An investigation into the practice of community care facility licensing in British Columbia. The framework for analysis describes variations in licensing practice across BC, and what changes in practice occur as a result of Licensing Officers participating in the JIBC Advanced Specialty Certificate in Community Care Licensing Program.

BC COMMUNITY CARE LICENSING OFFICER STUDY: PHASE ONE ANALYSIS

JIBC Office of Applied Research

NOVEMBER 2016
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JIBC CCLO Study: Phase 1 Data Analysis

1 THE STUDY: PHASE ONE

The first phase of this Community Care Licensing Officer (CCLO) study is an investigation into the practice of community care facility licensing in British Columbia funded by the BC Ministry of Health and conducted by The Justice Institute of BC Office of Applied Research.

As a result of recommendation #R153 in the Ombudsperson’s 2012 report, *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*, the JIBC was contracted to design, develop, and deliver a training program for licensing officers (LO’s) that “will allow them to appropriately respond to complaints about residential care facilities.” This research study seeks to document the current state of licensing practice in the province and assess the changes in practice that occur or may occur as a result of LOs participating in the JIBC Advanced Specialty Certificate in Community Care Licensing (ASCCCL) program.

The framework for analysis is to describe variation in licensing practice across the province (current state), describe what changes in practice occur, if any, as a result of LOs taking courses in the program, and describe the group norms associated with this particular community of practice. Understanding the application of administrative law, demonstration of best practices in conducting inspections and investigations, and ensuring compliance with relevant legislation will be sub-units of analysis.

2 THE GOAL

The goal is to demonstrate what changes, if any, occur in Community Care licensing practice as a result of participation in courses within the JIBC Advanced Specialty Certificate in Community Care Licensing.¹

3 RESEARCH QUESTION

What changes in practice regarding response to complaints about licensed care facilities can be attributed to Licensing Officers (LOs) participation in the JIBC Advanced Specialty Certificate in Community Care Licensing?

4 METHODOLOGY

Each of the five Health Authorities (HA) in BC were advised and solicited for support in requesting participants for this Grounded Theory qualitative study. An honorarium was provided to each HA to assist in any costs incurred by the HA for those staff that volunteered to participate in the study. The researcher conducted face-to-face interviews within each HA in the vast majority of interviews. Forty-

¹ The Advanced Specialty Certificate in Community Care Licensing (CCLO) is a 30-credit program designed to provide current and future Community Care Licensing Officers with the specialized knowledge, skills, and abilities that they need to carry out the statutory duties delegated to them by the Medical Health Officer.
eight participants were interviewed in this study. Data collection includes verbatim transcriptions of audio recordings of interviews and focus groups collected from each of the Health Authorities around the province of BC.

The study involved two phases of data gathering via semi structured interviews. The first phase of the study began conducting interviews in December 2015 and early January 2016. A second phase of interviews is scheduled for later in 2016 early 2017. The interviews conducted ranged from one to more than two hours comprising either a small focus group (4-5 people) or a one-on-one interview. Participants represented front line workers (licensing officers), and non front line workers that included several levels of managerial and supervisory staff. Voluntary demographic data collected from participants has been added to this analysis.

The same questions were asked of all participants, in all HAs; with slight variations per the role performed and individual versus focus group interviews. The original audio recordings have been transcribed and subsequently a random selection was reviewed in order to ensure accuracy. In addition, relevant researchers’ notes and journals formed additional data for this study.

Any and all questions asked of the participants, including biographical information, was voluntarily provided. All identifying information has been kept strictly confidential and only aggregated or anonymized data will be reported. The audiotaped and subsequent transcriptions have been assigned a reference code to ensure that confidentiality is protected. Participants will never be identified by name or by initials, only by a code number. Any and all information collected for this research will be kept strictly confidential.

**Findings**

Coding of the transcribed audio recordings was supported by Nvivo 10 qualitative data analysis software. The entire body of interviews and focus groups from all health authorities was initially coded with broad strokes. The initial coding identified key themes that supported the study framework and scope. Sub-themes emerged from within the first round of coding and have been positioned under the key themes following secondary coding.

Primary analysis identified key themes; secondary analysis identified sub themes that focused on current practice and effects, if any, of staff having participated in, or having completed, the JIBC Advanced Specialty Certification in CCLO program (at the time of the first phase of this study two participants had completed the Advanced Certification program with less than a month and a nine-month tenure respectively; several other participants had taken one or more courses). Only two other participants had expressed any knowledge of or interest in taking advantage of applying the prior experience option available toward gaining certification by completing five of the ten required courses. In fact, there is a significant lack of awareness of the JIBC program options available to current CCLO staff.

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2 Dependent on further funding
3 See Appendix 3
4 One regional manager and one long serving officer
5 See 6.1.4
5 KEY THEMES

CHANGE IN PRACTICE (CURRENT PRACTICE)

All participants were asked if they had noticed changes in practice during their tenure. The intent of this line of questioning at the beginning of the study was to measure change after staff had taken advantage of the JIBC ACCCL Program. It was very clear from the very first region interviewed that we would not be able to gather meaningful data as so few participants had taken courses or achieved their certification from the JIBC. Regardless, the question proved to be valuable in gathering data that responded to issues in the Ombudsperson Report of 2012, The Best of Care: Getting it right for the seniors of BC, and the earlier legislative changes (2008/2009).

Although the study attempted to distinguish between change in practice and current practice, the degree of relative overlap is salient and therefore, the following analysis can largely be interpreted interchangeably.

To wit: participants consistently referenced the change in regulation (Community Care and Assisted Living Act 2008/2009) from a ‘prescriptive’ application of the legislation where the LO would prescribe actions needed by a facility to be in compliance, to what is now known as an ‘outcome’ based application where that action planning is switched to the facility administrators. Participants noted that the lack of notice before the implementation of this regulatory change impacted the timely transition from LO to facility administration.

This major change switched the responsibility of LOs informing the facility administration how to change their practice and policy in order to be compliant, onto the facility administrators being required to develop a plan to remedy any identified contravention. The current requirement under the Community Care and Assisted Living Act (CCALA), is for the Facility Administration to present their proposal to the LOs for approval. The LOs welcome this change, however, many reports that facility administrators have found the change challenging.

Yeah. Practice is constantly evolving. ...in Island Health, I think, um, you know, we - we have a pretty dynamic leadership team. There’s lots of recognition that, you know, things change. We had a big regulatory change, which doesn’t happen very often, in 2008 and 2009. Um, you know, we’re still – I mean things have levelled out, but we’re – we’re still asking for interpretation on some of that regulation.

VIHA2

My workload didn’t change for me. Um, I’ve al – um.... I was a generalist, so I still covered both child and residential care, so um it was – it’s a bit more time consuming to work with the licensees a little bit more ah because you’re – you’re waiting for them to respond. You’re – you’re really working more collaboratively with them. Although the licensing regulation is still our - our benchmark. Um, but um coaching and mentoring licensees on some level does take more time. Um, I
found, though, the more time you took, the less compliance issues we had. So, for me, it - it – it didn’t really increase my caseload necessarily, but you did take more time with them. INT7

Another major change transformed many of the licensing officer’s portfolios from a mix of both residential care facilities in many cases to specialised portfolios in either residential care or child care. Before this change most regions had their licensing officers manage both types of facilities (referred to as generalists in some cases) and portfolios appear to have been designed based on geographic areas. The impact to some LOs following the change, has resulted in extended travel between facilities. The impact has been welcomed by some and not by others.

A major impact of this transformation is to the professional opportunities for the majority of LOs who entered the profession with Early Childhood Education (ECE) credentials6. Most regions changed the requirement for residential care facility licensing officers from the existing criteria of no particular credential, to either a Registered Nurse or related undergraduate degree credential. As a result of the change the officers who now manage child care facilities are no longer qualified to manage or transfer to be a residential care facility LO without further education (the JIBC ASCCCL would not be enough7). It is not hard to understand that this is difficult to accept for officers that have managed residential facilities for many years prior. Few mixed portfolios still exist unless an officer has more than 15 years’ experience or they possess a degree or a nursing credential (see Appendix 1).

...most of us have been doing this job now for many, many years. And actually, have found it very frustrating that there is nowhere for us to go. And even for the – even for early childhood um ah degree, which there is, it’s in the Masters. But nobody’s providing the undergrad. INT6

I know from sitting on the advisory um for this course, the advanced specialty certificate at the JI, a lot of discussion between licensing officers and just um at the table was around degree versus certificate. A lot of licensing officers, for example, myself, I don’t have a degree. I have an early childhood education license to practice. Um, I can’t move up in my profession into a team lead or a manager’s position without a degree. INT6

In 2003/2004 the BC Government implemented a major reorganisation of the BC Health Authorities. Prior to 2003, BC had 56 health boards. By 2004 the government of the day made the major change to reduce the management of health care from the 56 boards to five regional health authorities.8 The reorganisation impacted all sectors of health care in the province and the CCLO practice was no

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6 See demographic file: Appendix 1
7 To enable the JI ASCCCL to become part of a CCLO job description, it would require amendment to the BCGE Union collective agreement which at the time of writing had not occurred
8 See Appendix 4. Map of Health Authority Boundaries
exception. This study did not pursue regionalisation in the scope of this study, nor did it become a line of inquiry and is noted here for historical consideration only.

... [after] regionalization there was really um quite big differences in practice. Um, we had, ah, different understandings of administrative law, different, um, sort of requirements related to documentation. And so, there was huge divergence in practice and some of it, you know, didn’t actually fall under appropriate administrative law practices, so yeah. I have seen significant changes. FH8

Data illustrates that less change occurred the further the officer practices away from the regional office, and interestingly, the officers in positions further away from the regional offices appear to have held their position for more than a decade in most cases and now hold most of the remaining mixed portfolios.9

...for sure, the further away you get from Victoria, the more regulations and government is just like a vague concept. VIHA4

Additional changes of note address the issues of online documentation and public reporting. The CCLOs now file case notes, investigations, inspections and exemptions on line as opposed to the pen and paper method utilized not so many years ago in some regions and subject to criticism still today as historical information is sought and not found.

The public can now access CCLO compliance inspection reports on all the regional web sites. For the public, this is an invaluable tool as they search for information. The impact on LOs, however, now requires them to follow new procedures and forms in their documentation and report writing. In some participants’ minds this is an area that now necessitates an increase in their time not previously considered. It also requires an added layer of scrutiny within the region to ensure the report can defend challenge and remains objective.

So, the first thing I said to the licensee officer, “What part of this information actually needed to be recorded on this on this inspection report? Because there was lots of narrative, which has really no bearing on - on – the real issue... FHAP6

5.1.1 Leadership
In an effort to provide context, Appendix 2 provides, an overview of each regions’ management structure. One participant noted the organization chart in their region had changed more than three times in the past year. There is a significant variance in the management structure within the CCLO service across the province. Several participants noted that each time a regional reorganization occurred within their department it took time away from their caseloads resulting in them feeling behind in their prescribed responsibilities and legislated deadlines.

9 Appendix 1
I believe it was last year as leadership, um, a lot of time was spent too on a project called CBSM [Community-Based Social Marketing], and it - it wasn’t really directly related to our legislation, but it impacted, um, a lot of the work we were doing and it took up a lot of our time... it was a huge project... the one I was on was 3+ months... it had to take precedent over the work you did. So, um, and that was part of the leadership vision at that time. ...a huge chunk of our time and our manpower going into this.... P17

An example:

Interviewer:  How many managers? Is there lots of management?

It depends on the day. And who, what level? There’s no structure – like there’s just not structure. I’m just going to stop or I won’t have a job. [laughing] P22

I think probably a piece that’s a little bit different in what we’re seeing of late is a lot of times we’re having risk management come into conversations .... All of a sudden now, instead of our manager or our regional manager... there’s a risk management individual sitting there and that’s... ...different.... Um, so that’s a - and sometimes it’s – you could probably feel that um you’re not all going the same direction, if you will. That there’s some resistance in terms of maybe what our role is and what our mandate is. And as licensing officers what we have to ensure we’re maintaining at all times, right. Because we need to be fair, we need to be unbiased, we need to be [P: Objective] objective and focused on the task that’s before us. And you know what? ...Sometimes it doesn’t fit in terms of that [risk management] unfortunately. NP17

5.1.2 Consistency in practice

Data indicates the LOs recognize inconsistent practice within their region and it is apparent that there is no consistency province wide. Each health authority has implemented policy and process specific to their region. Interestingly, there is no province wide centralised information gathering network for LOs to access.

Risk assessment tool: The Ministry of Health introduced a provincial CCLO facility risk assessment tool approximately four years ago that has caused problems for front line staff. The participants reported that when using the tool, it more often than not indicated a low risk assessment to a facility. The problem to the LOs is that they assessed the facility at a medium or higher risk. It is reported in the data that the government is taking another look at the tool.

It's pretty robot, like in filling out a - a risk assessment tool... – it’s a relatively new risk assessment tool. It’s about four years old. And, um, we’re finding that when we use it without discretion, just the way it’s set up, it’s giving everybody a low risk. So,
some of us are going in and fudging it a little bit to try to get a... ... a little bit more accurate you know um by using language such as “um, oh there was a change in managers, so licensing does not have a history of this person. Or this facility is relative – has only been open for six months. Licensing doesn’t have a history of their ability to self-monitor.” So, now I’m not doing that because... I want the province to fix the risk assessment tool. Most of my facilities are low and I just keep sending emails to my supervisor saying, “Can’t wait for them to fix this risk assessment tool ’cause it’s not helping me manage my caseload.” I have to send myself little emails in my Outlook Manager to say, um to - to like in giving like a false score to the folks, you know so I’m – so I’m leaving the risk assessment tool as it is in the database, but I’m creating like another reminder to myself that, you know, even though they’re a low in on paper, you know what you you’ve seen.

VIHA4

**COMPLAINTS**

The most common response to any change in the type and management of complaints indicates that the type and management has not changed as much as the volume of complaints. All of the participants in all regions report an increase in the volume. As previously noted, participants put this down in large part to an increase in public awareness of the complaint process.

5.1.3 **Types of Complaints**

The types of complaints throughout the province generating most of the investigations revolve around abuse and neglect. Abuse and neglect in community care cover a range of specific implications. More often it is a case of staff on resident or child; resident on resident; child on child in that order. These complaints are ranked high and require an immediate response by the officers (<24 hours). Abuse may be physical, sexual, or financial.

Neglect complaints within residential care facilities often centre on the quality of food/nutrition and personal care of the resident. In child care, complaints of illegal child care centres is more common. Illegal operation investigations can be a potential risk to the officers as they are required to make an inspection without giving prior notification. Most of these complaints are initiated by licensed facilities.

**Abuse. Allegations of abuse or um certainly um one that we investigate quite often um ah unexpected deaths in residential care.... There’s so many [complaints]. Like there’s lots of little ones, right? Like one-offs. Um, but ultimately our primary or priority would be any allegations of abuse of any type – neglect, physical, sexual, financial. INT7**

5.1.4 **Management of Complaints/Investigations**

There has been some change in the internal/regional oversight or a change in the management involvement in complaints and investigations around the province; some changes supported by officers and some not. For example, participants have reported managers that override their findings and recommendations resulting in LO’s feeling fettered. Other officer’s work in regions with dedicated investigation staff, for example, Fraser Health has a specialized investigation team of five staff that
manage and resolve any complaint ranked medium to high. The Interior Health Authority had a
designated Investigation Specialist, but when that officer was reassigned, that position was not replaced
and LOs now do investigations; which they have reported adds a significant addition to their workload.

5.1.5 Public Reporting
The majority of reasons for the increase in volume proffered by participants related to the public’s
raised awareness. Many felt this raised awareness could be contributed to the media having shown an
increased interest in extended care in BC following several high-profile cases over the past decade.
Additionally, the public are much more aware of the avenues available for them to raise concerns
and/or complaints, e.g. the provincial governments’ and Health Authority websites.

http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/concerns-
and-complaints

Each health authority has a web site for the public to get information and/or put forward a concern
and/or complaint.

http://www.fraserhealth.ca/health-info/health-topics/residential-care-licensing/complaints-
investigations/

https://northernhealth.ca/YourHealth/HomeandCommunityCare/ComplimentsandComplaints.aspx

https://www.interiorhealth.ca/YourCare/PatientCareQualityOffice/Pages/default.aspx

http://www.viha.ca/mho/inspections/Community+Care+Complaints.htm

Vancouver Coastal Health Authority directs the public to the Patient Care Quality Office (PCQ) as a first
contact.

quality-office

Fraser Health Authority has developed a very good relationship with the PCQ office who seem to screen
public comments and either refer the public to the appropriate agency or deal with any low risk to the
patient issue rather than forwarding to the CCLO.

So, in residential – … when people have the issues with um their concerns about
care facilities they will phone the Patient Care Quality office [P: Uh hm.]. And so,
they um they also have a mandate to investigate concerns and complaints of the
care that somebody’s receiving in any ah care facility. Um, so typically historically
they - they would refer any complaint or concern on to licensing, if it’s a licensed
residential care facility. Um, what we’ve been finding now is they will actually go
ahead – if - if it’s an issue where um it’s not a high risk to the persons in care, um, if
it appears to be an issue that could just be dealt with um in discussions with the
facility manager, then they’ll go ahead and do that. Um, so I find I’m not getting as
many minor complaints that we have in the past. Right? Like somebody will call and
say you know the food sometimes it smells funny or it doesn’t look right um and if
that goes to the Patient Care Quality Office, ah oftentimes they’ll - they’ll contact
the facility manager and start that – they will be like mediators and try to respond
5.1.6 Challenges:
Reporting and recording has changed in many offices. One of the comments made by the Ombudsperson’s report was the lack of adequate records. Since the report HAs have gone paperless with all records and documentation now online, standardized and accessible by all officers in any given region. This was not the case not very many years ago. The paper system is still relevant as it is the only record of historical information for long operating facilities.

However, not all HAs utilize the same online system, and some have centralized reporting and others do not. Centralised reporting applies to applications, complaints and information requests and in some regions, they are managed by one desk. That position may be static or rotated through LOS within an ‘on call’ basis. There is no province wide clearing house for CCLO data.

... have to say that a huge change is ah in how we collect the data and keep it. There’s you know we’ve gone paperless and it is probably doubled to tripled our workload and time in the office. Um, going paperless I think is a great idea except for it - it comes with huge challenges – huge challenges. And it - the work to do something is – it’s so much easier to take a piece of paper, stamp it, put in the file than it is to pdf it, copy it, do this, do that, and name it right, put it in the right place, blahblahblahblah [laughing] and I mean really it is - it’s - it’s – it has doubled or tripled – it has slowed us down. INTFG

Several regional staff report that they are challenged to keep current with routine inspections as a result of all the required regional changes to their practice significantly impacting their daily work.

If I went back 5 or 6 years, I had twice the case load and never really had many overdue. I was caught up. You know I might – and I might get kind of stressed when I looked on my list – you know the old printed lists and so now I’ve got places that are a month overdue. Nowadays I mean I know child care here is way worse; I’ve got stuff six months overdue in residential care, but I know in child care they’ve got places that are 2 years overdue. Um and you know that’s just the way it works. Ah, we’re a lot further behind than we ever have been. INTFG

A unique challenge for the Lower Mainland is administrating/managing the developing change in structure and size of child care facilities not previously seen. Participants report that BC is experiencing the introduction of corporations installing and operating very large community child care facilities for as
many as 200 children. As a result of this development, the investing corporations are either buying large existing structures such as vacated box stores in order to remodel them to their purpose, or alternatively, constructing their own builds for purpose. The resulting impact has necessitated within the FHA a designated LO to oversee these developments from blue print to operation. The skill set for this position is presumed to be outside of any existing LO job description.

5.1.7 Successes:
Successes may seem small in the scheme of things, but they have a large impact on the practice and service. For example:

Access to information for the public and other regions has not only allowed this agency to become more transparent, but it has also improved compliance in some cases.

Now, with the inspection reports being online, we can direct the public also to, not only the referral agencies, but also they can view inspection reports online for childcare and residential care. So, there’s the whole – that whole shift in transparency has, in the last few years, because of public scrutiny in what’s going on with the Ministry and - and that kind of thing. INTFG

... think with the transparency it has been good having our website up to date with the most recent inspections. I have two sites... that were highs– high risk um for many non-compliance issues with the regulations and the media pulled the reports off of the website and went out to the sites and brought it out to the forefront and with that came - um - an overwhelming number of complaints because now families who may have been going to the facility and complaining to the facility, not really getting anywhere were then said you know that it was a licensing officer... that gave licensing direct information and so gave them an avenue um to come and - and bring those concerns forward. INTFG

The change in legislation for facility managers to now be accountable to plan their policy and process to remain compliant, has taken the onus away from licensing if the plan fails.

Serious complaints and or incident reports now receive a faster response, i.e. within the same day. Participants report that it could take 24 hours or longer if the LO was away, and incident reports could sit in an inbox for days. Certainly in those regions with centralised intake and or online contact intake systems, response should be in a few hours.

... high risk incident reports are dealt with that same day. They should be dealt with very quickly after if they’re not whereas before [Voice: uh hm] they might have been faxed and the just stuck in an in-box.... INTFG
6 JIBC Advanced Specialty Certificate in Community Licensing

The findings are mixed in relation to the participant’s assessment of the JIBC ASCCL education. The majority of participants had inaccurate information about the availability and advantages of previous experience credit and funding provided for current staff. It would suggest that more LOs would take advantage had they known.

Additionally, the general consensus for current staff is that they do not need to take any of the JIBC courses nor a need to become certified. The comment heard a lot was that, as they are doing the job already, there is no need to take any courses; no region has provided an incentive good enough to change LO’s opinion.

It is evident that future job descriptions may well include the need for certification and/or an undergraduate degree. Current front-line staff interviewed are confident they will not be affected. Management on the other hand are actively involved in job description development adding the need for more specific credentials and attention to union cooperation.

Analysis of the current demographic data indicates the education of LOs to be varied with the majority (43.1%) having Early Childhood Education qualifications in one form or other. (Appendix 1)

...I would love to do the program because I would love to have consistent practice with the rest of the province. Like I just think it would be wonderful INT

I agree and I’d like – and I’ve – like I’ve done investigating, interviewing courses I’ve done in administrative law, um, and report writing and I thought they were all great and I took courses at the JI in my previous – like I took Youth Violence Intervention and Youth Substance Abuse Management way back when. I’ve never – I like the courses there, but I – I’m still not willing to pay to do the courses on my time and my money when it doesn’t – I’m already doing the job. INTP14

The most significant finding in relation to the impact of the JIBC program for CCLOs was clearly articulated with graduates and management agreeing that the JIBC students are ‘job ready’ on being hired. Therefore, as more graduates are hired it must reduce previous regional costs for orientation and training.

...two came to us with - with that training, um, and one who I interviewed, um, it was very obvious that she did have a very secure understanding of administrative law, which stood out as very unique. It was the first time I’d seen that from the interview process. It’s usually the area that’s most struggling and I would say for her it really did impact on her orientation that she, um, you know she really had a good grasp on her – the orientation that was required was a condensed version almost. FH10

An example in relation to the impact to practice from JIBC graduates: a high-profile investigation recently/currently is headed by a JIBC graduate. The resulting outcome of the investigation will be a
valuable example and measure perhaps to demonstrate the influence of the JIBC ASCCL program graduates on practice.\textsuperscript{10} Importantly, this influence has not come without challenge.

So I have a sexual assault. Three sexual assaults and two physical assaults on right now.

Interviewer: How much latitude or discretion do you have in investigating situations?

I think it’s a huge conflict of interest to be a licensing officer working in a health authority and managing Northern Health facilities because I … in my role have kind of been I - I think in this investigation, I’ve been kind of threatened with my job twice. Um, and I find that to be an extra added stress. So I - I find it’s hard to stay um neutral. And we have to treat everybody equally. But the ante is not to be equal when you are looking at like I was reminded that I’m a Northern Health employee on many occasions. So, I think that’s a huge conflict within our role. So, it dampens down your thought process so you have something in your mind you want to do and then by the time it gets through all the managers, it might not be the end result. P22

Colleagues have noticed and been influenced by new staff hired who have completed the JIBC and have demonstrated skills that the colleague finds to be an improvement and that will no doubt be adopted.

being an LO who has had an opportunity to see, um, number 22 do her recent investigation and compile her recent summary report, and also taking into account our new leadership and their desire for the format of our summary and final investigative reports, um, Tammy came in doing her summary report, um, quite different from how I had done mine in the past, so mine tended to be very narrative; um, Tammy did her ah investigative report where it was point form; it was just the facts; it was, um, noting appendix; it was all of the gathering of the evidence. So I have found, um, and I know that she had learned that piece within a specific course that she took… NHFG

and one more comment that sums up the majority of the management views –

... so with regards to the changes that I’ve seen just with some of the staff that have either, um, taken the courses or they have come with um some of the courses… having that foundation especially around administrative law has been huge for us because it’s something that’s very, very difficult to kind of teach on the job. Because you really need that – it’s got to be your foundation before you start, you know, outside of the door. So, that has been a real highlight for me is to see staff coming with that basic, um, – those principles kind of already entrenched... FH6

\textsuperscript{10} Investigation is still ongoing and the final outcome is unavailable at the time of writing
7 HEALTH AUTHORITY SPECIFICS

CURRENT PRACTICE BY HEALTH AUTHORITY

Current practice is varied across and in all Health Authorities (HA). All regions have undergone change following the Ombudsperson’s (2012) report and government response to the recommendations of that report, as well as the latest legislation enactment (2008/2009) and the earlier regionalisation (2003/4).

A noteworthy change appears to be in the LOs portfolios. Data shows that mixed portfolios, i.e. responsibility for child care and adult residential facilities, have been changed to specifically one or the other in the majority of HAs. Officers maintaining mixed portfolios are those in areas the farthest distance from their regional office. At the same time as the portfolios changed to either residential or child care, the need for an undergraduate degree or RN became the standard entry level for new hires into residential care licensing. This left the majority of LOs around the province finding themselves no longer eligible to manage residential care facilities.

It is clear that there is very little inter-regional collaboration/communication, and each CCLO region maintains its autonomy. It is also clear that the CCLO regions have similar challenges. There is an indication in the data that historically there may have been more collaboration and more regional cross training that suffered from provincial government cutbacks in training and travel dollars over the past few years.

7.1.1 Northern Health Authority (NHA)

NHA has experienced many leadership changes and restructuring in recent years and into the present time. The impact has been felt by the front-line workers in several ways; one of consequence is officers feeling that as a result of being required to be involved in the restructuring process at each change, that this has had a negative impact on their ability to stay current with their caseloads.

NHA is a very large region covering many square miles. Arguably the largest region providing service to community care licensing in BC.11

...much more challenging because I also do Fort Nelson as well, which is another 5-hour drive for me. It adds that extra layer in um electronic and trying to get that personal connection in maintaining those relationships.

We also have some very remote Aboriginal communities that are very difficult to access. I believe there’s one you can only fly into, which makes it difficult to maintain the connections.

I have Haida Gwaii as well, so I have to boat travel. You can’t go in the winter. So if they need me in the winter, it’s literally impossible for me to be onsite for them so.

And there’s childcare... so we’re in an area here where First Nations Health Authority has planted themselves. They have established themselves here and so working within the confines of our role, but also being respectful to who they are

11 Appendix 4
and what they’re wanting and what — I guess basically how they’re wanting us to go in and work with their communities as well, right? Because I think that’s how we — we differ as well with licensing officers, we can be on federal land. NHAFG

As with other regions officers in the NHA feel that their opportunity for professional advancement is, if not impossible, certainly very limited. The option to take further education at the JIBC has little if any interest for them. There is no incentive recognized by the licensing officers. Staff who have been recently hired report finding the regions process and policies do not fit well with the best practice taught in the JIBC ASCCL program. However, there is recognition from management that the skills these staff possess is valuable to the region and its continuous improvement efforts.

Officers that have been practicing for more than a decade and in outlying areas away from the regional office in Prince George, such as Dawson Creek, report business as usual, and that they have no appetite for change, nor to engage with the professional development offered by the courses at the JIBC.12

This region has experienced significant change in their leadership in a relatively short period of time. They are experiencing the loss of long time staff at all levels and the introduction by the leadership of not previously known strategies. Long time staff and new staff are finding this a challenge to their practice.

**Interviewer:** How many managers? Is there lots of management?

It depends on the day. And who, what level? There’s no structure – like there’s just not structure. I’m just going to stop or I won’t have a job. [laughing] P22

I think probably a piece that’s a little bit different in what we’re seeing of late is a lot of times we’re having risk management come into conversations if we’re having teleconferences or debriefings. All of a sudden now, instead of our manager or our regional manager, it is maybe there’s a risk management individual sitting there and that’s a little bit different than how it’s looked. Um, so that’s a - and sometimes it’s – you could probably feel that um you’re not all going the same direction, if you will. That there’s some resistance in terms of maybe what our role is and what our mandate is. And as licensing officers what we have to ensure we’re maintaining at all times, right. Because we need to be fair, we need to be unbiased, we need to be [P: Objective] objective and focussed on the task that’s before us. And you know what? Finding the information and you know gathering our - our evidence, right? Sometimes it doesn’t fit in terms of that unfortunately. P17

7.1.2 **Interior Health Authority (IHA)**

This region had a high number of participants in this study, both front-line and management. This is another region covering a large area of the province. It is not unusual for LOs to have a day of travel to conduct routine inspections; nevertheless, the caseloads remain high.13

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12 Appendix 2. Fig:3
13 Appendix 1
As with other regions in the past few years this region experienced significant management change that impacted front-line workers in very similar ways to all other regions. One of the main distinctions of this region over others is that they have centralised their information intake. Previously each LO received all calls related to their areas of responsibility. Now all Interior Health region calls are received in one place and disseminated from that point. The advantage is that all records are centralised and accessible throughout the region aiding improvements in the consistency of practice; the disadvantage, for officers, is that they find they are sometimes required to respond to cases outside of their area and caseload that they have no previous knowledge about.

I think it’s improved because of the implementation of our… model that we - we put in place about four years ago, which is um a central intake model… there’s a… toll free number and a - and a single email address ah that’s like licensingdirectinteriorhealth.ca and so what we do is encourage the public, potential licensees and licensees to go through that toll free number or toll or common email address to make their inquiries and we handle all the applications, all the license amendments, all the complaints, um all the exemption requests and all the incident reporting – all come into the central intake. And um that way we get um we’ve identified inconsistent practice. INT11

**7.1.3 Vancouver Island Health Authority (VIHA)**

This is another region required to manage a large geographical area\(^{14}\).

Yeah, it’s a big piece of geography. For sure. I mean thank goodness we don’t have any facilities over on the Lower Mainland above Squamish because that’s in our health authority. I don’t even know what that would look like. Um, but you know geography is – yeah we have islands that we have to get to. Um, Ahousat… you know so um you know Ucluelet is a three hour drive from Nanaimo. And then you have to jump on a float plane to get out to the facility, plus do an inspection and rush through it to get back on *the last* a float plane to get back to Tofino. Like it’s big geography.

Access to meet the legislated mandate for LOs can be extremely challenging in this region as other regions in BC as the topography in the province as a whole is challenging to all community service providers. However, the need to support and service remote Islands like Lasqueti is an example of the challenges in meeting the mandate of CCLOs.

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\(^{14}\) Appendix 4
Lasqueti is not even serviced by BC ferries. You have to arrange for a ride on some kind of charter. It’s like a taxi boat. VIHA

The management structure of VIHA is unique from other regions. This office has a layer of middle management supervising the LOs called Practice Consultants. In all regions the Medical Health Officer (MHO) heads up the CCLO. In VIHA, what may be unique about this region is that the MHO has chosen not to delegate the decision making process in investigations or high risk or complex issues to the licensing officers. Licensing officers are delegated to do routine inspections. Beyond that the decision goes up the organisation with the MHO having the final authority. The regional manager believes that they probably utilise the Appeal Board more than other regions as they believe the avenue of the Appeal Board is the best quality assurance test. This added step does take time and a lot of work. The licensing officer does the initial reporting that then goes to the regional office in Victoria before they all sign off before forwarding to the MHO for a final decision.

...five health authorities are structured differently. We’re in our - our health authority does not have a Health Protection Director position. Um, and we haven’t – did not have Health Protection Director position from regionalization. ...there was a decision to - to make licensing a separate entity and, um, we’re not embedded – the other programs are embedded under environmental health leadership. We, as a program, make recommendations to the MHO, but we don’t – we don’t have frontline staff – or even myself making that decision. Um, and so licensing officers are delegated to do routine inspections. VIHA2

7.1.4 Vancouver Coastal Health Authority (VCH)

Although VCH covers a relatively small geographical area, the concentration of facilities is a challenge that is ever changing. This requires a lot of work with applications, exemptions if staff do not meet the requirements, language challenges in the understanding of legislation and communication, and fluctuating costs. Another unique consideration for VCH as with FHA is the level of multiculturalism officers may have to deal with, but seen as one of the richer aspects of an officer’s practice if managed properly.

[comment re requirement for Aboriginal facilities on reserves to be licensed] ... it was pre the 2007 change, but there was a time if it was on band land, it was administrated by the band. They didn’t require a licence. But I just want to make a point about that. I think that – maybe it’s just an aside, but one of the things that I really enjoyed when I first started my job was actually finding out about the Iranian culture and I think that a lot of that helped me establish my relationships with my providers and ah operators because I would go in curious and asking questions and they like have a celebration at Nowruz, which is their New Year where they put out all of these different things and like to actually just – like for you – you’ll probably learn best by asking them curious questions and that will help you forge your relationships. And it will be interesting. – you know then you have to try not to
This region like all the others has been experiencing recent restructuring challenges. During the study, they hired a recent JIBC grad who had completed their practicum in the VCH office. One comment of note was that as this ‘new’ person kept asking the ‘why’ questions which intrigued the staff to where the office now holds practice meetings where they meet and discuss practice decisions. It is a welcome addition by account.

... we are starting now to have practice meetings in this office. I wish that I – we had had it the whole time I was here. We’ve only had two. Um, and it - it - it arose because there’s somebody new here. And - and asking people you know questioning things and then everyone’s like, “Well, this is what I do, what do you do?” And so then you know it sparked conversations to see well I think I am approaching this the same way. You know we’re reading it in the same way – some of the, you know, some of the regulations were or when I’m writing the reports, the inspection reports, and I’m saying, “Well, I’m answering this with this in mind. Is this the same thing that everybody else is doing?” So, I really do enjoy them. And our senior licensing officers are in on those meetings...

This region has similar practice issues as FHA. A common issue is a lot of facilities where English is a second language to many staff. This brings challenges sometimes with different cultural beliefs and questionable problem solving skills.

Additionally, this office must deal with the larger facility operations run by corporations rather than the historical one owner operator facility where strong relationships between licensing and facility operators are often built.

Residential staff are all relatively new hires and all hold undergraduate degrees in related disciplines. A senior manager is completing the JIBC certification as she believes it to be of value and wants to encourage her staff to take advantage of the program. So far none of her staff are engaged in the JIBC program.

7.1.5 Fraser Health Authority (FHA)

FHA has a robust organizational structure that has been established for several years. Their distinction in the province is the establishment of management bands for each area of responsibility. For example, a unique investigation team that only handles high risk/profile investigations. Senior managers hold portfolios in the supervision and management of child care or residential care LOs, and a senior officer manages training and orientation as examples.

The relatively new development of very large facilities being built and operated in this region requires an additional skill set for staff. Fraser Health Authority has designated a full-time position to manage this
challenge. This position works closely with all regulatory agents from blue print to operation and continued inspection. No other area reported this development in their region to this extent.

8 FUTURE OPPORTUNITIES IDENTIFIED IN THE STUDY TO DATE

The level of communication since 2013 to all CCLO staff about the benefit of full funding and a 50% course credit available to them in pursuing an advanced certification in CCLO at the JIBC has lacked effect. At no time did a participant mention they had knowledge of the provided advantages; in fact, quite the contrary. This fact prevented meaningful gathering in relation to the impact of practice from the JIBC ASCCCL program.

Inconsistent regional participation in the study across the province may limit the value of the data in some areas of the study scope. Two regions participated with significant numbers that represented all areas of the region and both specialties of care. Conversely (Vancouver Coastal Health) one region had very few participants. Participants in that one region represented one senior manager but no officers willing to represent residential care facility licensing, and all focus group participants represented child care licensing. It is unclear how this inconsistency impacts the study outcome, but might speak to the level of management engagement and communication.

It is important to remember that the participation was optional; however, the regions were offered adequate compensation to fund any costs incurred. Two regions took advantage and utilised the funding compensation options offered in order to have a good level of participation in the study and in turn to conduct what amounted to a regional meeting where CCLOs reported the first opportunity in two years to meet face to face with each other, and how much they valued the opportunity.

9 CONCLUSION

The study analysis validates the current limitation in demonstrating the impact on practice of licensing officers being engaged in becoming certified by participating in the JIBC Advanced Specialty Certification in Community Care Licensing program. New hires during and since the original data collection; however, does demonstrate the applicants that have graduated from the ASCCCL have been the successful applicants and are now employed as CCLOs.

Since 2004 the most significant changes to practice, that in part resulted in the implementation of the JIBC Advanced Specialty Certification in Community Care Licensing program, probably started with the extreme reorganization of 56 health boards to five health authorities; the change in legislation reversing the responsibility to plan correction of noncompliance falling from the licensing officers onto the facility administration, and the impact of public awareness and high profile cases that generated the ombudsperson’s report of 2012 with action from the Ministry of Health based on the reports’ recommendations.

BC health authorities clearly have a level of autonomy to manage their CCLO programs as they see fit. The differences are profound and would be challenging for any licensing officer expressing an interest to

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16 These regions represented 62.5% of the total number of participants
move from one authority regional office to another. In fact, some practicing officers would not be qualified to move from one practice portfolio in one region to another region. The demographic information provided by participants was an invaluable addition to the study as it provided a clear picture of patterns of practice and regional diversity. There is consistent information relating to complaints and their management across the province and is the most consistent finding in the study so far, i.e. the type of complaint has not changed but the volume has increased is reported across the province. The study illustrates several reasons for this and current practice in the management and investigation of complaints may aid the direction moving forward for the JIBC ASCCCL investigation course offering.

Public knowledge and awareness along with a continued interest from the media has raised the profile of the licensing officers’ role and that, in turn, has generated a shift in the hiring practices of all regions. This has been welcomed by some CCLO areas and not by others. This shift in education and increase in required credentials for CCLOs is an area that the JIBC is directly involved with and can take the findings from this first phase of the study forward into the continued improvement of course content and structure in order to support existing licensing officers and those who are choosing to enter the profession.
APPENDICES

APPENDIX 1

CCLO Demographic Data

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<th>Name</th>
<th>Program</th>
<th>Degree</th>
<th>Gender</th>
<th>Age</th>
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*Notes:*
- BA: Bachelor of Arts
- BS: Bachelor of Science
- BSN: Bachelor of Science in Nursing
- RN: Registered Nurse
- BBA: Bachelor of Business Administration
APPENDIX 2

Health Authority Organization Charts as provided by each HA

**Figure 1: VIHA Organisation Chart**

```
1 FTE Regional Manager

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<thead>
<tr>
<th>1 FTE Supervisor (Licensing/Tobacco)</th>
<th>1 FTE Practice Consultant (Licensing/Tobacco)</th>
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</table>

Gateway Victoria

- 1 FTE Senior Licensing Officer
- 6.396 FTE Child Care LOs
- 3.31 FTE Residential Care LOs
- 0.7 FTE Licensing Nutritionists
- 1.48 FTE TRC/TEO (CRD)

Bowen Road/Nanaimo

- 1 FTE Senior Licensing Officer

Campbell River/Courtenay

- 1.48 FTE Child Care LOs
- 1 FTE Residential Care LO

Fort Royal

- 2.49 FTE Child Care LOs
- 1 FTE Residential Care LO

TEO/TRC

- 1.5 FTE South
- 1.05 FTE Central
- 1 FTE North

Tobacco Prevention and Control Coordinator

- 0.5 FTE Exempt

Marietta Busch

Administrative Support

1.5 FTE South
1.05 FTE Central
1 FTE North

Tobacco Prevention and Control Coordinator

0.5 FTE Exempt

Kim Bruce

1 FTE Regional Manager

Clare Cronin

.48 FTE Practice Consultant

Elaine Watson

1 FTE Administrative Coordinator

Carla Kane

1 FTE Practice Consultant (Licensing/Tobacco)

Alison Coupar

1 FTE Supervisor (Licensing/Tobacco)

Michelle Dennis

1 FTE Supervisor (Licensing)
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For each Health Authority, the chart outlines the organizational structure and the number of full-time equivalent (FTE) staff members for various positions. The chart includes details such as supervisors, practice consultants, and specific roles such as Senior Licensing Officers and Child Care Licensing Officers (LOs).
Figure 2: Interior Health Authority Organisation Chart

POPULATION HEALTH
Organization Chart

VP Population Health & Chief Medical Health Officer

Corporate Director
Population Health

Manager
Licensing

Team Leader - Child Care

Team Leader - Res Care

Licensing Officer
Licensing Officer (0.8)
Licensing Officer (0.6)
Licensing Officer (0.8)
Licensing Officer (0.6)
Licensing Officer
Licensing Officer (0.8)
Licensing Officer (0.6)
Licensing Officer
Licensing Officer (0.8)
Licensing Officer
Licensing Officer
Admin Support
Admin Support

Note:
EHO - Environmental Health Officer
HSE - Healthy Built Environment
LO - Licensing Officer
Figure 3: Northern Health Organisation Chart

NH Chief Medical Health Officer

Regional Director, Public Health Protection

Regional Manager, CCFL

North West
- 1 Degree LO (1 FTE)
- 1 Degree LO (.8 FTE) (currently vacant)

Northern Interior
- 4 Diploma LOs (4 FTEs)

North East
- 2 Diploma LOs (1.08 FTEs)
- 2 Degree LOs (2 FTEs)

Regional
- 1 Nurse LO (1 FTE - Residential)
- 1 Degree LO (.48 FTE)
Figure 4: Fraser Health Organisation Chart

Regional Director
Health Protection
E1060

Manager, EHS
Burnaby & New Westminster Health Protection, Emergency Planning
E1280

Manager, EHS
Tri-Cities & Maple Ridge Health Protection, Healthy Built Environment
E1280

Manager, EHS
Surrey Health Protection, Food Safety, Tobacco Enforcement
E1280

Manager, EHS
Mission/Chilliwack/Hope/Agassiz/Abbotsford Health Protection, Personal Svcs Establishments, Recreational Water
E1280

Manager, EHS
Langley/Delta Health Protection, Community Sanitation, Health Risk Assessment, Unintentional Injury
E1280

Manager, EHS
Regional Drinking Water Program
E1280

Manager, CCFL
Regional Investigation Team, Dietitian, Redevelopment & Quality Coordinator
E0279

Manager, CCFL
Regional Residential Care
E0279

Manager, CCFL
Regional Child Care
E0279

Manager, Clinical Operations
North Surrey Health Unit, Healthy Living, Healthier Communities, Healthy Schools, Tobacco Control
E4574

Administrative Assistant, Clinical Operations
E4485

Dual reporting to Karen Dickenson Smith
Manager
CCFL Child Care Licensing Team
E0279

Supervisor, Child Care Licensing Team - CCFL
BCGEU P10 1.0 FTE
P6760

Clerk Typist/Office Assistant
BCGEU CS05 1.6 FTE
C1115

Licensing Officer
BCGEU/CUPE P08 11.16 FTE
P4190

Licensing Officer
BCGEU/CUPE P07 11.98 FTE
P5912
Figure 5: VCH Organisational Chart

Manager
CCFL – Residential Licensing Team
E0279

Licensing Officer
BCNU CH2 1.0 FTE
N1693

Clerk Typist
BCGEU CS05 1.6 FTE
C1115

Licensing Officer
BCGEU/CUPE P07 2.96 FTE
P5912

Licensing Officer
BCGEU/CUPE P08 1.0 FTE
P4190

Licensing Officer, Residential
BCGEU/BUPE P07 3.0 FTE
P6715

Health Protection
CCFL Organizational Structure

Regional Manager
CCFL

Senior Licensing Officer
Central

Senior Residential Care Licensing Officer
Regional

Senior Child Care Licensing Officer
Vancouver

Senior Child Care Licensing Officer
Richmond

Senior Child Care Licensing Officer
North Shore

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APPENDIX 3
Study Questionnaires:

Interview Guides

Research Question: What changes in practice regarding response to complaints about licensed care facilities can be attributed to Licensing Officers (LOs) participation in the Advanced Specialty Certificate in Community Care Licensing?

Interview Phases:

Phase 1: Participants will be given an overview of the study and the types of questions they will be asked. At this time, participants will be invited to ask any questions they might have. If they wish to continue, participants will sign the consent form.

Phase 2: Participants will be invited to answer the questions outlined in this interview guide.

Phase 3: Participants are invited to complete the demographics form (See appendices).

Interview Guide A – Non-Front-Line Workers – Initial Interview

This protocol is designed for all individuals who are not front line workers. This includes licensing managers, regional directors of licensing, and medical health officers in the five regional health authorities. This protocol is designed for initial interviews with participants.

Introduction: Thank you for agreeing to meet with me. My name is _______ and I’m a researcher with the Justice Institute. As you probably know we’re looking at child and residential care and trying to get an understanding of current licensing practice across the province, we’re particularly interested in how licensing is perceived from the management level and from frontline levels. We are also looking at the relevance of efficacy of the Advanced Specialty Certificate in Community Care Licensing program at the JIBC and we would like to hear about your experiences, if any, with the program. I believe that you can help me to understand what it is like to work in this area and what the challenges and successes might be. I will be asking you some questions and ask you to reply to them in whatever way makes you feel comfortable and open. Please remember that there are no right or wrong answers because your experience belongs to you, and only you.

This interview will be recorded for transcription but I will remind you that everything that you say is confidential. All participants will be given a participant code to ensure the protection of their identity. During the interview, I may stop you to ask some clarifying questions, to ensure that I am understanding you to the best of my ability. Please feel free to ask me any questions throughout the interview. Any time you need a break, please let me know. As you know, I will be using a tape recorder during the session and I can stop it at any time. Do you have any questions at this time? Do you have any questions about the consent form?

Questions:

1) Tell me about your job and your role in relation to licensing practice.
• Clarifying Questions:
  o What is your background? How did you come into this position?
  o What is the context in which you work: child care, residential care, or mixed, or other specialized area (e.g. Specialized Investigations Team)
  o How long have you been in this field? And in this job?

2) Have you seen changes in practice during the time that you have had this job?

• Clarifying Questions:
  o If unable to think of changes: For example, I understand that there were some legislative changes in 2002 that made your work more outcome-based and less prescriptive.

3) In particular, have there been changes in the way that complaints are handled?

• Clarifying Questions:
  o Has there been a change in the types of complaints? If so, has that changed the way that things are done?
  o Can you provide some concrete examples?

4) How do you characterize the consistency and general practice of licensing operations within your health authority?

• Clarifying Questions:
  o Is practice consistent in approach across the various regional offices in your health authority?
  o Can you provide some concrete examples?

5) What are some of the common situations faced by LOs?

• Clarifying Questions:
  o What decisions would they make, and what rationale do they give?
  o What are the common types of complaints that received in your office/region?
  o Is there anything that makes your region/health authority unique? Are there situations that are specific to your area?
  o Can you provide some concrete examples?

6) What complaints or situations would be flagged for immediate consideration/action in your region?

• Clarifying Questions:
  o Why do you prioritize these?
  o Do you have a system in place for rating complaints or situations? Is it followed? Why or why not?
  o How much latitude or discretion do the LOs have for responding to these situations?
  o Can you provide some concrete examples?
7) Is any of your staff going through the Advanced Specialty Certificate in Community Care Licensing program? If so, how was the decision made to put staff into the program?

- Clarifying Questions:
  o What are your expectations? What would you like to see change as a result of having staff participate in the program?
  o Can you describe changes, if any, in the way people who have taken the course perform?
  o Please provide concrete examples
Interview Guide B – Front-Line Workers – Initial Focus Group

This protocol is designed for all individuals who are working as LOs. This protocol is designed for initial interviews with participants.

Introduction: Thank you for agreeing to meet with me. My name is _______ and I’m a researcher with the Justice Institute. As you probably know we’re looking at child and residential care and trying to get an understanding of current licensing practice across the province, we’re particularly interested in how licensing is perceived from the management level and from frontline levels. We are also looking at the relevance of efficacy of the Advanced Specialty Certificate in Community Care Licensing program at the JIBC and we would like to hear about your experiences, if any, with the program. I believe that you can help me to understand what it is like to work in this area and what the challenges and successes might be. I will be asking you some questions and ask you to reply to them in whatever way makes you feel comfortable and open. Please remember that there are no right or wrong answers because your experience belongs to you, and only you.

This interview will be recorded for transcription but I will remind you that everything that you say is confidential. All participants will be given a participant code to ensure the protection of their identity. During the focus group, I’m going to ask some questions. Feel free to respond or respond to other participants’ contributions as you see fit. I may prompt some of you to clarify what you’re saying to ensure that I am understanding you to the best of my ability and to ensure that everyone’s voice is heard. Please feel free to ask me any questions throughout the focus group. Any time you need a break, please let me know. As you know, I will be using a tape recorder during the session and I can stop it at any time. Do you have any questions at this time? Do you have any questions about the consent form?

Questions:

1) We’re going to go around the circle. Please tell me your name (so that we can assign you a participant code). Also, please tell me what area you practice in. Do you work in childcare, residential care, mixed practice or specialized practice?

2) Have you seen changes in practice during the time that you have had this job?
   - Clarifying Questions:
     - If unable to think of changes: For example, I understand that there were some legislative changes in 2002 that made your work more outcome-based and less prescriptive.

3) In particular, have there been changes in the way that complaints are handled?
   - Clarifying Questions:
     - Has there been a change in the types of complaints? If so, has that changed the way that you do your job?
     - Can you provide some concrete examples?
4) How do you characterize the consistency and general practice of licensing operations within your health authority?
   - Clarifying Questions:
     - Is practice consistent in approach across the various regional offices in your health authority?
     - Do you notice differences when you work in different offices?
     - Can you provide some concrete examples?

5) What are some of the common situations you face?
   - Clarifying Questions:
     - What decisions do you make on a regular basis, and what rationale do you give?
     - What are the common types of complaints that you receive?
     - Is there anything that makes your region/health authority unique? Are there situations that are specific to your area?
     - Can you provide some concrete examples?

6) What complaints or situations would be flagged for immediate consideration/action in your region?
   - Clarifying Questions:
     - Why do you prioritize these?
     - Do you have a system (matrix, decision-tree) in place for rating complaints or situations? Is it followed? Why or why not?
     - How much latitude or discretion do you have for responding to these situations?
     - Can you provide some concrete examples?

7) Have any of you taken courses? Have any of taken the courses in the Advanced Specialty Certificate in Community Care Licensing program at the Justice Institute?
   - Clarifying Questions:
     - If so, which courses and when?
     - Why did you take this/these course(s)?
     - Can you share some changes in your practice, if any, as a result of taking the courses?
     - Is there anything from the courses that you have brought into your everyday practice?
     - Has anything changed regarding how you think about your work as a result of this course?
     - Can you provide any concrete examples?

8) Have you noticed any change in practice in your region as a result of the course at this point?
   - Clarifying Questions:
     - Have you noticed changes in practice among the staff in your office/region?
     - Are you and/or others sharing what learned in the courses?
Interview Guide C – Non-Front-Line Workers – Follow-Up Interview (~6 months later)

This protocol is designed for all individuals who are not front line workers. This includes licensing managers, regional directors of licensing, and medical health officers in the five regional health authorities. This protocol is designed for follow-up interviews with participants.

Introduction: Thank you for agreeing to meet with me again. My name is _______ and I’m a researcher with the Justice Institute. I’ll remind you of why I’m here. As you probably know we’re looking at child and residential care and trying to get an understanding of current licensing practice across the province. We’re particularly interested in how licensing is perceived from the management level and from frontline levels. We are also looking at the relevance of efficacy of the Advanced Specialty Certificate in Community Care Licensing program at the JIBC and we would like to hear about your experiences, if any, with the program. I believe that you can help me to understand what it is like to work in this area and what the challenges and successes might be. I will be asking you some questions and ask you to reply to them in whatever way makes you feel comfortable and open. Please remember that there are no right or wrong answers because your experience belongs to you, and only you.

This interview will be recorded for transcription but I will remind you that everything that you say is confidential. All participants will be given a participant code to ensure the protection of their identity. During the interview, I may stop you to ask some clarifying questions, to ensure that I am understanding you to the best of my ability. Please feel free to ask me any questions throughout the interview. Any time you need a break, please let me know. As you know, I will be using a tape recorder during the session and I can stop it at any time. Do you have any questions at this time?

1) Have you seen changes in practice since our last meeting?
   - Clarifying Questions:
     o In particular, have there been changes in the way that complaints are handled?
     o Has there been a change in the types of complaints? If so, has that changed the way that you respond?
     o Can you provide some concrete examples?

2) How do you characterize the consistency and general practice of licensing operations within your health authority?
   - Clarifying Questions:
     o Can you identify any shifts, if any, that have occurred since we last spoke?
     o Is practice consistent in approach across the various regional offices in your health authority?
     o Can you provide some concrete examples?

3) What are some of the common situations faced by LOs?
• Clarifying Questions:
  o Can you identify any shifts, if any, that have occurred since we last spoke?
  o What decisions do they make, and what rationale do they give?
  o Can you provide some concrete examples?

4) What complaints or situations would be flagged for immediate consideration/action in your region?

• Clarifying Questions:
  o Can you identify any shifts, if any, that have occurred since we last spoke?
  o Why do you prioritize these?
  o Since we last spoke, have you implemented a system for rating complaints or situations? Is it followed? Why or why not?
  o How much latitude or discretion do the LO’s have for responding to these situations?
  o Can you provide some concrete examples?

5) Since we last spoke, is any of your staff going through the Advanced Specialty Certificate in Community Care Licensing program? If so, how was the decision made to put staff into the program?

• Clarifying Questions:
  o Has the program resulted in any change in practice in your region since we last spoke?
  o What were your expectations? What would you like to see change as a result of having staff participate in the program?
  o Have you noticed changes in the way people who have taken the course perform?
  o Have you seen any other changes?
  o Can you provide some concrete examples?
**Interview Guide D – Front-Line Workers – Follow-Up Focus Group**

This protocol is designed for all **individuals who are working as LOs**. This protocol is designed for follow-up interviews with participants.

**Introduction:** Thank you for agreeing to meet with me again. I’ll just remind you about why I’m here. As you probably know we’re looking at child and residential care and trying to get an understanding of current licensing practice across the province. We’re particularly interested in how licensing is perceived from the management level and from frontline levels. We are also looking at the relevance of efficacy of the Advanced Specialty Certificate in Community Care Licensing program at the JIBC and we would like to hear about your experiences, if any, with the program. I believe that you can help me to understand what it is like to work in this area and what the challenges and successes might be. I will be asking you some questions and ask you to reply to them in whatever way makes you feel comfortable and open. Please remember that there are no right or wrong answers because your experience belongs to you, and only you.

This interview will be recorded for transcription but I will remind you that everything that you say is confidential. All participants will be given a participant code to ensure the protection of their identity. During the focus group, I’m going to ask some questions. Feel free to respond or respond to other participants’ contributions as you see fit. I may prompt some of you to clarify what you’re saying to ensure that I am understanding you to the best of my ability and to ensure that everyone’s voice is heard. Please feel free to ask me any questions throughout the focus group. Any time you need a break, please let me know. As you know, I will be using a tape recorder during the session and I can stop it at any time. Do you have any questions at this time?

Do you have any questions about the consent form?

1) Have you seen changes in practice since our last meeting?

- **Clarifying Questions:**
  - In particular, have there been changes in the way that you handle complaints?
  - Has there been a change in the types of complaints? If so, has that changed the way that you respond?
  - Can you provide some concrete examples?

2) How do you characterize the consistency and general practice of licensing operations within your health authority?

- **Clarifying Questions:**
  - Can you identify any shifts, if any, that have occurred since we last spoke?
  - Is practice consistent in approach across the various regional offices in your health authority?
  - Can you provide some concrete examples?

3) What are some of the common situations you face in your work?

- **Clarifying Questions:**
  - Can you identify any shifts, if any, that have occurred since we last spoke?
What kinds of decisions do you make, and how do you explain those decisions?
Can you provide some concrete examples?

4) What complaints or situations would be flagged for immediate consideration/action in your region?

- **Clarifying Questions:**
  - Can you identify any shifts, if any, that have occurred since we last spoke?
  - Why do you prioritize these?
  - Since we last spoke, have you implemented a system for rating complaints or situations? Is it followed? Why or why not?
  - How much latitude or discretion do you have for responding to these situations?
  - Can you provide some concrete examples?

5) Since we last spoke, have you participated in courses with the Advanced Specialty Certificate in Community Care Licensing program? If so, why did you decide to take these courses?

- **Clarifying Questions:**
  - Have you noticed changes in practice among the staff in your office/region?
  - Are you and/or others sharing what learned in the courses?
  - Are you noticing an in impact on practices in your office?
  - Can you provide any concrete examples?
Questionnaire

The Practice of Community Care Facilities Licensing in British Columbia

Non-Front Line Staff

Participant Number: __________________

Age: ____________
Gender: _____________________
Education: _____________________
Job title: _____________________
Area of work:

__ Child care
__ Residential care, or
__ Mixed practice (please specify): ________________________________
__ Specialized practice (please specify): ________________________________

How many licensing officers do you manage? ________________

Length of time in current position: ________________

Length of time in this area of work: ________________

Previous professions? ________________________________
Questionnaire

The Practice of Community Care Facilities Licensing in British Columbia

Front Line Staff

Participant Number: _________________

Age: ____________
Gender: _____________________
Education: __________________________
Job title: __________________________
Area of work:

__ Child care
__ Residential care, or
__ Mixed practice (please specify): _______________________________
__ Specialized practice (please specify): _______________________________

Size of case load: _________________

Length of time in current position: _________________

Length of time in this area of work: _________________

Previous professions? _________________
APPENDIX 4

Figure 6: Map of Health Authority Boundaries

APPENDIX 5

Nvivo Data Model Example

Static View of Nvivo Word Tree Data
FIGURE 7: STATIC EXAMPLE OF WORD TREE DATA MODELLING RE COMPLAINTS

FIGURE 8: ILLUSTRATION OF STATIC NVIVO DATA MODELLING RE COMPLAINTS
**Figure 9: Static NVivo Model of Licensee Data Analysis**
Community Care and Assisted Living Act [SBC 2002] CHAPTER 75
http://www.bclaws.ca/civix/document/id/complete/statreg/02075_01

THE BEST OF CARE: GETTING IT RIGHT FOR SENIORS IN BRITISH COLUMBIA (Part 2)
https://bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%20047%20The%20Best%20of%20Care-%20Getting%20It%20Right%20For%20Seniors%20in%20BC%20(Part%202)%20Overview.pdf