McGILL UNIVERSITY

A STUDY OF HOMES FOR SPECIAL CARE PROGRAM, EASTERN ONTARIO

A Description of the Nursing Homes and Residential Homes located in seven counties of Eastern Ontario
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by

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ABSTRACT

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A Study of Homes for Special Care Programmes Eastern Ontario

The purpose of this research was to study community after-care facilities for discharged patients of the Brockville Psychiatric Hospital to determine whether they were becoming, as recently predicted, "mini institutions" or community back wards.

This descriptive-diagnostic study was carried out using the geographical boundaries of the Homes for Special Care unit at the Brockville Psychiatric Hospital. From a universe of twenty-one nursing home and residential home facilities, a random sample of five nursing homes and five residential homes was taken. An interview schedule was designed to be completed during standardized interviews with the operators of the homes in the sample.

The findings of the study did not totally support or refute the prediction that after-care facilities were becoming the mental hospitals' community back wards. Rather, it

provided additional factual information, and uncovered some characteristics that could be perceived as being problematic. Of particular significance were the findings that: (a) residential homes were located in non urban areas, (b) a large proportion of the staff providing nursing care were untrained, (c) there were no social workers or trained recreational leaders in the nursing homes, (d) programmes and routines were generally designed to ensure the efficient operation of the homes rather than to meet the individual needs of the residents, (e) there were no preparation, training or on-going development program for the over-all Homes for Special Care staff.

The recommendations focussed on the following areas: (a) a more careful selection of locations for residential homes, (b) more appropriate fit between the ex-patient and the individual residence, (c) the upgrading of the staff in general, and of the nursing personnel in particular, (d) the formation of an association for the operators of Homes for Special Care in Eastern Ontario, (e) the implementation of a professional team consisting most likely of a psychiatrist, an occupational therapist, a psychiatric nurse, a recreational leader, and a social worker, who would visit all facilities on a regular basis, (f) the expansion and individualization of recreational programmes, and (g) the on-going evaluation of the over-all Homes for Special Care programme in Ontario.

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I would like to add a special note of tribute to Dr. E. V. Shiner who patiently guided me in the planning and writing of this research.

A word of appreciation I feel is also forthcoming to a colleague for his interest and encouragement in the fulfilment of this endeavour.

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CHAPTER I

INTRODUCTION

Traditionally, patients in psychiatric hospitals were confined for prolonged periods. Affliction of mental illness as recently as the 1950's was almost synonymous to an indefinite term of prison incarceration. With the advent of symptom modifying medication more patients became candidates for discharge, and the newly afflicted could look forward to returning home much sooner.

For many patients, however, symptom control or modification did not mean a ticket back home. Some did not have homes to go to, others carried with them characteristics or traits that were unacceptable to families or community people. Because of a lack of alternatives they continued to remain in hospital accessible to room and board and varying degrees of care and supervision. As their numbers increased and as they remained for longer periods, the hospitals were obliged to meet their other needs: social, recreational, vocational, and many of the amenities of home. Concomitantly, the phenomenon of institutionalization emerged as a problem. Patients who had community options presented to them were reticent about leaving the institution that had become "home".

In the early sixties, the Ontario Ministry of Health endeavoured to do something about this large group of patients, or more accurately residents of its hospitals. It was decided

that these people should be domiciled in the community and that the private sector should assume responsibility for their care. This policy was consistent with the government's desire to decentralize its bureaucratic establishments, and to diminish the escalating cost of health care. It passed the Homes for Special Care Act in 1964 which called for the setting up of a number of residential and nursing home facilities across the province.

This Act, which was operationalized in January 1965 is under the jurisdiction of the Extended Care Division of the Medical Rehabilitation and Chronic Care Branch of the Ontario Health Ministry. Home for Special Care refers to a home for the care of persons requiring nursing, residential or sheltered care. Nursing care can be either "extended care" or "intermediate care". The former means nursing and personal care given by or under the supervision of a registered nurse or registered nursing assistant under the direction of a physician to a resident for a minimum of one and one-half hours per day is required. The latter means that less than one and one-half hours is required.

These homes will admit any person upon his own application or the application of a friend or a relative:

(a) who has been a patient in an institution within the meaning of the Mental Hospitals Act;

(b) who has been an informal patient under the Mental Hospitals Act or has been discharged under that Act; and

(c) for whom no immediate provision for care and lodging has been made; or

(d) who is a resident in a residential unit established under Regulation 579 of Revised Regulations of Ontario, 1970.

In 1974 an official of Homes for Special Care, henceforth called H. S. C., reported that there were 573 facilities in Ontario with 7,545 residents[1].

Recently, health professionals[2] have raised concerns about the H. S. C. programme. It was suggested that these facilities might very well become the "back wards of tomorrow"[3].

There has been very little research done on the H. S. C. programme, and it appears, especially in light of this publicity, that a study is timely.

This project reports on the physical settings, the residential population, the programmes, and operating policies of a number of the H. S. C. facilities in Eastern Ontario. The study is essentially descriptive in nature aiming at providing those concerned with additional data that can be

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1 Miss Elthea Lightbown, supervisor of Homes for Special Care programme, Kingston, Ontario.

2 Ottawa Citizen, October 5, 1975.

3 Ottawa Journal, August 28, 1974, p. 33.

useful in either supporting or discounting the prediction that the H. S. C. might become the back wards of tomorrow.

FRAME OF REFERENCE

After-care activity directed toward the psychiatric patient is a relatively recent innovation. Programmes began to emerge in the 1950's in some hospitals in the United States but to a very limited extent[1]. Psychiatric hospitals there as elsewhere, were afflicted by a custodial orientation, conceiving themselves as protectors of the community from its mentally ill.

In Canada in the late 1950's there was a growing interest in the rehabilitation of the chronically ill mental patient[2]. Treatment modalities other than chemotherapy and ECT were introduced and developed by an increasing number of professionals.

The early 1960's saw a significant number of patients transferred to residential units within hospital settings and the emergence of community-oriented psychiatrists. More concern about the after-care programmes came to be a concomitant.

The literature offers very few definitions of the term after-care, which appears to be used sometimes interchangeably with "follow-up care". Oldham describes after-care or perhaps

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1 Morris S. Schwartz, and Charlotte Green Schwartz, Social Approaches to Mental Patient Care, Columbia University Press, New York and London, 1964, p. 207.

2 F. A. Allodi, and H.B. Kedward, "The Vanishing Chronic", Canadian Journal of Public Health, Vol. 64, (May - June 1973), p. 283.

more accurately the goals of after-care as follows: "that of maintaining the mental stability of the patient in his various environments after discharge or completion of a specified course of treatment."[1] Kandel and Williams[2] discuss and distinguish between two approaches to after-care; the vigilant, and the intervention. The former does not involve any treatment "unless the person shows signs of relapse or a serious problem," and the latter is "characterized by a more continuous offering of services not necessarily geared to the presence of signs indicating possible relapse." Perhaps the most comprehensive definition of after-care is the one formulated by Schwartz and Schwartz: "After-care is the formal help, whether of treatment or rehabilitation, given a person who has been in a mental hospital."[3]

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1 A. J. Oldham, "After-Care and Rehabilitation". Presented to the First International Congress of Social Psychiatry. Symposium of Psychiatric After-Care. 1964.

2 D. B. Kandel, and R. H. Williams, Psychiatric Rehabilitation. Some Problems of Research, Atherton Press, New York, 1964.

3 Schwartz and Schwartz, Social Approaches to Mental Patient Care, p. 207.

These authors further identified three factors that were significant in the evolution of after-care:

> "... the conception that mental illness is a function of poor interpersonal relationships, furthering the belief that continued help in the post discharge period is necessary; ... distinction between psychodynamic processes constituting mental illness and the social crippling resulting from institutionalization itself; ... and acknowledgement of the important role played by persons in the community to the fate of the hospitalized person."[1]

Other studies have revealed that the c ommunity plays a very significant role in the success or failure of an after-care program. In discussing the findings of a survey of residential foster homes for ex-psychiatric patients in two provinces, Murphy writes:

> Many of the foster home features which discouraged initiative and activity gave the foster parents more work and cost, not less, and would have been discouraged by most supervisors. Yet they were initiated because the foster parents thought them good or proper for the patients, and the only source from which they could have acquired such ideas is from their surrounding community, that community which we thought would be so much healthier for the patients than the mental hospitals could be.[2]

In his conclusions Murphy theorized that although the public accepts that the psychiatric patient need not be locked up like a "wild beast", they experienced difficulties

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1 Ibid., pp. 208 - 210.

2 H. B. M. Murphy, Bernard Penny, and Daniel Luchins, "Foster Homes: The New Back Wards?", Canadian Mental Health Supplement, No. 71, (September - October, 1972) p. 16.

in classifying him. Their only real alternatives were to regard him as sick or deviant:

> Deviancy invites rejection, and we find rejection quite often in the attitude that although the foster homes may be desirable, they are not wanted by their neighbours or by some community leaders. Sickness does not invite rejection, but it does imply acceptance of a conventional sick-role, and the way in which the public views sickness may not be appropriate to our patients.[1]

Two psychiatrists, Chien, and Cole who were instrumental in establishing a landlord supervised cooperative apartment programme did not discover any difficulties with community people.

> The resistance often encountered by halfway houses when they try to move into a new neighbourhood has never been an issue in this program. In fact, once the neighbours see how well former mental patients adapt to the community, they are usually more than willing to give their assistance and often try to find out about the program for themselves.[2]

This programme which was centered in a lower class area of Boston and featured weekly visiting by a professional team, may account in part for the significantly different finding of Murphy's study. They point out that some of the people domiciled in the community where the cooperative apartments

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1 Ibid., p. 16.

2 Ching-Piao Chien, and Jonathan O. Cole, "Landlord-Supervised Cooperative Apartments: A New Modality for Community-Based Treatment", American Journal Psychiatry, Vol. 130:2, (February 1973), p. 158.

are located are in need of professional intervention and benefit from its accessibility:

> A program such as the Coop Apartment Program brings these two segments of society together to the benefit of each. Because the psychiatrist, nurse, and social worker make weekly visits to all the apartments, the landlords in particular and the community in general see them as people who want to help them rather than uncaring professionals hidden away in far-off offices. This provides community members with easier accessibility to help from these professionals when they need it.[1]

Schwartz and Schwartz[2] caution that not all former mental patients are in need of an after-care programme. They claim that for some patients it can be detrimental for the following reasons. It could foster over dependency on the professional and also foster "psychiatric hypochondriasis" which refers to the ex-patient being overly concerned with his emotional reactions, his job, or his family as a result of a continued connection with formal organizations. Thirdly, the authors feel that after-care may aggravate the stigma of having been a mental patient and encourage him to think of himself as sick.

These authors[3] identified five required elements for all after-care planning. They are as follows: (1) links

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1 Ibid., p. 159.

2 Schwartz and Schwartz, Social Approaches to Mental Patient Care, p. 211.

3 Ibid., pp. 208 - 210.

between all the patients' helpers, (2) cooperation on the part of the patient at the point of entering the after-care stage, (3) provision for transition between different settings or types of care, (4) appropriate timing of contacts, and finally (5) consideration of the patients previous experience to the kind of care planned for him.

Social work, it would appear has a very important role in after-care services. The social worker is usually in the best position to ensure continuity of care for the patient in the transition from hospital to the community facility. This transition often approaches crisis proportions for the patient and the social worker can make a significant contribution in helping the person through the crucial resolution stages.

In the Boston study,[1] a social worker was included in the professional team that visited the patients weekly in the cooperative apartments. A. Ytrehus[2] also emphasized the need for social workers in the provision of after-care to psychiatric patients. However, one realizes the necessity of the team approach in the tailoring of after-care services.

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1 Above., p. 9.

2 Aagot Ytrehus, "The Development of a Comprehensive Treatment Program. Experiences from After-Care Services of a Mental Hospital." Acta Psychiatrica Scandanavia. Supplementum 245, (1973), p. 55.

After-care programmers and theorists clearly point out the complexities and knowledge gaps which confront one studying after-care as a topic of research. However, the identified issues tend to reinforce the rationale for investigating the subject in the first instance.

METHODOLOGY

The Brockville Psychiatric Hospital is the primary psychiatric treatment facility in the Ontario Ministry of Health in Eastern Ontario. The study was carried out using the geographic boundaries of the Home for Special Care unit of this facility, that is; the counties of Prescott, Dundas, Glengarry, Stormont, Russell, Grenville and Leeds. Approval to pursue the study was granted by Mr. John Maynard, Director of the Psychiatric Hospitals' Branch in Toronto and officials in Brockville[1] and Kingston[2] indicated their receptiveness and cooperation.

A structured design was chosen to accommodate the descriptive - diagnostic intent of the study.

From a universe of twenty-one facilities in Eastern Ontario, ten nursing homes and eleven residential homes, a random selection of five nursing homes and five residential homes was taken. One nursing home was selected in each of the counties of Stormont, Glengarry, Prescott, Russell, and Grenville. One residential home was selected in the county of Stormont, two in the county of Dundas, and one each in the counties of Leeds and Prescott.

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1 Mr. C. Primavesi, administrator Brockville Psychiatric Hospital, Miss MacLean, and Mr. Sheffield, Home for Special Care workers.

2 Miss E. Lightbown, supervisor, Kingston.

Appointments with the home operators were arranged by the Brockville-based Home for Special Care workers. For the purpose of confidentiality, the nursing homes and residential homes studied were not identified by name or location. They are designated by letters A, B, C, D, and E in the subsequent sections of this report.

Interview Schedule

An interview schedule was designed to be completed during standardized interviews with the operators of the homes in the sample. It consisted of a total of forty-five questions. It was divided into four parts. Part I was oriented to the geographical location of the homes and basic admissions criteria. Part II pertained to biographical details of the residents, and information regarding the staff. Part III was directed to social and recreational programmes within the facilities and adjacent communities, and Part IV looked at the general operational and administrative policies of the homes.

The same interview schedule was administered to both nursing and residential homes, and, as indicated above.

Limitations and Sources of Error of the Study

As the standardized interview was chosen as the primary method of collecting data, the clarity in formulating the

questions and the accuracy of the responses rendered, largely determine the sources of error and limitations of the study. In this research, reliability suffered due to an instrument of unknown reliability and by the fact that each respondent felt more or less threatened by the interview schedule.

Only ten out of the twenty-one H. S. C. facilities were selected.[1] However, the judgement was made that they are sufficiently representative of the range of homes found within the geographic boundary.

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[1] The twenty-one H. S. C. facilities are dispersed throughout a wide geographical area which precluded study of the entire universe. In visiting the ten facilities in the sample, the distance travelled was in excess of 600 miles.

CHAPTER II

RESULTS

PART I

Physical Characteristics of Nursing and Residential Homes

Nursing Homes

All nursing homes in the sample are located either in or adjacent to urban centres, and have easy access to local and inter-city transportation facilities. The majority of residents speak English. However English might not be their mother tongue. Care is taken to admit the ex-patients to homes located in or close to their respective community.

Two nursing homes are situated in areas which are predominantly French speaking, two others are within a bilingual community, and one is located in an English village.

Most of the homes appear to have a rather formal and impersonal atmosphere with the exception of one home which is located near water and is elaborately furnished and decorated.

The admission criteria in all of the nursing homes in the sample were consistent with the Homes for Special Care admissions regulations.[1]

All nursing homes except one had served other purposes prior to their utilization as Homes for Special Care.

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[1] See Appendix II - Home for Special Care Act, 1974, O. Reg. 890, 1974.

Renovations, additions, etc., were effected to meet the specific requirements of both the Nursing Homes Act and the Homes for Special Care Act and Regulations. Each home is subject to on-going inspections and supervision by municipal and provincial government representatives to ensure that requested standards are met and respected.

Residential Homes

Residential homes are located in rural areas with populations which range in size from 200 to 2,800. All but one are situated in English speaking communities. Accessibility to the nearest business section varies between one and twenty miles. Local transportation is limited to taxi service from the adjacent business areas. All of the homes but one are immediately accessible to inter-city bus and/or train lines.

Residential homes are ordinary houses that meet the requirements of the Homes for Special Care Act and Regulations.

The admission policy for a residential home is identical to that described for nursing homes, with the distinction that residential homes were conceived for ex-patients requiring no nursing care.

All operators of these facilities expressed satisfaction with the admission policy established by the Ontario Ministry of Health as per the Homes for Special Care Act and Regulations.

Nursing homes differ from Residential homes in four ways:

(1) Nursing homes are located either in or adjacent to cities whereas residential homes are found mainly in rural areas.

(2) The nursing homes' purpose is to provide continuing nursing care to its residents while residential homes were created for ex-patients who require supervision but no nursing care.

(3) Nursing homes are situated in English, French, and bilingual cities. Residential homes are all established in English communities.

(4) Due to their size, structure, and purpose, nursing homes tend to appear like and perhaps are "mini-institutions" operated in a rather formal fashion. Residential homes seem to have a warmer, more family-like type of atmosphere.

PART II

Description of Facilities' Population

Nursing homes' population vary in size from 60 to 119 residents, and all have had full occupancy in the last year.

Sex

Female residents predominate. As Table 1 shows the average percentage of females was 54.5 per cent at time of survey.

Table 1

Sex of Residents in Nursing Homes

Nursing Homes	SEX		
	Male N -- %	Female N -- %	Total N - %
A	60 -- 55	49 -- 45	109 - 100
B	20 -- 31	45 -- 69	65 - 100
C	72 -- 61	47 -- 39	119 - 100
D	20 -- 33	40 -- 67	60 - 100
E	45 -- 48	49 -- 52	94 - 100

Table 2

Sex of Residents in Residential Homes

Residential Homes	SEX		
	Male N -- %	Female N -- %	Total N - %
A	0 -- 0	3 -- 100	3 -- 100
B	0 -- 0	4 -- 100	4 -- 100
C	0 -- 0	12 -- 100	12 -- 100
D	0 -- 0	3 -- 100	3 -- 100
E	0 -- 0	2 -- 100	2 -- 100

Table 2 reveals that residential homes in the sample have an all-female population which ranges from two to twelve people per home.

Age

Most of the nursing homes serve a geriatric population. The majority of the residents, 48.6 per cent are in the (61-80) age group.

Table 3

Age Distribution of Nursing Home Residents

by Numbers and Percentages

Nursing Homes	40 and Under		41 - 60		61 - 80		81		Total	
	N	%	N	%	N	%	N	%	N	%
A	3	2.8	40	36.7	56	51.4	10	9.1	109	100
B	0	0	6	9.2	39	60.0	20	30.8	65	100
C	0	0	59	49.9	60	50.1	0	0	119	100
D	0	0	3	5.0	9	15.0	48	80	60	100
E	10	10.6	15	15.9	54	57.6	15	15.9	94	100

Table 4

Age Distribution of Residential Home Residents by Numbers and Percentages

Residential Homes	AGE CATEGORIES							
	40 and Under		41 - 60		61 - 80-		Total	
	N	%	N	%	N	%	N	%
A	3	100	0	0	0	0	3	100
B	4	100	0	0	0	0	4	100
C	5	42	7	58	0	0	12	100
D	0	0	2	67	1	33	3	100
E	0	0	1	50	1	50	2	100

Table 4 reveals that the majority of residential home residents, 48 per cent, are in the (40 and under) age category, while 35 per cent are in the (41 - 60) age group.

Language of Communication

Most residents of nursing homes are unilingual English. A small proportion of the residents are bilingual (approximately twenty-four per cent). The official language in all nursing homes is English. It has been observed that

in most homes some staff members are bilingual and converse in the language of the resident.

In all residential homes surveyed, the residents were all English and English was the only language used.

Place of Origin and Family Ties

The majority of residents in nursing homes, seventy-five per cent, come from the same county in which the home is located, or the county immediately adjacent to it. Very few residents, however, have regular contacts with their families or friends. The various holidays or anniversaries are generally the only times during the year where some of the residents visit or are visited.

In the case of residential homes, fifty-five per cent of the residents originated from the area in which the home is located. The frequency of contact with friends and relatives is about the same as for residents of nursing homes.

Staff Distribution

The description of staff distribution applies to nursing home facilities only.

Table 5

Full Time Nursing Homes' Staff Distribution by General Category

Nursing Homes	CATEGORIES				
	Doctors	Nursing	Recreation	Food Service	Main-tenance
A	0	33	1	14	8
B	2	23	1	4	4
C	1	57	1	9	4
D	1	16	1	4	3
E	1	27	1	4	5
Total	5	156	5	35	24

Table 5 demonstrates that the nursing staff constitutes the majority of the full time personnel, sixty-nine per cent; the food service and maintenance people cover twenty-seven per cent; both doctors and recreational leaders represent two per cent each, and there are no social workers in any of the homes surveyed.

Table 6

Part-Time Nursing Homes' Staff Distribution by General Category

Nursing Homes	CATEGORIES					
	Doctors	Nursing	Recreation	Social Work	Food Service	Main-tenance
A	1	18	0	0	0	0
B	0	6	2	0	6	0
C	0	3	0	0	0	0
D	4	18	0	0	3	2
E	0	6	0	0	0	1
Total	5	51	2	0	9	3

Figures in Table 6 converted to percentages show that the part-time staff is distributed as follows: seventy-three per cent nursing, sixteen per cent food service and maintenance, seven per cent doctors, and four per cent recreational people. There are no part-time social workers in any of the homes.

Table 7

Consultant Nursing Homes' Staff Distribution by Classification

Nursing Homes	PROFESSIONAL CLASSIFICATION	
	Psychiatrist	Medical Doctor
A	1	0
B	2	0
C	0	0
D	1	0
E	0	0
Total	4	0

Table 7 reveals that four psychiatrists provide service to residents of nursing homes on a consultative basis only. There are no consultant physicians in any of the homes.

Table 8

Staff Distribution in Nursing Homes by Numbers and Level of Training

Number and Level of Training	Nursing Homes					
	A	B	C	D	E	Total
Psychiatrist	1	2	0	1	0	4
Physician	1	2	1	5	1	10
R. Nurse	5	3	7	4	5	24
R. Nurse's Aid	6	5	7	4	4	26
Social Worker	0	0	0	0	0	0
Orderly	8	0	4	2	2	16
Recreational Leader	1	3	1	1	1	7
Non-Registered Nursing Staff	32	21	42	24	22	141
Maintenance Employees	9	4	4	6	4	27
Food Service Personnel	14	10	9	6	5	44
Totals	77	50	75	53	44	299

Table 8 clearly indicates that the majority of employees in nursing homes are the untrained nursing staff, fourty-seven per cent, the food service personnel, fifteen per cent, and the maintenance people, nine per cent.

The current staff-patient ratio was described as being adequate and satisfactory by all directors of nursing homes in the sample.

PART III

Activity Programmes in Nursing and Residential Homes

Table 9

Time Spent in Organized Recreational and Social Activities in Nursing Homes by Hours per Week

Nursing Homes	HOURS PER WEEK			
	0 - 5	6 - 10	11 - 15	16 - 20
A	1	-	-	-
B	-	1	-	-
C	-	1	-	-
D	-	1	-	-
E	-	-	-	1
Total	1	3	0	1

Table 9 reveals that on the average, residents of nursing homes spend 10.4 hours per week in some form or other of organized recreational and social activities.

The same types of activities were seen consistently throughout the nursing homes visited. Physical fitness programmes, occupational therapy involving simple crafts, table games, mainly bingo and cards, television, community and out-of-town trips especially in the summer time, occasional parties on holidays and special anniversaries, seem to encompass the array of activities organized by the staffs of nursing homes.

Some nursing homes, however, are attempting to innovate. One home has implemented an interaction programme on a bi-monthly basis, two others have instituted a remotivation program. Another home with a population of 119 encourages its residents who are well enough, approximately thirty, to participate in occasional pub nights organized by the members of a local branch of the Royal Canadian Air Force Association. Residents are bused to and from the club house and enjoy an evening of dancing and social drinking with the members of the service association.

This same home also runs an educational film on a weekly basis, and most residents attend faithfully.

It was noticed that all nursing homes have a special activity room available to their residents and all of them are being used extensively. Weekend activities are more or less limited to church service attendance and receiving visitors.

All nursing homes with the exception of one provide adequate numbers of television sets and radios for their residents. Piped in music in the dining room is enjoyed by residents of one home while they are having their meals.

Most of the reading materials which consist mainly of newspapers and magazines are supplied by each nursing home. A few residents subscribe to reading material of their own choice. The Brockville Psychiatric Hospital makes available a certain number of old books discarded by its main library. One home has the services of the community's mobile library on a monthly basis. Reading takes place in the activities room or in sleeping quarters since no special room is set aside for this purpose in four out of five nursing homes.

Even though there exist recreational outlets in the local communities, very few residents take advantage of them. Occasionally, some attend a hockey match at the arena, others go to church bingos, movies, senior citizens' club activities, but only if encouraged by the staff to do so.

In general, the nursing home residents appear quite content with the slower pace of activities in their respective home. Most directors have mentioned they find it difficult to motivate their residents to engage in any type of activity.

Table 10

Time Spent in Organized Recreational and Social Activities in Residential Homes by Hours Per Week

Residential Homes	HOURS PER WEEK	
	0 - 3	4 - 6
A	0	1
B	1	0
C	0	1
D	0	1
E	0	1
Total	1	4

As indicated in Table 10, the amount of time spent in organized activities in residential homes is less than in nursing homes; 4.4 hours per week are devoted to such activities.

Simple arts and crafts, watching television, listening to the radio and to the record player, as well as the occasional community outings are among the most popular and common activities enjoyed by residents.

No specific educational or social programmes exist in any of these homes. The reading material available to the residents is that which the family provides, primarily newspapers and magazines.

Being located in small communities, residential homes do not have access to a great variety of social and recreational activities. Hence, the residents are restricted to the social outings preferred by the hostess. In two of the homes where residents are well integrated into the family unit, they are invited to accompany the family on outings.

PART IV

Operational and Administrative Policies

Monthly Fee

The monthly standard fee in nursing homes varies according to the degree of nursing care required by each resident. Extended care costs $18.50 per day whereas intermediate care is $15.75 per day.

If a proposed resident is eligible for the Extended Care Health Benefits of the Ontario Health Insurance Plan, the per diem rates are those listed under the plan.[1]

In residential homes, the daily rate is the amount currently set by the Ministry, that is; $8.15 per day.

Since the majority of residents are without financial resources, the provincial government assumes responsibility for all costs.

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[1] Ontario Ministry of Health, Homes for Special Care: It's a Matter of Caring, 73 2607, December 1974, p. 9.

Table 11

Sleeping Accommodation Arrangement in Nursing Homes by Room Categories

Nursing Homes	Private Rooms	Semi-Private Rooms	Small Dorms 3-4 Beds
A	35	2	22
B	4	18	11
C	6	15	20
D	1	25	1
E	0	4	28
Total	46	64	82

Table 11 shows that all types of sleeping arrangements are found in all nursing homes with the exception of one which has no private rooms. In general, residents share a room with one, two or three co-residents.

Table 12

Sleeping Accommodation Arrangement in Residential Homes by Room Categories

Residential Homes	Private Rooms	Semi-Private Rooms	Small Dorms 3-4 Beds
A	0	1	0
B	2	1	0
C	1	4	1
D	0	2	1
E	0	2	0
Total	3	10	2

Table 12 indicates that the semi-private room arrangement prevails in residential homes although the two other types of arrangement also exist in some of them.

Rising and Bed Time

Rising time in nursing homes varies between 6:00 a.m. and 7:00 a.m. Bed time is any where from 8:30 p.m. to 10:00 p.m. in all nursing homes.

In residential homes residents rise between 7:00 and 7:30 a.m. and the curfew is at 10:00 p.m. However, the residents of one home retire at 7:30 p.m. all year round.

Meals

Meal times are quite consistent in all nursing homes.

Breakfast - 7:30 - 8:00 a.m.
Snack - 10:00 a.m.
Lunch - 11:30 - 12:00 a.m.
Dinner - 4:45 - 5:00 p.m.
Snack - 8:00 p.m.

Residents of residential homes have their meals at the respective time adopted by each family.

Breakfast is usually served between 7:30 - 8:00 a.m.

Lunch is at 12:00 p.m.

Dinner between 5:00 and 5:30 p.m.

Nursing home residents take their meals in the dining room, with the exception of those who are confined to bed. In such cases, meals are served on trays in the residents' respective bedrooms. It has also been mentioned that some are asked to eat apart from the others because of poor eating habits which are intolerable to co-residents.

In three residential homes residents share the family meal. In two others, they eat alone.

Household Responsibilities

In nursing homes, the more capable residents help with small tasks. They are expected to keep their sleeping quarters clean and tidy. Some help in the dining room, and in one home, a few residents assist in the laundry room. All are renumerated for their services on a weekly basis. One nursing home has twenty residents on the payroll.

Residents of residential homes are asked to assist with the general household chores to the extent which they are able. Some hostesses allow the residents to help with kitchen tasks.

Visiting Rules

The visiting rules are most flexible in all nursing homes. Relatives and friends are quite free to come at their convenience. However, in spite of this, a very small proportion of residents are visited frequently or invited out on a regular basis. Family members and friends seem to visit mainly on days like Christmas, Easter, birthday, etc.

All residential homes try to accommodate themselves to the visiting time identified by family members or friends of its residents. Most of the visits take place on weekends and during holidays. In general, family members visit infrequently.

Residents of both nursing homes and residential homes are allowed to visit their families or friends according to H. S. C. regulations.

Adequacy of Per Diem Rate

All directors of nursing homes in the sample were unanimous in saying that the daily rate paid by the provincial government is insufficient. Two out of five directors have indicated that the rate ought to be $20.00 per day per resident.

The additional money would be used to improve the facilities, purchase mini-buses, and increase the salary of the non-professional staff. In most homes these people are paid minimum wages.

The same applies for residential homes. All hostesses feel that a per diem increase of $2.50 is needed to offset inflation.

Accountability

Both directors of nursing homes and hostesses of residential homes are directly accountable to their designated field worker, who is a representative of the Brockville Psychiatric Hospital's H. S. C. programme. These in turn, function under the supervision of the Eastern Area's supervisor

who is directly responsible to the director of the H. S. C. programme of the Provincial Ministry of Health.

Official visits to these individual homes are made on a bi-monthly basis by the individual field workers. All directors and hostesses claim to have a good working relationship with these government representatives, and are satisfied with the services provided by them.

Recommendations of Directors and Hostesses

Few recommended changes were made by the Directors of nursing homes. All complained about the lack of spending money allocated to the residents. These people, although fairly well provided for in terms of basic necessities, cannot afford amenities such as special clothes items or treats. One Director expressed the desire to be provided with comprehensive information on the patients' medical and social backgrounds by the Brockville Psychiatric Hospital. He claims that this data would assist his staff in providing better service. Some directors have indicated their preference in having residents from the psychiatric hospital.

A few hostesses have expressed the need for some form or other of structured guidance and counselling. This they feel would assist them to understand their residents better.

One has indicated she would like to meet periodically with the other hostesses in the area to discuss common problems.

Another wishes that the Brockville Psychiatric Hospital would provide the individual residential homes with arts and crafts material. This would they feel, encourage the residents' creativity and initiative.

CHAPTER III

CONCLUSIONS

From the findings of this study it is not possible to make a definitive statement about the relative quality of the H. S. C. programme in Eastern Ontario. However, the study has, as was intended, provided additional descriptive data and general information about the H. S. C. facilities, programmes, and residents. In reflecting on the results both positive and negative impressions emerge. Some of the findings are interesting and thought-provoking, others are confusing or paradoxical.

It is interesting that over fifty per cent of the residents of nursing homes were female and females accounted for one hundred per cent of those in residential homes. Even though a high proportion of Eastern Ontario is French Canadian, English was the official language in all residential and nursing homes in the sample. Two nursing homes were located in predominantly French-speaking communities and twenty-four per cent of the residents of nursing homes are bilingual.

Nursing homes in the sample were all located in more urban areas than were the residential homes, and accessibility to transportation was superior for the residents of nursing homes.

Presumably, people in residential homes could better utilize transportation facilities and the amenities of a more urban community. Although visiting with friends and relatives was not found to be a frequent event for residents of either type of home, it is unlikely that distance or accessibility are factors. More than fifty per cent of the residents originate from the immediate area where the homes are located.

Perhaps the most significant finding of this study was the distribution and training of staff found in nursing homes. It is not surprising that sixty-nine per cent of all staff are in the nursing category, but forty-seven per cent of these people are untrained. None of the homes employ social workers on either a full-time, part-time or consultative basis. Food service, maintenance and untrained nursing personnel comprise seventy-one per cent of the total staff of nursing homes. All of the nursing home administrators expressed satisfaction with both the staff distribution and staff resident ratios. In a more positive vein, however, three of these nursing homes had consultant psychiatrists on staff.

There was an average of ten hours a week spent in organized recreational activities in the nursing homes sampled. However, it was noted that the recreational programmes were not individualized to any extent, and were unavailable to the residents on weekends. As pointed out earlier, nursing home

residents do not have many visitors and without activities, time on weekends may pass very slowly for them. Two nursing homes in the sample have instituted different kinds of recreational programmes. In addition to the usual arts, crafts and table games, these homes have included a remotivation programme, a pub night, and educational films followed by discussion groups. Very few residents of nursing homes take advantage of recreational events in the community.

People in residential homes have half as many hours per week in recreational activities as their nursing home counterparts; yet they are younger and are situated in more rural environments which are lacking in social and recreational outlets. Transportation to larger communities is often difficult.

Generally, the day-to-day operation of both nursing and residential homes was geared to efficiency and expediency which one finds in institutional settings. This was revealed by such things as sleeping arrangements, rising and bed times, meal times, and meal-taking arrangements.

Most operators expressed a preference for former Brockville Psychiatric Hospital patients to others from the community, and one is led to wonder whether the institutionalized characteristics of these residents is an appealing attribute.

All residential and nursing home operators felt that the per diem rate was inadequate. When asked how they would use the proceeds from an increased rate they identified such things as purchase a mini-bus, improve physical facilities, and increase salaries of non-professional staff to levels exceeding minimum wages. It is to be noted that the hypothetical increases in rate would seem to favour the physical features of the homes rather than the improvement and expansion of their service component.

Finally, all operators are directly accountable to two field workers who are situated in Brockville. These workers visit the homes bi-monthly to counsel needful residents and advise the directors and hostesses on administrative as well as clinical matters. There are over five hundred residents in the Brockville Psychiatric Hospital's Homes for Special Care unit; hence, the current field worker / resident ratio appears to be rather disproportionate. When confronted with such figures, one wonders about the nature of the service given by the H. S. C. workers to both the operators and residents of the homes, and furthermore, one might be led to question the efficiency of the liaison between the psychiatric hospital and the homes.

Recommendations

It is apparent that even though some attention is given to the choice of a home suitable to each resident's needs and personality, the actual locations of the residential homes can be the object of special questioning. If one of the primary goals of the H. S. C. programme is to reintegrate the patient to the community, more attention deserves to be given to the selection of residential homes. Schwartz and Schwartz,[1] remark that:

> Individual patients, as well as groups, must be studied to develop an understanding of the fit between them and the system of help and of the ways in which their relations to their social world might be used therapeutically.

Another area of concern is the actual staff distribution found in nursing homes. The results[2] indicate that the majority of the nursing staff, forty-seven per cent, are untrained. Perhaps nursing home operators ought to be encouraged to work in liaison with local community colleges so as to conceive and develop training programmes to prepare ward aides and male attendants. Actually, one of the nursing homes

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1 Schwartz, and Schwartz, Social Approaches to Mental Patient Care. p. 296.

2 Above., p. 27.

in the sample already took this initiative and such a programme has been implemented.

An extensive staff training and development programme could be initiated by the authorities of the H. S. C. Division across the province. All staff, including H. S. C. workers, home operators, and staff of both types of facilities could benefit from on-going training, upgrading, seminars, and workshops, and subsequently provide better services to the residents.

Some directors and hostesses have expressed interest in meeting with their colleagues on a regular basis to discuss concerns and problems common to all of them, and perhaps, in response to this interest a H. S. C. operators' association could be formed in Eastern Ontario.

Furthermore, adjunctive services could be added to the already existing ones, to assist the residents to adapt and benefit from their new environment. Social services as well as professional recreational activities appear to be justifiable and necessary if these after-care facilities are to meet all the needs of their residents and satisfy the goals so clearly specified in the H. S. C. programme. Schwartz and Schwartz[1] affirm that: "If the institution's processes are

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1 Ibid., p. 296.

to be dedicated to the patients' welfare, there must be an intimate knowledge of each one's needs, and difficulties, and avenues of possible improvement."

Supported by the positive results of the Cooperative Apartment Program initiated in Boston[1] the suggestion that a professional visiting team be formed to visit all nursing and residential homes appears feasible. This actual team which consisted of a psychiatrist, a social worker, an occupational therapist, and a nurse made a weekly visit to the ex-patients living in apartments. The purpose of this team was twofold; firstly it provided the required services to the ex-patients, and secondly, their very presence in the community provided the community members with easier accessibility to help from these professionals when they needed it. Obviously the composition of the team could be altered to suit the specific needs of the H. S. C. facilities.

Perhaps, constant evaluation and follow-up study of the H. S. C. programme would help to identify programme strengths and deficiencies, and on the long run, help to shift the traditional health delivery system for the mentally handicapped to a more humanity-oriented community basis.

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1 Chien, and Cole, "Landlord-Supervised Cooperative Apartments," American Journal of Psychiatry.

SUMMARY

The purpose of this research was to study community after-care facilities for discharged patients of the Brockville Psychiatric Hospital to determine whether they were becoming, as recently predicted, "mini institutions" or community back wards.

This descriptive-diagnostic study was carried out using the geographical boundaries of the Homes for Special Care unit at the Brockville Psychiatric Hospital. From a universe of twenty-one nursing home and residential home facilities, a random sample of five nursing homes and five residential homes was taken. An interview schedule was designed to be completed during standardized interviews with the operators of the homes in the sample.

The findings of the study did not totally support or refute the prediction that after-care facilities were becoming the mental hospitals' community back wards. Rather, it provided additional factual information, and uncovered some characteristics that could be perceived as being problematic. Of particular significance were the findings that: (a) residential homes were located in non urban areas, (b) a large proportion of the staff providing nursing care were untrained, (c) there were no social workers or trained recreational leaders in the nursing homes, (d) programmes and routines were

generally designed to ensure the efficient operation of the homes rather than to meet the individual needs of the residents, (e) there were no preparation, training or on-going development program for the over-all Homes for Special Care staff.

The recommendations focussed on the following areas: (a) a more careful selection of locations for residential homes, (b) more appropriate fit between the ex-patient and the individual residence, (c) the upgrading of the staff in general, and of the nursing personnel in particular, (d) the formation of an association for the operators of Homes for Special Care in Eastern Ontario, (e) the implementation of a professional team consisting most likely of a psychiatrist, an occupational therapist, a psychiatric nurse, a recreational leader, and a social worker, who would visit all facilities on a regular basis, (f) the expansion and individualization of recreational programmes, and (g) the on-going evaluation of the over-all Homes for Special Care programme in Ontario.

INTERVIEW SCHEDULE

PART 1

GEOGRAPHICAL SETTING

1. Name of Home:

2. Type of Home: Nursing home ___ Residential home ___

3. Address:

4. Type of community:

   a) Population: _____

   b) Area predominantly: French ___ English _____

   c) What is the distance to business section of the community? ____ miles.

   d) Is home accessible to out of town bus or train facilities?

      Yes ____ No ____

   e) If no, how far is the nearest community where these transportation facilities are available?

      Bus _____ mi.

      Train _____ mi.

   f) Is a taxi or mini bus service available to residents of your home?

      Yes ____ No ____

   g) If yes, does resident himself pay the service?

      Yes ____ No ____

5. What are the basic admission criteria for:

a) Nursing Home: _____

_____

_____

_____

b) Residential Home: _____

_____

_____

_____

6. Are these admission rules satisfactory? Yes _____

No _____

If no, what changes ought to be implemented?

_____

_____

_____

_____

PART 2

FACILITIES' POPULATION

1. Total capacity of Home: _____

_____

_____

2. What has been your average occupancy in the last year? _____ males _____

females ___

3. What is the residents' age distribution

- under 20 _____
- 21 - 40 _____
- 41 - 60 _____
- 61 - 80 _____
- over 80 _____

4. What number of your residents are:

a) unilingual French _____

b) unilingual English _____

c) bilingual _____

5. How many residents come from: a) this county _____

b) adjoining counties __

c) other counties _____

6. Do you have any contact with families and/or relatives of your residents? Yes _____ No _____

7. Approximately how many of the residents have family ties? _____

8. How many staff do you employ? _____

9. Describe the training background of the staff, their respective number, and whether they are full time employees or otherwise.

TRAINING BACKGROUND	NUMBER	FULL TIME	PART TIME	CONSULTANT
Psychiatrist	_____	____	____	_____
Medical doctor	_____	____	____	_____
R. Nurse	_____	____	____	_____
R. Nurse's Aid	_____	____	____	_____
Social Worker	_____	____	____	_____
Orderly	_____	____	____	_____
Recreational Leader	_____	____	____	_____
Experienced, but no formal training	_____	____	____	_____
Maintenance employees	_____	____	____	_____
Food service personnel	_____	____	____	_____

10. Do you feel that your current staff ratio is satisfactory?

Yes ____ No ____

11. If no, how do you feel it should be altered?

_____

_____

PART 3

RECREATIONAL AND SOCIAL ACTIVITIES

1. On the average, how many hours per week do the residents spend in organized recreational programmes such as:

   - physical fitness _____
   - table games _____
   - bowling _____
   - pool, ping pong _____
   - community outings _____

2. What other kinds of programmes are available to the residents in your Home, i.e.:

   - educational _____
   - social _____
   - remotivation _____

3. Is there a specific games or activity room available for the residents?

   Yes _____ No _____

4. If yes, how many hours per day is it used? _____

5. Is there any difference in programming during weekends?

   Yes _____ No _____

6. If yes, describe the differences.

   _____

   _____

7. How many radios _____ t.v. sets _____ are supplied by the Home?

8. Do the residents have individual radios?

   All _____

   Some_____

   None_____

9. Is there a special room set aside for reading?

   Yes _____ No _____

10. How much reading material do you supply?

    All _____

    Half_____

    None_____

11. What recreational outlets are there in the local community?

    Place a check beside the most popular ones among the residents.

_____	_____
_____	_____
_____	_____
_____	_____

PART 4

RULES AND REGULATIONS OF YOUR HOME OR RESIDENCE

1. What is the monthly standard fee paid by residents?

   _____

2. What kind of sleeping accommodation are there?

   - Private rooms _____
   - Semi-private _____
   - Small dormitory _____
   - Large dormitory _____

3. What is: rising time _____

   bed time _____

4. What are the meal times?

   breakfast _____

   lunch _____

   dinner _____

5. Are meals served -

   in a dining room _____

   on trays in sleep-

   ing accommodation_____

6. Are residents expected to assume some responsibilities in the maintenance of the Home?

   none _____

   some _____

   Please list: _____

   _____

   _____

7. What are the rules for visitors of residents?

	Frequency	Hours
Daily	_____	_____
Weekend	_____	_____

8. Are residents allowed to visit family or friends?

Yes _____ No _____

9. If yes, state:

Frequency _____ Length of visit _____

10. In your view, is the provincial per diem subsidization adequate for the operation of your home?

Yes _____ No _____

11. If no, how much do you think the per diem rate should be? _____

12. What could the extra money be used for?

_____

_____

13. To whom are you accountable within the Provincial Government?

REPRESENTATIVE	YOUR RESPONSIBILITY
_____	_____
_____	_____
_____	_____

14. How often are you in contact with them?

_____

15. As Director or Host/Hostess, are there any recommendations that you would make in order to improve this programme?

_____

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Ontario

The Homes for Special Care Act

Revised Statutes of Ontario, 1970

CHAPTER 205

— and —

Regulation 438

Revised Regulations of Ontario, 1970

as amended to O. Reg. 890/74

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CHAPTER 205

The Homes for Special Care Act

Interpretation

1. In this Act,

(*a*) "home for special care" means a home for the care of persons requiring nursing, residential or sheltered care;

(*b*) "Minister" means the Minister of Health;

(*c*) "regulations" means the regulations under this Act;

(*d*) "resident" means a person received and lodged in a home for special care under this Act. R.S.O. 1970, c. 205, s. 1.

Administration

2. The Minister is responsible for the administration of this Act. R.S.O. 1970, c. 205, s. 2.

Establishment of homes

3.—(1) The Lieutenant Governor in Council may establish one or more homes for special care.

Idem

(2) The Lieutenant Governor in Council may designate the name by which any home for special care established under subsection 1 shall be known. R.S.O. 1970, c. 205, s. 3.

Approval of homes

4.—(1) The Lieutenant Governor in Council may approve all or any part of any institution, building or other premises or place as a home for special care.

Aid to approved homes

(2) The Minister may make grants out of moneys that are appropriated therefor by the Legislature to homes for special care that he has approved under subsection 1 in such manner, in such amounts and under such conditions as are prescribed by the regulations. R.S.O. 1970, c. 205, s. 4.

Licensing of homes

5.—(1) The Minister may license homes for special care that have not been established under section 3 or have not been approved under section 4, and he may renew or cancel such licences upon such terms and conditions as the regulations prescribe.

Fee

(2) The fee for the licence mentioned in subsection 1 and the renewal thereof shall be that prescribed by the regulations.

Payments for care and maintenance

(3) The Minister may pay such amounts for the care and maintenance of residents in homes licensed under this section as are prescribed by the regulations. R.S.O. 1970, c. 205, s. 5.

R.S.O. 1970, c. 269 may be made applicable to homes

6. The Lieutenant Governor in Council may designate any provision of *The Mental Health Act* or of the regulations thereunder as being applicable to any home for special care. R.S.O. 1970, c. 205, s. 6.

Regulations

7. The Lieutenant Governor in Council may make regulations with respect to homes for special care for,

(*a*) their construction, location, alteration, equipment, safety, maintenance and repair;

(*b*) their inspection, control, government, management, conduct, operation and use;

(*c*) their administrators and other officers and staffs and the powers and duties thereof;

(*d*) their classifications, grades and standards, and the classification of residents, and regulating and prescribing the rates and charges for residents, and prescribing the liability therefor;

(*e*) the admission, treatment, care, conduct, control, custody and discharge of residents or of any class of residents;

(*f*) prescribing the classes of grants to homes approved under section 4 and the methods of determining the amounts of grants, and providing for the manner and times of payment and the suspension and withholding of grants and for the making of deductions from grants;

(*g*) providing for the licensing of homes for special care under section 5 and the renewal and cancellation thereof, and prescribing the fees payable for such licences;

(*h*) prescribing the amounts to be paid by the Minister for the care and maintenance of residents in homes for special care licensed under section 5;

(*i*) any matter necessary or advisable to carry out effectively the intent and purpose of this Act. R.S.O. 1970, c. 205, s. 7.

8. The expenses of the administration of this Act shall be paid out of the moneys appropriated therefor by the Legislature. R.S.O. 1970, c. 205, s. 8. Expenses

REGULATION 438

under The Homes for Special Care Act

GENERAL

INTERPRETATION

1. In this Regulation,

(*a*) "administrator" means a person appointed by a board to administer an approved home or the person in charge of a licensed nursing home or a licensed residential home;

(*b*) "approved home" means an institution, building or other premises or place, or any part thereof, approved under section 4 of the Act as a home for special care;

(*c*) "board" means the governing board of an approved home;

(*ca*) "burial" means,

(i) the provision of a grave for burial where a grave is not provided free of charge under section 53 of *The Cemeteries Act*,

(ii) the opening and closing of a grave,

(iii) the perpetual care of a grave,

(iv) where required, a grave marker, and

(v) such other services and items in addition to those set out in subclauses i to iv, both inclusive, as approved by the Director;

(*d*) "Department" means the Department of Health;

(*e*) "Director" means the Director of Homes for Special Care;

(*ea*) "extended care" means skilled nursing and personal care given by or under the supervision of a registered nurse or registered nursing assistant under the direction of a physician to a resident for a minimum of one and one-half hours per day;

(*eb*) "extended care unit" means that part of a licensed nursing home in which residents in need of extended care are lodged;

(*ec*) "funeral" means,

(i) the provision of a casket, embalming, graveside services and related services,

(ii) the use of the facilities of a funeral home by friends and relatives of a deceased person for twenty-four hours and for religious services and transportation for a casket and clergy to a place of interment,

(iii) the provision of a wooden outer case for a casket where required,

(iv) the religious services at a burial, and

(v) such other services and items in addition to those set out in subclauses i to iv, both inclusive, as approved by the Director;

(*f*) "inspector" includes a medical officer of health or his representative;

(*fa*) "intermediate nursing care" means nursing and personal care given by or under the supervision of a registered nurse or registered nursing assistant under the direction of a physician to a resident for less than one and one-half hours per day;

(*g*) "licensed nursing home" means a nursing home licensed under section 5 of the Act as a home for special care;

(*h*) "licensed residential home" means a private residence licensed under section 5 of the Act as a home for special care;

(*i*) "physician" means a duly qualified medical practitioner;

(*j*) "trustee" means the Public Trustee, a committee duly appointed under *The Mental Incompetency Act*, or a trustee duly appointed under a will or other instrument. R.R.O. 1970, Reg. 438, s. 1; O. Reg. 57/72, s. 1; O. Reg. 219/72, s. 1; O. Reg. 212/74, s. 1.

2. A home for special care is classified as an approved home, a licensed nursing home or a licensed residential home. R.R.O. 1970, Reg. 438, s. 2.

PART 1

APPROVED HOMES

APPLICATION

3. This Part applies to approved homes. R.R.O. 1970, Reg. 438, s. 3.

ADMINISTRATION

4. An administrator is responsible to the board for the efficient management and operation of the approved home that he administers. R.R.O. 1970, Reg. 438, s. 4.

QUALIFICATIONS OF STAFF MEMBERS

5. No person shall be employed in an approved home unless he is qualified to perform his duties in the home. R.R.O. 1970, Reg. 438, s. 5.

MEDICAL EXAMINATIONS FOR ADMINISTRATORS AND STAFFS

6.—(1) No person shall be appointed as an administrator or be employed in an approved home unless he has obtained from a physician a certificate certifying that he is,

(*a*) free from active tuberculosis or other communicable or contagious disease; and

(*b*) physically fit to undertake his duties in the home.

(2) At least once a year the administrator and each member of the staff of an approved home shall obtain the certificate prescribed in subsection 1. R.R.O. 1970, Reg. 438, s. 6.

POWERS AND DUTIES OF ADMINISTRATORS

7. In every approved home, the administrator,

(*a*) is responsible for,

(i) the proper performance of his duties under this Regulation,

(ii) the efficient management and operation of the home,

(iii) keeping the records required by this Regulation, and

. . . . .

(*b*) shall admit persons to the home in accordance with this Regulation; and

(*c*) shall ensure that forms required in respect of admission to the home are properly completed and that a written record is kept of illnesses, transfers, discharges and deaths of residents. R.R.O. 1970, Reg. 438, s. 7; O. Reg. 57/72, s. 2.

FIRE PROTECTION AND FIRE DUTIES

8. The administrator of an approved home shall ensure that,

(*a*) all fire-hazards in the home are eliminated;

(*b*) fire-extinguishers, hose and standpipe equipment are inspected at least once a month;

(*c*) the heating equipment and chimneys are inspected at least once every six months to ensure that they are safe and in good repair;

(*d*) a written record is kept of inspections and tests of the fire equipment, the fire-alarm system, the heating system and chimneys;

(*e*) the staff, and so far as possible, the residents, know the method of sounding the fire-alarm;

(*f*) the staff is trained in the proper use of the fire-extinguishing equipment;

(*g*) a procedure is established to be followed when a fire-alarm is given, including the duties of the staff and residents;

(*h*) the staff and residents are instructed in the procedure established under clause *g*, and that the procedure is posted in conspicuous places in the home;

(*i*) a fire drill is held at least once a month;

(*j*) matches available to the staff or residents or used by them in or around the home are safety matches;

(*k*) an inspection of the building is made each night to ensure that there is no danger of fire, and that the doors in stairwells and smoke barriers are closed. R.R.O. 1970, Reg. 438, s. 8.

9. and 10. REVOKED: O. Reg. 57/72, s. 3.

BONDING OF ADMINISTRATOR

11.—(1) The administrator of an approved home shall be bonded by a bond of a guarantee company approved under *The Guarantee Companies Securities Act* in an amount or amounts satisfactory to the board that appointed him.

(2) The board shall pay the cost of the bond. R.R.O. 1970, Reg. 438, s. 11.

PART II

Licensed Nursing Homes

APPLICATION

12. This Part applies to licensed nursing homes. R.R.O. 1970, Reg. 438, s. 12.

13. The administrator of a licensed nursing home is responsible for the efficient management and operation of the home. R.R.O. 1970, Reg. 438, s. 13.

14. The administrator shall provide sleeping accommodation for residents in rooms with a minimum of,

(*a*) 400 cubic feet of air space and fifty square feet of floor space for each person under sixteen years of age; and

(*b*) 600 cubic feet of air space and seventy-five square feet of floor space for each person sixteen years of age and over,

and each room so used shall contain at least one window capable of being opened directly to the outside, and the area of the window shall not be less than 10 per cent of the floor area of the room. R.R.O. 1970, Reg. 438, s. 14.

15. Sleeping accommodation shall not be provided in any space in a licensed nursing home used as a lobby, hallway, closet, bathroom, stairway or kitchen. R.R.O. 1970, Reg. 438, s. 15.

16. The administrator shall provide toilet and bathing facilities which are readily accessible to all residents with a minimum of one wash-basin and one flush toilet for every eight residents and one bathroom or shower for every twelve residents. R.R.O. 1970, Reg. 438, s. 16.

17. The administrator shall,

(*a*) provide and maintain proper and adequate nursing service and personal care for residents under the direction of a competent nursing attendant;

(*b*) ensure that a sufficient staff of qualified nursing and other personnel is provided to give adequate nursing and personal care and prepare and serve meals and maintain the rooms and premises in a clean and sanitary condition; and

(*c*) ensure that medical care and attention are made available by a physician to residents as required. R.R.O. 1970, Reg. 438, s. 17.

18. The administrator shall ensure that,

(*a*) nourishing meals, including special diets where required, are provided at regular intervals and prepared by or under the supervision of a competent person, and

(*b*) adequate and sanitary supplies of milk and drinking water are provided. R.R.O. 1970, Reg. 438, s. 18.

19. The administrator shall maintain the licensed nursing home in a clean, safe and sanitary condition and shall ensure that,

(*a*) all fire hazards in the home are eliminated;

(*b*) there is adequate protection from radiators or other heating equipment;

(*c*) the water supplies are adequate for all normal needs, including those of fire protection;

(*d*) there are at least two separate means of egress to the outside from floors with sleeping accommodation;

(*e*) the premises are inspected at least quarterly by an officer authorized to inspect buildings under *The Fire Marshals Act*;

(*f*) all parts of the home are kept free from rubbish, garbage, ashes, flammable materials and other debris;

(*g*) the basement of the home is well drained and ventilated;

(*h*) the home is weatherproof, free from dampness, adequately heated and all heating equipment is in good repair;

(*i*) adequate kitchen equipment and facilities to ensure the proper preparation and protection of food are provided and maintained; and

(*j*) all necessary steps are taken to keep the building free from vermin, insects and pests. R.R.O. 1970, Reg. 438, s. 19.

PART III

Licensed Residential Homes

20. This Part applies to licensed residential homes. R.R.O. 1970, Reg. 438, s. 20.

21. A licensed residential home in which a person may be received as a resident shall,

(*a*) be a fit and proper place for that person, as evidenced by a written report of an inspection filed with the records of that person in the home; and

(*b*) not be the residence of a parent or child of that person. R.R.O. 1970, Reg. 438, s. 21.

22. Sleeping accommodation for a person who is a resident in a licensed residential home shall,

(*a*) be in a room with the beds so placed that no part of the bed is closer to another bed than 2½ feet and that no part of a bed overlaps a window or radiator;

(*b*) subject to clause *c*, be in a room that is located on the ground floor or the floor immediately above it;

(*c*) where the room is located on a floor above the floor immediately above the ground floor, be on a floor from which there are two separate and independent means of egress to the outside; and

(*d*) be in a room that is adequately ventilated and lighted by natural light. R.R.O. 1970, Reg. 438, s. 22.

INSPECTION OF LICENSED RESIDENTIAL HOMES

23.—(1) A licensed residential home in which a person may be received as a resident shall be,

(*a*) inspected and approved by an inspector not more than four months before the day on which a person is placed in that residence; and

(*b*) inspected by an inspector at regular intervals after the first inspection.

(2) A licensed residential home may be inspected by an inspector at any reasonable time. R.R.O. 1970, Reg. 438, s. 23.

FIRE SAFETY STANDARDS

24. The administrator of a licensed residential home shall ensure that,

(*a*) all fire hazards in the home are eliminated;

(*b*) fire extinguishers, hose and standpipe equipment are inspected at least once a month;

(*c*) the heating equipment and chimneys are inspected at least once every six months to ensure that they are safe and in good repair;

(*d*) a written record is kept of inspections and tests of the fire equipment, the fire alarm system, the heating system and chimneys;

(*e*) the staff and so far as possible the residents, know the method of sounding the fire alarm;

(*f*) the staff is trained in the proper use of the fire extinguishing equipment;

(*g*) a procedure is established to be followed when a fire alarm is given, including the duties of the staff and residents,

(*h*) the staff and residents are instructed in the procedure established under clause *g* and that the procedure is posted in conspicuous places in the home;

(*i*) a fire drill is held at least once a month;

(*j*) matches available to the staff or residents or used by them in or around the home are safety matches;

(*k*) an inspection of the building is made each night to ensure that there is no danger of fire, and that the doors in stairwells and smoke barriers are closed;

(*l*) all hallways, stairways and means of entrance or egress are kept free from obstruction at all times; and

(*m*) all flammable materials and supplies are properly stored. R.R.O. 1970, Reg. 438, s. 24.

25.—(1) In this section, "fire resistance rating" means the rating assigned to any element or assembly of materials of construction as published by The National Research Council of Canada, The Underwriter's Laboratories of Canada, the Joint Fire Research Organization, United Kingdom, The Underwriters' Laboratories Inc. or the Factory Mutual Engineering Division. R.R.O. 1970, Reg. 438, s. 25 (1).

(2) The administrator of a licensed residential home shall comply with the following additional fire safety requirements according to the class of occupancy of the licensed residential home:

1. Licensed residential home, Class I, four or less residents, excluding family and staff.

   i. Reasonable fire safety precautions shall be adhered to.

   ii. Good housekeeping shall be practised.

   iii. Proper heating unit maintenance shall be observed.

   iv. Precautions shall be taken for residents who smoke.

2. Licensed residential home, Class II, five to seven residents, excluding family and staff.

   i. Two separate means of egress, remote from each other, shall be provided for every floor or section of the building.

   ii. Where there is no interior secondary stairwell provided as an exit, an exterior fire escape connecting all floors and leading directly to grade level shall be provided.

   iii. All stairways shall be enclosed by a fire resistant partition having a fire resistance rating of three-quarters of an hour and self-closing door.

   iv. The ceiling or open joists over the furnace shall be covered with fire resistant material having a fire resistance rating of thirty minutes, to an area of two feet beyond the perimeter of the furnace and the area above the smoke pipe shall be covered in its entirety.

   v. At least one fire extinguisher approved by the Director shall be provided.

3. Licensed residential home, Class III, eight or more residents, excluding family and staff.

   i. Two separate means of egress, remote from each other, shall be provided for every floor or section of the building.

   ii. An exterior fire escape connecting all floors and leading directly to grade level shall be provided where no interior secondary stairwell is provided as an exit.

   iii. All stairways shall be enclosed by a fire resistant partition having a fire resistance rating of three-quarters of an hour and self-closing door.

   iv. The furnace or boiler room shall be separated from the remainder of the building by construction having a fire resistance rating of at least one hour.

   v. All combustible ceilings, including exposed wood and joists, shall be fully covered with fire resistant material having a fire resistance rating of at least one hour.

   vi. The furnace room door and inside door jamb shall be metal-clad and the door shall be equipped with a self-closing device.

   vii. Provision shall be made to provide sufficient air for proper combustion in the boiler or furnace rooms.

   viii. Each floor shall be equipped with a fire extinguisher approved by the Director.

   ix. All vertical shafts, dumb waiters, laundry chutes, rubbish chute and every other shaft shall be enclosed with material having a fire-resistance rating of not less than forty-five minutes and shall be equipped with self-closing doors at all floors, including the basement, incorporating a degree of fire resistance equivalent to the shaft.

   x. There shall be an electric fire alarm system in the building.

   xi. Every fire alarm system shall be a closed circuit electrically supervised system, components of which have been tested and listed by the Underwriters' Laboratories of Canada or the Canadian Standards Association Testing Laboratories.

   xii. A fire alarm station shall be installed on every floor in the building.

   xiii. Heat actuated detectors shall be installed according to the manufacturer's listing in all areas in the building, except corridors and washrooms.

   xiv. The fire alarm sounding device shall have a sound that is readily distinguishable from the sound produced by any other sounding device used in the building.

   xv. Every fire alarm system shall be provided with two independent sources of power, and where batteries are used as a secondary source of power, the batteries shall be rechargeable by means of a trickle charger connected to the hydro-electric power supply.

xvi. Power for the fire alarm system shall be taken directly from the line side of the service after transformation and no power for the system shall be taken from secondary distribution panels or lighting panels.

xvii. The fire alarm electrical supply system shall be equipped with separate circuit breakers or fused switches that serve only the fire alarm system.

xviii. Every fire alarm panel shall be equipped with a glowing light that ceases to glow when the system is shut off and the panel shall be conspicuously marked to indicate that the system is inactive when the light is not glowing. R.R.O. 1970, Reg. 438, s. 25 (2); O. Reg. 535/71, s. 1.

GENERAL

26. Nothing in this Regulation affects any by-law relating to fire safety requirements lawfully passed by a municipal council, or the authority of a municipal council to pass any such by-law, insofar as such by-law imposes additional or more stringent requirements than those prescribed in this Regulation. R.R.O. 1970, Reg. 438, s. 26.

PART IIIA

TRUST ACCOUNTS

26a. The administrator of an approved home, or a licensed nursing home or a licensed residential home shall,

(*a*) establish and maintain a non-interest bearing trust account in a chartered bank or a Province of Ontario Savings Office in which he shall deposit all moneys received by him from any resident of the home or from any trustee acting on behalf of such resident;

(*b*) provide a resident, or a trustee acting on behalf of a resident, with a written receipt for all moneys received by him for deposit in the trust account to the credit of such resident;

(*c*) maintain a separate book of account showing all deposits to and withdrawals from the trust account, the name of the resident for whom such deposit or withdrawal is made and the date of each deposit or withdrawal;

(*d*) in those instances where he has deposited in the trust account moneys received from a resident, make part or all of the moneys available to such resident upon the resident providing him with a written receipt therefor,

(*e*) in those instances where he has deposited in the trust account moneys received from a trustee on behalf of a resident, make part or all of the moneys available to such resident only in accordance with the written instructions of the trustee;

(*f*) with respect to each resident on whose behalf money is deposited in the trust account to the credit of such resident, retain in his possession for a period of not less than six years,

(i) the deposit books, deposit slips, passbooks, monthly bank statements, cheque books and cancelled cheques applicable to the trust account referred to in clause *a*,

(ii) the book of account referred to in clause *c*,

(iii) the written receipts referred to in clause *d*, and

(iv) the written instructions of the trustee referred to in clause *e*,

and at any time and from time to time on written demand of a resident, or his authorized agent, or a trustee acting on behalf of a resident, or such trustee's authorized agent make the foregoing documentation available for inspection at reasonable hours during any business day. O. Reg. 57/72, s. 4, *part*.

26b. The trust account established under section 26*a* shall be audited annually by a chartered accountant or a licensed public accountant. O. Reg. 57/72, s. 4, *part*.

PART IV

LICENCES

27.—(1) A licence issued to a nursing home shall be in Form 1 and an application for a licence in Form 1 shall be in Form 2.

(2) A licence issued to a residential home shall be in Form 3 and an application for a licence in Form 3 shall be in Form 2. R.R.O. 1970, Reg. 438, s. 27.

28.—(1) The Minister may issue a licence,

(*a*) to a nursing home that complies with this Regulation upon payment of the prescribed fee; and

(*b*) to a residential home that complies with this Regulation and the Minister finds suitable for the reception and care of residents.

(2) A licence in Form 1 or Form 3 expires with the 31st day of December in the year in which it is issued.

(3) The Minister may renew,

(a) a licence in Form 1 upon receipt of an application in Form 2 and payment of the prescribed fee; and

(b) a licence in Form 3 upon receipt of an application in Form 2.

(4) The fee for a licence in Form 1 is $10 and the fee for a renewal thereof is $5. R.R.O. 1970, Reg. 438, s. 28.

29. The Minister may at any time cancel any licence for any reason that he deems proper and notice of the cancellation shall be given by the Minister by registered letter mailed to the administrator at the address shown on the licence and to the local medical officer of health. R.R.O. 1970, Reg. 438, s. 29.

30. Each application for a licence in Form 1 or a renewal thereof shall be accompanied by,

(a) a certificate of an officer authorized to inspect buildings under *The Fire Marshals Act* certifying that the nursing home has been inspected by him within three months of the date of the application and is reasonably safe from fire hazard; and

(b) a certificate of an inspector certifying that the home has been inspected by him within three months of the date of the application, and that, in his opinion, it is in reasonable compliance with the requirements of Part II of this Regulation. R.R.O. 1970, Reg. 438, s. 30.

31. The administrator shall post a licence in Form 1 in a conspicuous place in the lower hallway of the home. R.R.O. 1970, Reg. 438, s. 31.

ADMISSION OF RESIDENTS

32. Any person,

(a) who has been a patient in an institution within the meaning of *The Mental Hospitals Act*;

(b) who has been an informal patient under *The Mental Hospitals Act* or has been discharged under that Act; and

(c) for whom no immediate provision for care and lodging has been made; or

(d) who is a resident in a residential unit established under Regulation 579 of Revised Regulations of Ontario, 1970,

may be admitted to a home for special care as a resident upon his own application or the application of a friend or relative. R.R.O. 1970, Reg. 438, s. 32.

33. The application referred to in section 32 shall be submitted to the Director who shall arrange for the admission of the applicant as a resident. R.R.O. 1970, Reg. 438, s. 33.

34.—(1) Part III of *The Mental Health Act*, and the relevant regulations thereunder apply *mutatis mutandis* to a resident in a home for special care as if the resident had continued as a patient in a psychiatric facility under that Act.

(2) Notwithstanding subsection 1, where a notice of continuance has been issued under subsection 2 of section 37 of *The Mental Health Act*, prior to the discharge of the resident from a psychiatric facility, the provisions of clause *d* of section 38 of that Act shall not apply. R.R.O. 1970, Reg. 438, s. 34.

RECORDS

35. The administrator of an approved home or a licensed nursing home shall keep or cause to be kept a written record for each resident that shall set forth,

(a) a detailed report on the medical history of the resident before admission and all physical and mental examinations, and all illnesses and accidents after admission;

(b) observations on the conduct and behaviour of the resident while in the home;

(c) where a resident is discharged from the home, the name and address of the person in whose charge the resident was placed at the time of discharge or the name and address of the institution to which the resident was discharged; and

(d) where a resident dies, a report of the time, date and circumstances of the death and the name and address of the person, if any, who claims the body. R.R.O. 1970, Reg. 438, s. 35.

36. Where,

(a) a fire has occurred in a home for special care; or

(b) a resident has been assaulted or injured,

the administrator shall forthwith submit to the Director a written report containing full details of the fire, assault or injury, as the case may be. R.R.O. 1970, Reg. 438, s. 36.

INSPECTORS

37. The Minister may designate officers of the Department as inspectors for the purposes of the Act and this Regulation. R.R.O. 1970, Reg. 438, s. 37.

38. An administrator shall permit an inspector or an officer authorized to inspect buildings under *The Fire Marshals Act* to enter a home for special care at any and all reasonable times for the purpose of inspecting the premises and every part thereof to ascertain whether the provisions of this Regulation are being complied with. R.R.O. 1970, Reg. 438, s. 38.

39. A medical officer of health shall inspect homes for special care within the area under his jurisdiction at regular intervals or when requested by the Director. R.R.O. 1970, Reg. 438, s. 39.

CHARITABLE ORGANIZATIONS

40. With the approval of the Minister, the Director may arrange with the board of any organization having objects of a charitable nature for assistance from such board in the inspection and supervision of accommodation and facilities for the care and maintenance of residents in licensed nursing homes and licensed residential homes and the supervision of the residents therein. R.R.O. 1970, Reg. 438, s. 40.

41.—(1) Where a resident in an approved home, a licensed nursing home or licensed residential home is unable to pay for his care and maintenance, the Minister may pay to the Board of an approved home or the licensee of a licensed nursing or residential home,

(*a*) where the resident qualifies on medical grounds for and receives extended care in an extended care unit, the amount of $17.00 for each day the resident receives extended care;

(*b*) the amount of $14.50 for each day the resident receives intermediate care; and

(*c*) where the resident does not require nursing care, the amount of $7.50 for each day the resident receives care and maintenance. O. Reg. 890/74, s. 1.

(2) The Minister may pay the amounts mentioned in subsection 1 in respect of a resident during any period where, with the approval of the Director, a resident has been granted leave-of-absence not exceeding fourteen consecutive days.

(3) The amounts paid by the Minister for extended and intermediate nursing care under subsection 1 shall be accepted by the Board or the licensee as payment in full for standard ward accommodation. O. Reg. 219/72, s. 2, *part*.

(4) In addition to the amounts prescribed in subsection 1, the Minister may pay for any medical care, medicine, clothing, toiletries or other personal necessities required by and supplied to a resident and may pay, in respect to the funeral and burial of a resident, a maximum of $350 for the total cost of any funeral, and $150 for the total cost of any burial but, upon the recommendation of the Director, the Minister may pay an amount for the funeral and burial expenses of a resident in excess of these amounts. O. Reg. 212/74, s. 2.

(5) A resident who has property or subsequently acquires property shall be liable for payment made on his behalf under subsections 1 and 4.

(6) The husband of a resident shall be liable for payments made on behalf of his wife under subsections 1 and 4.

(7) Except where the entitlement has been paid to him, the amounts recoverable under subsections 5 and 6 shall be reduced by a resident's entitlement under *The Family Benefits Act*.

(8) A resident who is receiving extended care or the husband of a resident shall not be required to repay that portion of payments made under subsections 1 and 4 which would be extended care benefits under *The Health Insurance Act, 1972* were the resident not excluded from extended care benefits under that Act.

(9) Where a resident is entitled to a reduction under subsection 8, the reduction shall be reduced by any entitlement due the resident under *The Family Benefits Act*. O. Reg. 219/72, s. 2, *part*.

42. In the event of the death in a home for special care of a resident who is an indigent person, the Minister may pay the expenses of his burial. R.R.O. 1970, Reg. 438, s. 42.

Form 1

The Homes for Special Care Act

NURSING HOME LICENCE

Under *The Homes For Special Care Act* and the regulations and subject to the limitations thereof,

this licence is issued to.....

.....

(name and address of home)

as a nursing home for special care.

This licence expires with the....day of .....,

19

.....

(signature of issuer)

Dated at Toronto, this....day of.....,

19.....

R.R.O. 1970, Reg. 438, Form 1.

Form 2

The Homes for Special Care Act

APPLICATION FOR LICENCE AS

—NURSING HOME

—RESIDENTIAL HOME

To The Director of Homes for Special Care,
Department of Health,
Parliament Buildings,
Toronto 2, Ontario.

1. Name of Applicant.....
2. Address of Applicant.....
3. Location of Home .....
4. Occupation of Applicant.....
5. Number of bedrooms available for residents...
6. Number of residents the applicant proposes to accommodate at one time.....
7. Number available for use by residents:
   (*a*) wash-basins.....
   (*b*) flush toilets.....
   (*c*) bathrooms.....
   (*d*) showers.....
8. Interest of applicant in home.....
   (owner, lessee, etc.)

.....
(signature of applicant)

Dated at.....this....day of.....,
19.....

R.R.O. 1970, Reg. 438, Form 2.

Form 3

The Homes for Special Care Act

RESIDENTIAL HOME LICENCE

Under *The Homes for Special Care Act*, and the regulations, and subject to the limitations thereof, this licence is issued to.....
(name and address of home)
as a residential home for special care.

This licence expires with the....day of.....,
19.....

.....
(signature of issuer)

Dated at Toronto, this....day of.....,
19.....

R.R.O. 1970, Reg. 438, Form 3.