There was general agreement that an inquiry line or advocate would be desirable but there was not a strong desire to see public dollars used on the development of another 'bureaucracy' when there are other outstanding needs and concerns.

While it was somewhat difficult to engage seniors and elders in discussing *falls prevention*, one main theme came through, there needs to be increased awareness and education about falls prevention. In addition, there was some desire to see coordination of falls prevention resources at a provincial level.

Lastly, the topic of *abuse of older adults* generated some interesting findings. Seniors strongly voiced their right to choose to live 'at risk' and were thus opposed to mandatory reporting. A strong message was that there needs to be increased awareness and education about abuse of older adults. For those individuals requiring (and wanting) some supports to deal with abuse of older adults, additional options need to be available.

While the discussions at the public consultations were limited to the five topic areas, a range of concerns and issues were expressed centred around a general lack of geriatric focused services. They ranged from the oral health of seniors to the capacity of occupational therapists to provide further supports to seniors in their homes.

This report describes the current situation of the five topic areas, the major consultation findings and identifies opportunities for future action.

Introduction

As Legislative Secretary, I was asked to undertake a Long-Term Care Initiative to investigate the following five specific issues through public consultations and research:

- accessibility of personal care homes;
- home care supports;
- feasibility of developing a seniors' secretariat;
- falls prevention; and
- abuse of older adults.

Throughout the months of September and October 2009, I held thirteen public consultations throughout the province in twelve Regional Health Authorities with a separate consultation for senior employees of Regional Health Authorities. In total I met with approximately 450 seniors, employees of Regional Health Authorities and other interested stakeholders. Additionally, I met with other interested individuals who were unable to attend one of the consultations but had concerns and thoughts they wanted to express and share. I also hosted a 'focus group' in January 2010 to reconfirm my preliminary findings and to ensure that the opportunities for action I was considering were acceptable to seniors and other stakeholders. See *Appendix A – Consultations* for complete details.

Continuing Care in Saskatchewan

The seniors population in Saskatchewan falls along a continuum of care, starting at point where a healthy, active senior is living independently and in their home all the way to those seniors living in institutional settings such as a special-care home. While the majority of residents in special-care homes are seniors, this represents about only 5% of the seniors' population in Saskatchewan. That being said, it is not unreasonable to conclude that the majority of Saskatchewan's seniors are continuing to live healthier lives and remaining independent in their community. This is supported by the clear message from the public consultations that seniors want to age-in-place and remain in their homes and communities for as long as possible.

Given the above, and the issue of the sustainability of the health system – including the continuum of care – there may be some merit in considering how resources might be allocated to ensure seniors remain independent, and living in their homes and communities for as long as possible. Saskatchewan has one of the highest bed ratios in special-care homes among jurisdictions at 109.1 per 1,000 population age 75+ (the national average long-term care bed ratio is 93.6 per 1,000 population age 75+). On the other hand, Saskatchewan has one of the lowest per capita spending on home care services at $1,508 per person age 75 + where the national average is $2,236 per person age 75+. The statistics suggest there may be some cost-efficiencies in bringing Saskatchewan in-line with the national averages, both for home care and long-term care, as long-term care is the most costly service to provide in the continuum of care while home care is one of the most cost-effective and economical. This, combined with exploring opportunities for how other community-based services can be maximized to their full potential, will ensure the continuum of care is sustainable for our future seniors.

In November 2007, the Premier of Saskatchewan outlined a number of key initiatives to carry out our Government's plan for *Securing the Future*. There is a need to identify and address gaps in the current continuum of care provided through home care, community care and long-term care. It is important to consider programs and services that assist seniors in accessing appropriate health care services and accommodate the future growth and corresponding needs of Saskatchewan's seniors population, identify issues that interfere with the growth and care of our seniors population, and recommended approaches to communicate the importance of the seniors of today and tomorrow in Saskatchewan.

Patient First Review

The Patient First Review was completed in October 2009 and it identified a number of items that focus on strengthening the continuum of care:

- system capacity to support independent living;
- accessibility to personal care homes by addressing the current financial barriers for low-income seniors;
- accessibility and quality of assisted living and long-term care;
- programming for seniors with extraordinary behaviours that cannot be safely managed in the general long-term care population (e.g. specialized assessment and treatment units); and
- capacity of geriatric assessment programs to provide multidisciplinary assessments, short-term rehabilitation, day programs, and a specialized outpatient clinic.

II. Summary of Major Consultation Findings and Recommendations

Area of Investigation	Major Consultation Findings	Recommendations
Accessibility of Personal Care Homes	A subsidy is needed for residents of personal care homes with an assessed care and income need.	Where an individual has an assessed care and income need for a personal care home, as identified by the Regional Health Authority, provide a subsidy to the individual.
	There needs to be more frequent inspections of personal care homes to ensure quality of care. In addition, more information about personal care homes needs to be publicly available to assist individuals with selecting an appropriate personal care home.	Increase the frequency of personal care home inspections and make more information about them available to the public.
Home Care Supports	There are inadequate levels of homemaking and home maintenance services available through the home care program.	Provide Regional Health Authorities with targeted funding for home supports to bring Saskatchewan in line with the national average.
	Home care clients frequently do not have a consistent care provider.	Health care workers and decision-makers should ensure they are patient and family-centred in all aspects of their work.

Area of Investigation	Major Consultation Findings	Recommendations
Feasibility of Establishing a Seniors' Secretariat	There is a need for a general inquiry line.	Ensure there is a well advertised toll-free phone number for 'senior-related' public inquiries.
	There is a need for a seniors' (or vulnerable adults) advocate.	Create a Seniors' Secretariat within the Ministry of Health using existing human resources and ensure that seniors' issues are recognized at executive decision-making tables. Lastly, establish a council of seniors to advise government and to advocate on behalf of seniors.
Falls Prevention	There needs to be increased awareness and education about falls prevention.	Undertake a public service campaign to raise the awareness of falls prevention.
		The Ministry of Health and Regional Health Authorities collaboratively develop falls prevention materials.
Abuse of Older Adults	There needs to be increased awareness and education about abuse of older adults.	Undertake a public service campaign to raise the awareness of the abuse of older adults.
	Additional options need to be available for those individuals requiring (and wanting) some supports to deal with abuse of older adults.	Explore the possibility of the Ministry of Justice and Attorney General implementing legislation for a public personal guardian.

III. Areas of Investigation

Accessibility of Personal Care Homes

Personal care homes, while monitored and regulated by the Ministry of Health, are privately owned and operated by individuals or corporations. Personal care homes are not publicly subsidized – the resident pays for the full cost of their care. Personal care home fees can range from about $1,000 per month to over $3,500 per month. Despite this, personal care homes are a component of the continuum of care. For further details on the continuum of care, see *Appendix B – Continuum of Care*.

Personal care homes provide accommodation and care options for individuals with usually lighter care needs. The average age of a personal care home resident is 81.4 years of age. It is not necessary for individuals to demonstrate need to be admitted to a personal care home; rather a resident is admitted when he or she chooses this option. Since 1991, the number of personal care home beds has grown by over 120% (e.g., 1,464 in 1991 to 3,249 in 2010). See *Appendix C – Growth in Personal Care Home Beds*.

The Ministry of Health is responsible for regulating a number of programs, such as public health and approved mental health homes. For both of these programs, the Regional Health Authority is directly responsible for undertaking the inspecting and monitoring responsibilities. Personal care homes is somewhat different, in that the Ministry of Health is responsible for regulation, including licensing, monitoring (e.g., inspections), complaint investigations, case management, policy development, education, etc. to ensure that the residents who live in these homes receive safe and adequate care. There is currently one provincial co-ordinator and five personal care home consultants to carry out these responsibilities for the province.

The Ministry of Health and the Ministry of Social Services regularly hear from individuals and organizations respecting the difficulties that low-income individuals, mostly seniors, are having in affording personal care homes when their needs cannot be sustained with home care or their needs are not great enough to access a publicly subsidized special-care home. This issue is continuing to grow as there are increasing pressures on special-care homes and home care.

Major Consultation Findings

A subsidy is needed for residents of personal care homes with an assessed care and income need. There was almost unanimous agreement at all consultations that there is a 'gap' in the continuum of care. This sentiment was also echoed in the *Patient First Review*. While all other care options have some form of subsidy for the individual based on need (home care, social housing and special-care) the fee for personal care homes is paid for fully by the resident. Many individuals and interest groups pointed out the significant difficulties that low-income individuals, most times seniors, have in affording personal care homes. This is especially difficult for those individuals whose needs cannot be sustained with home care (e.g. persons with early stage dementia) yet their needs are not great enough to access a publicly subsidized special-care home. Many seniors need intermediate, transitional support, such as a personal care home, yet this option is often unaffordable.

There needs to be more frequent inspections of personal care homes to ensure quality of care. In addition, more information about personal care homes needs to be publicly available to assist individuals with selecting an appropriate personal care home. There was considerable concern expressed about the low frequency and lack of transparency of inspections.

There were other concerns raised that there are a lack of training opportunities for staff of personal care homes – ranging from general care to specialized care. In addition, the care needs of residents is increasing which further increases the needs for additional training. These two issues combined present a challenge for staff working in personal care homes in meeting the increasing care needs of their residents.

There were also concerns raised regarding personal care homes, such as the availability of funds for capital development and maintenance, particularly for those personal care homes that are non-profit, which are typically community-based and governed by a board.

Given the clear message that seniors want to age-in-place, there may be opportunities to explore how personal care homes can assist with addressing this concern. For example, it was expressed in consultations that a resident of a personal care home should have the option to remain there regardless of their care needs. Yet many personal care homes do not have the ability to manage residents' increasing care needs as it can be difficult to access professional nursing services through home care. This may be viewed as not supporting an aging-in-place philosophy as the resident typically has to move to a special-care home.

Lastly, some personal care home operators pointed out that there is a discrepancy in level of care rates between personal care homes and approved homes (approved mental health homes and approved private service homes) paid by the Ministry of Social Services.

Research

(a) Jurisdictional Scan of Subsidies Available to Residents of Similar Facilities

A scan in Alberta, British Columbia and Manitoba of facilities that are similar to Saskatchewan's personal care homes found that all three jurisdictions provide some form of subsidy or coverage. In British Columbia, Alberta and Manitoba, an individual must have an assessed need to receive coverage in a 'personal care home'. Their care component is covered while the resident pays for the accommodation component or service package. In all three jurisdictions, the assessment is done by the local Regional Health Authority. See *Appendix D – Jurisdictional Scan of Personal Care Homes* for further details.

(b) Frequency of Inspections and Caseloads

The caseloads of personal care home consultants tend to be at least double what their colleague's caseloads are from other regulatory programs in Saskatchewan which affects how frequently they can be in personal care homes to conduct inspections. The Ministry of Education has a program that functions similarly to that of the personal care homes program in that they have direct responsibility for licensing and regulating child care homes and centres. When comparing the caseload per consultant for these two programs, the average caseload is 23 child care homes and centres per consultant versus 51 personal care homes per consultant. See *Appendix J – Caseloads of Regulatory Programs in Saskatchewan*.

(c) Ombudsman Saskatchewan

In January 2010, the Provincial Ombudsman voiced support for addressing the financial barriers to low-income seniors in accessing personal care homes. In addition, the Provincial Ombudsman also raised concern "*that the Ministry of Health does not provide any information to the public on any reviews or investigations conducted on personal care homes to assist families in selecting one*."

To conclude, the issues raised throughout the consultations regarding personal care homes are consistent with the review of Ombudsman Saskatchewan which focuses on strengthening "*the accessibility of personal care homes by addressing the current financial barriers for low-income seniors*."

Recommendations

Where an individual has an assessed care and income need for a personal care home, as identified by the Regional Health Authority, provide a subsidy to the individual.

Increase the frequency of personal care home inspections and make more information about them available to the public.

Home Care Supports

Home care was designed to help people who need acute, palliative and supportive care to remain independent in their home. The functions of home care include acute care/hospital substitution, special-care home substitution, and assistance with keeping people as independent as possible at home. Home care services include case management and assessment, nursing, meals, therapies (in some areas), personal care, home management and homemaking, respite, minor home maintenance, and certain volunteer services such as visiting, security calls, and transportation.

The Regional Health Authorities provide the direct service delivery of the home care program. The role of the Ministry of Health is to provide policy direction and development, program reviews, monitoring, and case management where required in very special circumstances.

Major Consultation Findings

There are inadequate levels of homemaking and home maintenance services available through the home care program. Individuals felt that these services are difficult, if not impossible, to access. There was general agreement these services would allow some seniors to remain longer in their home and community. Regional Health Authorities acknowledged that these services have significantly decreased over the years as individuals are returning home from hospital earlier and thus, home care has become more focused on acute home services.

Home care clients frequently do not have a consistent care provider. Individuals often expressed frustration with having a different care provider when they received home care services. They felt it was difficult to establish a relationship and level of trust with the care provider. There was also some acknowledgement that the

inconsistency of care providers was somewhat due to existing provisions in collective agreements. This was also a concern raised in the Patient First Review.

A common concern that was raised throughout many of the consultations was the concept of aging-in-place. It was generally acknowledged that seniors want to live at home for as long as possible, and that given the major consultation findings, it is sometimes difficult to do that. But there also is a lack of aging-in-place options in Saskatchewan. The larger centres, such as Saskatoon and Regina, offer this in a somewhat piecemeal fashion (e.g., a few projects offer assisted living services and a personal care home in the same facility). It was also raised that it can be difficult to get professional nursing support from home care for residents in personal care homes. Individuals felt there were some opportunities to explore the concept of aging-in-place and how that might 'look' within the programs of home care, personal care homes and special-care homes.

Research

Saskatchewan had the third lowest (excluding the Territories) annual per capita spending on home care services at $110 per person whereas the national average was $124 per person. In addition, Saskatchewan had the second lowest (excluding the Territories) per capita home care spending per person age 75+ at $1,429 compared to the national average of $1,976. While home care funding per capita aged 75+ is second lowest among jurisdictions, this is somewhat mitigated by the fact that the number of special-care home beds per 1,000 population aged 75+ is second highest among jurisdictions. The table below compares Saskatchewan's home care funding to the western provinces.

	2006/07 Per Capita Home Care Budget	Per Capital Age 75+ Home Care Budget
Saskatchewan	$109.84	$1,429.38
British Columbia	141.42	2,100.21
Alberta	84.04	1,698.24
Manitoba	201.79	2,897.97

See *Appendix E – Jurisdictional Scan of Home Care Funding* for further details.

In addition, the Ministry of Health undertook a comprehensive review of the home care program in 2005. One of the recommendations found in the review was that "preventive and maintenance home care services should be accorded a higher priority and be provided through a coordination/facilitation/community development function, for clients who can receive a clear benefit from such services." In addition, the review also found that there needed to be a review of existing human resource issues and develop creative solutions to address those issues which impact service delivery (e.g., consistent care providers). Both of these findings are consistent with the above referenced major findings from the consultations.

The Patient First Review also confirmed the above findings, in that it stated "*Despite modest increases in resources for home care, demand exceeds availability, leaving people to rely on informal caregivers such as an aging spouse, children, and other relatives and friends."*

Recommendations

Provide Regional Health Authorities with targeted funding for home supports to bring Saskatchewan in line with the national average.

Health care workers and decision-makers should ensure they are patient and family-centred in all aspects of their work.

Feasibility of Establishing a Seniors' Secretariat

Throughout the 1980s and early 1990s there was a Seniors' Secretariat. The seniors' portfolio became the responsibility of the Ministry of Social Services throughout the 1990s and in 1999 the seniors' portfolio has been managed by the Community Care Branch, Ministry of Health. The primary objective of the seniors' portfolio is to promote and enhance the health and well-being of older persons in Saskatchewan by working collaboratively with stakeholders, other government ministries (e.g., Social Services, Justice and Attorney General, etc.) and organizations to jointly address issues related to older persons. The Community Care Branch is also the key contact with the federal government on seniors' issues and programming (e.g., New Horizons for Seniors, Federal/Provincial/Territorial Seniors Forum, etc.).

In addition, the seniors' portfolio works with other branches and consultants within the Ministry of Health to address seniors' issues such as active and healthy aging, special-care homes, home care, personal care homes, access to extended benefits such as dental and optical services, etc. Given that many seniors' issues and concerns are health-related, the Community Care Branch has been in a favourable position to respond to and manage many of the issues and concerns.

Major Consultation Findings

There is a need for a general inquiry line. Individuals, including non-seniors, felt it was difficult to connect with the 'right' person to answer their questions, direct them to the appropriate program and/or resource, and have their issues/concerns resolved (e.g., case management). They felt that they frequently had to repeat their 'story' which left them feeling frustrated, angry and sometimes confused.

There is a need for a seniors' (or vulnerable adults) advocate. In particular, there was general agreement that vulnerable adults need someone who can advocate on their behalf particularly when it comes to health services and navigating the health system. There was some suggestion that there should be a seniors' ombudsman. However, the Provincial Ombudsman indicated they have staff assigned to manage seniors' issues and concerns and by developing an official seniors' ombudsman, there will likely be criticism for not having other specialized ombudsmen.

There was general agreement that an inquiry line or advocate would be desirable but there was not a strong desire to see public dollars used on the development of another 'bureaucracy' when there are other outstanding needs and concerns. In some instances, there was even a strong negative reaction to creating another 'bureaucracy'.

Of the few individuals who supported the concept of a seniors' secretariat, they strongly felt that it should be at 'arms-length' from government, similar to the Children's Advocate Office, have a broad focus and be 'driven' by seniors and 'for' seniors.

Research

A scan across Canada found that the majority of jurisdictions have a seniors' secretariat located within a Ministry – the majority of which were Health. On the other hand, five jurisdictions, including Saskatchewan, do not have a seniors' secretariat but manage a seniors' portfolio or file. There was only one jurisdiction that had a stand-alone secretariat.

Stand-Alone	Nova Scotia
Secretariat Within the Ministry of: - Health - Social Services - Culture - Families, Seniors and Women - Social Development	Manitoba, Newfoundland, British Columbia Prince Edward Island Ontario Quebec New Brunswick
No Secretariat	Northwest Territories Yukon Nunavut Alberta Saskatchewan

See *Appendix F – Jurisdictional Scan of Seniors' Secretariats* for further details.

Within the Government of Saskatchewan, there are a number of secretariats, such as the Office of Disability Issues, Status of Women Office and Nursing Secretariat. These offices are similar to what a seniors' secretariat might look like as they represent select groups. All of these offices exist within other Ministries and focus primarily on policy direction.

Office of Disability Issues (Ministry of Social Services)	3 FTEs 2009/10 Budget = $280K
Status of Women Office (Ministry of Advanced Education, Employment and Labour)	4 FTEs 2008/09 Expenditures = $384K
Nursing Secretariat (Ministry of Health)	3 existing FTEs No additional funding required upon creation.

Recommendations

Ensure there is a well advertised toll-free phone number for 'senior-related' public inquiries.

NOTE: An alternative to this recommendation would be that this function be managed by HealthLine, however, there would be significant additional costs. On the other hand, there may be merit in investigating the re-establishment of the provincial inquiry line which was for all inquiries and open to the general public, however, this also would have significant additional costs.

Create a Seniors' Secretariat within the Ministry of Health using existing human resources and ensure that seniors' issues are recognized at executive decision-making tables. Lastly, establish a council of seniors to advise government and to advocate on behalf of seniors.

NOTE: An alternative to this recommendation is that the advocacy function could be managed, in part, by a newly developed Health Ombudsman, however, there may be additional costs. However, the Provincial Ombudsman indicated there would be challenges in being both an advocate and the ombudsman and that personal guardianship legislation would go a long way in addressing the need for a vulnerable adults advocate. For further details and analysis of personal guardianship legislation, see *Abuse of Older Adults*, pages 22 to 29.

Falls Prevention

Falls are one of the most complex injury issues facing seniors. Research has suggested that in Saskatchewan falls are the leading cause of injury for children and for all adults 35 and older. They account for almost half of the hospitalized injuries and unintentional falls and were the leading cause of death among seniors. According to the *Saskatchewan Comprehensive Injury Surveillance Report, 1995-2005,* falls among Saskatchewan seniors living in their own homes are common and have significant costs to the individual and the community in terms of death, pain, disability and handicap, reduced confidence and activity, as well as financial burden.

According to Safe Saskatchewan, of the $125 million in direct costs spent on falls, over $56 million is due to falls among Saskatchewan's seniors. As well, over 80% of injury costs related to seniors are the result of falls. They also state that one in three seniors will fall every year and that half of seniors who fall, do so repeatedly. Lastly, Safe Saskatchewan's statistics indicate that seniors' falls result in close to 3,000 hospitalizations every year.

Major Consultation Findings

There needs to be increased awareness and education about falls prevention.

It was difficult to engage seniors and elders in discussing this particular topic. For the most part, health care providers and professionals primarily participated in this discussion and were quite supportive of falls prevention programs. Health professionals and care providers seemed to be well informed of the effects of a fall and the benefits of preventative efforts. Many Regional Health Authorities and health care providers shared information about falls prevention resources they had developed

and that were used. It was suggested that falls prevention materials and information be shared with other Regional Health Authorities in the spirit of collaboration.

On the other hand, many seniors seemed indifferent or less concerned about a fall. When they were urged to provide their view on falls prevention many seniors indicated they were not *old enough* to worry about a fall or that they did not need an assistive device because it "*made them look old"*. Other seniors expressed that they never had a fall or never really thought about it.

Research

(a) Federal/Provincial/Territorial Seniors Forum

There is significant research on falls prevention, ranging from the economic cost falls has on our society to the psychological effects it has on a senior and the effectiveness of fall prevention programs. The F/P/T Seniors Forum has undertaken a number of initiatives over the years looking at falls among seniors:

- *An Inventory of Canadian Programs for the Prevention of Falls Among Seniors Living in the Community* (2001) – compilation of community-based fall prevention programs, including scope and type of fall prevention activities.
- *A Best Practices Guide for the Prevention of Falls Among Seniors Living in the Community* (2001) – looks at the effectiveness of fall prevention strategies and interventions.
- *Listing of Initiatives for Falls Prevention Among Seniors Living in the Community* (2003) – highlights injury and fall prevention projects across Canada.

– *Inventory of Fall Prevention Initiatives in Canada* (2005) – provides a snapshot of falls prevention activities across Canada.

(b) Fall Injuries Among Saskatchewan Seniors, 1992/93-1997/98

In October 2002, the Ministry of Health undertook a research project investigating fall injuries among Saskatchewan seniors. The major findings were:

– Almost 17,000 fall episodes were recorded in the six-year study period. This corresponds to an average of almost 3,000 fall episodes per year, and an average rate of 19.5 falls per 1,000 senior population.
– The number of seniors hospitalized for fall-related injuries was 14,691, averaging 2,449 per year, and an annual average rate of 16.9 admissions per 1,000 senior population.

See *Appendix H – Jurisdictional Scan of Falls Admissions, 1999/2000* for a provincial summary.

(c) Safe Saskatchewan – Seniors' Falls Injury Prevention Strategy/Regional Health Authority Falls Prevention Programming

Safe Saskatchewan's *Seniors' Falls Injury Prevention Strategy* promotes the provision of appropriate and accessible education, and awareness on fall prevention for everyone. The Strategy advocates for a coordinated approach in addressing falls prevention and additional human and financial resources of 15 FTEs and $1.8M annualized impacting both the Ministry of Health and Regional Health Authorities.

In December 2009, Safe Saskatchewan undertook a provincial seniors' fall inventory and almost every Regional Health Authority is undertaking some

kind of work focused on falls prevention and seems to have resources dedicated to this issue. See *Appendix I – Provincial Falls Inventory* for a complete listing of falls activities happening in Regional Health Authorities.

Recommendations

Undertake a public service campaign to raise the awareness of falls prevention.

The Ministry of Health and Regional Health Authorities collaboratively develop falls prevention materials.

Abuse of Older Adults

Saskatchewan has a wide range of legislative and non-legislative options in place to protect vulnerable adults. These options span both the Ministry of Health and the Ministry of Justice and Attorney General. In addition, health professionals typically have a code of ethics that encompass core values protecting and promoting the well-being of their clients/patients. Lastly, health programs and services delivered by Regional Health Authorities have policies on reporting and managing incidents of abuse.

Major Consultation Findings

There needs to be increased awareness and education about abuse of older adults.

An interesting finding of the consultations was that the majority of health care professionals/care providers felt that mandatory reporting of elder abuse was necessary. On the other hand, many seniors felt that if they were 'competent' it was their right to choose to live 'at risk' and were thus opposed to mandatory reporting.

Additional options need to be available for those individuals requiring (and wanting) some supports to deal with abuse of older adults.

As mentioned above, many seniors expressed they have a right to live their lives the way they want as long as they are mentally capable and competent. But, they also expressed an interest in having options available to provide them with support and advice if they were in an abusive situation.

This particular topic was one of the most difficult to engage seniors and elders to discuss. For the most part, health care providers and professionals primarily participated in this discussion and were quite supportive of mandatory reporting. But, when seniors were urged to provide their view on mandatory reporting it was clear that many were opposed to the concept. And to paraphrase the viewpoint of one senior on this topic "*If I am of sound mind and want to provide my family with gifts of money, or make a decision to live in a situation someone does not support or agree with, that should be my choice and nobody has the right to take that away from me.*"

Many people voiced the belief that since there is mandatory reporting for abuse of children the same should be required for abuse of older adults. But many articulated that there is one significant difference between children and seniors – almost all children are dependent and vulnerable whereas only a small minority of seniors are dependent and vulnerable. In addition, a number of individuals raised concern about the inadequate resources in place to thoroughly investigate and follow-up on alleged cases of child abuse. Therefore, before government considers mandatory reporting of abuse of older adults, government should ensure the proper resources are in place for follow-up and investigation.

Research

(a) Mandatory Reporting

In 2003, the F/P/T Seniors Forum undertook *An Environmental Scan of Abuse and Neglect of Older Adults in Canada: What's Working and Why*. One of the components of that scan was a jurisdictional review of adult protection legislation – including reporting requirements. Only two jurisdictions (Newfoundland and Labrador and Nova Scotia) have general mandatory reporting requirements in their adult protection legislation (e.g., the law states that everyone has a duty to report suspected abuse or neglect). According to Canadian Network for the Prevention of

Elder Abuse, Newfoundland and Labrador's law has been viewed as dealing with neglect, self neglect and possibly physical abuse. Nova Scotia's adult protection law covers physical and psychological abuse, but does not cover financial abuse. It should be noted that a discussion paper on Nova Scotia's *Adult Protection Act* noted that the province is recommending that the current provisions for mandatory reporting should be amended and that only certain professionals be required to report suspected abuse or neglect. Lastly, neither Nova Scotia nor Newfoundland and Labrador collect data on their mandatory reporting so there is not any indication whether it is effective.

On the other hand, three jurisdictions have adult protection legislation which includes a voluntary reporting requirement (British Columbia, New Brunswick and Prince Edward Island). Lastly, all jurisdictions have some form of adult protection statute but without a reporting requirement. See *Appendix G – Jurisdictional Scan of Adult Protection Legislation*.

Table 1 – Arguments in Favour of and Against Mandatory Reporting

Pros	Cons
+ people believe there is some degree of social responsibility for the well-being of older adults + eliminates the perception that there is a lack of response/resources from community services + demonstrates that abuse of older adults will not be tolerated + all members of society have equal protection of the law + moves service providers to action	– research indicates that reporting is substantially less effective than public and professional awareness – older adults have right to live their lives the way they want as long as they are mentally capable of doing so – there are already many laws in place to protect vulnerable adults – mandatory reporting systems are typically under-resourced – may result in a two-tiered approach to investigation – initially by civil authority and then by police later – resulting in impediments to police investigations and loss of evidence – requires considerable human and financial resources

(b) Situation in Saskatchewan

The Ministry of Health has a number of legislative options in place to address the issue of abuse (including abuse of older adults).

i. *The Regional Health Services Act* addresses the governance and accountability of the Regional Health Authorities and establishes standards for the operation of various programs.

- Under the critical incident regulations a Regional Health Authority must give the Minister notice of any critical incident that: occurs in a facility that the Regional Health Authority operates; is in relation to a health service that the Regional Health Authority provides or a program that the Regional Health Authority operates.
- A 'critical incident' means a serious adverse health event including, but not limited to, the actual or potential loss of life, limb or function related to a health care service provided by, or a program operated by, an Regional Health Authority or health care organization.
- The *Saskatchewan Critical Incident Reporting Guideline, 2004*, was developed to accompany the regulations. The *Guideline* defines 'critical incident' and lists 40 events to be reported to the Ministry of Health. Criminal events are captured under Section VI of the Guideline.

ii. *The Personal Care Homes Act* regulates the establishment, size and standards of services of personal care homes.

- A home must be licensed as a personal care home if it provides accommodation, meals and assistance or supervision with activities of daily living to an adult aged 18 and older who is not a relative.

iii. *The Hearing Aid Sales and Services Act* regulates private businesses in Saskatchewan involved in the selling of hearing aids.

iv. *The Housing and Special-Care Homes Act* regulates the establishment, licensing and funding of special-care homes (long-term care facilities) in the province.

- This Act has been repealed, but not all sections of the repeal have been proclaimed, given the transfer of responsibility to Regional Health Authorities.

v. *The Mental Health Services Act* regulates the provision of mental health services in the province and the protection of people living with mental health issues.

The Ministry of Health also has a non-legislative option in place to address this issue. Each Regional Health Authority has a quality of care co-ordinator or client representative in place. The role of the quality of care co-ordinator is to: assist individuals and families with questions or concerns about health services in their region; ensure individuals are informed about their rights and options; and recommend changes and improvements to enhance the quality of health services delivered in the region based on their findings and trends of concerns raised.

The Ministry of Justice and Attorney General also has a number of legislative options in place to address the issue of abuse (including abuse of older adults).

i. *The Adult Guardianship and Co-decision-making Act* sets out the procedures for the appointment of:

- a personal or property guardian for individuals who are incapable of managing their own personal or financial affairs;

- a personal or property co-decision-maker for adults requiring assistance in decision-making but who do not require guardians; and
- temporary personal or property guardians in emergency situations.

ii. *The Public Guardian and Trustee Act* gives the Office of the Public Guardian and Trustee the ability to appoint a public official to protect vulnerable persons' property.

- If there does not appear to be any other suitable person to be appointed, the Public Guardian and Trustee may act or be appointed:
  - to administer the property of deceased persons;
  - as a trustee, to protect the property rights of children under the age of 18;
  - as an attorney respecting the property of a person in accordance with the terms of a power of attorney; and
  - to administer the property and finances of adults who are incapable of managing their financial affairs.

iii. *The Mentally Disordered Persons Act* provides that the chief psychiatrist of a facility may have a patient of that facility examined by a physician to determine whether the patient is competent to manage his or her estate.

- If he or she considers it advisable, the chief psychiatrist may also make arrangements for any person to be examined to determine that person's competence to manage his or her own estate.
- If a patient or any person is found incompetent, the chief psychiatrist shall:
  - issue a certificate of incompetence in respect of that person;
  - forward the certificate to the Public Guardian and Trustee; and

- ~ notify the patient and his or her nearest relative of the issue of the certificate, and of their right to apply to a review panel for a review of the certificate.

iv. *The Health Care Directives and Substitute Decision Makers Act* provides that competent persons who are at least 16 years of age may make a health care directive to give instructions for the medical treatment they wish to receive if they become unable to make a health care decision, or to designate a proxy regarding the same.

v. *The Dependants' Relief Act, 1996,* provides maintenance obligations for dependants following the death of a person. Dependants include spouses, common-law spouses, same sex spouses, and children.

- – Allows parents to make financial plans for their adult child living with a disability to enhance their independence and quality of life.

There is also *The Saskatchewan Evidence Act* which applies to all matters over which the province has jurisdiction.

The Ministry of Justice and Attorney General has passed public personal guardianship legislation which would protect vulnerable adults but it has never been proclaimed because of financial requirements to implement the legislation. The Provincial Ombudsman has noted that the absence of a public personal guardian demonstrates a significant gap in services by government for vulnerable persons.

Lastly, the Consumer Protection Branch at the Ministry of Justice and Attorney General helps people understand their rights and responsibilities as consumers by offering advice and direct assistance in response to consumer inquiries. They also

investigate consumer complaints like telemarketing scams and fraudulent door-to-door sales schemes.

Recommendations

Undertake a public service campaign to raise the awareness of the abuse of older adults.

Explore the possibility of the Ministry of Justice and Attorney General implementing legislation for a public personal guardian.

IV. Conclusion

This project has examined five specific issues through two methods – public consultations and research – and identified recommendations to overcome some of the major issues and concerns related to each. While none of the recommendations are a perfect 'fix', they are steps in the right direction to provide Saskatchewan's seniors with the best possible programs and services.

Seniors are fiercely independent and have vehemently stated they want to remain in their home and their community. They have also voiced loud and clear that they feel the major issues and concerns lie within accessibility to personal care homes and the range of home care supports that are available to them in their time of need.

By addressing two components of the continuum of care – personal care homes and home care – major benefits and results could be achieved. Yet realizing that the continuum of care is interconnected and that improvements or changes in one program may mean other services are affected.

If action does not happen in addressing either of the two major concerns identified within personal care homes and home care, with the increasing number of seniors yet to come as the baby boomers age, these issues will become even more critical. Through the process of this project, seniors and stakeholders have been engaged.

While some of the report recommendations require financial investment and a long-term commitment for action, other recommendations can be implemented with minimal cost over the short-term.

Appendix A – Consultations

Date	Regional Health Authority	Location	Attendees
September 21, 2009	Prairie North Health Region	North Battleford	24
September 28, 2009	Sun Country Health Region	Weyburn	6
September 30, 2009	Heartland Health Region	Rosetown	16
October 1, 2009	Cypress Health Region	Swift Current	26
October 2, 2009	Five Hills Health Region	Moose Jaw	40
October 5, 2009	Sunrise Health Region	Yorkton	25
October 6, 2009	Kelsey Trail Health Region	Melfort	18
October 7, 2009	Prince Albert Parkland Health Region	Prince Albert	28
October 8, 2009	Saskatoon Health Region	Saskatoon	100
October 13, 2009	Mamawetan Churchill River Health Region	La Ronge	14
October 14, 2009	Mamawetan Churchill River Health Region	Pinehouse Lake	26
October 15, 2009	Keewatin Yatthé Health Region	Ile a la Crosse	6
October 30, 2009	Regina Qu'Appelle Health Region	Regina	91
November 5, 2009	Administrators – Regional Health Authority		25

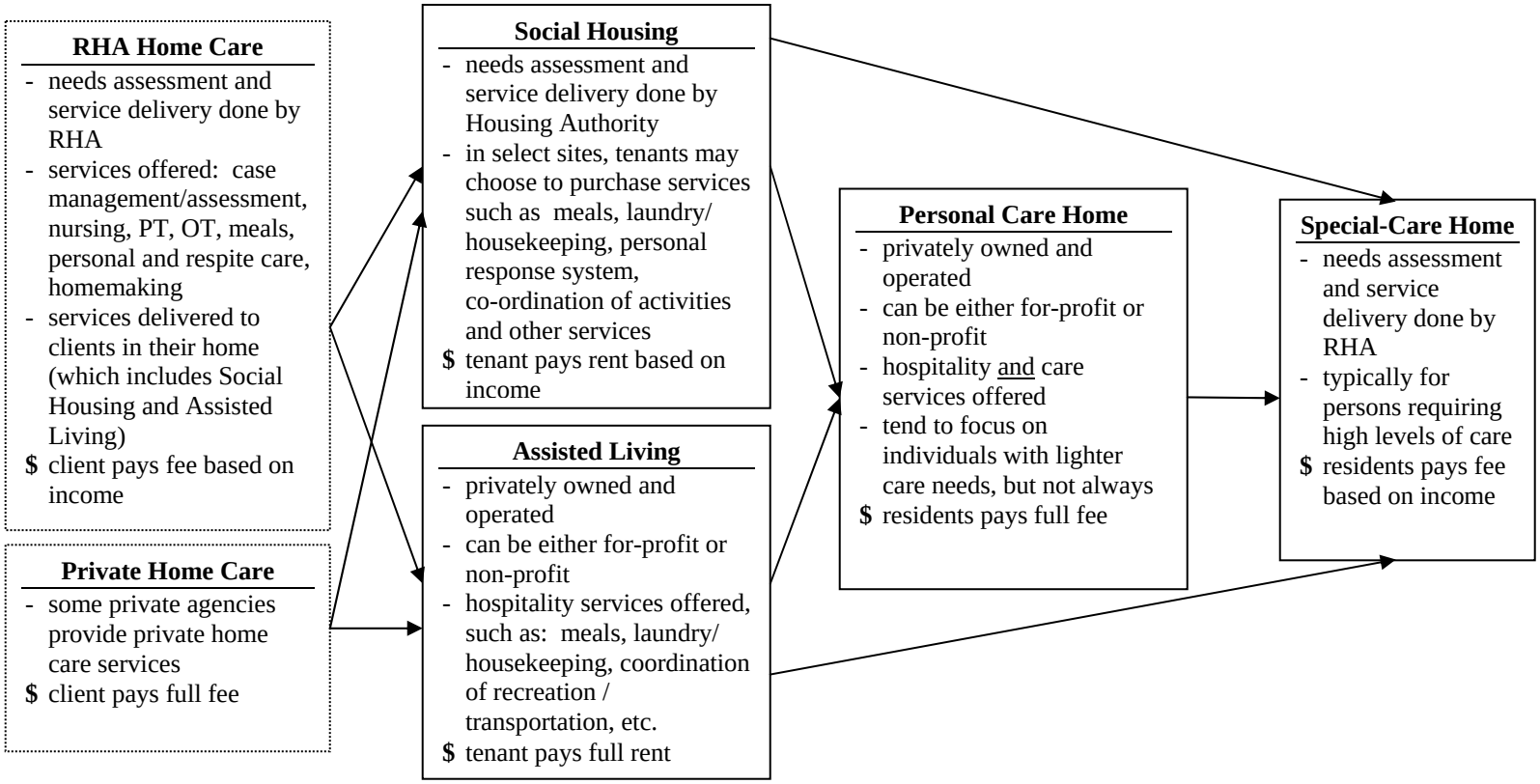
Information Gathering – Interviews/Meetings:

- Kevin Fenwick, Provincial Ombudsman, Ombudsman Saskatchewan
- Holly Schick, Executive Director, Saskatchewan Seniors Mechanism
- Creighton Working Group, Mamawetan Churchill River Health Region
- Deb Morgan, Rural and Remote Memory Clinic, University of Saskatchewan
- Regina and District Personal Care Home Association
- Saskatchewan Society of Occupational Therapists
- Jim Dalrymple and Jan Day, Coteau Range Manor
- Dr. Jenny Basran, Geriatrician, Saskatoon Health Region
- Federation of Saskatchewan Indian Nations
- Dave Moore, The Seniors' Mental Health Policy Lens Toolkit
- Dr. Anu Bhargava, Dental Care of Seniors

Focus Group Participants

- Kevin Fenwick
- Dr. Jenny Basran
- Jan Day
- Dolores Ast
- Dr. William Klassen
- Loretta Solway
- Ron Kruzeniski, Q.C.
- Sandy Devine
- Pat Kessler
- Dianne Hergott
- Brenda Pasloski
- Heather Monaghan
- Art Battiste
- Gordon Wyatt

Appendix B – Continuum of Care



Appendix C – Growth in Personal Care Homes Beds

Date	Personal Care Home Beds	Date	Personal Care Home Beds
July 1991	1,464	September 2003	2,666
August 1992	1,912	February 2004	2,653
November 1993	1,431	September 2004	2,821
March 1994	1,491	March 2005	2,935
March 1995	1,372	October 2005	2,916
March 1996	1,509	March 2006	2,994
October 1997	1,787	October 2006	3,165
March 1998	2,087	February 2007	3,197
March 1999	1,962	September 2007	3,190
September 2000	2,320	February 2008	3,242
November 2001	2,403	July 2008	3,236
February 2002	2,468	January 2009	3,254
December 2002	2,604	February 2010	3,249
March 2003	2,628		

Appendix D – Jurisdictional Scan of Personal Care Homes (PCH)

	British Columbia Community Care Facilities	Alberta Designated Assisted Living Facilities	Manitoba Residential Care Facilities
Services	– regular assistance with activities of daily living – management, control and distribution of medication – management of residents' finances or property – monitoring of residents' food intake or of adherence to therapeutic diets – behaviour-related interventions – intensive therapy for psychological and physical rehabilitation	– meals – social/recreation programs – 24-hour supervision – laundry and housekeeping services – assistance with activities of daily living – medication management administration	– accommodation – meals – on-site 24-hour supervision – control and administration of medication – assistance with personal grooming, dressing and bathing – management of the residents' personal finances
Financial Support for Residents	Community Care Facility Options: A. Contract with RHA – Ministry of Health Services covers the cost of the care component – accommodation component is paid for by the resident based on a sliding income scale – assessment done through RHA for placement in these facilities B. No Contract with RHA – resident pays full fee – similar to Saskatchewan's PCHs	A. Designated Assisted Living – Level III – private owner/operator provides care and accommodation – may have a contract with RHA for the care component through Ministry of Health and Wellness – accommodation component is paid for by the resident – placement in a 'contract' facility is determined by an RHA needs assessment – no contract with RHA → resident pays full fee → no needs assessment required → similar to Saskatchewan's PCHs B. Designated Assisted Living – Level IV – private owner/operator provides care and accommodation but with increased complexity of care from that of a Level III DAL (e.g., requires different care providers to be on staff) – may have a contract with RHA for the care component through Ministry of Health and Wellness – accommodation component is paid for by the resident – placement in a 'contract' facility is determined by an RHA needs assessment – no contract with RHA → resident pays full fee → no needs assessment required → similar to Saskatchewan's PCHs	– can be either private for-profit or private non-profit, although some are owned and operated by Manitoba Housing and Renewal Corporation (MHRC) ~ if owned and operated by MHRC, they contract with a sponsor, such as an RHA, to provide the accommodation and personal care services ~ if not owned and operated by MHRC or an RHA, it is the RHAs responsible for find a sponsor to operate the supportive housing facility – to access supportive housing, a needs assessment must be done by the RHA's home care program – resident is responsible for paying for rent and service package (meals, laundry and housekeeping); the cost of personal care is covered by the RHA who receives funding from Manitoba Health ~ personal care can be delivered by home care, the sponsor, or a separate sponsor contracted to deliver the personal care (e.g., nursing home) – if the supportive housing facility is owned and operated by MHRC, accommodation component is rent-geared-to-income

Appendix E – Jurisdictional Scan of Home Care Funding

	Total Population	Population Age 75+	2006/07 Home Care Budget	Per Capita Home Care Budget	Per Capita Age 75+ Home Care Budget
Saskatchewan	1,014,650	77,968	$111,445,627	$109.84	$1,429.38
British Columbia	4,310,452	290,257	609,600,000	141.42	2,100.21
Alberta	3,384,046	167,459	284,385,000	84.04	1,698.24
Yukon	32,335	839	4,600,000	142.26	5,482.72
Northwest Territories	42,401	720	7,702,890	181.67	10,698.46
Nunavut	31,113	222	7,441,140	239.16	33,518.65
Manitoba	1,178,457	82,056	237,796,200	201.79	2,897.97
Ontario	12,696,199	776,158	1,544,256,600	121.63	1,989.62
Quebec	7,631,552	495,032	937,500,000	122.85	1,893.82
New Brunswick	749,782	51,574	82,377,950	109.87	1,597.28
Nova Scotia	934,147	64,828	148,361,000	158.82	2,288.53
Prince Edward Island	139,089	9,430	9,045,300	65.03	959.20
Newfoundland & Labrador	506,275	30,863	77,092,422	152.27	2,497.89
TOTAL	**32,650,498**	**2,047,406**	**$4,061,604,129**	**$124.40**	**$1,983.78**
TOTAL (excluding the Territories)	**32,544,649**	**2,045,625**	**$4,041,860,099**	**$124.19**	**$1,975.86**

Appendix F – Jurisdictional Scan of Seniors' Secretariats

Jurisdiction	Seniors' Secretariat	FTEs/$s	Functions
Manitoba	**Manitoba Seniors and Health Aging Secretariat (SHAS)** – located within the Ministry of Healthy Living, Youth & Seniors – www.gov.mb.ca/shas	10 FTEs 2009/10 Budget = $1.8M	– Support the Minister to ensure the needs and concerns of seniors are reflected through a co-ordinated and comprehensive framework of legislation, public policy and programs. – The Minister and SHAS work with all departments to create an environment within the province that promotes the health, independence and well-being of all seniors. – The overall responsibilities of SHAS include: ▪ providing leadership to province-wide strategies that promote the interests of older Manitobans; ▪ acting in an advisory capacity to government departments; ▪ liaising between the provincial government, other levels of government, and organizations serving seniors; ▪ performing an education, information and referral function on a wide variety of topics and in differing formats; and ▪ providing research and administrative support to the Manitoba Council on Aging.
New Brunswick	**Senior & Health Aging Secretariat** – located within the Department of Social Development – www.gnb.ca/seniors	4 FTEs 2009/10 Budget = $1.8M	– Primary focus is the development and dissemination of information for seniors. – Promote the healthy aging and wellness of seniors. – Collaborate with senior related organizations. – Oversee the coordination of the development and implementation of initiatives under the *Renewed Long Term Care Strategy*. – Coordinate all strategies that promote healthy active living for seniors. – Coordinate all long-term care strategies that increase support for informal caregivers. – Coordinate the Senior Goodwill Ambassador Program. – Coordinate the development and dissemination of information for seniors which is prevention-focused working in partnership with partner departments and stakeholders. – Provide some funding to seniors' organizations and activities.

Jurisdiction	Seniors' Secretariat	FTEs/$s	Functions
Ontario	**Ontario Seniors Secretariat** – located within the Ministry of Culture – www.ontarioseniors.ca	19 FTEs 2009/10 Budget = $2.0M	– To undertake and support policy initiatives that improve the quality of life of Ontario seniors: ▪ Lead policy initiatives for seniors with a multi-ministry or cross jurisdictional focus ▪ Make 'value added' contributions to policy activities in other ministries – To undertake and support public education and awareness initiatives: ▪ For seniors, about the programs and services to which they're entitled ▪ For seniors, about healthy aging/lifestyles ▪ For the broader public, about the ongoing contributions seniors make to families, communities, province, and country
Quebec	**Seniors Secretariat** – located within the Ministère de la Famille et des Aînés	21 FTEs 2009/10 Budget = $14.367M	– Direct provision of services and programs: Funding programs: ▪ From the heart into action for Quebec seniors ▪ Support for initiatives targeting respect for seniors ▪ Information forums for seniors ▪ Municipalities, friends for seniors – Direct provision of funding to seniors groups/organizations ▪ Recurring funding for the 17 regional issue tables for seniors ▪ To support organisations through community based projects.
Newfound-land & Labrador	**Office for Aging and Seniors** – located within the Ministry of Health & Community Services	5 FTEs 2009/10 Budget = $4.5M	– Not available
Prince Edward Island	**Seniors' Secretariat** – located within the Department of Social Services and Seniors –		– Not available

Jurisdiction	Seniors' Secretariat	FTEs/$s	Functions
Nova Scotia	**Department of Seniors** – stand-alone Department – www.gov.ns.ca/seniors	9 FTEs 2009/10 Budget = $2.0M	– Committed to ensuring the inclusion, well-being, and independence of seniors facilitating the development of policies on aging and programs for seniors across government and through the provision and coordination of strategic planning, support, services, programs and information. ▪ policy development/horizontal management across government ▪ advocacy ▪ inquiry/help line ▪ direct provision of programs and services – Funding to seniors' groups is provided through three grant initiatives: the *Positive Aging Fund*, *Age-Friendly Communities Program* and the *Senior Safety Grant*. – Direct service is provided through a toll-free information line (provides information about services available to seniors) and a Senior Abuse Line (provides information, referral and support to seniors experiencing abuse or those concerned about a situation of abuse).
British Columbia	**Seniors' Healthy Living Secretariat** – located within the Ministry of Healthy Living and Sport – ww.hls.gov.bc.ca/seniors	17 FTEs 2009/10 Budget = $2.4M	– Advocacy within government for consideration of seniors' population health initiatives. Provide a seniors population health lens to government initiatives. – While the Secretariat doesn't provide the inquiry line, there is a toll-free Health and Seniors Information Line which is jointly funded by the Ministries of Health Services and Healthy Living and Sport to provide information about and assistance in accessing programs and services for seniors, as well as health programs and services. – The BC Seniors' Healthy Living Secretariat has a stewardship and implementation role for *Seniors in BC: A Healthy Living Framework*. The Framework is the BC government's action plan to support an aging population. The actions fall into four categories: create age-friendly communities, mobilize and support volunteerism, promote healthy living, and support older workers. The Secretariat's role includes: coordinating aging-related policy and initiatives across ministries and with partners, stakeholder engagement and information services, and monitoring and reporting on progress.

Jurisdiction	Seniors' Secretariat	FTEs/$s	Functions
Alberta	NO Seniors file resides within the Seniors Services Division, Alberta Seniors and Community Supports		
Yukon	NO Seniors File resides within Department of Health & Social Services		
Northwest Territories	NO Seniors File residents within Department of Health & Social Services		

Appendix G – Jurisdictional Scan of Adult Protection Legislation

Jurisdiction	Legislation	Type of Adults Affected	Reporting Requirement
British Columbia	Adult Guardianship Act	All if incapable	Voluntary
Alberta	Adult Guardian and Trusteeship Act	All if incapable	–
	Protection Against Family Violence Act	Spouse, person residing in the same household and related by blood or marriage; person residing in same household who has care and legal custody over another.	–
Manitoba	Vulnerable Persons Living with a Mental Disability Act	Adults with mental disabilities (cognitive impairment) diagnosed before 18 years of age	Yes, limited to service providers, substitute decision makers and committees
	Domestic Violence and Stalking Act	"Cohabitants": reside or have resided together in a family, spousal or intimate relationship	–
Ontario	Substitute Decisions Act	All incapable adults	–
Quebec	Civil Code of Quebec	Those in need of protective supervision	–
	Charte de Droits et Libertés de la Persone	Handicapped person or vulnerable older adults	–
New Brunswick	Family Services Act	Disabled or elderly adults	Voluntary, for professionals
Prince Edward Island	Adult Protection Act	Vulnerable adults (18 years and older) unable to protect themselves from abuse or neglect	Voluntary
	Victims of Family Violence Act	Those in spousal or sexual relationship; members of same family	Voluntary
Nova Scotia	Adult Protection Act	All incompetent adults	Mandatory
	Domestic Violence Intervention Act	Those "cohabiting in a conjugal relationship"	–
Newfoundland & Labrador	Neglected Adults Welfare Act	Neglected, incapable adults only	Mandatory
Northwest Territories	Guardianship and Trusteeship Act	Incapable adult	–
	Family Violence Protection Act, Bill 21	Spouse, former spouse, persons who resided or are residing together in a family or intimate relationship, parents, grandparents	–

An Environmental Scan of Abuse and Neglect of Older Adults in Canada, F/P/T Seniors' Forum, 2003 – revised January 2010.

Appendix H – Jurisdictional Scan of Falls Admissions, 1999/2000

	Admission Rate per 10,000 – Falls Age 65+	Mean Length of Stay – Falls Age 65+	Percent Male – Falls Age 65+
Saskatchewan	167.2	11.8	29.0%
British Columbia	171.6	19.6	28.3
Alberta	193.7	17.1	32.5
Territories (Yukon, Northwest Territories, Nunavut)	245.4	8.2	31.1
Manitoba	177.9	28.7	28.5
Ontario	157.6	15.4	29.3
Quebec	122.9	17.2	26.4
New Brunswick	162.2	14.6	29.5
Nova Scotia	146.6	18.7	28.0
Prince Edward Island	173.4	15.4	29.4
Newfoundland & Labrador	127.9	17.1	31.3
Canada	**154.8**	**17.2**	**28.9%**

Falls Leading Cause of Injury Admissions to Canada's Acute Care Hospitals, Canadian Institute for Health Information (2002).

Appendix I – Provincial Falls Inventory

Regional Health Authority	Summary of Falls Prevention Activities/Targeted Programs
Cypress	Community Falls Prevention – Put Your Best Foot Forward a. Group Falls Prevention Education Session b. Wellness Clinics c. Home Care Clients Acute Care Falls Prevention Outpatient Falls Prevention Long-Term Care Falls Prevention
Five Hills	Creating Supportive Environments Strengthening Community Action Building Healthy Public Policy Health System – Organization of Health Care Self-Management/Development of Personal Skills Delivery System Design/Re-orient Health Services Decision Support Information Systems
Heartland	Seniors on the Move Seniors on the Move – Stay Fit…Stay Safe Falls Risk Screening
Keewatin Yatthé	Home Care Clients Fall Prevention Awareness Long-Term Care
Kelsey Trail	Regional Blitz of Falls Prevention Education Hip Protectors
Mamawetan Churchill River	Long-Term Care Unit Falls Program Acute Care/Medicine Services Mental Health Home Care
Prince Albert Parkland	Prince Albert Parkland Health Region Steering Committee (fall reduction)

Regional Health Authority	Summary of Falls Prevention Activities/Targeted Programs
Regina Qu'Appelle	Wellness and Fall prevention Clinic Seniors' Healthy Living Program Regina and Region Falls Prevention Committee Regina Qu'Appelle Health Region Education Services Primary Care Portfolio SK South Acquired Brain Injury Outreach Team – Education and Prevention Canadian Falls Prevention Curriculum Workshops Home Safety: Adults/Falls Prevention Resource Kit Provincial and Regional Falls Prevention Committee Involvement Home Care (Rural)
Saskatoon	College of Nursing, University of Saskatchewan Forever…In Motion for Older Adults Geriatric Services Meri Mistfits Public Health Services – Older Adult Wellness Osteoporosis Canada a. COPN (Canadian Osteoporosis Patient Network) b. Saskatoon Chapter Saskatoon Falls Consortium Staying On Your Feet School of Physical Therapy, University of Saskatchewan SAFE: Senior Aquatic Fitness and Education
Sun Country	Long-Term Care Fall Prevention Initiative Home Care Falls Prevention Program
Sunrise	Regional Falls Prevention Committee Home Care Falls Prevention Acute Care Falls Prevention Long-Term Care Falls Prevention Community-Based Fall Prevention Program

Appendix J – Caseloads of Regulatory Programs in Saskatchewan

	Personal Care Homes (Ministry of Health)	**Child Care Homes and Centres** (Ministry of Education)	**Child Care Homes and Centres** (Ministry of Education)	**Mental Health Approved Homes** (Regina Qu'Appelle Health Region/ Ministry of Health)	**Approved Private Service Homes** (Ministry of Social Services)
Role	– Monitoring and regulating approximately 255 homes. – Licences vary from 1 to 106 spaces home. – Includes complaint investigations, inspections, licensing, training, coaching, and policy development.	– Monitoring and regulating approximately 259 child care homes and centres. – Licenses vary from 1 to 90 spaces day care. – Includes complaint investigations, inspections, and licensing.	– Monitoring and regulating approximately 205 child care homes and centres. – Licenses vary from 1 to 90 spaces day care. – Includes complaint investigations, inspections, and licensing.	– Monitoring and regulating approximately 25 homes. – Licences/certificates vary from 1 to 5 spaces per home. – Includes complaint investigations, inspections, licensing, training, and coaching.	– Monitoring and regulating approximately 222 homes. – Licences/certificates vary from 1 to 5 spaces per home. – Includes complaint investigations, inspections, licensing, coaching, and assessments.
Service Area	Provincial	Regina Service Centre	Saskatoon Service Centre	Regina Qu'Appelle Health Region	Provincial
Approximate Caseload	51 homes per consultant	26 homes per consultant	21 homes per consultant	25 homes per consultant	7 homes per consultant

Glossary of Terms

Activities of Daily Living – Activities that include, but are not limited to, eating, bathing, dressing, grooming and participating in social and recreational activities.

Aging-in-Place – Aging-in-place means that a senior does not have to move from their existing residence for securing necessary support services in response to varying or shifting care needs.

Approved Mental Health Home – Approved mental health homes provide residential services for persons with a mental illness. Approved mental health homes are privately owned and operated facilities licensed by the Ministry of Health but managed by the Regional Health Authorities.

Approved Private Service Home – Approved private service homes provide residential services for persons with intellectual disabilities. Approved private service homes are privately owned and operated facilities managed through the Ministry of Social Services.

Assisted Living – Housing typically targeted to seniors offering hotel-like services only, such as transportation, meals, laundry, housekeeping, etc.

Continuum of Care – Health care services and programs can be recognized as ranging from community-based services to institutionalization. While episodic acute and emergent care may occur at any stage in the continuum, chronic diseases typically begin to overlay this structure at the supportive care stage and continue to increase all the way to special-care homes. For a diagram of the continuum of care, see *Appendix B*.

Home Care – Home care helps many individuals with health problems who may need acute, palliative or supportive care in order to live independently, longer, and in the comfort of their homes. The program helps to maintain quality of life and provides support for people who may otherwise have to be in hospital or long-term care facilities.

Personal Care Home – Personal care homes are privately owned and operated facilities that provide another option to adults who generally do not require the health services of a special-care home, but who need to receive assistance or supervision with personal care.

Special-Care Homes (Nursing Homes/Long-Term Care Facility) – Special-care homes are typically for persons requiring higher levels of care whose assessed needs cannot be met through community and home-based services or other housing options.

Specialized Care – Sometimes residents of personal care homes require a procedure that is typically performed or directed by a health professional.

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