THE BEST OF CARE:
GETTING IT RIGHT FOR SENIORS IN BRITISH COLUMBIA (Part 2)

OVERVIEW

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Dedication

This report is dedicated to seniors in British Columbia who require care and support and their families and friends. It is also dedicated to the hardworking people who provide care to seniors in British Columbia.

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Introduction

Introduction

This report is a comprehensive and in-depth look at home and community care issues affecting seniors in British Columbia from an Ombudsperson's perspective.

As an independent Officer of the Legislature, the Ombudsperson is tasked with oversight of the administrative actions of provincial public authorities with the goal of ensuring they deal with people and deliver services in a fair and reasonable manner. While the Office of the Ombudsperson receives, investigates, and resolves thousands of individual complaints each year, it also has a role to "generally oversee the administrative actions of government authorities with a view to upholding the democratic principles of openness, transparency, and accountability."

In this investigation, the provincial public authorities we have looked at and that have responsibility for seniors' care are the Ministry of Health and the five regional health authorities: Fraser Health, Interior Health, Northern Health, Vancouver Coastal Health, and Vancouver Island Health. In addition, the Ministry Responsible for Housing was included as it had a role in dealing with the tenancy rights of those seniors in assisted living residences.

Our investigation focusses on issues of administrative fairness including adequacy of information; program accessibility; standards of care; and monitoring and enforcement of those standards.

The complexity of seniors' care issues and the division of responsibility between different provincial public authorities led to a long systemic investigation which has resulted in a two-part public report. Part 1 was released in December 2009 and addressed an important but narrow range of issues in the area of residential care. Part 2 deals not only with residential care but also general home and community care issues; home support; and assisted living – in short, a significant range of interconnected seniors' care services in British Columbia.

As a consequence, Part 2 is a more detailed and diverse report that includes a total of 143 findings and 176 recommendations. The largest number of these recommendations necessarily involve the Ministry of Health taking a leadership role, providing direction and support to health authorities and working in conjunction with them to ensure consistent province wide standards and processes that treat seniors across British Columbia in a fair and equitable manner.

Introduction

Background

This investigation was initiated in 2008 in response to complaints received by the Ombudsperson's Office about various aspects of seniors' care and public concerns about seniors care. It has been one of the longest systemic investigations conducted by this office and has resulted in the most comprehensive report the Office has produced.

While we issued Part 1 of our report in December 2009, Part 2 has taken much longer to complete. Once people have had an opportunity to read it however, I believe they will understand why.

While we express our thanks in other places in the report, I would like to say that the work done by the staff in our office was supported by equally hard-working staff in various parts of the Ministry of Health and the five regional health authorities who are dedicated to improving the system of seniors care in British Columbia and who provided files for review, facts, data, information and ideas to our office and responded to our many questions.

Our approach to issues, as set out in our Act is consultative and resolution-oriented. Our focus is on fixing problems and improving service delivery. We see unfair or unreasonable treatment as ultimately ineffective and inefficient program management.

There are various ways to look at the administrative fairness issues raised in a review of seniors care. We chose to organize our investigation and report under the headings of Home and Community Care, which deals with issues that affect different types of seniors care in British Columbia; Home Support, which deals with issues that affect seniors who receive support services to assist them to continue to live in their own homes; Assisted Living, which deals with issues that affect seniors who live in residences registered as assisted living residences; and Residential Care, which deals with issues that affect seniors who live in residential care facilities.

Equally, each of these major divisions includes sub-headings that deal with administrative fairness issues: availability of information; accessibility of service; standards of care; monitoring and enforcement of those standards; and how complaints about service delivery are dealt with by authorities. So, another way of approaching the report is to look at those issues in a comparative approach across the major home and community care divisions. For example, how standards of care are established and monitored in residential care facilities in comparison to how they are established and monitored in home support.

Finally some people may wish to begin with the recommendations for rectification, change, or improvement, and look at which ones can be done quickly, which ones will take some time to implement, and which are ones where additional study is recommended before a decision is made.

Whichever approach is taken, I think it will be clear that there are many areas where practical improvements can be made that will improve service delivery to seniors and their families and which do not involve complicated and costly changes.

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Our Investigative Process

In conducting this systemic investigation we obtained information from a number of different sources. Foremost was from the Ministry of Health and the five regional health authorities. In situations where there were any differences that could not be reconciled in the information or data we received from the Ministry and the health authority, we have relied upon the health authority data as it has been collected closest to the source. In addition, we obtained information during the course of our investigations into individual complaints. We also received information from various stakeholder groups and from individuals who had experiences as "end users" with the seniors care system in British Columbia. All this information was supplemented with visits that we made to assisted living and residential care facilities and to home support agencies.

At a relatively early stage in our investigation, we identified three interrelated areas where we believed straightforward changes could be made that would quickly improve the quality of life for seniors in residential care facilities. The changes we recommended were clearly setting out the rights of seniors living in all types of residential care facilities and ensuring these rights were respected; providing timely access to useful, consistent and comparable information on residential care facilities; and providing support for the role of resident and family councils. The recommendation on establishing a Residents' Bill of Rights was accepted and implemented in November 2009.

The themes that were highlighted in Part 1 of the report include the importance of ensuring equal rights and consistent standards of care and protection; timely access to useful, and accurate information; and the importance of considering the input and interests of seniors and their families in the delivery of services. These themes continue to be reflected throughout this part of the report.

Once our investigation was complete, we followed our normal process of providing a draft report to the authorities to provide them with an opportunity to respond. A copy of the draft report including our preliminary findings and recommendations was sent to the Ministry of Health and the health authorities on October 28, 2011. We provided an opportunity for them to identify any factual clarifications they believed should be included and which they believed would be useful in finalizing our findings and recommendations.

Format of This Report

One of the questions that I expect to be asked is "why is Part 2 of this report so long and detailed" and "why are you making so many specific recommendations". In answering the first question, I can also answer the second.

Home and community care in British Columbia is a complex and interconnected system involving a number of provincial government authorities as well as private service providers (both for profit and not for profit). In order to ensure that our recommendations are useful and practical, it was necessary to look at a range of services rather than to deal with them on a piecemeal basis.

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I also believed a detailed report would, in addition to explaining the rationale for recommending certain changes and improvements, illustrate what sort of information could be usefully provided to the public.

We have also produced a summary of the report which is found in the volume titled "Overview". This contains the essential information underlying the recommendations but it does not contain all the detailed supporting information. I would stress that the full report, or the section that deals with the issue you are interested in, should be read to fully understand and appreciate the reasons for the recommendations. The summarized version has also been produced in a larger font to increase accessibility.

Progress to Date

I believe that there has already been some improvements made during the course of our investigation. Clearly, the recognition of the importance of ensuring consistent standards of protection for all seniors receiving similar care that the Bill of Rights embodies is significant.

One of the advantages of a longer investigation is that it can provide an opportunity for changes and improvements to be made by authorities while responding to our inquiries. That has happened during this investigation.

An example of this is that the Ministry of Health changed its policy in April 2011 to eliminate a long-standing distinction between the rates charged to some sponsored immigrants for residential care and those charged to other seniors. In the same April 2011 manual there is a new chapter on performance management in home and community care services that stresses the importance of performance standards, performance measures, reporting progress and quality improvement. Those are themes that are echoed in specific recommendations in this report.

In addition the Ministry of Health completed and publicly released a report on the use of antipsychotic drugs in British Columbia Residential Care Facilities in December 2011.

Equally, I have observed movement over the past three years towards the Ministry of Health taking a more active stewardship role in the area of seniors' care. I believe the Ministry and health authorities responses to this report reflect a recognition that the Ministry, with its policy making and funding responsibilities, is the only agency that has both the ability and authority to ensure that issues of accessibility, standards of care, and monitoring and enforcement of these standards are consistently addressed.

Looking back at Part 1 of this report, which was issued in December 2009, I am also heartened that many groups have "taken up the cause" of some of the recommendations that were not implemented at that time, such as the establishment of a single provincial website reporting useful information about residential care facilities, and are still pushing for their full implementation. There have been improvements in the amount of information made available to seniors and their

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families about seniors' care and it is also noteworthy that the Ministry of Health, in its response to this report, identified that one of its immediate priorities was taking action to improve the accessibility of information.

Areas Dealt With in this Report

In a comprehensive and detailed report it is often easy to get lost trying to identify what are the most significant recommendations. In this case, I believe, given the range and number of recommendations, it is most useful to look at some underlying themes that connect the recommendations.

At the highest level, those themes are support; protection; consistency; and choice. Almost every recommendation relates to one of those themes. For example, our recommendations about information and reporting are designed to improve consistency and to facilitate choice. Our recommendations about accessibility are designed to improve support, protection, and choice. Our recommendations about standards, monitoring, and enforcement are designed to improve protection and consistency.

Key issues include providing adequate, accurate and accessible information to seniors and their families to allow them to make necessary decisions in an informed manner; evaluating the consistency of current home support criteria with the government's provincial goals and principles and the overall goals of the home support program; expanding current programs such as standard training, supervision of gift giving and criminal records checks to ensure equal protection for all vulnerable seniors receiving home support, assisted living and residential care; ensuring that vulnerable seniors have equal or better protection than other British Columbians in areas such as tenancy; creating one statutory and regulatory framework for all residential care facilities in BC; and establishing clear, objective measurable and enforceable standards of care in home support, assisted living and residential care.

Areas where improvements can be made can also be grouped under administrative fairness issues. It is important that seniors have timely access to useful information which is why, for example, I have recommended that the Ministry of Health work with health authorities to develop a program to ensure all seniors and their families are informed of the availability of home and community care services (Recommendation 9) and ensure information about application processes and how to apply for fee waivers are clear, consistent, and available to all those who may benefit from them (Recommendations 11 and 41).

It is important that the Ministry of Health and health authorities have clear authority for the actions they take which is why, for example, I have recommended that the Ministry of Health ensure there is a clear, province-wide policy on when the *Mental Health Act* can be used to

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involuntarily admit seniors to mental health facilities and then transfer them to residential care facilities (Recommendation 130) and that the health authorities stop charging fees to these seniors who are involuntarily detained in residential care facilities (Recommendation 131).

It is important that seniors in similar circumstances receive similar care and protection and support which is why, for example, I have recommended that the Ministry of Health takes steps to end the two different legislative frameworks that apply to residential care, the *Community Care and Assisted Living Act* and the *Hospital Act* (Recommendation 94), which result in unfair differences in services, standards, monitoring, and fees. As well, I have recommended that the Ministry of Health take the necessary steps to require operators of residential care facilities governed under the *Hospital Act* to report incidents in the same manner as facilities licensed under the *Community Care and Assisted Living Act* (Recommendation 162).

It is important that standards of care are clear and enforceable which is why, for example, I have recommended that the Ministry of Health, after consulting, establish specific and objectively measurable regulatory standards that apply to key aspects of care in all residential care facilities (Recommendation 133) and similarly, it establish standards of care for key areas in assisted living residences (Recommendation 69) and home support services (Recommendation 42).

It is important that the organization responsible for monitoring and enforcing standards have the tools they need to do so effectively which is why, for example, I have recommended that the Assisted Living Registrar be given expanded authority to obtain information about incidents it is tasked with investigating and the Ministry of Health develop an active inspection and monitoring program for assisted living residences (Recommendations 90 and 88), as well as expanding the enforcement options that apply to residential care facilities under the *Community Care and Assisted Living Act* (Recommendation 166).

It is important that seniors receiving care and their families have access to timely and responsive complaint systems, which is why, for example, I have recommended that the Ministry of Health revise and expand the complaints process of the Assisted Living Registrar (Recommendations 75, 78 and 79) and require all residential care facility operators to have a process for responding to complaints (Recommendation 148).

It is also important that authorities track and have access to the information needed to ensure they can fulfill their oversight roles which is why, for example, I have recommended that the Director of Licensing in the Ministry of Health receive quarterly reports about the number and nature of residential care complaints and reportable incidents from the regional health authorities (Recommendation 151) and that the Ministry of Health, when developing new information management systems, ensure the new system is fully operational before allowing information reported under the old system to be discontinued (Recommendation 6).

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While I believe it is the inter-connectedness of the recommendations which is the real strength of this report, I am sure that one or another of them may resonate with individual readers as most important because of their particular circumstances.

Responses of Authorities

I believe it is clear from the Ministry of Health's response it believes there is significant public interest in seniors care and it has indicated that this report's focus on issues such as accessibility, consistency, continuity, accountability, transparency, and choice are ones that it supports. It has indicated its immediate priorities will be to improve administrative fairness and access to information within the current legislative and regulatory framework and it recognizes the need for timely responses to concerns and complaints, as well as for greater navigational support for system users.

As the Ministry of Health has also taken the lead in responding to recommendations directed to all the health authorities, this means that the great majority of the recommendations in the report are in its hands.

The responses of the individual health authorities have focussed on the specific recommendations directed to them. The majority have been accepted and are being implemented. In situations where a health authority has not accepted a finding or recommendation I have carefully considered the rationale it provided for not doing so.

I recommended that Interior Health track the length of time seniors wait to be assessed for home and community care services (Finding 7 and Recommendation 8). This was based on its inability to provide factual information on tracking for the entire health authority. The information provided did not include the Kootenay Boundary area. Consequently I have not changed this finding. I also recommended Interior Health fully comply with a February 2009 directive issued by the former Ministry of Health Services by including a description of the complaints processes and direct contact information for the Patient Care Quality Review Board and the Office of the Assisted Living Registrar on its website (Finding 57 and Recommendation 71). This was based on reviews of Interior Health's website done in June and December 2011. The website did not include a description of the complaints processes and direct contact information for the Patient Care Quality Review Board and the Office of the Assisted Living Registrar. Consequently I have not changed this finding.

I also recommended that Vancouver Coastal track the length of time seniors wait to be assessed for home and community care services (Finding 7 and Recommendation 8). Vancouver Coastal recently began recording what percentage of the time it met performance measures for seeing a home and community care client after a referral within timeframes ranging from 24 hours to two weeks. While that may be very useful information, it is not the same as tracking the actual time that a senior waits for a home and community care assessment. Vancouver Coastal Health has confirmed that currently it does not have information available on average wait times for

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assessment or the number of seniors waiting for an assessment. Consequently I have not changed this finding. Vancouver Coastal's response concerning Finding 57 and Recommendation 71 is an example of where, when an authority provides additionnal or updated information that establishes that a finding and recommendation no longer applies to them, then I reflect that in the appropriate finding and recommendation.

The response from the Minister Responsible for Housing clarifies that it is now the Ministry of Health which is now responsible for issues relating to assisted living tenancies.

Conclusion

Administrative fairness operates within a wider context. During the course of our investigation into home and community care issues, it became evident that context includes questions about whether the changes in service delivery models for seniors care made since 1984 should be considered during any review of the *Canada Health Act*; whether a conversation with seniors and others about the type of services needed, their costs and how these costs are paid, would be timely and produce positive change; whether there is a rationale for the difference in support in British Columbia provides to vulnerable children and their families (a Ministry and a provincial-level representative) and vulnerable seniors and their families; and whether the current home and community service delivery model which is a mix of private and public agencies delivering home and community care services under contract to the health authorities is the most effective model. While, to the disappointment of some, I have made it clear those issues are not matters which fell within the scope of this investigation, I hope that this report will still be valuable to those who are engaged in considering such matters.

I will conclude by saying, as I have done in earlier reports, that this is a lengthy and detailed examination of a complex and important government program. I believe that it has demonstrated areas where fair and reasonable policies, processes, and procedures will improve program delivery and as a result, the lives of individual British Columbians. The focus on good administration, service delivery, and accountability approached through the Ombudsperson lens of fairness and reasonableness will, I believe, assist the Ministries and health authorities and their staff who provide these important services as well as the seniors who receive them – who may from time to time be us, or our family members, friends and colleagues.

Kim S. Carter
Ombudsperson
Province of British Columbia

Background

Investigative Process

In early 2008, while conducting outreach tours and giving presentations throughout the province, I heard many comments about care for seniors in British Columbia. As a result, I issued a news release on June 26, 2008, asking anyone with concerns about seniors' care that had not already been reasonably and fairly addressed by provincial authorities to contact the Office of the Ombudsperson.

Following the news release, our office received over fifty complaints from across the province within a two month period about the services provided to seniors.

On August 21, 2008, I initiated a province-wide investigation into the care provided to seniors, including home support, assisted living and residential care services. My decision to launch a systemic investigation like this was prompted in part by concerns about the vulnerability of seniors in care facilities. In addition, our office recognized that not every senior has loved ones available to provide advocacy and support, and that those seniors with physical and mental challenges may experience difficulty in raising concerns.

In December 2009, our office completed its first phase of reporting on seniors' care with the release of *The Best of Care: Getting It Right for Seniors in British Columbia (Part 1)*. This report addressed three major issues related to residential care services: residents' rights, public information and reporting, and resident and family councils.

The current report, Part 2, considers a broader scope of issues related to the care of seniors who are receiving home support, assisted living and residential care services. For example, we examined funding processes, access to services, and quality of care. To do this, we used a variety of sources and methods, including document review, meetings and consultations, and site visits. Our staff met with over with forty different organizations and visited more than fifty facilities across the province. We also received an impressive amount of input from the public.

Most of the individuals and organizations we consulted were very supportive of our investigation, and responded to our requests for information in a timely, open and straightforward fashion. We would like to thank everyone who took the time to meet with us, answer our questions and provide us with input for this investigation.

Who Are British Columbia's Seniors?

In this report, we define seniors as people who are 65 years or older. BC Stats has estimated that approximately 677,770 seniors were living in British Columbia in 2010.[1] The distribution of seniors varied considerably across the province. The Fraser Health Authority has more seniors

[1] BC Stats, *British Columbia Population Projections 2011 to 2036*, September 2011, 35.

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than any other region: almost one-third of the provincial population of seniors. The Northern Health Authority has the fewest seniors, while the Interior Health Authority, Vancouver Coastal Health Authority and Vancouver Island Health Authority have similar numbers of seniors.

By 2020, seniors are expected to make up 19 per cent of the province's population, increasing to 24 per cent by 2036.[2] That means that today's provincial senior population of about 678,000 is expected to grow to an estimated 984,000 in 2020, and to reach nearly 1.46 million in 2036.

Values and Principles for Care

A commitment to "build the best system of support in Canada for persons with disabilities, those with special needs, children at risk and seniors" was identified in the province's *2011/12-2013/14 Strategic Plan* as one of five "great goals for a golden decade." The plan also identifies the following core values of British Columbia's government:

- *integrity:* to make decisions in a manner that is consistent, professional, fair, transparent and balanced
- *fiscal responsibility:* to implement affordable public policies
- *accountability:* to enhance efficiency, effectiveness and the credibility of government
- *respect:* to treat all citizens equitably, compassionately and respectfully
- *choice:* to afford citizens the opportunity to exercise self-determination

Types of Care

Our investigation focused on three health services that are integral to seniors' care in British Columbia. These services — home support, assisted living, and residential care — are contained within a larger framework known as home and community care.

Home support workers, also referred to as community health workers, help seniors with daily activities such as getting up and around, getting dressed, using the bathroom, preparing meals and taking medications. These services are provided in the senior's home and are designed to allow the individual to live independently for as long as safely possible.

Assisted living is a form of housing that combines private units in apartment-style residences with the provision of hospitality and prescribed care services. These services include meals, housekeeping, personal care and help with medications. Assisted living is meant for seniors and others who are able to direct their own care, but can no longer live safely on their own.

Residential care facilities provide 24-hour professional nursing care and supervision in a protected, supportive environment to seniors with complex care needs. This type of care is meant for people who can no longer safely live on their own.

[2] BC Stats, *British Columbia Population Projections 2011 to 2036*, September 2011, 5.

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Service Providers

Ministry of Health

The Ministry of Health is the overall steward of the provincial health care system. The following principles appear on the ministry's website: clients and their families should have the information required to make their own decisions about lifestyle and care; clients have the right to make their own care decisions; home and community care services will promote the well-being, dignity and independence of clients; palliative care services will provide the best possible quality of life for people nearing the end of their life and their families.[3]

Director of Licensing

The director of licensing, an employee of the Ministry of Health is responsible for the provincial community care licensing program. The director sets policies and practice standards for community care facilities and has specific powers under section 4 of the *Community Care and Assisted Living Act* (*CCALA*), including the power to inspect or order an inspection of a facility licensed under the *CCALA*.

Office of the Assisted Living Registrar

The mandate of the Office of the Assisted Living Registrar (OALR) is to protect the health and safety of residents in assisted living facilities. Assisted living facilities must be registered with the OALR. The registrar establishes policies and procedures that apply to assisted living settings. The registrar is also responsible for receiving and acting on complaints about assisted living facilities or services.

Health Authorities

In 1993, the provincial government passed legislation to begin the transfer of responsibility for the delivery of health services to health authorities. There are now five health authorities that deliver health services within their geographic regions: the Fraser Health Authority (FHA); the Interior Health Authority (IHA); the Northern Health Authority (NHA); the Vancouver Coastal Health Authority (VCHA); the Vancouver Island Health Authority (VIHA).

The overall mandate of each health authority is to plan, deliver, monitor and report on health services within its region. These services include home and community care.

[3] Ministry of Health, "Home and Community Care" <http://www.health.gov.bc.ca/hcc/index.html>.

Home and Community Care

Program Overview

Home and community care services are an important and integral part of the health care system in British Columbia. These services include care giver relief and respite, adult day care and supportive housing as well as the program areas of home support, assisted living and residential care that are examined in this report. While these services are not only provided to seniors, seniors do make up the largest number of persons receiving this type of health care.

Together with acute care, mental health services and public health protection, home and community care is a significant health care program area. The following figures provide an idea of the number of people receiving these services and the money spent by health authorities in providing them. In 2009/10 health authorities provided home support services to more than 24,000 people and spent approximately $339 million on those services. In 2010/11 there were more than 4,300 subsidized assisted living units and health authorities spent approximately $74 million on this program area. On March 31, 2011 there were more than 24,000 subsidized residential care beds in British Columbia and in 2010/11 the health authorities spent approximately $1.6 billion on residential care.

Unlike health care services delivered in a hospital or by a physician in many cases the person receiving home and community care services must pay something towards the cost of the service provided. These fees are often called co-payments and may include contributions towards the cost of housing and food. Depending on individual circumstances these costs can range from less than $10 a day for home support to over $2,900 a month for residential care.

Delivering home and community care services is the responsibility of the five regional health authorities. The services themselves may be provided by employees of a health authority, or by staff working for a not-for-profit or for profit organization that has a contract with a health authority. The seniors who receive these services may be living in their own homes in the community or their home may now be a supportive housing facility such as an assisted living residence or residential care facility.

While there are several pieces of important legislation that regulate the provision of these services including the *Continuing Care Act*, the *Community Care and Assisted Living Act* and the *Hospital Act*, much of the actual operation of home and community care is guided by policy.

Funding

As with any other provincial government program, the delivery of home and community care services depends on the funding provided. The provincial government makes decisions about funding for programs and services as part of its overall budgeting process.

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In the case of home and community care, the Ministry of Health and the health authorities each play a role in determining what funding is provided.

Ministry of Health

The Treasury Board advises the Ministry of Health about how much funding it will receive for the budget year. In turn, the ministry decides how much funding each health authority will receive. To do that, the ministry uses a "population needs-based funding model." Population needs-based funding is a way to determine a health authority's funding allotment based on the characteristics and needs of that region's population. This approach does not guarantee that a health authority's needs will actually be funded. As a result, there may be differences between the funding the health authorities identify as necessary and what they receive in any particular budget year.

Health Authorities

Once the ministry informs the health authorities of what their individual budgets will be, each health authority decides how to distribute the funding it will receive to each major program area. The health authorities develop plans for projected spending in each sector.

Planning Framework

Clearly it is important that the Ministry of Health and the health authorities monitor the demand for home and community care services, not only to plan for future funding needs but also to ensure that those people eligible for services are able to receive them in a timely manner.

We asked the Ministry of Health and the health authorities how they determined whether the funding provided is sufficient to meet the demand for subsidized home and community care services. In November 2011, the Fraser Health Authority told us it monitors the demand for these services annually and takes the increased demand into consideration in its annual budget and financial planning decision-making. Neither the Ministry of Health nor the other health authorities could provide us with any information on how they are monitoring the demand for these services to determine whether the funding provided is adequate.

In October 2008, the Office of the Auditor General of British Columbia released a report titled *Home and Community Care Services: Meeting Needs and Preparing for the Future.*[4] One of the Auditor General's key conclusions was that the ministry did not have the comprehensive planning framework necessary for ensuring that the home and community care system is meeting the needs of the aging population.

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[4] Office of the Auditor General of British Columbia, *Home and Community Care Services: Meeting Needs and Preparing for the Future*, October 2008.

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Along with the need for better planning in the home and community care system is the need for greater transparency in the funding process. In the report, the Auditor General recommended that the ministry increase its accountability to the public through more comprehensive performance reporting. I agree with this recommendation.

In my view, the ministry has a responsibility to provide the public with clear, accessible and easily understandable information about how and where funds are being invested in the system and whether these funds are achieving the goals set for home and community care services in British Columbia. Part of the ministry's stewardship role is to ensure that funding that is assigned for specific purposes produces results. Providing reliable and consistent information on an ongoing basis about the funding of home and community care services, and about the resulting outcomes, allows the public to evaluate the adequacy of available services. It may also make public discussion on the financial realities faced by the ministry and health authorities better informed. Furthermore, reporting this information publicly reflects a fundamental respect for the people and taxpayers who are the users and funders of this system.

I have recommended that the Ministry of Health report publicly on an annual basis in a way that is clear and accessible:

- **the funding allocated to home and community services by each health authority**
- **the funds expended on home and community care services in each health authority**
- **the planned results for home and community care services in each health authority**
- **the actual results delivered by home and community care services**
- **an explanation of any differences between the planned results and the actual results (R1)**

Difficulties in Obtaining Information

During our investigation, while people were responsive to our requests for information we encountered difficulties gathering comprehensive, consistent and reliable information from the health authorities and the Ministry of Health. In many cases, the information we requested was simply not tracked.

In other cases, the information we requested was tracked, but it was not broken down into relevant categories. Some information was not available on a regional or provincial level, either because it is recorded only in individual case files and not in a central location, or because the ministry does not collect the relevant data from the health authorities.

We also received data that was incomplete or varied inexplicably depending on the source or the time at which was submitted.

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I have recommended that the Ministry of Health work with the health authorities and other stakeholders to identify key home and community care data that should be tracked by the health authorities and reported to the ministry on a quarterly basis; and that the ministry include the reported data in an annual home and community care report that it makes publicly available. (R2, R3)

Collecting, Managing and Reporting Information

To successfully fulfill its role as the steward of the health care system in British Columbia, the Ministry of Health needs to set standards and monitor and evaluate performance. To do this, the ministry must have consistent, reliable data from the health authorities that are responsible for service delivery.

Transition to the Minimum Reporting Requirements System

Since 1978, the provincial government has used a complex database known as the continuing care information management system (CCIMS). The CCIMS is now considered outdated. The original purpose of the CCIMS was to allow service providers to bill the ministry for work done. Over time, the system was adapted so that it could also track information about home and community care clients and the services they receive.

The Ministry of Health and the health authorities began planning strategies to address the need of the old CCIMS data system in the 1990s. By 2005, the ministry determined that it had outgrown the capabilities of the database. A new system was required. However the health authorities said they wanted to develop their own systems for managing home and community care information, so the ministry decided not to implement a single province-wide information system. Instead, the ministry worked with the health authorities to establish a set of minimum reporting requirements (MRR) for home and community care.

The ministry's decision to allow the health authorities to develop their own systems has led to gaps in reporting and challenges to timely implementation of the minimum reporting requirements system. Given that the rationale for implementing the new system was to provide the ministry with key information that it lacked, the fact that a fully effective means of collecting such information is still not fully operational is a serious concern.

I have recommended that the Ministry of Health ensure that all health authorities are reliably reporting all the information required by the minimum reporting requirements (MRR) by May 31, 2012; and that the health authorities ensure that the MRR system is fully operational in their regions by May 31, 2012. (R4, R5)

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I have also recommended that the ministry, when developing a new information management system, ensure that the new system is fully operational before allowing information reported under the old system to be discontinued. (R6)

Eligibility, Assessment and Access

A fair, consistent and reasonable process for assessing eligibility and timely access to a program is an important aspect of administrative fairness. People seeking subsidized home support, assisted living or residential care services must apply to their health authority to have their need and eligibility assessed before they can begin receiving these services.

To be eligible for subsidized home and community care services, a senior must:

- be a Canadian citizen or permanent resident, or have applied for permanent residence and been issued a Temporary Residence Permit on medical grounds by the federal government
- be a B.C. resident at the time of application and have lived in British Columbia for at least three months
- have an impaired ability to function independently because of chronic health conditions requiring care following discharge from hospital, home care rather than hospitalization, or end-of-life care

As a further condition of receiving subsidized home and community care services, seniors must give their written consent allowing the ministry to obtain and verify their income from the Canada Revenue Agency.

Assessment is an important part of the application process. It is the basis on which the health authorities decide whether they will provide home and community care services to each person who applies and, if approved, the nature, level, amount, cost and duration of those services.

Waiting to Be Assessed

Ministry policy states that assessments should be ranked according to the urgency of the senior's health care needs, the availability of family or other caregivers and community support, the potential risk in the senior's present living situation, and the length of time the senior has been waiting for an assessment.[5] The ministry's policy on assessment timelines is set out in the *RAI-HC Clinical Practice Standards and "Best Practice" Guidelines* (2006).[6] These guidelines state that seniors should be assessed within two weeks of referral to a health authority.

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[5] Ministry of Health, *Home and Community Care Policy Manual,* April 2011, Client Access: Referral and Intake, 2.C.

[6] Ministry of Health, *RAI-HC Clinical Practice Standards and "Best Practice" Guidelines*, September 2006, 2.

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Delays in assessment are a serious concern because seniors generally cannot receive subsidized services until their regional health authority has assessed them as eligible and in need of assistance. It is also important that reliable information about waiting times for assessments is collected and tracked because only then will the health authorities and the ministry be in a position to measure their performance in this area.

The Ministry of Health has taken some steps to address the gap in data it receives by issuing a directive to the health authorities requiring them to provide the ministry with the percentage of seniors whose assessments had been completed within 14 days of referral.[7] The directive required the health authorities to report the completed assessments data to the ministry every quarter beginning in July 2009. As of October 2011, the ministry was not yet able to provide us with what it considered to be reliable information. We asked the health authorities to provide us with the average time seniors waited for an assessment in 2010/11. In Northern Health the average waiting time was 205 days, compared to 21 days in Fraser Health and 68 days in VIHA. Interior Health was not able to provide complete information due to a system upgrade in one of its health areas. Interior Health reported that the average waiting time was 6 days, excluding this health area. Vancouver Coastal Health was unable to provide this information but explained that it recently began tracking how often clients are seen within priority time frames, for example 24 hours or 48 hours.

Once these data collection issues are resolved, we expect the ministry to be able to calculate the percentage of clients whose assessments were completed within 14 days of referral. Health authorities with substantially longer waiting times can then develop methods for eliminating, or at least greatly reducing, those backlogs.

> **I have recommended that the health authorities ensure that seniors are assessed for home and community care services within two weeks of referral and that the Interior Health Authority and the Vancouver Coastal Health Authority track the length of time seniors wait to be assessed for home and community care services. (R7, R8)**

Percentage of Seniors Assessed

We learned from the health authorities and the Ministry of Health that approximately 70 per cent of seniors over 80 in British Columbia have never been assessed for home and community care services. While many of these seniors may be in good health, others may have care needs that could

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[7] Minister of Health Services, *Home and Community Care Quality and Performance Monitoring*, 27 February 2009. The directive was issued pursuant to the 2008/09 government letters of expectations sent by the minister to the board chairs of each of the five regional health authorities. This document is cited subsequently in this overview as "Ministry of Health directive, February 2009."

qualify for assistance and support. In comparison, under *Preventative Home Visits to the Ageing Law*, Denmark government agencies must proactively offer home visits once a year to all seniors over 75 in order to inform them of available services and identify those who may require support.

I have recommended that the Ministry of Health work with the health authorities and other stakeholders to develop a program to ensure that:

- **all seniors and their families are informed of the availability of home and community care services**
- **all seniors and their families are informed that they can meet with health authority staff to determine what supports are available to them. (R9)**

Information about Assessments Provided to Clients

A number of people complained to us that their regional health authority had refused to give them a copy of their own home and community care assessment, telling them they would have to request it under the *Freedom of Information and Protection of Privacy Act (FOIPPA)*.

In the course of investigating these complaints, we confirmed that the Interior, Fraser, Vancouver Island and Vancouver Coastal health authorities require people to use the *FOIPPA* process to access their own assessment information. In addition, Northern Health reported that it does not routinely provide seniors with copies of their home and community care assessments because the assessments are difficult to understand. However, Northern Health stated that it believes an assessment is the senior's information, and that a case manager would explain an assessment to a senior and his or her family if requested to do so.

It is unreasonable for the health authorities not to provide seniors with copies of their assessments and to require seniors to submit a freedom of information request to obtain a copy because seniors have a right to understand the information on which decisions about their care is based.

I have recommended that the health authorities offer seniors copies of their home and community care assessments. In any case where health authorities believe that providing the complete assessment would harm a senior's health, they should provide an edited copy. (R10)

Fees and Fee Waivers

After a health authority decides that a senior is eligible for subsidized service, its staff calculate how much the senior will have to pay to receive the home support, assisted living or residential care services it has identified the senior as needing.

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If a senior or the senior's spouse experiences serious financial hardship as a result of an assessed fee, the senior can apply for a temporary reduction or waiver. Unfortunately, not everyone is aware of this option. We received complaints from seniors who said that even after they expressed concern during the application process about their ability to pay, health authority staff did not tell them they could ask to have their fees reduced or waived.

> **I have recommended that the Ministry of Health and the health authorities include information about how to apply for fee reductions and waivers when they mail fee notices to clients who receive subsidized home and community care services, and that they look for other opportunities to make this information accessible in a timely manner to those who need it. (R11)**

We also asked the health authorities how many fee reduction applications they received in 2008/09 and 2009/10 from home support, assisted living and residential care clients, and how many they approved.

The Interior Health Authority does not track the number of applications it receives, but since February 2010 it has been tracking the number of approvals by program area. As of July 2010, Interior Health had approved a total of 105 fee reductions. The Fraser Health Authority provided us with information from 2008/09 and 2009/10 that indicated that it had approved 95 per cent of the applications it received for reductions to residential care fees, and 91 per cent of applications it received for reductions to assisted living fees.

None of the other three health authorities — Northern, Vancouver Coastal or Vancouver Island — tracks this information and so could not respond to our request.

The Ministry of Health's Definition of Hardship

According to Ministry of Health policy, a senior experiences "serious financial hardship" if paying the "client rate" means that the senior or the senior's spouse is unable to pay for shelter, food, heating, prescribed medication or other prescribed health care services.

Source: Ministry of Health, *Home and Community Care Policy Manual*, April 2011, 7.D.

If each health authority tracked the number of fee reduction applications received and the number granted and denied by program area, the information could assist the ministry when it is considering adjustments to rates for home and community care services.

> **I have recommended that the health authorities track the number of fee reduction applications they receive, approve and deny, and report this information to the Ministry of Health to assist the ministry in evaluating the capacity of seniors to pay home and community care fees. (R12)**

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Equally important is making decisions on applications for fee reductions in a timely manner. For example, in early 2010, the ministry directed the health authorities to begin charging a daily fee of $29.40 to people receiving convalescent care. This type of care is temporary and is commonly referred to as "short-term residential care." It is often required after people are discharged from an acute care hospital, and means that those receiving convalescent care will normally still have their own shelter costs too, such as mortgage or rent payments. Having to pay convalescent care fees can therefore quickly cause serious hardship, and so the opportunity to apply for a reduction — and have the application considered quickly — is important.

> **I have recommended that the Ministry of Health establish a reasonable time limit within which health authorities must decide and respond in writing to fee reduction applications. (R13)**

Sponsored Immigrants

Sponsored immigrants are people who have been sponsored by a close relative to immigrate to Canada. Between 2005 and 2009, 5,733 new immigrants who were 65 years of age and older came to British Columbia; 86 per cent of them were sponsored by their families.[8] To obtain permanent resident status (formerly called "landed immigrant status") a sponsored immigrant's relative to sign a financial support agreement called an "undertaking."

A significant issue that we looked into during this investigation was eligibility of sponsored immigrants for home and community care services and the fees they are charged. As with most other seniors' care issues, health authorities make the day-to-day decisions about eligibility and fees in this area, but they are guided in these tasks by provincial legislation and the overarching policies set by the Ministry of Health. Until April 2011, an unfair distinction existed between sponsored immigrants and other permanent residents and citizens regarding the payment of fees and eligibility.

While this issue has been largely resolved, it remains a useful reminder of some of the challenges that newer members of British Columbia's communities can face. It also highlights the importance of ensuring that all of the province's citizens are treated in a fair and equitable manner.

Eligibility Policy

Although all permanent residents are eligible for subsidized home and community care, a previous version of the ministry's policy manual stated that permanent residents who were sponsored immigrants were *not* normally eligible during the period covered by their undertaking. This period

8 Figures calculated based on information from Ministry of Regional, Economic and Skills Development, *Immigrant Seniors in British Columbia,* December 2010 <http://www.welcomebc.ca/local/wbc/docs/communities/fact-seniors-2010.pdf>.

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lasted three years for a spouse and ten years for a parent. Sponsored immigrants could be exempted from this policy (and thus receive subsidized care) only under one of two conditions. The first condition was if the sponsor was found to be unable to meet financial obligations. The second was if a sponsored immigrant was assessed as being in need of "extended care" services. If one of the conditions did not apply, the sponsored immigrant would have to pay the full unsubsidized rate.[9]

In September 2009, the ministry explained to us that the policy meant that any sponsored immigrant assessed as requiring a of level of care equal to "extended care" (high care need intensity) was considered eligible for subsidized home and community care services, but had to pay the maximum rate. This policy was in effect until April 1, 2011, when the current version of the ministry's policy manual replaced it.

Section 6(2) of the *Continuing Care Act* permits operators to charge amounts in excess of the rate prescribed by regulation when the minister has directed this or when permitted in an agreement made with the operator. Although health authorities were charging sponsored immigrants rates in excess of the rate prescribed, the Minister of Health had not issued any directives authorizing this practice. The ministry confirmed that the previous *Home and Community Care Policy Manual* and the draft sponsorship manual were not considered directives made under section 4(4) of the *Continuing Care Act.*

Although, under section 6(3) of the Act, cabinet also has the power to make regulations that set different rates for different classes of home and community care clients, it has never done so for sponsored immigrants. Despite this the ministry's previous *Home and Community Care Policy Manual* set out a specific and separate process for determining the rates charged to sponsored immigrants when the sponsor was unable to fulfill his or her obligations.

After our office asked the Ministry of Health questions about the eligibility of sponsored immigrants for home and community care services, and the costs that they were charged for those services, the ministry changed its eligibility policy to eliminate the distinction between sponsored immigrants and other permanent residents and citizens. The change is reflected in the April 2011 version of the *Home and Community Care Policy Manual*.

These changes are welcome, but the fact remains that from at least March 1997 until April 1, 2011, the policies and practices of the ministry and the health authorities regarding sponsored immigrants had no basis in legislation and were unclear.[10] The practices were not only unfair in principle, but they also increased the likelihood that sponsored immigrants would be unable to access the care they needed and were entitled to receive.

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9 Ministry of Health Services, *Home and Community Care Policy Manual*, March 1992, Client Access: Eligibility, 2.A, 1-2.

10 While we are unable to pinpoint the date the ministry's practice on sponsored immigrants began, it was clearly outlined as a practice expectation for assessors as of March 1997, the date of the draft sponsorship manual that the ministry provided to us in September 2009.

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The ministry has corrected the situation by eliminating the distinction between sponsored immigrants and other permanent residents and citizens when it comes to eligibility and rates charged for home and community care services. While this is a very positive step, some sponsored immigrants will have already felt the financial consequences of the ministry's former policy.

> **I have recommended that the Ministry of Health establish a process that permits any sponsored immigrants charged home and community care fees between March 31, 1997, and April 1, 2011, to apply to the ministry for a review of the fees paid and, where appropriate, a reimbursement for excess fees paid. (R14)**

Complaints

People who want to complain about home and community care services are faced with many choices about how to proceed. Bringing concerns or problems to the attention of the staff who provided the service is usually the first step, and may result in a quick resolution without the need to involve senior staff. However, there are times when discussing a complaint with front-line staff is not possible, appropriate or sufficient.

If the complaint involves someone who receives subsidized home and community care services, taking it to that person's case manager at the regional health authority is usually the next step.

Another option is to complain to the regional patient care quality office. If not satisfied with that office's response, a person may pursue the complaint by taking it to the regional patient care quality review board. Both of these options became available in October 2008, when the provincial government brought in a new piece of legislation called the *Patient Care Quality Review Board Act.*

Patient Care Quality Offices and Review Boards

Patient care quality offices and patient care quality review boards were created in 2008 by the *Patient Care Quality Review Board Act.* Under this Act, each health authority must establish a patient care quality office (PCQO) to receive and process complaints about care quality in its jurisdiction.[11] A care quality complaint is defined in the Act as a complaint about the delivery of, or the failure to deliver, health care or a related service, or a complaint about the quality of health care or a related service.[12]

Complaints to a PCQO must be submitted by a person who received the care in question or by someone acting on his or her behalf. Complaints cannot be submitted anonymously.

[11] *Patient Care Quality Review Board Act,* S.B.C. 2008, c. 35, s. 2.

[12] *Patient Care Quality Review Board Act,* S.B.C. 2008, c. 35, s. 1.

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The limitation on who can submit a complaint to a PCQO prevents some individuals and groups from accessing this process. The ministry informed our office that in addition to responding to care quality complaints, the PCQOs can "respond to a broader range of inquiries and complaints," including complaints from family councils who wish to raise a general care quality issue about a facility. However, the Act has not been changed to reflect this understanding of the ministry. If the ministry intends PCQOs to be able to respond to a broader range of complaints this change needs to be clarified through amendments to the Act.

> **I have recommended that the Ministry of Health take the steps necessary to ensure that patient care quality offices can respond to broader range of complaints, including complaints from resident and family councils. (R15)**

Once PCQO staff have received a complaint, a ministerial directive issued under section 6(1)(d) of the *Patient Care Quality Review Board Act* requires them to acknowledge the complaint and inform the complainant of the next steps of the process within two business days.[13] As soon as possible the PCQO must confirm that the complaint is within its jurisdiction, and if it is, then proceed with recording the steps of the investigation and relevant documents, and engage the complainant and other affected parties. The complaint management process must be completed within 30 business days, unless the complainant agrees to an extension. If an extension is granted, the PCQO must update the complainant no less than once every 20 business days. Finally, the PCQO must inform the complainant about the result of the process. According to the Ministry of Health, the PCQOs must communicate back to complainants even if they cannot resolve a complaint.

A person who is not satisfied with how a patient care quality office has handled his or her complaint has the option of taking that complaint to the regional patient care quality review board (PCQRB). As with PCQOs, there is a separate PCQRB for each health authority. The PCQRBs differ from the PCQOs in that they are accountable directly to the Minister of Health and operate independently of the health authorities. Each board consists of four to six members, including a chair, and are appointed by the Minister of Health.

One of the most significant difficulties with the current complaints process is the lack of consistent province-wide guidelines for how the PCQOs actually process complaints. Neither the Patient Care Quality Review Board Act nor the Minister's directive provide adequate guidance on how the patient care quality offices should respond to complaints or what information they should consider before attempting to resolve them. A consistent province-wide process would include a definition and examples of the steps that PCQOs must take to respond to complaints.

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[13] Ministry of Health, ministerial directive under Section 6(1)(d) of the *Patient Care Quality Review Board Act*, undated.

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In the absence of a well-defined process for responding to complaints, and working with limited resources, PCQOs often refer complaints back to the health authority staff who were involved in providing the care in question and then communicate their response to the complainant. In the files we reviewed, we observed that PCQO staff did not consistently analyze the issues or make their own determinations of whether the responses offered were appropriate. This practice is consistent with the wording in the Act which indicates that the role of the PCQOs is to process complaints rather than investigate. This approach creates a disconnect between what the public expects is a new review and what actually happens.

While PCQOs are required to report the outcome of a complaint to the complainant, they are not required to do so in writing. Adding a requirement to report the outcome of a complaint in writing would assist complainants in understanding the result of their complaint and help them in deciding whether they wish to proceed to a review.

> **I have recommended that the Ministry of Health provide specific direction to the patient care quality offices (PCQOs) on the steps they should follow in processing care quality complaints. (R16)**
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> **I have recommended that after the PCQOs and patient care quality review boards have been fully operational for five years, the Ministry of Health review its complaint-handling processes and implement any improvements that arise in the course of this review. (R17)**
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> **I have recommended that the Ministry of Health develop and make public a clear policy to guide the patient care quality review boards on when they should treat review requests as urgent. (R18)**
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> **I have also recommended that the health authorities provide clear and consistent information to the public on how the PCQOs respond to complaints and the complaints they will consider; that the health authorities ensure that PCQOs carefully document the steps taken in response to a complaint as set out in the ministerial directive; and that the health authorities ensure that PCQOs inform all complainants in writing about the outcome of their complaint. (R19, R20, R21)**

Need for Advocacy and Support

Advocacy and support play a critical role in a system where seniors are vulnerable and face barriers to raising concerns. Currently, with the exception of the role played by resident and family councils, advocacy and support do not have a clearly defined role in home and community care services.

Access to advocacy and support is an essential complement to an effective complaints process when complainants face physical and cognitive challenges and are highly dependent on the services they receive and the individuals that they may complain about.

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As we noted in *The Best of Care: Getting It Right for Seniors in British Columbia (Part 1)*, not all seniors have family or friends who can advocate for or support them when care concerns arise. Without advocacy and support, the concerns of these seniors may never be raised or addressed.

Advocacy is necessary for seniors, to ensure that their voices are heard, their rights are respected and their needs are met.

> **I have recommended that the Ministry of Health establish a program to provide support for seniors and their families to navigate the home and community care system and bring forward concerns and complaints by January 2013. (R22)**

Training and Qualifications for Community Health Workers

Community health workers, often referred to as home support workers, care aides or resident care attendants, are on the front lines of seniors' care. They provide care and help seniors with daily activities such as getting up, washing, dressing, eating, going to the bathroom and moving around. They work in private homes, assisted living residences and residential care facilities.

Education and Training

In 2007, a cross-section of home and community care managers and educators began to modernize the curriculum for community health worker programs. The ministry supported this project and the new curriculum was completed in 2008. The Ministry of Advanced Education told us that all 16 public post-secondary institutions offering training programs for community health workers now follow the new curriculum.

In addition to the public institutions, 30 of the private institutions that offer these training programs have signed licensing agreements allowing them to use the curriculum. However, private colleges can still use any curriculum they wish and are not required to use the one endorsed by the ministry. This means that students in private institutions may graduate without the training and skills that the ministry requires public institutions to provide.

Given the effort invested in overhauling the curriculum and the fact that graduates from both types of program provide care and support to seniors in British Columbia, it is unclear to me why the government has not required both public and private institutions to use it. It would provide certainty that all community health workers receive the same level of training.

> **I have recommended that the Ministry of Health work with the Ministry of Advanced Education to require all institutions offering training for community health workers to use the approved new curriculum commencing in September 2013. (R23)**

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Registration

In January 2010, the Ministry of Health announced the creation of the BC Care Aide & Community Health Worker Registry.[14] Every community health worker employed by a publicly funded organization providing home support, assisted living or residential care services must be registered.

All publicly funded agencies that provide care to seniors are obligated to send a written report to the registry each time one of these employees is suspended or terminated on the grounds of alleged abuse.[15] When the registry receives such a report, it suspends that employee's registration. Registration cannot be reinstated until the person is cleared by an investigation conducted by the employer, or by another process overseen by the registry.

While the provincial government has encouraged all community health workers who provide care for seniors to register, currently it is only those who work for publicly funded agencies and facilities who are actually required to register as a condition of employment. In the January 29, 2010, news release announcing the creation of the registry, the government indicated that it intended for the registry to eventually cover community health workers at all agencies and facilities.

> **I have recommended that the Ministry of Health, by January 2013, require care aides and community health workers at all home support agencies, assisted living residences and residential care facilities to register with the BC Care Aide & Community Health Worker Registry. (R24)**

The current registration process also does not specifically require applicants to disclose their disciplinary record. This means that people who have a disciplinary record that includes suspension or termination on the grounds of abuse could be able to register.

> **I have recommended that the Ministry of Health require applicants to the BC Care Aide & Community Health Worker Registry to disclose whether they have ever been disciplined or terminated by a health care employer on the grounds of abuse, and establish a process for evaluating whether it is appropriate to allow registration. (R25)**

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14 BC Care Aide & Community Health Worker Registry, "Home" <http://www.cachwr.bc.ca/>.

15 The definition of abuse used by the registry is the same as the definition in the *Residential Care Regulation* of the *Community Care and Assisted Living Act*, which states, "A licensee must ensure that a person in care is not, while under the care or supervision of the licensee, subjected to (a) financial abuse, emotional abuse, physical abuse, sexual abuse or neglect as those terms are defined in section 1 of Schedule D, or (b) deprivation of food or fluids as a form of punishment" *Residential Care Regulation,* B.C. Reg. 96/2009, s. 52(1). The obligation of a contracted agency to report disciplinary actions taken to address instances of abuse to the registry is part of the agency's contract with the ministry.

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Criminal Record Checks

Under the *Criminal Records Review Act*, certain employers are required to ensure that every person they intend to hire for work involving "vulnerable adults" undergos a criminal record check.[16] A criminal record check is a record search conducted by a police department to determine whether a person has ever been convicted of a crime.[17] The Criminal Records Review Program within the Ministry of Public Safety and Solicitor General is responsible for processing and investigating criminal record checks under the Act to determine whether a person may pose a risk of physical, sexual or financial abuse to vulnerable adults.

Previously, such checks were required only for people working with children. However, the Act was amended on January 1, 2011, and now requires criminal record checks for people who work with vulnerable adults when they are employed by certain types of health care providers.[18]

While these amendments are a positive step, they still do not require that prospective or current employees of private hospitals or home support agencies that do not receive public funding to undergo criminal record checks as a condition of working with vulnerable adults, including seniors.

> **I have recommended that the Ministry of Health, in consultation with the Ministry of Solicitor General, take all necessary steps by June 2013 to ensure that all persons who work with vulnerable adults in home support agencies and private hospitals are required to obtain criminal records checks as a condition of employment. (R26)**

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16 *Criminal Records Review Act,* S.B.C. 1996, c. 86, s. 9. "Employer" is defined for the purposes of the Act under section 1.

17 The fee payable for a criminal record check is $20. *Criminal Record Check Fee Regulation,* B.C. Reg. 238/2002, s. 1(1).

18 *Criminal Records Review Act,* S.B.C. 1996, c. 86, s. 1. Under s.1 of the Act, a "vulnerable adult" is defined as "an individual 19 years or older who receives health services, other than acute care, from a hospital, facility, unit, society, service, holder or registrant." Section 1 of the Act also separately defines "work with vulnerable adults" as working with vulnerable adults directly or (potentially) having unsupervised access to them in the course of work or education.

Home and Community Care

Reporting and Responding to Allegations of Abuse and Neglect

Seniors who are receiving home and community care services are vulnerable because they require some level of care. This is true whether they are receiving home support services in their own homes or are being cared for in assisted living or residential care facilities. This vulnerability means that those who oversee and provide care for seniors have a duty to protect them from harm.

The *Adult Guardianship Act (AGA)* allows — but does not require — people to report the suspected abuse or neglect of a vulnerable adult. The fact that those who work with seniors are not required to report suspected abuse or neglect does not accord with the important role these people play in protecting seniors

> **I have recommended that the Ministry of Health take the necessary steps to require staff providing care to seniors to report information indicating that a senior is being abused or neglected to the regional health authority. (R27)**

Another gap in the system of protections for seniors is in facilities governed by the *Hospital Act.* Under the *Community Care and Assisted Living Act (CCALA)* and the *Residential Care Regulation* operators are required to report instances of emotional, financial, physical and sexual abuse to the resident's family and doctor, the community care licensing office, and to a representative of the funding program if applicable. The *Hospital Act* does not include provisions that are equivalent to these reportable incident requirements in the *Community Care and Assisted Living Act* and *Residential Care Regulation*. This means that residents of the province's more than 100 facilities governed by the *Hospital Act* do not benefit from the same level of protection as residents of facilities licensed under the *CCALA*.

> **I have recommended that the Ministry of Health take the necessary steps to require operators of residential care facilities governed by the *Hospital Act* to report instances of abuse and neglect of residents. (R28)**

We asked the health authorities to tell us how many times they had provided emergency assistance to an adult under the *AGA* since it came into force in 2000. They were not able to do so because they only document these investigations in individual case files and do not have a way of tracking the overall number they conduct. It is therefore not possible to determine how many reports of abuse or neglect of adults the health authorities receive or whether that number is going up or down from year to year.

Home and Community Care

On a broader level, health authorities would be better informed and positioned to respond to the abuse and neglect of seniors if they had accurate and current information on the extent of the problem. While it is important to record incidents of abuse and neglect in individual client files, each of the health authorities should track this information on a regional basis. This would help identify systemic problems and inform potential solutions.

> **I have recommended that the health authorities track the number of incidents of abuse and neglect investigated in their region and the number of support and assistance plans implemented in response to their investigations of these reports. (R29)**

Also lacking are clear guidelines for when health authorities should report incidents of abuse or neglect to the police. This means that health authorities may not be making appropriate or consistent decisions about when to report potential criminal offences.

> **I have recommended that the Ministry of Health require service providers to immediately notify the police of all incidents of abuse and neglect that may constitute a criminal offence. (R30)**

> **I have recommended that the Ministry of Health work with the health authorities to develop provincial guidelines on when service providers should report incidents of abuse and neglect to the police. (R31)**

Protecting Seniors in Care from Financial Abuse

Seniors who receive care from paid caregivers often form strong attachments to those people and may want to demonstrate their appreciation through gifts. These gifts are usually offered freely and without coercion, but not always. Because seniors in care are vulnerable to financial exploitation, they need protection. Both the *Community Care and Assisted Living Act (CCALA)* and the *Hospital Act* provide some protection from financial abuse for residents of facilities that are governed by these acts.

Under the *CCALA,* facility operators and their employees must not induce or persuade a resident to give them something that would benefit either themselves or their relatives or friends. The Act makes doing so an offence for which a person can be fined up to $10,000.[19] In addition, any gifts or changes to an adult's will that benefit a facility operator or a person working for the operator are void unless the public guardian and trustee has consented to them in writing.[20] Similar provisions exist in section 4.1 of the *Hospital Act.*[21]

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[19] *Community Care and Assisted Living Act,* S.B.C. 2002, c. 75, s. 18(3); s. 33.

[20] *Community Care and Assisted Living Act,* S.B.C. 2002, c. 75, s. 18(4).

[21] *Hospital Act,* R.S.B.C. 1996, c. 200, s. 4.1. The *Hospital Act* provisions regarding financial abuse do not apply to those in acute care.

Home and Community Care

No such provisions apply to those in assisted living residences or receiving home support services. Given that seniors who are receiving care in their own private homes may be even more vulnerable to financial abuse than those who receive more closely supervised care in regulated facilities, the rationale for this exclusion is not clear.

> **I have recommended that the Ministry of Health take the steps necessary to ensure that seniors who receive home support services or live in assisted living residences have the same level of legal protection from financial abuse as those who live in residential care facilities. (R32)**

Protecting Those Who Report Concerns

People in care rely on their caregivers for some or all of their most basic needs. They are vulnerable and may be unable to report concerns due to physical or cognitive challenges. Friends and family members of a person in care may be able to complain on a senior's behalf, but they may not know that there is a problem. Employees who provide care to seniors, especially those who provide front-line services, are well placed to observe problems. Ideally, staff feel free and welcome to report any concerns or issues they observe. However, some may be reluctant to speak up if they fear that doing so could undermine their job security.

Any fear of retaliation, whether well-founded or not, either against the person in care or against the person making the complaint, has a chilling effect on the reporting of concerns. It is critical that people feel secure in registering concerns. Unfortunately, the current legislative framework provides an incomplete set of protections for persons in care and other complainants. The scope and nature of protection varies depending on the type of services provided, the type of subject matter of complaint, and who is making the complaint.

The *Adult Guardianship Act* provides protection for those who report concerns about the abuse or neglect of adults, including seniors who are receiving home support, assisted living or residential care services, where the seniors themselves are unable to seek action. The *Community Care and Assisted Living Act (CCALA)* provides additional protection for anyone who reports abuse or neglect that takes place in a licensed residential care facility. However, these additional protections apply only in a residential care facility licensed under the *CCALA.* Staff of *Hospital Act* facilities do not receive the same protection. In fact, there are no legislated protections for employees or agents who raise a concern or complaint other than about abuse or neglect.

Residents who live in *CCALA* – licensed facilities are protected against adverse consequences for making complaints by both the *Residential Care Regulation* and the Residents' Bill of Rights, while residents who live in residential care facilities licensed under the *Hospital Act* receive the benefit of only the Residents' Bill of Rights. Seniors who receive home support or assisted living services are not similarly protected.

Home and Community Care

There is no legislative provision that applies to all people — residents, employees and others — who raise any type of concern or complaint about home and community care services, and that protects both the person receiving services and the person making the complaint. This patchwork approach to legislated protections is highly problematic.

In my view, the Ministry of Health in British Columbia should ensure that everyone who in good faith raises concerns or complaints about the care provided to seniors is protected from reprisals.

> **I have recommended that the Ministry of Health take the necessary steps to provide comprehensive legal protection from adverse consequences for anyone, including staff, who makes a complaint in good faith about home and community care services. (R33)**

Home Support

Program Overview

Home support services are intended to help seniors live independently in their homes and communities for as long as they can safely do so. Home support workers, also referred to as community health workers, help seniors with daily activities such as getting up and around, getting dressed, using the bathroom, preparing meals and taking medications. In addition to these services, home support may include safety maintenance activities and specific nursing and rehabilitation tasks that have been delegated by other health professionals.[22] Currently, services such as housekeeping, yard maintenance, grocery shopping and transportation are not generally available through the provincial home support program.

Home support services are meant to supplement the care that families and others provide.[23] In 2009/10, at least 24,724 seniors were receiving subsidized long-term home support services in British Columbia.[24]

Services may be provided by employees of health authorities or by other organizations (non-profit or for-profit) under contract to a health authority. Seniors who do not qualify for subsidies can arrange to receive home support services directly from a private provider.[25]

In 2009/10, the regional health authorities spent a total of about $339 million providing subsidized home support services throughout British Columbia. It typically costs the health authorities $30 to $40 to provide each hour of subsidized home support.

Health authorities use a formula set by regulation to calculate how much subsidized home support clients will be charged. The formula is based on income tax information from the previous year. Currently, under this formula, about 71 per cent of home support clients pay nothing to receive these services; 3 per cent pay up to $10 per day; 6 per cent pay between $10 and $20 per day; 20 per cent pay more than $20 per day; and seniors with earned income pay a maximum of $300 per month for home support.

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22 Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Home Health Services: General Description and Definitions, 4.A.

23 Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Overview: Home and Community Care Services, 1.A.

24 Because of incomplete data submissions from the Interior Health Authority and Vancouver Coastal Health Authority to the Ministry of Health for 2009/10, this measure may be understated.

25 Individuals in British Columbia may choose to privately purchase various services that are similar in nature to the subsidized home support services.

Home Support

Changes in Home Support Policy

Provincial policy on access to home support and on the range of services available under the home support program has changed over the past 30 years. The provincial government recognized home support as a health program in 1978.

Home Support from the 1980s to the 2000s

In the 1980s, the goal of the program was "to provide personal assistance with activities of daily living and/or essential household tasks which the client was unable to perform independently."[26] Home support workers (then referred to as "homemakers") were responsible for cleaning, grocery shopping, cooking, bathing and providing help using the bathroom. They also helped seniors with general hygiene, walking, transferring, feeding, nail and skin care, and medication. Shopping and home maintenance tasks such as chopping firewood, removing garbage and shovelling snow could be authorized on an exceptional basis.[27]

In 1992, the provincial government began making changes to home support policies. Significant changes included elimination of meal preparation, transportation and housekeeping services that had been part of the program before.[28] Housekeeping could only be provided as a stand-alone service on an exceptional basis.

The provincial government's revised 1999 policy marked the first significant shift toward reliance on community-based programs. The health authorities were told to develop voluntary community support for services such as grocery shopping, home maintenance, hospice care and transportation.

In 2002, the provincial government and health authorities announced that the home and community care program would be redesigned over the next three years. The stated purpose of doing so was, in part, to address the need for a broader range of care options and to avoid the unnecessary institutionalization of seniors. Central to the redesign was expanding the home support program and creating the assisted living program.[29]

In October 2005, the government established the Premier's Council on Aging and Seniors' Issues and tasked it with identifying how society can support the participation, health and well-being of older people in British Columbia.

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26 Canadian Centre for Policy Alternatives, *From Support to Isolation: The High Cost of BC's Declining Home Support Services*, June 2006, 15.

27 Ministry of Health and Ministry Responsible for Seniors, *Service Provider Policy Handbook,* December 1987, Home Support Services: Homemaker Agency, 5.A.

28 Ministry of Health Services, "Home Support," fact sheet, 2008.

29 Ministry of Health Services, "Home and Community Care Redesign," fact sheet, 4 February 2008.

Home Support

The council issued its report and recommendations to government in November 2006. The report said that "the support services currently available to older British Columbians in their communities fall well short of meeting the needs of some older people.[30] The council recommended that:

> The B.C. government introduce a new broader and more widely available home support system by providing a wider range of home support services, including cleaning and home maintenance (culturally specific where appropriate, such as with meal preparation) to people who are unable to carry out these tasks on their own.[31]

As well, the council recommended that, as a preventive measure, home support be made available to people with lower care needs.[32]

In September 2008, the government created the Seniors' Healthy Living Secretariat and made it responsible for developing models for non-medical home support services. Since its establishment in September 2008, the Seniors' Healthy Living Secretariat has been working with the United Way of the Lower Mainland to create a pilot program called Community Action for Seniors' Independence (CASI). CASI began with projects in five communities across the province: Dawson Creek, Maple Ridge, Osoyoos, Surrey (Newton) and Vancouver (Renfrew-Collingwood). The five pilot projects are expected to be completed by May 2012. As of November 2011, a total of 738 seniors were registered to receive non-medical home support services through the CASI program and 562 had received services, the most common services being transportation to medical appointments and shopping, housekeeping and friendly visiting. Other services provided include snow shovelling, yardwork, home maintenance and information/referral services.

Other Models

While it may be necessary to find and create new ways of delivering non-medical home support, it is also useful to learn from existing models. The Premier's Council on Aging and Seniors' Issues noted that the Veterans Independence Program provides expanded personal care, meal assistance, housekeeping, transportation and outdoor maintenance services.

Across Canada, nine provinces and territories include housekeeping services (also known as homemaking, household management or domestic help services) as part of their home support program.

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30 Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, iii <http://www.gov.bc.ca/seniors/documents/pdf/aging_well_in_BC.pdf>.

31 Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, 56.

32 Premier's Council on Aging and Seniors' Issues, *Aging Well in British Columbia*, 2006, 52.

Home Support

Analysis

Although the Seniors' Healthy Living Secretariat has been working in this area, it is significant that the Community Action for Seniors' Independence (CASI) model, the only home support initiative that has come out of the Premier's Council on Aging report, is identified by the government as "not a government program."

While the objective of the provincial home support program is clear — to help clients to live in their own homes as long as it is practical and in their and their families' best interests — the reality is that the current limitations on services means many seniors are not receiving the support that they need to do that.

As most seniors want to remain in their own homes as long as this remains a safe and viable option, making a broader range of home support services available would help achieve this objective. Moreover, because providing home support usually costs much less than providing care in an assisted living or residential care setting, expanding the home support program would also appear to make fiscal sense.

I have recommended that the Ministry of Health:

- **analyze whether the current home support program is meeting its goal of assisting seniors to live in their own homes as long as it is practical and in their and their families' best interests and make any necessary changes**
- **evaluate the home support eligibility criteria to ensure that they are consistent with program goals and make any necessary changes**
- **analyze the benefits and costs of expanding the home support program up to the cost of providing subsidized residential care when it is safe and appropriate to do so**
- **report publicly on the results of this analysis and evaluation by October 2013 (R34)**

The Number of Seniors Supported

In 2010, there were approximately 677,770 seniors in British Columbia.[33] The provincial population of seniors has grown by nearly 20 per cent since 2002.[34] The number of seniors over 75 years of age rose 18 per cent in the period July 1, 2002, to July 1, 2008.[35] Given this

[33] BC Stats, "Population Estimates — Standard Age Groups" <http://www.bcstats.gov.bc.ca/data/pop/pop/dynamic/ProvPop/Query.asp?category=Prov&type=1&topic=Estimates>.

[34] There were 548,907 people over 65 on July 1, 2002, and 656,335 on July 1, 2009. BC Stats, "Population Estimates — Standard Age Groups" <http://www.bcstats.gov.bc.ca/data/pop/pop/dynamic/ProvPop/Query.asp?category=Prov&type=1&topic=Estimates>.

[35] BC Stats, "Population Estimates — Standard Age Groups" <http://www.bcstats.gov.bc.ca/data/pop/pop/dynamic/ProvPop/Query.asp?category=Prov&type=1&topic=Estimates>.

Home Support

steady growth and the government's goal of supporting seniors to live independently for as long as possible, we expected to find that the number of people receiving home support services would steadily increase. However, the table below shows, this has not been the case.

Table 1 – Seniors Receiving Subsidized Long-Term Home Support Services, Including Choice in Supports for Independent Living (CSIL), 2002/03 to 2010/11[1]

Health authority*	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
FHA	8,095	7,991	7,725	7,403	8,216	9,671	9,435	8,599	Not available
IHA[2]	5,146	5,157	5,069	6,503	6,240	6,139	5,929	4,695	Not available
NHA	1,426	1,031	1,007	1,001	899	892	881	813	Not available
VCHA[3]	7,964	6,862	6,085	6,173	6,525	5,784	4,581	3,200	Not available
VIHA	6,508	6,618	6,590	6,753	7,274	7,874	8,294	7,417	Not available
Provincial total[4]	**29,139**	**27,659**	**26,476**	**27,833**	**29,154**	**30,360**	**29,120**	**24,724**	Not available

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

1 Data provided by the Ministry of Health

2 Due to incomplete data submissions to the Ministry of Health by the IHA for 2008/09 and 2009/10, some measures may be understated.

3 Due to incomplete data submissions to the Ministry of Health by the VCHA for 2008/09 and 2009/10, some measures may be understated.

4 Due to incomplete data submissions to the Ministry of Health by the IHA and VCHA for 2008/09 and 2009/10, some provincial measures may be understated.

The overall number of seniors in British Columbia who received subsidized home support services increased from 29,139 in 2002/03 to 30,360 in 2007/08, the only years for which we were provided complete data. This is an increase of 1,221 seniors (4 per cent). During that same period, seniors consistently accounted for about 84 per cent of long-term home support clients.

The total number of hours of home support services provided to seniors increased from 5,368,191 in 2002/03 to 5,948,085 in 2007/08, an increase of 579,894 hours (11 per cent). The long-term home support hours provided to seniors between 2002/03 and 2009/10 made up about 69 per cent of the total hours provided to all long-term home support clients.

Home Support

Assessment, Eligibility and Access

All British Columbia residents, or persons acting on behalf of residents, can apply to receive subsidized home support services from their regional health authority. While being a senior is not a condition of eligibility for home support, seniors are the majority of home support clients.

When someone submits an application, a health professional, usually a case manager, visits that person at home to conduct an assessment.[36]

To be eligible for home support, applicants must have been assessed by the health authority as being in need of personal assistance and/or of respite for their caregiver, and must have agreed to pay the assessed client rate.[37] They must also meet the citizenship and residency requirements described in the Home and Community Care section of this report.[38]

Each health authority has developed guidelines for staff to use when deciding which home support services and how many service hours each client will receive. These guidelines all state that home support services are not intended to replace the support that others may be able to provide for clients and that all other options must be explored before making decisions about home support services.

The guidelines that the Vancouver Coastal and Fraser health authorities provided us with were more comprehensive than those we received from the Vancouver Island, Interior or Northern health authorities and included standard time allotments for various activities.[39] We noted that Vancouver Coastal Health generally allowed more time for various tasks than Fraser Health did. For example, Vancouver Coastal Health allots 30 minutes for meal preparation, while Fraser Health allots 10 minutes, including cleanup.

In addition to using these guidelines, health professionals rely on their clinical judgment to determine the home support tasks that need to be included in each person's care plan. However, it is difficult to understand why the amount of time that it is considered necessary to safely perform a home support task should vary by region. While there may be a few exceptions in which this variation is justified, overall these variations illustrate the need for provincial standards for home support services.

> **I have recommended that the Ministry of Health work with the health authorities to develop a consistent province-wide process for determining adequate time allotments for home support activities. (R35)**

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[36] The Ministry of Health's *Home and Community Care Policy Manual* defines "health professional" as a registered nurse, registered psychiatric nurse, licensed practical nurse, occupational therapist, physiotherapist or social worker.

[37] Ministry of Health, *Home and Community Care Policy Manual,* April 2011, Home Health Services: Home Support Services, 4.B.

[38] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Eligibility, 2.B.

[39] After our review of the health authorities' guidelines, Interior Health informed us that it has been using an adaptation of Fraser Health's guidelines for the time allotment for tasks since April 2011.

Home Support

Waiting for Service

When we asked each health authority how long it takes for their clients to begin receiving home support services after being assessed and approved for those services, we learned that this information is not consistently tracked across the province. However, based on the information we were able to gather, we found that in some communities the home support system is flexible enough to provide same-day service for those with an urgent need — but in most cases, seniors wait up to three weeks after being assessed and approved to begin receiving services. The ministry has not set a time frame or target for the delivery of home support services after assessment.

The inconsistent tracking of waiting times makes it impossible to know if, and for how long, seniors are waiting for home support services. Seniors who receive subsidized home support services have been determined to be at risk and in need of some care so it is important that they and their families know how long they can expect to wait for the help that they need. Establishing a time frame for waiting for service after assessment and measuring the health authorities' efforts to meet that time frame would be an important step towards offering more consistent and transparent service.

> **I have recommended that the Ministry of Health set a time frame within which eligible seniors are to receive home support services after an assessment; that the health authorities track the time it takes for seniors to receive home support services after assessment and report the average and maximum times that eligible seniors wait to receive subsidized home support services to the ministry quarterly; and that the ministry report annually to the public on the average and maximum time that eligible seniors wait to receive subsidized home support services after assessment. (R36, R37, R38)**

Cost of Receiving Services

In 2009/10, about 71 per cent of subsidized home support clients in British Columbia received their home support services free of charge. Seniors are not required to pay for home support services if they receive any of the following: the Guaranteed Income Supplement or spouse's or survivor's allowance provided under the *Old Age Security Act*; income assistance provided under the *Employment and Assistance Act*; disability assistance provided under the *Employment and Assistance for Persons with Disabilities Act*; or a war veteran's allowance paid under the *War Veterans Allowance Act*.

Among the 29 per cent of home support clients who paid for home support services in 2009/10, 3 per cent paid up to $10 per day, 6 per cent paid between $10 and $20 per day, and 20 per cent paid more than $20 per day.[40] Seniors and other home support clients who are not eligible for a subsidy must pay the full costs of services, which is typically $30 to $40 per hour, using their own funds.

[40] Ministry of Health letter dated June 16, 2011, with undated "Home Support" fact sheet.

Home Support

Costs for Seniors with Earned Income

While many seniors have income only from private or public pensions or government programs, some also earn income from employment or running a business. In November 2007, the provincial government placed a cap on the amount that seniors who have what is referred to as "earned income" can be charged for home support.[41] Earned income is defined in the *Continuing Care Fees Regulation* as the sum of employment income, net business income, net professional income, net commission income, net farming income and net fishing income.

Under section 3(1.1) of the *Continuing Care Fees Regulation,* home support fees for seniors (or their spouses) who earn even a small amount are capped at $300 per month, while no cap applies to the fees charged to seniors who have the same overall income but no earned income. The regulation does not prescribe a minimum amount that seniors must earn in order for the cap to apply.

This means that seniors who have a relatively large income that includes some earned income may end up paying lower home support fees than seniors with less overall income but no earned income.

> **I have recommended that the Ministry of Health take the steps necessary to extend the $300 monthly cap to seniors who do not have earned income so that they are treated the same way as those seniors who do have earned income. (R39)**

Continuity of Care

Seniors and their families told us it was common for them to have many different and unfamiliar workers coming to their homes to provide home support services. This lack of continuity is one of the concerns that we heard most frequently from seniors who receive these services.

One of the problems with a high rate of turnover in home support workers is that it takes time to familiarize a new worker with a particular senior's home, medical condition and care needs. This leaves less time available for the worker to provide the actual service. In addition, home support is often provided with the goal of preventing a senior from becoming sicker or frailer, or from having to be institutionalized. In order to realize this goal, the workers who provide home support must be familiar enough with a senior's condition to notice when that condition is changing and respond appropriately.

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[41] In November 2007, the government amended the definition of "qualified client" in the *Continuing Care Fees Regulation* with Order in Council No. 799 by removing the "aged 19 to 64" criterion, making seniors eligible for this cap. In January 2010, this regulation was amended to replace "qualified client" with "client," defined as a person who is receiving continuing care.

Home Support

Only two of the health authorities, Fraser Health and Vancouver Coastal Health, have specific policies on home support worker continuity. Both use a performance-based funding model. VIHA also uses a cluster care model in the higher-density areas of Victoria, Salt Spring Island and the Saanich Peninsula.

If home support is to play the prevention role for which it is intended, it is critical that seniors be able to establish reliable, ongoing relationships with home support workers. Taking further steps to prioritize continuity of care in home support would promote the health, well-being, independence and dignity of seniors.

> **I have recommended that the Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority include the principle of continuity in home support in their policies, service agreements and performance measures. (R40)**

The Choice in Supports for Independent Living Program

The Choice in Supports for Independent Living (CSIL) program was introduced in 1994 to provide an option for people requiring care who wish to manage their own home support services. While health authorities manage the delivery of home support services to most seniors, those who want more direct control and choice over their care, and can show that they are able to do so, may prefer to use the CSIL program. To qualify for the CSIL program, seniors must be able to direct all aspects of their care, or have a designated representative through a valid representation agreement, or a client support group, that can direct their care for them.[42] If approved for CSIL funding, the senior, representative or support group is responsible for hiring, scheduling and supervising the home support workers, as well as overseeing the care provided. A family member (defined as parent, child or spouse) cannot be hired to provide care unless the senior, representative or support group has applied for an exception and the health authority has approved this exception.

During our investigation, our office received complaints from seniors in different health regions who were frustrated with the CSIL application process and were having problems accessing the program. Some seniors told us that their case manager did not make them aware of the CSIL option. Others found the application requirements and process confusing.

The CSIL application process is understandably complex, as the CSIL program involves providing individuals and members of the public with funds to purchase and manage their own services. The small number of home support clients who make use of the CSIL program, may well reflect

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[42] Ministry of Health, *Home and Community Care Policy Manual,* April 2011, Home Health Services: Choice in Supports for Independent Living (CSIL), 4.C.1. A client support group is a group of five or more people who have registered as a non-profit society for the purpose of managing home support services on behalf of a CSIL client.

the lack of public information about the program and its application process. Deficiencies in the information provided about CSIL limit the probability of seniors and their caregivers considering CSIL as an option.

In our review, we found that none of the health authorities has a complete description of the CSIL application process program on its website.[43] VIHA's website provides the most information, including a description of the program and its eligibility criteria, as well as information on funding and client responsibilities. Fraser Health, Interior Health, Northern Health and Vancouver Coastal Health each provide a brief explanation of the CSIL program and Fraser Health also lists the program's eligibility criteria.

> **I have recommended that the Ministry of Health establish a standard Choice in Supports for Independent Living application process and ensure that clear and accessible information about that application process is made available by the health authorities. (R41)**

Quality of Care

The Absence of Provincial Standards

Home support services are administered under the *Continuing Care Act*.[44] However, the Act, which covers a broad range of care programs, does not include any specific legislative or regulatory requirements for home support. Instead, the Act authorizes the Minister of Health to issue "standards, guidelines or directives" that are binding on home support service providers.[45]

We learned that no provincial standards, guidelines or directives for home support have been created under the *Continuing Care Act* since it came into force in 1990.

Standards are important because they establish a legally binding minimum baseline for service delivery. The ministry told us it expects health authorities to ensure that publicly funded home support services comply with the policies in the ministry's *Home and Community Care Policy*

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[43] Information about the CSIL program can be found in Ministry of Health Services, *Choice in Supports for Independent Living (CSIL) Program Review*, November 2008 <http://www.health.gov.bc.ca/library/publications/year/2008/CSIL_Review_2008.pdf>.

[44] *Continuing Care Act,* R.S.B.C. 1996, c. 70.

[45] *Continuing Care Act,* R.S.B.C. 1996, c. 70, s. 4(4).

Home Support

Manual and, where applicable, with its *Model Standards for Continuing Care and Extended Care Services,* its *Personal Assistance Guidelines* and the accreditation standards set by Accreditation Canada.[46] None of these, however, are legally binding standards.

There is a need for specific, consistent and legally binding provincial standards for quality of care in home support services. The creation of home support standards under section 4 of the *Continuing Care Act* would provide consistency in the level and quality of home support provided throughout the province.

> **I have recommended that the Ministry of Health exercise its power under section 4(4) of the *Continuing Care Act* to establish clear, specific and enforceable quality of care standards for home support services, including the type and level of care to be provided, minimum qualifications and training for staff, complaints processes, and procedures for reportable incidents. (R42)**
>
> **I have also recommended that the Ministry of Health require health authorities to provide information about these standards to home support clients. (R43)**

Complaints

Home support services are usually provided for seniors by home support workers in private homes. Given the nature of home support services, the environment in which they are typically delivered and the vulnerability of the clients served, it is particularly important that seniors and other home support clients have access to a clear, transparent and timely complaints process when they are dissatisfied with or have concerns about those services. For a complaints process to be effective, it is also critical that seniors are confident that making a complaint will not have adverse consequences.

> *"Clients who express concerns to their workers often are reluctant to contact the agency directly, fearing that they will be branded as complainers."*
>
> Source: Home support worker.

The Ministry of Health's revised provincial *Home and Community Care Policy Manual* states that health authorities are required to have a clearly defined appeal process for client disputes about health service decisions related to home and community care services, including home support.[47]

[46] Ministry of Health and Ministry Responsible for Seniors, *Model Standards for Continuing Care and Extended Care Services,* April 1999; Ministry of Health Services, *Personal Assistance Guidelines,* November 2008. The *Personal Assistance Guidelines* clarify the boundaries of practice and the roles and responsibilities of Unregulated Care Providers (UCPs).

[47] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Appeal Process, 2.E.

Home Support

Seniors and their families are encouraged, as a first step, to raise any concerns about home support services with the person providing care. However, we heard from some seniors and their family members who were uncomfortable bringing complaints directly to their care provider's attention, either because of their reliance on the care provider's services or because they felt vulnerable. These situations can be particularly sensitive when a service provider is the only source of subsidized home support in a community. Seniors may also be unsure about whom to raise their concerns with, because they can receive home support from different workers.

If a problem cannot be resolved through discussion with the care provider, a senior receiving subsidized services has several options for complaining. These include taking the problem to:

- the contracted agency that employs the person who provided the service (if applicable)
- the health authority employee responsible for conducting assessments
- the regional patient care quality office

Contracted Service Providers

As seniors are expected to first try to resolve any concerns they have with their care provider, it is important that contracted service providers have their own complaints process and that they make clients aware of it. It is also important for contracted service providers to tell people who are not satisfied with the outcome of a complaint how to contact the health authority with their concerns.

When delivering services through a contracted agency, it is up to the health authorities to ensure that the service provider has an appropriate complaints process. However, health authorities' practices in this area are inconsistent, and not all service agreements explicitly require service providers to have a complaints process.[48] Fraser Health, Vancouver Coastal Health and VIHA require their contracted home support agencies to have complaints processes. This requirement is included in service agreements for these three health authorities. In addition, contractors with Fraser Health are required to inform it of any significant complaints they receive. We did not find similar requirements in the Interior Health service agreement. Northern Health does not use contracted service providers for home support.

> **I have recommended that the Interior Health Authority require all of its contracted service providers to have a clearly defined complaints process. (R44)**

[48] All health authority service agreements require service providers to comply with the *Model Standards for Continuing Care and Extended Care Services* established by the former Ministry of Health and Ministry Responsible for Seniors in April 1999, which in turn require service providers to have formal complaints processes. However, this requirement on its own is unlikely to ensure that service providers develop and maintain clearly defined complaints processes.

Home Support

I have also recommended that the health authorities require their contracted home support providers to inform residents and families about how to complain about home support services and to report to the health authorities on the number, type and outcomes of complaints received once per quarter. (R45)

Health Authority Case Managers and Patient Care Quality Offices

Complaints to case managers are informal. There is no consistent process for receiving or responding to complaints at this level, nor do staff in each health authority consistently track these types of complaints. Tracking complaints made informally to case managers would help the health authorities to know the type and quantity of complaints made, and if there are any systemic or recurring problems with service delivery that are responsible for multiple complaints.

I have recommended that the health authorities develop and implement methods for tracking complaints made to case managers about home support. (R46)

In addition to complaining to their service providers, seniors who are not satisfied with the publicly funded home support services they receive can complain to either the case managers or the regional patient care quality office. These options are not available to seniors who receive home support services that are paid for privately.

I have recommended that the Ministry of Heath ensure that all seniors who receive home support services have access to the same complaints processes. (R47)

Public Information

Home support services are provided in a client's home rather than in a facility, so seniors may not always be able to promptly and easily speak to someone other than their care provider. This means that home support clients must rely on clear written information to guide them on how to pursue a complaint.

While some seniors can access information through the Internet, some are unable to do so. Up-to-date written material about complaints processes should therefore be available to all home support clients in their homes. At a minimum, they should have access to information about who to direct a complaint to (including that

Best Practice: The Fraser Health Authority's "Giving Feedback" Fact Sheet

Fraser Health provides home support clients with a fact sheet that provides information about who to complain or offer feedback to, who can make a complaint, what will be done in response to a complaint, how long it will take to receive a response, and what to do if you are unhappy with the outcome of a complaint, including how to request an appeal. The fact sheet also reassures seniors that their care will not be affected if they submit a complaint.

person's contact information), how a complaint will be dealt with, and any deadlines that apply. Written information should also assure clients that they have the right to complain without any adverse consequences.

We found that the written information the health authorities provide to home support clients about complaints processes varies from one health authority to the next and does not include clear and detailed information about available complaints processes.

> **I have recommended that the Ministry of Health and the health authorities work together to develop and provide clear and consistent information for seniors and their families on how they can complain about home support services and how the health authorities will handle those complaints. (R48)**

Monitoring and Enforcement

Home support service quality may be monitored by supervisors through client surveys, or through case management and contract reviews. However, actual observation of worker performance requires on-site visits to clients in their homes. This poses a challenge for the effective monitoring of home support services, as some large home support agencies have more than 1,000 staff who provide service to thousands of clients, often on a daily basis.

As there are no binding provincial standards for home support in British Columbia, it is also difficult to monitor the quality of home support services.

Role of the Health Authorities

The Ministry of Health plays a limited role in direct hands-on monitoring and enforcement. It has made the health authorities responsible for managing and monitoring the delivery of home support services. The health authorities sometimes act as direct providers of home support services. At other times they contract with, and fund, other agencies to provide these services on the authorities' behalf.

The health authorities carry out their monitoring and enforcement responsibilities through various means. In some cases, health authorities rely on service providers to seek and maintain accreditation through an organization such as Accreditation Canada. While accreditation is a useful process, it cannot replace government standards and monitoring and enforcement.

The health authorities have access to various tools to monitor and enforce standards for home support services. In addition to client visits, surveys and regularly submitted reports, other useful monitoring tools include file audits, complaints tracking, reportable incident reporting and

inspections. However, the lack of provincial standards for the quality of home support services and the lack of requirements regarding reportable incidents and inspections leave the health authorities with little guidance. It also results in inconsistent approaches to monitoring and enforcement.

Monitoring and enforcement activities also differ depending on whether a health authority is providing services directly or through a contracted agency. When providing services directly, health authorities tend to rely on human resource policies to determine when and how to take action against employees who have acted inappropriately. However, this may not address systemic care quality issues. When providing services through contracted agencies, some health authorities retain the right to inspect or audit service providers and to withhold funding or terminate contracts. They also include reporting requirements in their service agreements with contracted agencies, but the indicators used by some of the health authorities focus on organizational efficiency and service use, not on whether the needs of individual clients are actually being met.

I have recommended that the Ministry of Health work with the health authorities to establish clear and consistent processes to monitor the quality of home support services provided directly by health authority staff or by contractors, and to enforce any applicable standards. (R49)

I have also recommended that the Interior and Vancouver Island health authorities adopt more specific reporting requirements in their service agreements in order to more effectively monitor contracted home support services. (R50)

Assisted Living

Program Overview

Assisted living is a form of housing that combines private units in apartment-style residences with the provision of hospitality and personal care services. These services include meals, housekeeping and help with medications and daily living activities. Assisted living is meant for seniors and others who are able to direct their own care but can no longer live safely on their own.

Assisted living residences can be owned and operated by health authorities, non-profit groups or private companies. Individual facilities may contain only subsidized units, only non-subsidized units or a mix of both. Health authorities administer subsidized assisted living services, overseen by the Ministry of Health.

As of March 2011, there were 194 registered assisted living residences in British Columbia, containing a total of 6,832 units, the majority of them single occupancy.[49] Of this total, 4,380 units were subsidized and 2,452 were not.

Assisted living, which is regulated by the *Community Care and Assisted Living Act (CCALA)*, requires assisted living operators to register their residences with the assisted living registrar and operate them in a manner that does not jeopardize residents' health or safety.

In 2010/11, the total funding provided by the five regional health authorities for assisted living was $74.7 million. This includes the cost of both housing and services. In 2007/08, the average per-unit subsidy paid by health authorities was $55 a day, or $1,650 per month.[50]

Non-subsidized residents typically pay between $1,500 and $5,000 per month. Subsidized residents pay a maximum of 70 per cent of their after-tax income. As of March 2010, this amount ranged from $801 to $3,860 per month, and averaged $1,224 per month.[51]

Housing is one of the key components of assisted living. In addition to housing, all assisted living operators must provide hospitality services to the seniors who live in their residences.[52] Hospitality services are defined in section 1 of the *CCALA* as "meal services, housekeeping services, laundry services, social and recreational opportunities and a 24-hour emergency response system."

Assisted living operators must also provide at least one but no more than two "prescribed" services, along with accommodation and hospitality services.

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49 Although the Office of the Assisted Living Registrar tracks the number of units, it does not track how many assisted living units are double occupancy.

50 This is the most recent available information.

51 Information provided by the Ministry of Health in April 2011. Note that the rates include income-based rates only and do not take into account rates paid by residents receiving a government income benefit (income assistance or disability assistance).

52 Ministry of Health, *Home and Community Care Policy Manual,* April 2011, Housing and Health Services: General Description and Definitions, 5.A.

Assisted Living

Every assisted living operator in British Columbia has chosen to provide the same two "prescribed" services: assistance with daily activities and assistance with medications. Assistance with the activities of daily living includes services such as "mobilization, nutrition, lifts and transfers, cueing, bathing, grooming and toileting, as well as specific nursing and rehabilitation tasks."[53]

The Office of the Assisted Living Registrar

The *Community Care and Assisted Living Act (CCALA)* established the Office of the Assisted Living Registrar (OALR) in November 2003. The mandate of the OALR is "to protect the health and safety of assisted living residents."[54] To meet this mandate, the registrar registers assisted living residences, develops policies and procedures, and responds to complaints and concerns about the health and safety of assisted living residents.

The OALR is part of the Ministry of Health and is accountable to its minister, who designates the registrar.

Funding

Funding for the OALR comes from the Ministry of Health, as well as from registration and application fees paid by operators. The application fee is $250 per residence and the annual registration fee is $12.40 per assisted living unit. The OALR also receives some modest revenue from the sale of its registrant handbooks.

In 2010/11, the OALR had operating expenses of $494,330, broken down by revenues of $89,031 and Ministry of Health funding of $405,299.

While the number of assisted living units more than tripled between 2004/05 and 2010/11, the OALR's budget was reduced by more than $165,000 or 29 per cent in this same period.

Staffing

The OALR has four full-time equivalent (FTE) employees, including the registrar. Since the office's creation in 2003, it has obtained its staff by contracting with the Health Employers' Association of BC (HEABC). The association is a registered non-profit society responsible for the human resources and labour relations interests of health care employers who receive public funds,

[53] Ministry of Health, *Home and Community Care Policy Manual,* April 2011, Housing and Health Services: General Description and Definitions, 5.A.

[54] Ministry of Health, "Mandate of the Registrar" <http://www.health.gov.bc.ca/assisted/mandate.html.>

including the regional health authorities.[55] While the Ministry of Health pays the registrar's salary directly, the HEABC pays the salaries of the office's other three FTE employees, and the ministry then reimburses the association for these costs.

From an administrative fairness perspective, this contractual arrangement with the HEABC is a concern. The OALR is a government agency that is responsible for regulating assisted living residences, which are operated by agencies or individuals who are members of the HEABC. A reasonable person might question whether OALR staff are in a good position to act independently when processing applications, receiving complaints and conducting inspections of facilities that are operated by members of the same organization that employs them.

> **I have recommended that the Ministry of Health stop contracting with the Health Employers Association of BC to staff the Office of the Assisted Living Registrar and instead staff all positions with permanent employees of the ministry. (R51)**

Powers of the Assisted Living Registrar

Under the *CCALA*, the registrar may enter and inspect a facility, inspect and copy any records found there, and make a record of anything observed during the inspection. The registrar may also apply to a justice for a warrant to enter and inspect a private single family dwelling.[56]

In practice, however, OALR staff members rather than the registrar are investigating complaints and conducting inspections. While the Act allows the registrar to delegate her or his powers to staff so that they can enter and inspect residences, the registrar has typically not done this.[57] As a result, OALR staff have been exercising the registrar's investigative powers without the authority to do so.

> **I have recommended that the assisted living registrar delegate the investigative powers she has under the *Community Care and Assisted Living Act* to any of her staff who require those powers. (R52)**

Funding Assisted Living

The Ministry of Health determines the total amount of funding that each health authority will receive at the beginning of each fiscal year. Once informed of its overall budget, each health authority then determines how to allocate the funds to best meet its service obligations.

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55 For more information, see the Health Employers Association of BC <http://www.heabc.bc.ca>.

56 *Community Care and Assisted Living Act,* S.B.C. 2002, c. 75, s. 25.

57 The registrar has on occasion delegated authority on a temporary basis to cover absences of the registrar.

Assisted Living

It is important that the Ministry of Health and the health authorities monitor the demand for subsidized assisted living, so that they are able to plan for future funding needs and ensure that those who are currently eligible are able to access services in a timely manner. Neither the Ministry of Health nor the health authorities were able to provide us with any information indicating how they monitor this.

As I recommended in the Home and Community Care section of this report, the Ministry of Health should publicly report on the forecasted budget and the money actually spent by each health authority on assisted living services annually.

Cost of Receiving Services

In addition to paying the assessed rate, seniors may also be charged for certain additional items and services in assisted living. Between August 2008 (when we began our investigation) and April 2011, the ministry had no policy regarding which items and services should be included in the assessed client rate for assisted living, and which ones operators could charge extra for. The revised *Home and Community Care Policy Manual* that took effect on April 1, 2011, includes a new "Benefits and Allowable Charges" section that lists what services must be offered to all assisted living seniors at no additional charge above the assessed client rate. Among the services included are personal care and weekly housekeeping.

The inclusion of the "Benefits and Allowable Charges" section in the revised *Home and Community Care Policy Manual* is an important step toward ensuring that assisted living residents across the province are charged in a similar manner for similar services and that no residents are charged extra for services that are included in their assessed rate.

However, although these "benefits" are identified by the ministry as included in the assessed client rate, the ministry has told health authorities and assisted living operators that they have until April 1, 2013, to comply with this policy. That means that assisted living residents could be "double billed" for some benefits until the policy comes into force. It is unfair and unreasonable for the ministry to delay the implementation of this policy until April 1, 2013.

> **I have recommended that the Ministry of Health require the health authorities and assisted living operators to comply with its policy on benefits and allowable charges immediately rather than by April 1, 2013. If this results in an unexpected financial inequity for certain operators, the ministry take steps to resolve this inequity in a fair and reasonable manner. (R53)**

Assisted Living

The Legal Definition of Assisted Living

According to the definition of "assisted living residence" in section 1 of the *Community Care and Assisted Living Act (CCALA),* assisted living residences can provide no more than two prescribed services. A residence that offers three or more prescribed services must be licensed as a residential care facility.[58]

In August 2007, the Ministry of Health developed a policy to distinguish between services provided at the "prescribed level" and those provided at what the ministry calls the "support level," a "less intensive" level.[59] This means that operators can offer any number of the prescribed services that are listed in section 2 of the *Community Care and Assisted Living Regulation* at the "support level."

The difference between providing service at the prescribed level and the new support level is not always obvious. For example, monitoring food and fluid intake is described as prescribed, but monitoring food consumption "for purposes of satisfaction and quality control" is described as support. It may not be obvious how these activities differ.

This policy, which has the effect of allowing facilities to offer more than two prescribed services, is not in compliance with the *Community Care and Assisted Living Regulation*. The Ministry of Health does not have the authority to expand the legislated definition of assisted living residence by creating new policy. The *CCALA* defines an assisted living residence as one that offers one or two prescribed services and does not permit offering additional prescribed services "at a lower intensity."

At the same time, in allowing assisted living operators to provide more than two services, the Ministry of Health has weakened the distinctions between assisted living residences residential care facilities. This is a problem because the level of oversight that residential care facilities are subject to corresponds with the needs and vulnerabilities of the seniors served in these facilities. A high level of oversight is appropriate and necessary to protect people whose care needs make them very vulnerable.

Permitting assisted living residences to provide additional services to seniors with higher-level care needs while not protecting them with a higher level of oversight is a concerning shift in practice.

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58 Residential care is provided in a community care facility which is defined in section 1 of the *Community Care and Assisted Living Act* as a premises or a part of a premises where care is provided to three or more unrelated people or is designated to be a community care facility. Care is defined as supervision that is provided to an adult who is vulnerable because of family circumstances, age, disability, illness or frailty and who is dependent on caregivers for continuing services in the form of three of more prescribed services.

59 Office of the Assisted Living Registrar, *Registrant Handbook*, August 2007, Personal Assistance Services, 6.2.

Assisted Living

I have recommended that if the Ministry of Health believes that the practice of allowing operators to provide prescribed services at the support level is useful, the ministry should take steps to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act* so that it provides a statutory basis for doing so. (R54)

I have also recommended that if the Ministry of Health decides to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act*, it ensure that any changes in service delivery practices maintain a clear distinction between the services provided in assisted living residences and those provided in residential care facilities, and that it ensure that this is accompanied by increased oversight, monitoring and enforcement. (R55, R56)

Availability of Information

Clear, accessible and comparable information is important because once seniors have been determined eligible for placement in a subsidized assisted living unit, they are then given the opportunity to identify a preferred facility or location.[60]

In February 2009, the former Minister of Health Services directed the health authorities to make specific information about facilities in their region (including assisted living residences) available to the public.[61] The Minister directed the health authorities to provide public information on how to access community programs and facility-based care, intake and screening processes, how to complain about home and community care services, and progress on ensuring quality standards of care.

Given the importance we put on clear, accessible information our office has monitored the implementation of this directive since it was issued. The ministry has more recently directed that "clients must be provided with information on assisted living options, and the health authority's process for managing access to assisted living services" in its new *Home and Community Care Policy Manual* effective April 1, 2011. While the health authorities have made considerable progress, not all health authorities have the necessary information available on their websites.

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60 Ministry of Health, *Home and Community Care Policy Manual,* April 2011, Housing and Health Services: Assisted Living Services, 5.B.2.

61 Ministry of Health directive, February 2009.

Assisted Living

I have recommended that the health authorities fully comply with the February 2009 Minister of Health's directive immediately. (R57)

I have also recommended that the Ministry of Health ensure that the health authorities make the following additional information available to the public by June 1, 2012:

- **the basic services available at each assisted living facility in their region and their costs, as well as the type and costs of any other services available at each facility**
- **billing processes for each assisted living residence in their region**
- **the care policies and standards for each assisted living residence in their region (R58)**

Eligibility and Assessment

Section 26(3) of the *Community Care and Assisted Living Act*

To be eligible for publicly subsidized assisted living, a person must be assessed by a health professional in a health authority as being able to make his or her own decisions. Section 26(3) of the *Community Care and Assisted Living Act (CCALA)* specifies that assisted living operators must not house people who are "unable to make decisions on their own behalf." This means operators must not admit applicants who are incapable of making their own decisions, and that operators must regularly monitor residents' capability to do so.

Legally, adults are presumed to be capable of making their own decisions unless there is evidence to the contrary. The Act does not list or define the type of decisions residents must be able to make, nor does the Act establish a process for evaluation, assessment and appeal or review of decisions made about residents' capability to make decisions on their own behalf.

In the absence of such details, the Ministry of Health has created a policy to guide decision-makers in the application of section 26(3). The policy requires that residents be able "to make the range of decisions necessary to function safely in an assisted living setting" and has further specified the types of decisions this includes.

Because the Act does not indicate how operators are to determine the decision-making capacity of residents, the ministry expects operators to rely on the interpretation of section 26(3) outlined in its policy. This policy indicates that operators should use medical evaluations to inform their decisions, but that such evaluations are not the only factor to be considered. According to the policy, an operator's decision under section 26(3) should involve a wider consideration of each resident's abilities and circumstances.

Assisted Living

When an assisted living operator decides that a resident is unable to make decisions on his or her own behalf, this will likely result in that person having to move to another care setting, and may have other consequences. For example, if a resident is required to leave assisted living, the resident may need to be cared for in a residential care facility. Admission to residential care requires the consent of the senior or his or her legal representative. However, if a person is identified as unable to make the decisions necessary to function safely in assisted living it reasonably raises questions about whether they can make other personal and health care decisions.

When this important assessment of decision-making capacity is made by an operator, it determines whether an applicant is permitted to move into assisted living, or whether an assisted living resident must move out. We therefore expected to find a clear, consistent and fair process for making a decision under section 26(3) that included an opportunity for people who disagree with the decision to challenge it through an independent review or appeal process. Instead, we found that the Act does not set out what legal test should be applied and what process should be followed in making the decision.

> **I have recommended that the Ministry of Health create a legally binding process with appropriate procedural safeguards for determining whether assisted living applicants and residents have the required decision-making capacity. I have also recommended that if the ministry retains the test in section 26(3) of the *Community Care and Assisted Living Act*, it provide more specific direction on the meaning of the phrase "unable to make decisions on their own behalf", and that the ministry ensure that assisted living applicants and residents have access to an independent process through which decisions about capacity made under section 26(3) can be reviewed. (R59, R60, R61)**

Exceptions to the Eligibility Requirements

The *Community Care and Assisted Living Act* currently allows two exceptions to the legal requirement that assisted living residents be able to make decisions on their own behalf: involuntary patients who are on leave under section 37 of the *Mental Health Act* and assisted living residents who live with a spouse able to make decisions on their behalf.[62]

According to the Office of the Assisted Living Registrar, ministry practice is to go beyond the exception for spouses and recognize a broader range of relationships, such as siblings. While recognizing other relationships provides seniors with more options is an excellent idea, additional exceptions to a legislative requirement cannot be created by practice.

[62] *Community Care and Assisted Living Act,* S.B.C. 2002, c. 25; ss. 26(4) and (6). Section 26(4) of the Act enables people on leave under section 37 of the *Mental Health Act* to live in assisted living. The individual is exempted from making an informed decision to enter to the assisted living residence because the director of the mental health facility makes this decision for him or her. According to policy 5 of the OALR *Registrant Handbook,* because section 26(4) does not establish someone to live with the person and provide daily decision-making support, the person is not exempt from being able to make the range of decisions necessary to function safely in assisted living. There is at present only one resident in assisted living who is on leave under section 37 of the *Mental Health Act.*

Assisted Living

I have recommended that the Ministry of Health take the steps necessary to broaden the exception in section 26(6) of the *Community Care and Assisted Living Act* to include a wider range of relationships. (R62)

The Placement Process

Waiting for Placement

Once seniors have been determined eligible for placement in publicly subsidized assisted living, the ministry's *Home and Community Care Policy Manual*, which took effect April 1, 2011, states that seniors must be given the opportunity to identify a preferred residence or location. Once seniors make their choices, they are added to the waiting lists for their preferred residences.

Between 2009/10 and 2010/11, waiting times for placement in subsidized assisted living went up in every health authority that tracked this information. The shortest waiting time in 2010/11 was in the Fraser Health Authority, where seniors waited four months on average. The longest waiting time was in the Northern health region, where seniors waited on average almost one year for placement in subsidized assisted living.

"There was a 1.5 year wait to get into assisted living. During the time [my mother] was waiting to get into assisted living, she had home support up to four times per day plus continual visits (every few hours) from family. She also ended up in hospital two or three times. . . . "

Source: Respondent, Ombudsperson's questionnaire.

Based on the information we received from the health authorities, 1,628 people in British Columbia were waiting for placement in subsidized assisted living units as of March 31, 2011. This is about 37 per cent of the total number of subsidized assisted living units in the province.

The ministry places responsibility for the management of assisted living waiting lists on the health authorities. While the February 2009 minister's directive required the health authorities to report the average number of days from referral to the start of home support services, it did not require health authorities to report waiting times for placement in a subsidized assisted living unit.

I have recommended that the Ministry of Health set a time frame within which eligible seniors are to receive subsidized assisted living services after assessment; that the ministry require the health authorities to report the average and maximum times that eligible seniors wait to receive subsidized assisted living services to the ministry quarterly; and that the ministry report annually to the public on the average and maximum time that eligible seniors wait to receive subsidized assisted living services after assessment. (R63, R64, R65)

Assisted Living

Moving into a Subsidized Assisted Living Unit

During our investigation, we heard from people who told us that they had not had enough time to move into a subsidized assisted living unit that was offered to them. Most people find it very difficult or may be unable to move with only a few days' or even one week's notice.

Operators of assisted living residences have explained to us the difficulties they face in holding subsidized units open. Health authorities pay for the time subsidized units are actually occupied, so having empty units can cause financial problems.

We learned that the Ministry of Health does not have a policy on the length of time provided to move into assisted living residences. Instead, the ministry requires the health authorities to manage this process — and their approaches vary widely.

> **I have recommended that the Ministry of Health work with the health authorities to a develop a clear and consistent provincial policy that provides reasonable time frames for moving, has the flexibility to respond to individual circumstances and sets out:**
>
> - **how long a person has to accept an offered placement in an assisted living residence**
> - **how long a person has to move into an assisted living unit once it has been offered**
> - **any consequences of declining an offered placement (R66)**

The Exit Process

The exit process requires a plan stating the resident's relocation plans, who is responsible for making the relocation arrangements, and any additional services that may be necessary until the move is completed.

The plan may result in operators providing additional support to residents during the exit process. However, doing so could result in operators providing more than two prescribed services and therefore exceeding the definition of assisted living residence.

> **I have recommended that the Ministry of Health take the steps necessary to provide facility operators with the legal authority to offer additional support to assisted living residents during the exit process; and that the ministry establish reasonable time frames for completing the exit process for assisted living residents. (R67, R68)**

Assisted Living

Quality of Care

During our investigation, seniors and their families told us that the quality of assisted living services was their biggest concern.

Although section 34 of the *CCALA* allows cabinet to make regulations about assisted living, including care standards, the only regulatory provisions cabinet has made under this authority are on storing and administering medication. The remaining guidelines that apply to assisted living operators are set by non-binding policy, not legislation or regulation, and concern staffing, food services and housekeeping.

The Ministry of Health's Policy on Health and Safety

When the assisted living provisions in the *CCALA* came into force on May 30, 2004, the provincial government planned to include health and safety standards in regulation. This never happened. Instead, in August 2007, the Ministry of Health published policy 4, "Health and Safety Standards," in the Office of the Assisted Living Registrar's *Registrant Handbook,* to address these details. The policy establishes desired outcomes, but does not specify how those outcomes should be achieved. For example, the policy requires that sufficient staff be available to meet the needs of residents, but does not specify what staffing mix, staff-to-resident ratio, or other considerations constitute "sufficient staff."

There are areas where clear legally binding standards for assisted living residences would be of assistance. For example, staffing, residents' rights, food safety and nutrition, emergencies, record management and assistance with daily activities would all benefit from clear and enforceable standards. Without such minimum legally binding requirements, it is difficult to ensure the health, safety, dignity and overall well-being of seniors is being met.

I have recommended that the Ministry of Health, after consulting with stakeholders, establish legally binding minimum requirements for assisted living residences in key areas, including:

- **staffing**
- **residents' rights**
- **food safety and nutrition**
- **emergencies**
- **record management**
- **assistance with activities of daily living (R69)**

I have also recommended that the Ministry of Health provide clear and accessible information to residents on the standards assisted living operators are required to meet. (R70)

Assisted Living

Complaints

Concerns of assisted living residents and their families may be about eligibility and placement decisions, waiting times, food, personal care, activities, rent increases and evictions. There is no single agency that will accept and can deal with all complaints about assisted living, although there are several agencies that can deal with complaints about certain issues.

Residents and families are encouraged to first raise their concerns directly with the residence operator or service provider. If the problem can't be resolved at that level, there are a number of possible options, depending on what the complaint is about and whether the resident is in a subsidized or a non-subsidized unit.

Residents of publicly subsidized assisted living residences can complain to the Office of the Assisted Living Registrar (OALR) about health and safety issues. Complaints about quality of care can be taken to the operator or to the regional patient care quality office (PCQO) and then the regional patient care quality review board (PCQRB). Complaints about placement and transfer issues can be brought to the resident's case manager at the health authority.

Residents of non-subsidized assisted living residences have fewer avenues for complaint. Health and safety complaints can still be taken to the OALR, but all other issues can be dealt with only by the facility operator or contracted service provider.

In February 2009, the former Minister of Health Services issued a directive requiring the health authorities to make information on how to complain about assisted living available to the public. This information was supposed to include details on review processes and direct contact information for the designated staff members responsible for receiving complaints in each area. In June 2011 and again in December 2011, we reviewed the health authorities' websites to determine whether they had complied with the minister's directive. We found that each health authority had most of the information required by the directive; however, only VIHA and Vancouver Coastal Health websites were in full compliance, providing both descriptions of the complaint processes and direct contact information for the PCQO, PCQRB and OALR. The other authorities had gaps in their information.

I have recommended that the Fraser Health Authority, Interior Health Authority and Northern Health Authority fully comply with the minister's directive by:

- **in the case of Fraser Health Authority, providing direct contact information for the Office of the Assisted Living Registrar (OALR),**
- **in the case of Interior Health Authority, including a description of the complaints processes and direct contact information for the patient care quality review board and OALR, and**
- **in the case of Northern Health Authority, providing a description of the complaints process and direct contact information for the OALR (R71)**

Assisted Living

Complaints to Assisted Living Operators

Facility operators are generally the first point of contact for complaints about assisted living. The *Registrant Handbook* indicates that each operator should have a written complaints process, should make residents and others involved in their care aware of it, and should include contact information for the Office of the Assisted Living Registrar (OALR).

We visited 13 different assisted living residences in the course of this investigation and found that, despite the OALR policy, some residents remained unsure of where to direct their complaints. In some cases, confusion over which agency to complain to seemed to stem from the fact that various delivery models of subsidized assisted living services exist in the province, each with its own complaints process requirements.

The fact that assisted living services may be delivered by a variety of agencies makes it especially important for residents and their families to have clear information about who is providing the services they are receiving, and where they can bring concerns about those services.

> **I have recommended that the Ministry of Health take the necessary steps to establish a legal requirement for assisted living operators to have a process for responding to complaints, and to establish specific standards for that process. (R72)**
>
> **I have also recommended that the health authorities ensure that by September 30, 2012, all assisted living operators are providing residents with clear and comprehensive information on how to complain about the care and services they receive, including where to take complaints about services provided by contractors. (R73)**

Complaints to Case Managers

Case managers are responsible for determining the eligibility of applicants and the fees they will pay for subsidized assisted living services.[63] They monitor and assess residents' ongoing eligibility for assisted living. They also find other appropriate housing for residents who are no longer eligible for assisted living and ensure that these residents are supported in the meantime.

While all the health authorities said that they inform assisted living applicants and residents that they can bring their complaints to case managers, none have an established process for tracking responses to complaints at this level.

> **I have recommended that the health authorities develop and implement a process for tracking complaints made to case managers about assisted living. (R74)**

[63] Note that while the term "case manager" is used here, the ministry's revised policy manual refers to assessments being done by a "health professional." Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

Assisted Living

Complaints to the Office of the Assisted Living Registrar

Unlike oversight in residential care, oversight of assisted living is mainly reactive and carried out in response to complaints rather than proactive and on an ongoing and routine basis.

The OALR responds to complaints about violations of the health and safety policies contained in the *Registrant's Handbook*, residents who are unable to make their own decisions, and the operation of unregistered assisted living residences.[64]

The following table lists the number of complaints the OALR received between 2004/05 and 2010/11, shows whether the complaints were jurisdictional or not, and shows the number of complaints that resulted in an inspection.

Table 2 – Complaints to the Office of the Assisted Living Registrar, 2004/05 to 2010/11

Fiscal year	Number of assisted living residences	Number of assisted living units	Complaints received	Non-jurisdictional complaints	Jurisdictional complaints	Complaints resulting in inspection
2004/05	54	1,786	58	44	14	1
2005/06	96	3,367	42	27	15	4
2006/07	117	4,231	67	45	22	5
2007/08	150	5,235	89	32	57	7
2008/09	184	6,187	68	22	46	8
2009/10	196	6,685	84	12	72	6
2010/11	194	6,832	75	8	67	4
		Total complaints	**483**	**190**	**293**	**35**

How the Office of the Assisted Living Registrar Handles Complaints

The approach that the OALR takes to complaint resolution is educational and remedial. When it receives a complaint that it determines to be within its jurisdiction to investigate, its usual response is to confirm whether the operator is following its health and safety policies. If the operator is not doing so, the OALR will tell the operator how to comply with the policy.

Staff only report the outcome of a complaint to the person who complained when they have been specifically asked to do so. People who are not satisfied with the OALR's handling of their complaint can complain to the Office of the Ombudsperson, though not everyone may be told of this option.

[64] Office of the Assisted Living Registrar, *Registrant Handbook,* August 2007, Complaint Resolution, 9.2.

Assisted Living

Ombudsperson's Review of OALR Complaint Files

As part of this investigation, Ombudsperson staff reviewed a random selection of 25 complaints received by the OALR in 2007, 2008 and 2009. We looked at how the complaints were investigated and resolved.

We found that the process was generally effective however it did have some challenges. For example, the OALR often considered verbal information from operators to be sufficient, forgoing interviews with residents or examinations of their case files. As well, the OALR complaint process seemed to focus primarily on the existence of operator policies and procedures and rarely involved an inspection of the facilities to see the procedures in practice. OALR staff were inconsistent in informing complainants about the conclusion of an investigation. Indeed, sometimes staff never contacted the complainants at all during the process.

The effectiveness of a complaint-driven oversight process depends on the rigorous and timely investigation of complaints and on following up to ensure that operators take necessary corrective actions.

> **I have recommended that the Ministry of Health revise the complaints process used by the Office of the Assisted Living Registrar to include time limits for responding to complaints, an established process for investigating complaints, and a requirement that all complainants be informed in writing of the outcome of their complaint and any further actions they can take. (R75)**
>
> **I have recommended that the Ministry of Health take the necessary steps to establish a right of review or appeal from decisions or complaints made to the Office of the Assisted Living Registrar. (R76)**
>
> **I have also recommended that the Ministry of Health develop a process for monitoring whether operators implement the actions it recommends through the Office of the Assisted Living Registrar to resolve complaints and taking further action if they do not. (R77)**

Complaints to the Patient Care Quality Offices and Review Boards

The health and safety complaints about subsidized assisted living can be dealt with by either the Office of the Assisted Living Registrar (OALR) or the PCQOs. We found that the health authorities are inconsistent in determining whether health and safety complaints about assisted living matters should be referred to the OALR or to the PCQOs. Many health authorities refer to the registrar's office for one type of complaint and to the PCQO for another, but the practices are inconsistent.

Assisted Living

Confusion also exists at the individual level, because people can choose whether to contact the OALR or their regional PCQO with a health and safety complaint about subsidized assisted living. Furthermore, the PCQOs are not required to refer health and safety complaints about assisted living to the OALR, nor are they required to advise the OALR of the outcome of such complaints. As of the end of 2010, the OALR had received no referrals from the PCQOs.

The overlapping jurisdiction of the OALR and the PCQOs is concerning as it means that the OALR can no longer accurately track all the health and safety complaints about assisted living.

The PCQOs have even fewer and weaker powers to investigate complaints and enforce consequences than the OALR does. The PCQOs have no investigative or remedial powers, and they are confined to resolving complaints based on the information that a health authority (or its contractor) or a complainant provides. Furthermore, the PCQOs and PCQRBs are limited to dealing with complaints about services that are either provided by a health authority or its contractor, or funded in whole or in part by a health authority. The PCQOs and PCQRBs cannot accept complaints from residents who pay for their assisted living services entirely privately, even though these residents make up about one-third of all assisted living residents in the province.[65] This is different from the approach the provincial government has taken to residential care services, where the PCQOs and PCQRBs can consider all complaints, from all residents regardless of whether they are receiving a subsidy.

We reviewed how complaints about assisted living are dealt with, and found that the complaints processes in place are not clear, consistent or thorough enough to respond effectively to the needs of seniors in assisted living. Currently, several individuals and agencies are responsible for responding to complaints about assisted living. Which agencies people can complain to and what they can complain about depends upon a variety of factors, including whether they are paying the full cost of services privately or receiving a subsidy, who delivers the service, and whether the complaint is considered to be an issue of health and safety or personal care. This leads to confusion, gaps in the complaints system and overlapping jurisdiction in some areas. It also means no single agency is able to monitor all assisted living complaints to ensure that they are handled appropriately and to identify any systemic issues that may arise. This type of monitoring is essential to identifying problems.

[65] The ministry's draft orientation manual for new members of the PCQRBs says that complaints about assisted living services that are not provided by a health authority will not be considered by the PCQOs and PCQRBs. This is inaccurate, as subsidized assisted living is not always provided by a health authority but is frequently funded in whole or in part by a health authority and provided by one of its contractors. This error should be corrected before the orientation manual is finalized.

Assisted Living

It would be far more effective and fair to have a single, consistent and clearly communicated complaints process available to all assisted living residents, regardless of how they pay for their services. This process should, however, also include a mechanism that allows for communication with the home and community care section of the health authority that may have an interest in such decisions.

> **I have recommended that the Ministry of Health take the steps necessary to expand the powers of the Office of the Assisted Living Registrar so that it has the authority to respond to complaints about all aspects of care in assisted living from all residents; and that the ministry review the structure of the Office of the Assisted Living Registrar with the goal of ensuring that it has the necessary support to fulfill this expanded role. (R78, R79)**
>
> **I have also recommended that the Ministry of Health take the necessary steps to ensure that the patient care quality offices refer all complaints about assisted living to the Office of the Assisted Living Registrar; and that the ministry establish a mechanism that allows the Office of the Assisted Living Registrar to share the results of its complaints with the home and community care sections of the health authorities on a timely basis. (R80, R81)**

Complaints about Tenancy Issues

All assisted living residents rent the units they live in and therefore would generally be thought of as tenants of the operators of their residences. In the course of our investigation, we heard from assisted living residents who were concerned about rent increases and being evicted from assisted living residences.

The *Residential Tenancy Act* outlines the rights and responsibilities of tenants and landlords. It also provides a process for resolving tenancy disputes. However, assisted living residents are not currently covered by this Act or other comparable legislation.

The Office of the Assisted Living Registrar (OALR) has no jurisdiction to consider complaints about tenancy issues from assisted living residents.

This leaves assisted living residents, who are generally more vulnerable than other tenants, with fewer options for recourse when issues arise.

Sarah's Story

Sarah had paid a $300 damage deposit when she moved into an assisted living residence. Two years later, the operator sent a letter to her and other residents requiring an additional $700 for a damage deposit.

Sarah and the other residents contacted the Office of the Assisted Living Registrar after receiving this letter. They were told that their complaint was outside the office's jurisdiction and they were referred to the Residential Tenancy Branch.

An informal resolution was achieved.

Assisted Living

Although the OALR's website clearly states that it does not deal with tenancy complaints, the office continues to receive them.[66] In all cases, the OALR either did not to pursue these complaints or referred them to client relations officers at the Residential Tenancy Branch even though that organization also has no formal or legislated process for dealing with these types of complaints.

Attempts to Address the Protection Gap

The provincial government has been considering addressing the gaps in tenancy protection for people in supportive living facilities, and more recently assisted living residences, since 1997.[67] On May 18, 2006, the legislature passed the *Tenancy Statutes Amendment Act.* Although the *Tenancy Statutes Amendment Act* (2006) contained provisions addressing assisted living residences, these provisions were never proclaimed, and so are still not in force.

The process set out in that Act would result in a number of benefits for assisted living residents. In addition to the protection of the *Residential Tenancy Act* standard provisions for security deposits, repairs, rent increases, ending tenancies and dispute resolution, the amendments proposed in the *Tenancy Statutes Amendment Act* included additional protections for assisted living and supportive living tenants. If brought into force, for example, operators and residents would have to sign a service agreement in addition to a regular tenancy agreement.

There is currently no timetable for the proclamation of the assisted living provisions in the Tenancy Statutes Amendment Act.

In 2004, the Residential Tenancy Branch established an informal dispute resolution process to deal with tenancy disputes referred by the OALR. While dealing with assisted living residents is outside its mandate, when the Residential Tenancy Branch receives a referral from the OALR its staff work with the person making the complaint to clarify the nature of the dispute and may contact the other party to try to resolve the dispute. However, this is an informal process and as such, lacks legal requirements or protection. In addition, it does not follow any established procedures and is not publicized.

In my view assisted living residents should reasonably receive equal or greater legal protection than other tenants.

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[66] Ministry of Health, "Office of the Assisted Living Registrar — Complaint Investigation" <http://www.hls.gov.bc.ca/assisted/complaints.html>

[67] In this section, "supportive living" refers to subsidized and non-subsidized living arrangements that provide a range of hospitality services, and may also offer additional features to enhance accessibility and safety. While supportive living tenants are included in the *Tenancy Statutes Amendment Act*, we do not include them in this discussion because they are outside the scope of our investigation. Our focus here is on assisted living.

Assisted Living

I have recommended that the Ministry Responsible for Housing take the steps necessary to better protect assisted living residents by bringing the unproclaimed sections of the *Residential Tenancy Act* into force by January 1, 2013, or by developing another legally binding process to provide equal or greater protection by the same date. (R82)

I have also recommended that the Ministry of Health, in consultation with the Ministry Responsible for Housing, consider whether to expand the jurisdiction of the Office of the Assisted Living Registrar to deal with complaints and disputes about tenancy issues in assisted living; and, if the ministry decides not to include complaints about tenancy within the jurisdiction of the Office of the Assisted Living Registrar, that the ministry require the Office of the Assisted Living Registrar to automatically refer tenancy issues to the agency that has the power to resolve them. (R83, R84)

Monitoring and Enforcement

Serious Incident Reporting

There are several distinctions between the requirements for incident reporting in assisted living residences and residential care facilities licensed under the *Community Care and Assisted Living Act (CCALA).* Residential care operators are legally required by the *CCALA* to immediately report reportable incidents, while ministry policy states that operators of assisted living residences are to maintain a record of serious incidents and report them to the OALR by the end of the next business day after they occur.[68]

The *CCALA* sets out a long list of "reportable incidents" that residential care operators are required to report, while the range of serious incidents that operators of assisted living residences are expected to report is much narrower.

The *CCALA* also requires residential care operators to report reportable incidents to the representative of the person in care, the person's doctor, the regional medical health officer and the funding program. In contrast, under Ministry of Health policy, assisted living facilities are expected to report serious incidents only to the OALR.

The OALR told us that it monitors the filing of serious incident reports by operators when reviewing a facility file for some other reason, such as in preparation for a call with a new manager. Unfortunately, however, operators are not required by law to report this information to the OALR and the OALR does not have authority to take enforcement action where operators do not comply.

[68] Office of the Assisted Living Registrar, *Registrant Handbook,* October 2009, Serious Incident Reporting, 8.1.

Assisted Living

The OALR tracks the responses to serious incident reports on the files of individual residences and not in one central location, and staff were therefore unable to tell us conclusively how many times a serious incident report lead to an investigation or inspection. OALR staff estimated that since 2004 only four serious incident reports have led to formal investigations.

> **I have recommended that the Ministry of Health take the necessary steps to legally require assisted living operators to report serious incidents to the Office of the Assisted Living Registrar, the representative of the person in care, the person's doctor and the funding program. (R85)**
>
> **I have also recommended that the Ministry of Health review the current list of serious incidents applicable to assisted living residences and expand it; and that the ministry develop a formal process to monitor operators' compliance with serious incident reporting requirements and ensure appropriate enforcement action is taken. (R86, R87)**

Investigations and Inspections

As of March 31, 2011, the Office of the Assisted Living Registrar (OALR) had conducted a total of 40 inspections of 34 sites since 2004, which means that the office has inspected 18 per cent of all assisted living residences. Of those inspections, 21 were prior to registration, 15 were conducted in response to complaints, and 4 were follow-ups to serious incident reports received by the OALR. Although OALR staff are not required to announce an inspection beforehand, they generally notify operators in order to schedule a mutually convenient time.[69] The OALR has never conducted an unannounced inspection.

Relying on responses to complaints and voluntary incident reporting to provide oversight of assisted living does not account for the realities and vulnerabilities of assisted living residents and is consequently an inadequate approach. Although seniors in assisted living are generally more capable and independent than those in residential care, they live in assisted living residences because they can no longer live safely on their own and need support. While it is admirable that the regulatory framework for assisted living seeks to avoid intruding on residents' lives, it is possible to respect their dignity and decisions while still providing them with a higher level of oversight and regulatory protection.

> **I have recommended that the Ministry of Health develop an active inspection and monitoring program for assisted living, including:**
>
> - **a regular program for inspecting existing facilities**
> - **more frequent announced and unannounced inspections of facilities it receives complaints about**
> - **a risk-rating system for assisted living residences**
> - **publicly available inspection reports (R88)**

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[69] Ministry of Health, "Office of the Assisted Living Registrar — Frequently Asked Questions" <http://www.health.gov.bc.ca/assisted/faq.html#e_e>.

Assisted Living

I have also recommended that the Office of the Assisted Living Registrar develop and implement a program to conduct more inspections of assisted living residences before they are registered; and that the Ministry of Health take the necessary steps to expand the authority of the assisted living registrar to obtain information from all relevant parties, including employees, operators of assisted living residences, residents, contractors and others with information about incidents under investigation. (R89, R90)

Performance Management

The Ministry of Health also oversees assisted living by developing policy to ensure quality in the delivery of subsidized assisted living services. The ministry's April 2011 *Home and Community Care Policy Manual,* includes a new chapter on performance management. The provincial Home and Community Care Council has also approved a Performance Management Framework for Assisted Living Residences.

The implementation of the ministry's Performance Management Framework is a good step forward in information gathering. If all the health authorities were to adopt the same tools and performance measures, the ministry could then use the resulting data to enhance its stewardship of the assisted living program.

I have recommended that the Ministry of Health work with the health authorities to standardize performance management processes for assisted living and adopt the best practices within each health authority provincially; and that the ministry make information it obtains under the Performance Management Framework for Assisted Living publicly available on an annual basis. (R91, R92)

Enforcement

The *Community Care and Assisted Living Act (CCALA)* provides the assisted living registrar with only limited enforcement powers. Section 27 of the Act allows the registrar to suspend, cancel, attach conditions to or vary the conditions of a residence's registration if operators are not complying with the Act, its regulations or the conditions of their registration.

As well, the Act allows the registrar to attach conditions to a registration, but only when the registrar has discovered non-compliance in the course of an inspection or complaint investigation. The OALR has taken formal enforcement action under the Act twice since 2004/05, once by cancelling an operator's registration, and once by attaching conditions to a registration.

Assisted Living

The assisted living program has expanded rapidly since 2004/05. However, while the number of registered assisted living units tripled between 2004/05 and 2010/11, the OALR's funding decreased in the same period from $571,454 to $405,299.[70] Considering the reduced resources of the OALR, the small number of inspections it has conducted, and the registrar's limited enforcement powers, it is not surprising that few enforcement actions have been taken. In addition, to having a more rigorous monitoring program, the OALR needs a more active and progressive approach to enforcement.

I have recommended that the Ministry of Health review the Office of the Assisted Living Registrar's enforcement program to ensure that it has adequate resources and more power to actively ensure compliance with required standards. (R93)

70 The ministry informed us that the higher funding level in 2004/05 was partly due to "start-up" costs for the Office of the Assisted Living Registrar.

Residential Care

Program Overview

Residential care facilities provide 24-hour professional nursing care and supervision in a protected, supportive environment to seniors with complex care needs. This type of care is meant for people who have the highest level of care needs and can no longer safely live on their own. Seniors reside in private or shared rooms. They receive meal service; medication administration; personal assistance with daily activities, including bathing and dressing; laundry; housekeeping; and social and recreational activities.

As of September 2011, there were 26,491 publicly subsidized residential care beds in British Columbia.

There are two different approaches to regulating the provision of residential care in British Columbia. The majority of residential care facilities are community care facilities governed by the *Community Care and Assisted Living Act (CCALA)*. Residential care is also provided in private hospitals and extended care hospitals, both of which are governed by the *Hospital Act*.

The Ministry of Health estimates the average monthly cost of operating a residential care bed at about $6,000. Facility operators who operate subsidized beds obtain the money to run their facilities from two main sources: operating grants from their regional health authority and fees paid by residents.

In January 2010, the province implemented a new rate structure for subsidized residential care. Under this structure, people in subsidized residential care pay up to 80 per cent of their after-tax income, provided that they have at least $275 remaining from their income each month. On December 11, 2011, the Ministry of Health announced that the minimum amount available to residents each month had increased to $325, in order to accommodate a Guaranteed Income Supplement (GIS) increase of $50 announced by the federal government in July 2011. The residential care fee, referred to as a "co-payment," ranges from $898 to $2,932 per month.[71]

Regulating Residential Care — Two Approaches

The following table shows that in 2010/11, there were 246.5 facilities, or 71 per cent of the 348 total residential care facilities for seniors in the province, licensed under the *CCALA*. In 2010/11, there were 101.5 facilities, or 29 per cent of the total facilities, governed by the *Hospital Act.*

[71] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates: Income-Based Client Rates, 7.B.2.

Residential Care

Table 3 – Residential Care Facilities and Beds by Type of Facility, 2010/11

	CCALA	*Hospital Act*			Total
		Extended care hospital	Private hospital	Total *Hospital Act*	
Number of facilities[1]	246.5	77.5	24	101.5	**348**
Percentage of total (%)	71	22	7	29	**100**
Number of beds	**19,165**	**7,099**	**2,728**	**9,827**	**28,992**

[1] Several health authorities have facilities with both *CCALA* and *Hospital Act* beds. These facilities were counted as 0.5 of a *CCALA* facility and 0.5 of a *Hospital Act* facility.

The *CCALA* was created in 2002 to replace the *Community Care Facility Act.* At that time, significant changes were made to the provincial home and community care program, and a new model of care was introduced. One of the outcomes of the 2002 changes was that everyone in subsidized residential care was identified as in need of "complex care." However, nearly 10 years later, the *Hospital Act* continues to refer to extended care facilities as providing a "higher level" of care than that provided in private hospitals.

Under Part 1 of the *Hospital Act,* a "hospital" is defined as a non-profit institution that has been designated a hospital by the Minister of Health and is operated for people "who require extended care at a higher level than that generally provided in a private hospital licensed under Part 2."[72] Today, however, all facilities governed by the *Hospital Act* provide care to "complex care" patients.

In my view, this fact is inconsistent with the definition set out in Part 2 and should be addressed. Ministry policy also perpetuates this inaccuracy.

Despite eliminating the different levels of care in 2002, the government has not fully addressed the historical differences in facility design, standards, services and user charges that continue because residential care is still provided in the three different types of facilities: community care facilities licensed under the *CCALA* and private hospitals and extended care hospitals governed by the *Hospital Act.*

[72] *Hospital Act*, R.S.B.C. 1996, c. 200, s.1. Hospitals under both parts currently provide care to complex care patients.

Residential Care

Differences between *Hospital Act* Facilities and Community Care Facilities

In general, the standards and oversight mechanisms that apply to facilities licensed under the *CCALA* are more extensive and rigorous than those that apply to facilities governed by the *Hospital Act.* The general public, and even seniors and their families, often may not know which act a particular facility is subject to. The act that governs the facility, however, does make a significant difference to the rules, standards and oversight mechanisms that govern the care provided.

For example, *CCALA* facilities are subject to routine inspection by licensing officers to ensure compliance with the standards set out in the Act and its regulation. *Hospital Act* facilities are not subject to routine inspection, and most have not been subject to regular inspection by the community care licensing offices in the health authorities or the Ministry of Health. Similarly, *CCALA* facilities are required to submit "reportable" incidents (as defined by the *CCALA*) to their local community care licensing office and their funding body, as well as to the affected resident's family and the resident's family doctor. *Hospital Act* facilities are not required to report these incidents.

Another difference is that, the *Hospital Act* requires extended care facilities (though not private hospitals) to provide both prescription and non-prescription drugs at no extra cost to residents. Facilities licensed under the *CCALA* are not required to do this. Those who live in either *CCALA* facilities or in private hospitals typically have their prescription costs covered by PharmaCare's Plan B, but must pay for their own non-prescription drugs.

Seniors do not have a choice about whether they are placed in a facility licensed under the *CCALA* or in a private or extended care hospital that is governed by the *Hospital Act.* Seniors who are assessed as eligible for a subsidized residential care bed are expected to accept the first bed they are offered and must be prepared to take that bed within 48 hours.[73]

In my view, the two regulatory approaches result in discrepancies and inequalities in care, oversight and costs to individual residents.

The Creation of New Residential Care Facilities under the *Hospital Act*

The discrepancies and inequalities created by the two regulatory approaches to residential care is an ongoing problem because of the creation of new facilities and new residential care beds governed by the *Hospital Act.*

[73] Ministry of Health, *Home and Community Care Policy,* April 2011, Residential Care Services, Long-Term Service Needs Determination, 6.C.

Residential Care

New *Hospital Act* facilities can only be created after they have been "designated" by the Ministry of Health. Similarly, the Minister of Health must issue a licence in order for a private hospital to operate. New residential care facilities and new residential care beds have been designated under the *Hospital Act* as recently as 2010.[74]

The designation of new facilities and replacement beds under the *Hospital Act* means discrepancies and inequalities continue to be created.

Harmonizing the Two Regulatory Approaches to Residential Care

The provincial government has started to recognize the need to harmonize the regulation of residential care facilities, but it has not yet completed the steps necessary to doing so.

The *CCALA* was passed in 2002 and the majority of it came into force in May 2004, but section 12 has not yet been proclaimed. Section 12 would bring the regulation of all residential care facilities under the *CCALA*.

The ministry identified several financial issues that it needed to address before implementation. These included the handling of capital advances for operators, the provision of pharmacy and diagnostic services, additional oversight costs, and the loss of exemptions from property taxes and goods and services tax (GST) for operators of *Hospital Act* facilities.

Proclaiming section 12 would put the 101.5 facilities and the 9,827 residents now governed by the *Hospital Act* in a similar situation as those under the *CCALA*. The decision to maintain two separate legislative frameworks for residential care has resulted in unfair differences in the care and services that seniors receive, the fees that they pay and the levels of monitoring and enforcement, depending on which act applies.

> *Proclaiming section 12 "will ensure that all vulnerable persons in residential care facilities are provided with the best possible protection to their health, safety and well-being."*
>
> Source: Ministry of Health, information bulletin, 5 October 2005.

[74] In March 2010, we were informed by the Fraser Health Authority that both the Madison in Coquitlam and the rebuilt Simpson Manor in Langley had been designated under the *Hospital Act*. Both facilities were built on property previously occupied by a facility licensed under the *Hospital Act*.

Residential Care

I have recommended that the Ministry of Health harmonize the residential care regulatory framework by January 1, 2013, by either taking the necessary steps to bring section 12 of the *Community Care and Assisted Living Act* into force, or taking other steps to ensure the same standards, services, fees, monitoring and enforcement and complaints processes apply to all residential care facilities. (If this option is chosen, the Ministry of Health should also amend the definitions in the *Hospital Act* to accurately reflect the fact that extended care hospitals and private hospitals provide complex care.) (R94)

I have recommended that until the regulatory framework for residential care is standardized, the Ministry of Health require the health authorities to include residential care facilities governed under the *Hospital Act* in their inspection regimes and report the results of those inspections on their websites. (R95)

I have also recommended that the Ministry of Health ensure that harmonizing the residential care regulatory framework does not result in any reduction of benefits and services for residents in any residential care facility. (R96)

Funding

Funding for subsidized residential care comes from two main sources: the provincial government and the monthly payments from residents (or their families). According to the Ministry of Health, the total cost of operating a residential care bed is about $6,000 per month, or $200 per day.[75] Depending on their incomes, subsidized residents currently pay between $898 and $2,932 per month of that cost.[76]

Provincial Government Decisions and Responsibilities

The Ministry of Health determines the total annual funding for each health authority. To do so, the ministry uses the previous year's budget for the health authorities and makes incremental adjustments based on predicted needs of the population for the coming year.[77] The ministry establishes the policies, directives and expectations that guide how the health authorities use the funds the ministry provides, and it sets the rates that subsidized residential care facility residents will pay.[78]

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75 Ministry of Health, "Home and Community Care Residential Care Facilities," fact sheet, undated.

76 Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates: Income-Based Client Rates, 7.B.2.

77 For more information on this process, see the description of the population needs-based funding model in the Home and Community Care section of this report.

78 Ministry of Health, *Revised 2011/2012-2013/2014 Service Plan*, May 2011, 6.

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While the ministry is not involved in day-to-day service delivery, it is accountable for the overall operation of the health care system. As the steward of health care in British Columbia, the ministry is responsible for ensuring that the health authorities receive the funding required to fulfill their service obligations and the ministry's expectations.

The ministry's funding decisions for residential care are guided primarily by past funding levels and the health authorities' overall budget requests. The ministry does not conduct an evaluation to determine whether the residential care budget in each health authority is sufficient to meet the needs of its population.

> **I have recommended that the Ministry of Health, working with the health authorities conduct an evaluation to determine whether the residential care budget in each health authority is sufficient to meet the current needs of its population. (R97)**

Health Authority Decisions and Responsibilities

In 2010/11, the total amount that the health authorities spent on residential care was more than $1.6 billion. This represents 76.6 per cent of their overall budget for home and community care programs and services.

We asked the health authorities how they decide how much of their budget will go to residential care services every year. Their responses were similar. They explained that they review the history of the residential care program in their region and the amount spent the previous year. They also consider predicted population and health status changes, program and service changes, the introduction of any new policies by ministries or other bodies, and the potential for increased costs.

The health authorities' overall spending on residential care has grown by an average of 3.5 per cent per year since 2002/03, resulting in a 23 per cent increase as of 2009/10. However, during that same period, the funding that the Ministry of Health provided to the health authorities increased by an even larger amount — 42 per cent.[79] As a percentage of their overall funding, the health authorities' total spending on residential care actually decreased from 19 per cent in 2002/03 to 16.3 per cent in 2009/10.[80]

79 This is based on figures found in the ministry's annual service plan reports from 2002/03 and 2009/10. Ministry of Health Services, *2002/03 Annual Service Plan Report,* 55 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2002_2003/hs/hs.pdf >; Ministry of Health Services, *2009/10 Annual Service Plan Report* Page 28 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2009_2010/hs/hs.pdf>.

80 This is based on figures found in the ministry's annual service plan reports from 2002/03 and 2009/10. Ministry of Health Services, *2002/03 Annual Service Plan Report,* Page 55 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2002_2003/hs/hs.pdf>; Ministry of Health Services, *2009/10 Annual Service Plan Report,* 28 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2009_2010/hs/hs.pdf>.

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Factors That Affect Funding for Individual Facilities

Past Funding Levels

The amount of funding that health authorities provide for an individual facility is based on the number of publicly funded beds it has and the level of funding it received in the past. When making funding decisions, health authorities begin with each facility's funding for the previous year and then adjust for inflation, negotiated salary increases and any exceptional circumstances, as defined by the health authority.

This approach can be problematic when all seniors who are in residential care today have complex needs. A number of older facilities in operation before 2002 had provided care to residents who did not have complex needs and so had historically been funded at a lower level.

Form of Ownership, Operating Costs and the Care Needs of Residents

During our investigation, we heard from operators of privately owned residential care facilities who were upset at what they saw as inequities in the funding that health authorities provide to the facilities they own (publicly owned facilities) versus the ones that are owned by non-profit or for-profit organizations (privately owned facilities).

Publicly owned facilities in the Interior Health, Vancouver Coastal and Vancouver Island health authorities, generally receive more funding than privately owned facilities. In the Fraser Health Authority, the reverse is true. These funding discrepancies exemplify the challenges in a system with a combination of public and non-public operators. The issues raised here also illustrate why it would be useful to publicly report the amount of funding provided to each facility.

Operating costs are another factor affecting the funding that health authorities provide to individual facilities. These costs differ depending on the legislation that facilities are governed by, which affects for example, how the facilities are taxed and whether or not they can charge for certain services and supplies, such as medication.

Budget Review Best Practice

When it does annual budget reviews, the Northern Health Authority examines actual costs and expenditures in detail to determine funding, and uses this process to reconcile any differences between the funding it provides for facilities governed by the Hospital Act *and those governed by the* CCALA.

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While all seniors must meet the same criteria to receive subsidized residential care, the actual care needs of residents vary, as does the funding required for their care. With the exception of Northern Health, we found that the health authorities do not have a process to consistently account for this difference when making funding decisions.

I have recommended that the Ministry of Health work with the health authorities to remedy any historically based anomalies in funding by establishing a consistent method to determine the funding requirements of residential care facilities, and that the ministry ensure that the process takes into account the care needs of residents, actual costs, capital expenses and taxes. (R98)

I have also recommended that the Fraser, Interior and Vancouver Island health authorities establish a three-year review cycle for determining the funding needs of individual facilities. (R99)

Eligibility and Assessment

Eligibility Criteria

In order to be eligible to receive subsidized residential care, a senior must be a Canadian citizen, a permanent resident or the holder of a Temporary Residence Permit that was issued on medical grounds by the federal minister responsible for immigration. It is also necessary for the senior to have lived in British Columbia for at least three months preceding application.

In addition to these general requirements, seniors must meet the other eligibility criteria for residential care that the Ministry of Health has established through policy. On April 1, 2011, the ministry's revised *Home and Community Care Policy Manual* took effect and with it, a new set of eligibility criteria for residential care. The policy manual states that health authorities can approve residential care services for a senior who:

- has been assessed as needing 24-hour professional nursing supervision and other care that cannot be adequately met in the senior's home or with community housing and supports
- is at significant risk by remaining in his or her current living environment, and the degree of risk is not manageable through available community resources and services
- has an urgent need for residential care services
- has been investigated and treated for medical causes of disability and dependency
- has a caregiver living with unacceptable risk to his or her well-being, or who is no longer able to provide care and support, or has no caregiver[81]

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[81] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

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These criteria all concern the degree and urgency of a senior's need for care. The amount of income or assets that seniors have is not a factor in determining their eligibility for subsidized residential care. While after-tax income determines the actual rate that seniors who are eligible for these services will pay, no one is disqualified from receiving subsidized residential care because his or her income is too high. However, in order to be eligible to receive subsidized care, seniors who wish to be placed in a subsidized residential care bed must also:

- agree to accept the first appropriate bed they are offered
- consent to be admitted to the facility
- agree to occupy the bed offered within 48 hours of being notified of its availability unless alternative arrangements are approved by the health authority[82]
- agree to pay the assessed client rate and any other permissible facility charges[83]

Under the existing policy and practices, seniors either have to accept the first appropriate bed they are offered or risk having their names removed from the waiting list. Some seniors and family members we spoke to during our investigation believed that they did not have any choice but to accept the bed being offered.

Requiring seniors to agree to take an offered bed within 48 hours, at an unidentified facility is not a reasonable pre condition for access. It is also unreasonable to make it a condition of eligibility that seniors agree to pay all applicable and permissible facility charges. Different types and amounts of charges and fees apply depending on which piece of legislation is in effect at a particular facility. Many people are not aware of these differences.

I have recommended that the Ministry of Health remove the two unreasonable conditions of eligibility for a subsidized bed in a residential care facility. (R100)

The two unreasonable conditions of eligibility are

- that seniors have to accept placement in an unknown residential care facility and move in within 48 hours of when a bed is offered
- that seniors have to agree to pay the applicable room rates and other permissible facility charges before knowing the amount of those costs

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[82] The revised *Home and Community Care Policy Manual,* effective April 1, 2011, requires health authorities to ensure that a client's capacity to provide informed consent to facility admission has been assessed, and that the client has consented in writing to be admitted to a residential care facility. Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: General Description and Definitions, 6.A.

[83] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

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Placement Process

Before 2002, access to subsidized residential care was based on the order in which a person's name was placed on a waiting list at each residential care facility. This process did not allow people who had more urgent care needs to be given higher priority for a subsidized bed. Since 2002, placement in residential care has been based on a system of priority access for people with higher needs as established by the health authorities in their assessment process. This is commonly referred to as the "first available bed" process.

Identification of Preferred Facilities

Given the current diversity of residential care facilities in British Columbia, it is important that seniors be offered as much choice as possible about the facility that will become their home and in which they will receive care. However, some seniors and family members we spoke with during our investigation told us that they were not asked to identify any preferred facilities during the assessment process. Others said that they understood they had to accept the first available bed but were not told it also had to be considered appropriate.

Neither the *Community Care and Assisted Living Act (CCALA)*, nor the *Hospital Act* establish a process for seniors who require residential care to choose where they want to live. The Ministry of Health's 2011 *Home and Community Care Policy Manual* requires health authorities to ensure that a senior eligible for residential care be given "the opportunity to identify a preferred facility or location."[84] However, the ministry does not track or require the health authorities to track the number of seniors who are asked to identify their preferred facilities or how many seniors are eventually placed in or transferred to their preferred facility.

Health authority practices vary in this regard. The Fraser Health Authority and Vancouver Island Health Authority (VIHA) told us their practice is to ask seniors to identify their preferred geographic area and one preferred facility. The Northern Health Authority allows seniors to specify two preferred facilities in communities that have more than one facility. The Interior Health Authority allows seniors in the Okanagan to identify up to three preferred facilities, while seniors outside the Okanagan can identify one. The Vancouver Coastal Health Authority allows seniors to identify one preferred facility.

Residential Care Access Policy — The First Appropriate Bed

The Ministry of Health's Residential Care Access policy requires seniors who are eligible for subsidized residential care to accept the first appropriate bed they are offered. While the ministry's home and community care policy manual does not define what constitutes an "appropriate"

[84] Ministry of Health, *Home and Community Care Policy Manual,* April 2011, Residential Care: Access to Services, 6.D.

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placement, it does state that "health authorities are responsible for determining the appropriate long-term residential care services to meet the client's needs."[85] During the assessment process, health authorities are expected to ensure that clients will agree to accept the first appropriate bed, even when a bed is not in their preferred facility or location.[86]

The Ministry of Health does not require health authorities to give seniors the opportunity to raise their concerns when they believe a placement they've been offered is inappropriate. Thus, the current system does not formally recognize resident choice as a factor in determining what is appropriate.

> **I have recommended that the Ministry of Health work with the health authorities to ensure that seniors who believe an offered placement is inappropriate have an adequate opportunity to raise their concerns and have them considered. (R101)**

VIHA's Placement Policy

In December 2010, VIHA distributed instructions to residential access case managers regarding how residential care bed placements are prioritized. The instructions give first priority to clients in the hospital when a new bed becomes available, and seek to ensure that a maximum of 25 per cent of placements come from the community.

Source: Vancouver Island Health Authority, *Plan to Achieve 75/25: Instructions for Residential Access Case Managers*, 6 December 2010, 1.

Management of Waiting Lists

As the number of people waiting for a subsidized residential care bed in British Columbia exceeds the number of available beds, each health authority maintains waiting lists. Seniors may be in a variety of places while they are waiting, including at home, in an assisted living residence, in the hospital, in a non-subsidized residential care bed, or in a subsidized residential care bed that is not in their preferred facility or community. According to ministry policy, clients on the waiting list should be prioritized based on the urgency of their care needs. In order for the management of waiting lists to be fair and reasonable, health authorities have methods for prioritizing clients based on their care needs and risk levels. When assessing risk levels, the health authorities consider where clients are currently living and whether and how their needs are being met. We reviewed the health authorities' practices for allocating available beds and noted significant differences among them.

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85 Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

86 Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C. Previously, clients were expected to accept the first available and appropriate bed. In the April 1, 2011, revision to the manual, the ministry removed the word "available."

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Transfers to Preferred Facilities

Seniors who are not able to move directly into their preferred facility can put their names on a waiting list to be transferred to their facility of choice. The health authorities maintain transfer waiting lists in addition to the lists of people waiting for placement. The ministry's *Home and Community Care Policy Manual* states that health authorities should equitably manage such a transfer.[87]

Given that the average length of stay for seniors in residential care is approximately 24 months, it is important that transfers occur quickly.[88] Yet in the cases we looked at during our investigation, we found it took an average of 12 months for seniors to be transferred out of the first bed they accepted to their preferred facility. In part, this occurs because seniors who are already in a subsidized residential care bed are assumed to be receiving good care and are generally considered to be a lower priority for placement than those who are in hospitals or living at home. Still, the length of the average waiting time means that for some seniors the opportunity to move to their preferred facility may be illusory.

We found that it is unfair for the Ministry of Health and the health authorities to tell seniors they can transfer to a residential care facility they prefer after accepting admission to the first appropriate bed without also informing them that they will be considered lower priority for transfer once they have accepted the first appropriate bed.

> **I have recommended that the Ministry of Health require the health authorities to inform seniors that they will be considered lower priority for transfer to their preferred facility once they have accepted the first appropriate bed and how long it is likely to take to transfer to their preferred facility. (R102)**
>
> **I have also recommended that the Ministry of Health require the health authorities to ask seniors who are waiting to be placed in residential care facilities to identify their three preferred facilities and accommodate those preferences whenever possible. (R103)**

Transfer from a Non-subsidized Bed

Seniors who need residential care wait an average of one to three months before they are offered a placement. The wait for a non-subsidized bed is much shorter, so seniors (or their families) who can afford to do so sometimes choose to pay for a non-subsidized bed, especially when they believe care is urgently needed. Meanwhile, they continue to wait for a placement in a subsidized

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[87] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Access to Services, 6.D.

[88] The average length of stay for seniors in residential region in 2008/09 was 28.3 months in the Fraser health region, 19.5 months in the Interior health region, 38 months in the Vancouver Coastal health region and 23.2 months in the Vancouver Island Health Authority. Northern Health was unable to provide this information, instead referring us to the Ministry of Health.

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bed. Because of the urgency of arranging care, families sometimes decide to do this even when they know they can only afford to pay for a non-subsidized bed for a short time. The cost of a non-subsidized bed may be $5,000 per month or more.

We heard from a number of people who were paying or had paid for a non-subsidized residential care bed while waiting for placement in a subsidized bed. They complained that they waited longer to be placed in a subsidized bed than they would have if they or their relative had stayed in the hospital or their own homes. Ministry of Health policy prioritizes access to residential care based on the urgency of need; however, once a person has been placed in a non-subsidized bed, the urgency of his or her assessed need drops.

As a result of a complaint our office received, we compared waiting times in two facilities to determine how long it took to receive a subsidized bed depending on where the resident was transferring from. In the two facilities, we found that the health authorities had clearly prioritized placement for seniors waiting for subsidized beds in hospitals or at home, because the placement times ranged from three weeks to two months from these two locations. By comparison, seniors who were waiting to be transferred to their preferred facility or who were transferring from a non-subsidized to a subsidized bed had waiting times between 12 months and 23 months. This discrepancy in waiting times may occur regardless of the seniors' needs and is also consistent with what the health authorities told us about how they manage their waiting lists for residential care.

> **I have recommended that the health authorities stop penalizing seniors who pay for a non-subsidized residential care bed while waiting for a subsidized bed by assigning them a lower priority on their waiting list for that reason. (R104)**

The ministry's revised *Home and Community Care Policy Manual* requires health authorities to inform seniors and their families about how the authorities manage their residential care waiting lists.[89] Having this information would be useful to people who are forced to make decisions on how to obtain the best care for their family members. However, because health authorities currently track overall waiting times only (and do not track how those times differ depending on seniors' circumstances), accurate information about wait times for initial placement in a subsidized care or transfer to a preferred facility is limited.

> **I have recommended that the health authorities provide clear information to seniors and their families on how priorities are determined for seniors waiting for initial placement in a subsidized residential care bed when the senior is waiting in acute care, at home, in assisted living and in a non-subsidized residential care facility. (R105)**

[89] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: General Description and Definitions, 6.A.

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I have recommended that the health authorities provide clear information to seniors and their families on how priorities are determined for seniors waiting to transfer to their preferred residential care facility. (R106)

I have also recommended that the health authorities track and publicly report every year on:

- **the average and maximum times seniors wait for initial placement from acute care, home, assisted living and non-subsidized residential care**
- **the average and maximum times seniors wait to be transferred to their preferred facility**
- **the percentage of seniors in residential care who are placed in their preferred facility immediately and within one year of their initial placement (R107)**

Waiting Times for Placement

In order to better understand how health authorities are managing the demand for residential care, we asked the health authorities to tell us how many people were waiting for placement in subsidized residential care on three dates: September 30, 2008, March 31, 2010, and March 31, 2011.

The following table shows that as of September 30, 2008, there were at least 1,246 people waiting for placement in a subsidized residential care bed in four of the five health authorities. Northern Health could not provide us with this information for 2008. As of March 31, 2010, there were a total of 1,805 people waiting for placement in subsidized residential care beds in all five regional health authorities, which was approximately 7 per cent of all subsidized residential care beds in British Columbia. As of March 31, 2011, there were at least 1,660 people waiting for placement in all five of the health authorities. This figure does not include one region in the Interior Health Authority as it did not provide that information.

The number of people waiting for placement grew between September 30, 2008, and March 31, 2011, in the Fraser, Interior and Vancouver Coastal health authorities. Fraser Health's waiting list grew in that time by 79 people, or 68 per cent; Interior Health's list grew by 102 people, or 21 per cent, and the Vancouver Coastal Health's list grew by 21 people, or 11 per cent. In comparison, VIHA's waiting list shrank during the same period by 1 person, a change of less than 1 per cent.

Northern Health did not provide information on its waiting list for 2008, but between March 31, 2010, and March 31, 2011, its waiting list declined by 12 people, or 6 per cent.

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Table 4 – People Waiting for Placement in Subsidized Residential Care, 2008, 2010 and 2011

Health authority*	Number waiting on		
	September 30, 2008	March 31, 2010	March 31, 2011
FHA	116	285	195
IHA	489	529	591[1]
NHA	Not provided	214	202
VCHA	191	255	212
VIHA	450	551	449
Total	**1,246 + NHA**	**1,834**	**1,649 + 1 IHA area unreported**

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

1 The IHA's 2011 figure excludes data for one area.

In February 2009, the Minister of Health sent a directive to the health authorities requiring them to report quarterly, beginning on July 1, 2009, on the percentage of clients admitted to residential care within 30 days of being assessed as eligible, as well as on the average waiting time from assessment to admission. According to the ministry, thirty days is the maximum wait advised for seniors with complex care needs. In 2010/11, the health authorities reported to the ministry on the percentage of clients admitted within 30 days as follows: 63 per cent in Fraser Health, 47 per cent in Interior, 29 per cent in Northern, 65 per cent in Vancouver Coastal and 30 per cent in VIHA.

As illustrated by these figures, there is still considerable work to be done to ensure that seniors who have been identified as high-needs clients who require 24-hour professional services are provided access to residential care within 30-days.

> **I have recommended that the Ministry of Health set a time frame within which eligible seniors are to receive subsidized residential care services after assessment and that the health authorities track the time it takes for seniors to receive residential care after assessment and report the average and maximum times to the ministry quarterly. (R108, R109)**
>
> **I have also recommended that the Ministry of Health report annually to the public on the average and maximum time that eligible seniors wait to receive subsidized residential care services after assessment. (R110)**

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Waiting Times for Transferring Seniors from Hospital to Residential Care

It is common for hospitalized seniors to be assessed as requiring residential care and then have to wait to be transferred to an appropriate facility. Ideally, seniors in this situation will be discharged from the hospital to home with support, and can wait there for an available bed. However, sometimes seniors have needs that cannot be met at home. In these cases, they may have no choice but to wait in hospital until they can be transferred to a residential care facility.

The waiting times for transfer from hospital to residential care can range from days to months. In one complaint we received, a woman had been in the acute care section of a hospital in the Northern Health Authority for a total of 16 months before she was placed in a subsidized residential care bed.

Except for Northern Health, each of the other health authorities provided us with figures from 2010/11 on their average waiting times for transfer from hospital to residential care.[90] Fraser Health reported 19 days, Interior Health 38 days, Vancouver Coastal 24 days, and VIHA 25 days.

> **I have recommended that the Northern Health Authority track the length of time seniors wait in hospitals for residential care before being transferred to a residential care facility. (R111)**

The overall cost of caring for a senior in the acute care ward of a hospital is far higher than the cost of doing so in a residential care facility. Despite this, the ministry does not have a meaningful way to track the increased costs to the health system that result from seniors who require residential care waiting in hospital to transfer. In addition to the higher costs, the beds that waiting seniors occupy are not available for other patients.

We learned that, like the Northern Health, the Ministry of Health itself does not track the length of time seniors wait in hospitals for transfer to residential care facilities, nor has it established time limits for this period.

Without this important information, the ministry cannot know how much more it costs to keep seniors in higher cost acute care beds in hospitals while they wait for a subsidized residential care bed.

Cost of Acute Care vs. Residential Care

Cost of an acute care hospital bed: $1,200 a night per senior

Cost of a residential care bed: $200 a night per senior

Savings of residential care vs. acute care: $1,000 a night, or $30,000 per month per senior

Source: BC Care Providers Association, "*Care Quarterly*," Winter 2010/11.

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[90] While this information is tracked for acute care, it is not made available to the public.

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I have recommended that the health authorities track the extra costs that result from keeping seniors who require residential care in acute care hospital beds and report these extra costs to the Ministry of Health on a quarterly basis, and that the health authorities report the length of time that seniors occupy acute care beds while waiting for placement to the Ministry of Health on a quarterly basis. (R112)

I have also recommended that the Ministry of Health report publicly every year on the length of time and the extra costs that result from keeping seniors who require residential care in acute care hospital beds. (R113)

Seniors in Hospital Waiting for Transfer to Residential Care

Seniors who are waiting in hospitals do not have access to the social and recreational activities that are a standard and required part of the service provided in residential care facilities. Furthermore, seniors who stay in a hospital longer than 30 days after the date on which they were assessed as needing residential care must pay the same monthly fee as that charged to people already receiving residential care, even though the waiting seniors are not yet receiving the same level of service. People who contacted us during our investigation told us that they thought charging seniors for hospital stays was inconsistent with the *Canada Health Act.*[91] People also thought that it was unfair to do so given that seniors in these circumstances are in hospitals only because of the lack of available residential care beds.

The *Canada Health Act* does not allow a province to charge user fees for services covered under its provincial health insurance plan, including hospital services. The only exception is found in section 19(2), which permits a province to charge a user fee for accommodation and meals provided to a person who, in the opinion of a doctor, requires chronic care and is "more or less permanently resident" in a hospital or other institution. The *Canada Health Act* is clear that people in these circumstances can be charged for accommodation and meals but that all other hospital services must be covered by the provincial health care insurance plan. Under the Act, these other hospital services include nursing, diagnostic procedures, and drugs when administered in the hospital; use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies, medical and surgical equipment and supplies; use of radiotherapy and physiotherapy facilities; and services provided by persons who are paid by the hospital.

Because the *Canada Health Act* permits charging people awaiting residential care for accommodation and meals, health authorities should know the daily cost of these services at every hospital. However, the ministry and the health authorities do not currently separate the costs of accommodation and meals in hospitals from the costs of the rest of the services seniors in hospital receive, which makes it impossible to determine whether the amounts charged are in compliance with the *Canada Health Act.*

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[91] *Canada Health Act*, R.S.C. 1985, c. C-6.

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When seniors stay in a hospital longer than 30 days after being assessed as requiring residential care, hospitals are authorized under section 8.1 of the *Hospital Insurance Act Regulations* to charge the same monthly rate as that charged to people receiving residential care.

Seniors in this situation do not receive the full range of residential care services, and the reason they are forced to wait in these less than ideal circumstances is the shortage of available beds. Since the ministry has said that 30 days is the maximum time seniors should have to wait for placement, I concluded that it is unfair for health authorities to charge seniors for their hospital stay when they are forced to wait longer than 30 days after assessment for a bed to become available.

> **I have recommended that the Ministry of Health ensure that the health authorities stop charging seniors assessed as needing residential care but who remain in hospital for longer than 30 days because of the unavailability of appropriate residential care beds. (R114)**

Consenting to Admission to a Care Facility

The question of consent should play a central role in discussions about admission to residential care facilities. Legally, adults are presumed to be capable of making decisions unless there is evidence to the contrary. It follows that seniors themselves should be the ones who consent to their admission to a residential care facility unless their capacity to make this decision is unclear. In these cases, seniors' capacity should be assessed.

If a senior is assessed as not being able to consent to admission and has not appointed a legal representative to make this decision on their behalf, steps have to be taken to appoint a legal representative or if there is imminent risk, the health authorities may admit the senior using the *Mental Health Act*.

There are however, other ways this could be more appropriately dealt with. One way the ministry could address this issue is to bring Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act (HCCFAA)* into force. Part 3 creates a process for appointing a substitute decision-maker when a person has been assessed by a health care provider as incapable of consenting to admission to a care facility and a substitute decision-maker is not already in place. The creation of Part 3 of the *HCCFAA* in 1996 and the changes made to it in 2007 attempted to establish a specific consent process for care facility admissions. However, Part 3 has yet to be brought into force. If Part 3 were brought into force, a substitute would be appointed in a way similar to how temporary substitute decision-makers are now appointed to make health care decisions.

> **I have recommended that the Ministry of Health take the necessary steps to bring into force Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act*, and in the interim provide health authorities with direction on when and how to conduct an assessment of a senior's capacity to consent to admission. (R115)**

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Neither the *Community Care and Assisted Living Act* nor the *Hospital Act* includes any specific provisions on the admissions process or on how to obtain consent to admission to a residential care facility. During our investigation, we observed inconsistencies in how facilities obtained this agreement, with some, but not all, requiring consent in writing. Problems can arise even when some form of written consent does exist. We saw examples of inadequate admissions documentation. In one case, a facility operator relied on a very general term in an admissions agreement as proof that a person had authorized future medical treatment.

> **I have recommended that the Ministry of Health work with the health authorities and service providers to develop a standard consent to admissions form for residential care facilities. (R116)**

Time Allowed for Moving In

Due to the pressures on the residential care system and the growing demand for beds, health authorities and facility operators try to minimize the time that beds are vacant. This creates pressure on seniors and their families to move into an offered bed as soon as possible.

The ministry's policy on approving people for admission to residential care requires them to occupy an offered bed within 48 hours of being notified of its availability.[92] As well, health authorities do not consistently inform people of their right to request an exception to the requirement to move into a facility within 48 hours of when a bed is offered. We heard from seniors and their families who found that this time limit caused them considerable difficulty. When we asked the Ministry of Health to explain the rationale for the time limit, it explained that its policy was based on several assumptions, including that the client will have had detailed discussions with case management staff about the options for placement.

While such a scenario may represent the ideal circumstances, we know that events often unfold in other ways. We received complaints from people who had not had a lengthy period of discussion and consultation in order to prepare themselves for their move. Some families also told us it was difficult to plan for a move when they did not know where or when their senior family member would be moving.

While the ministry's objective is to minimize the length of time that beds are empty, the policy does not strike a reasonable balance between this goal and the equally important goal of allowing seniors and their families enough time to properly prepare for a move.

> **I have recommended that the Ministry of Health develop a policy that is more flexible regarding the length of time allowed to move into a facility when a bed is offered, and provides a reasonable amount of time to plan for the move. (R117)**

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[92] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

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Challenges for Operators — Lack of Information about New Residents

In the course of our investigation, we heard from a number of facility operators who were concerned that they did not always receive enough information from health authorities about incoming residents. Effective management of underlying medical conditions, diet limitations, past behavioural concerns and other issues requires full and complete information. When they do not have such information, it is unfair to expect facility operators to be able to effectively meet their care obligations.

> **I have recommended that the health authorities work together with facility operators to develop a list of standard information about any new resident to be provided to the facility by the health authority a reasonable amount of time before a resident is scheduled to move in. (R118)**

As well, all health authorities have a first appropriate bed policy that can result in a senior being removed from a waiting list and having to reapply for placement if the offered bed is turned down.

This approach is heavy-handed, unfair, and counter productive given that seniors in this situation will have already been assessed and determined to require 24-hour care and supervision.

> **I have recommended that the health authorities stop making seniors reapply for services if they decline the first residential care bed offered but still want a residential care placement. (R119)**

> **I have also recommended that the health authorities inform seniors of their right to request an exception to the requirement to move into a facility within 48 hours of when a bed is offered. (R120)**

What Seniors Pay for Subsidized Residential Care

The amount a senior pays for subsidized residential care is based on his or her after-tax income. These charges, referred to as a "co-payment," range from $898 to $2,932 per month.[93] The ministry estimates the average cost of accommodation and hospitality services to be $2,932 per month, which it has established as the maximum rate seniors pay for subsidized residential care. The ministry identifies co-payments as residents' contribution to the cost of accommodation and hospitality services, such as meals, laundry and housekeeping.

The ministry considers the funding that health authorities provide to facility operators to be for the care services that residential care facilities provide, including nursing, therapy and assistance with daily activities such as eating, dressing, grooming and bathing. It has stated that the key principles

[93] Ministry of Health Services, *Home and Community Care Policy Manual*, April 2011, Client Rates: Income-Based Client Rates, 7.B; Client Rates for Specific Services, 7.B.2.

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underlying the co-payment structure are that the cost of residential care is shared between the province and the resident, that no person will be denied a placement in a facility because of the inability to pay, that residents should have enough disposable income after paying the co-payment to meet their basic personal needs, and that residential care clients should not pay more than the accommodation costs.[94]

The Residential Care Rate Structure

In January 2010, the province implemented a new rate structure for residential care. At the time it was announced, the ministry stated that the goal of the new rate structure was to free up ministry and health authority resources to use in the delivery of care in residential care facilities. Under the new structure, residents pay a monthly amount based on 80 per cent of their after-tax income and at the time of implementation were guaranteed to have a minimum of $275 left over each month. On December 11, 2011 the Ministry of Health announced that the minimum amount available to residents each month had increased to $325, in order to accommodate a Guaranteed Income Supplement (GIS) increase of $50 announced by the federal government in July 2011.

According to the Ministry of Health, the maximum charge is meant to represent the full cost of accommodation (room and board). In practice, however, the maximum client co-payment is based on the average cost of accommodation in residential care facilities across the province. This is a problem because the ministry has stated that one of the key principles of the residential care rate structure is that a resident's co-payment should not exceed the cost of accommodation.

In order to ensure that residents are not paying more than their actual accommodation costs, the ministry should review what the actual costs of room and board are in residential care facilities across the province. This would be simple to do if private facility operators and health authorities published the actual accommodation costs for their facilities.

> **I have recommended that the Ministry of Health work with the health authorities to develop a process for accurately calculating the costs of accommodation and hospitality services for each residential care facility that provides subsidized residential care, and ensure that seniors receiving subsidized residential care do not pay more than the actual cost of their accommodation and hospitality services. (R121)**

Room Differential Charges

We also received complaints from people who told us that they had no money left for living expenses after paying an extra fee or "room differential" for a private or semi-private room.

[94] Ministry of Health letter to Office of the Ombudsperson, 9 March 2010, 2-3. Accommodation costs include housing and hospitality services, such as meals, laundry and housekeeping.

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Since August 2000, all newly licensed facilities have been required to provide private bedrooms for residents at no additional charge. Similarly, new facilities licensed since that time have been permitted to house up to 5 per cent of residents in double-occupancy rooms as long as certain privacy and other conditions are met.[95] However, some facilities that were licensed before August 1, 2000, or facilities governed by the *Hospital Act* have more rooms with multiple residents, and some continued to charge an extra room differential fee for residents who want a semi-private or private room.

In the course of this investigation, we visited facilities with only private rooms, facilities with semi-private rooms, facilities with four-bed rooms, facilities with a combination of private and semi-private rooms and even one facility that had six people in a room. We observed inconsistencies in how facility operators charged room differentials. For example, in many of the newer facilities that we visited, private rooms were the norm and residents were not charged a room differential. However, in other facilities, we found that every resident had to pay a room differential of either $6 or $9 per day ($2,190 or $3,285 a year).

As of January 31, 2010, ministry policy on allowable charges in residential care allowed room differentials to be imposed only where the health authority determined that the room was "demonstrably superior" and the resident requested, and occupied, the room. However, there was a delay in the implementation of this policy, and room differentials were not discontinued in some facilities until October 2010. This meant that some residents were still paying room differential fees even after the ministry imposed its new residential care rate structure in January 2010. In all, 75 per cent of residents paid higher rates after the introduction of the new fee structure, and we received complaints that some had little or no money left after paying both the new rates and room differential. There is a hardship waiver process for fees, but people told us that they were not allowed to claim the room differential as an expense.

The ministry has since indicated that its policy on eliminating room differentials is not mandatory until April 1, 2013. Until then, there is no policy in place to prevent facility operators from charging room differentials as they did before, even though operators are already being compensated for eliminating differentials by the new rate structure, and even though ministry policy states that the charging of room differentials should end.

In my view, the ministry should have anticipated this result and taken steps to remedy the inequities before changing the residential care rate structure. Alternatively, it should have ensured that those people who were adversely affected by the practice were able to claim the room differential as an expense on hardship waiver applications.

[95] Because the *Hospital Act* and its regulations do not require private and extended care hospitals to have room requirements similar to those in *Community Care and Assisted Living Act* facilities, we observed that these facilities often had two- and four-bed rooms.

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I have recommended that the Ministry of Health establish a process for people to apply to the ministry for a review of the fees paid if they believe they were unfairly charged room differentials between January 1, 2010, and October 1, 2010. (R122)

Plans for Use of the New Money

When the ministry introduced the residential care rate structure in October 2009, it gave a number of reasons for the increase. One of these reasons was that all the extra revenue generated by the new residential care rate structure would be reinvested in residential care services to improve the care provided to seniors.[96] In a debate of the legislative assembly on October 19, 2009, the minister stated that "every dollar raised will go back towards providing increased staffing and increased care" in residential care facilities.

After introducing the new rate structure, the ministry required every health authority to submit estimates of their actual revenues and spending by March 15, 2010. As well, the ministry required every health authority to account for how it would spend the new money over the next four years (2009/10 to 2012/13). The ministry identified the spending priorities it would support and specifically advised Fraser Health and Vancouver Coastal Health that they should prioritize increasing direct care hours. The health authorities then asked for the ministry's consent to use a portion of the new money to offset the lost revenue from eliminating room differentials. The ministry agreed that the health authorities could use some of this additional revenue to do that. This change was made despite the ministry's public assurances that all additional revenue would be directed to improving care.

This was surprising given that none of the health authorities' plans, with the exception of Northern Health's, showed how the new revenue would be spent on increasing the average number of daily direct care hours provided per resident. The Ministry of Health provided the health authorities with a framework to assist in the development of their plans for spending the new money generated from the increased rates. The health authorities used cost assumptions provided by the framework to ensure that their plans reflected a consistent provincial approach to residential care staffing. One of the cost assumptions was that there would be 3.36 worked hours of direct care provided per day, per resident, of which 3.00 hours was to be of nursing, and .36 was to be of allied, or supporting care. The Ministry indicated that this number of direct care hours was a "guide for health authorities to aspire to".[97]

The table below shows the number of total daily direct care hours projected in the plans submitted by each health authority.

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96 Minister of Health Services, "Residential Care: Rate Structure for Residential Care Clients," presented 25 May 2010.

97 Home and Community Care Program, "Residential Care Staffing and Reporting Tool Frequently Asked Questions", internal document, 3.

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Table 5 – Projected Daily Direct Care Hours Compared with Ministry Guideline (3.36 Hours), 2009/10 to 2012/13

Health authorities*	2009/10		2010/11		2011/12		2012/13	
	Hours	% of guideline	Hours	% of guideline	Hours	% of guideline	Hours	% of guideline
FHA	2.64	79	2.80	83	2.88	86	2.89 (approx.)	86
IHA	3.13	93	3.23	96	3.35	99	3.35	99
NHA	3.66	109	3.72	111	3.57	106	3.57	106
VCHA — initial plan	2.81	84	2.81	84	2.81	84	2.81	84
VCHA — revised plan	2.81	84	2.91	87	2.95	88	2.95	88
VIHA — initial plan	3.11	93	3.02	90	3.02	90	3.02	90
VIHA — revised plan	3.11	93	3.18	95	3.18	95	3.18	95

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

The figure of 3.36 care hours does not appear to be a binding target or requirement. It was a guideline from the ministry to the health authorities in developing their plans for use of the extra revenue.

Even with increased revenue, none of the health authorities, except Northern Health, plan to meet the ministry's guideline of 3.36 of daily direct care hours per resident by 2012/2013. The Fraser, Interior, Vancouver Coastal, and Vancouver Island health authorities' plans still fall short of the 3.36 hours of daily care per resident used as a costing assumption by the ministry. It is therefore surprising to see approval for non-care-related measures such as offsetting the impact of room differential elimination and complying with the ministry's policy on chargeable extras.

I have recommended that the Ministry of Health provide further and more detailed public information on how the additional revenue generated by the new residential care rate structure is being spent and what improvements to care have resulted in each facility. (R123)

I have recommended that the Ministry of Health, together with the Interior, Fraser, Vancouver Coastal and Vancouver Island health authorities, ensure that each health authority, at a minimum, meets the ministry's guideline of providing 3.36 direct care hours by 2014/15. (R124)

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Chargeable Extras

Extended care hospitals are not permitted to charge extra for some of the services and items private hospitals that are governed by Part 2 of the *Hospital Act* and facilities that are licensed under the *Community Care and Assisted Living Act* can. These regulatory differences have resulted in disparities in the additional charges that seniors pay in residential care facilities across the province. Aside from the differences in the legislation that applies, this inconsistency has no apparent rationale and results in people who require the same level of care being treated differently.

> **I have recommended that the Ministry of Health establish a process to review the fees at different facilities and take all steps necessary to ensure that they are consistent and that this action does not result in increases in fees for seniors in residential care. (R125)**

The ministry's *Home and Community Care Policy Manual* that took effect January 31, 2010 defined several residential care services and supplies as "benefits" that had to be provided at no charge to the client. Health authorities were to ensure that operators did not charge residents extra for these benefits.[98] These benefits include supplies such as incontinence management items, and services such as routine laundry for bed linens, towels, washcloths and clothing.

In April 2011, the ministry replaced that version of the *Home and Community Care Policy Manual* with a revised manual, which is currently in effect. In distributing the revised manual, the ministry told health authorities and operators that they did not have to comply with the policy on benefits and allowable charges until April 1, 2013.

This means that the ministry's current position permits residential care facility operators to charge residents for items and services that they were not allowed to charge for between January 2010 and April 2011, and which the ministry describes as benefits included in resident fees. These charges may place a significant financial burden on seniors.

> **I have recommended that the Ministry of Health require health authorities and facility operators to comply with its policy on benefits and allowable charges immediately rather than by April 1, 2013. If this results in an unexpected financial inequity for certain operators, the ministry take steps to resolve this inequity in a fair and reasonable manner. (R126)**

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[98] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Benefits and Allowable Charges, 6.F.

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Rate Reductions and Waivers

Many seniors in residential care facilities, especially if their only or main source of income is government programs, can be left with very little per month after paying their assessed rate for residential care. This amount has to cover the costs of basics such as non-prescription medication, wheelchair rental, bus trips, cable, extra baths and telephone — as well as less strictly necessary but still important items such as birthday gifts for grandchildren.

Seniors who are receiving subsidized residential care can apply to their regional health authority for a reduction or waiver if they experience "serious financial hardship" as a result of paying their assessed rate. According to the policy, "serious financial hardship" is when paying the assessed rate results in the resident or spouse being unable to pay for food, heat, prescribed medication, health care services, mortgage or rent.

When deciding whether to grant rate reductions or waivers for home and community care services, health authorities use an Application for Temporary Reduction of Client Rate form. Seniors must supply proof of their own income and expenses as well as those of their spouse and/or dependants. However, not all expenses can be claimed on the application. Seniors living in a residential care facility are only allowed to claim their costs for medical services premiums, life insurance (to a maximum of $50 per month), prescription drugs not covered by PharmaCare, dental costs and the cost of medical equipment purchase, rental or maintenance. Costs for services such as telephone, cable and transportation can only be claimed for a spouse or dependant living at home. Seniors in residential care facilities cannot claim for personal hygiene products or services or for items such as shoes, clothes and gifts.

Costs for spouses and dependants that are not identified as allowable expenses are meant to be accounted for under the heading "General Living Expenses" on the Application for Temporary Reduction of Client Rate form. A resident without a spouse or dependant at home cannot claim general living expenses because these costs are considered benefits that are covered by his or her assessed rate. A resident with a spouse or one dependant can claim general living expenses of $5,796 per year, which works out to $483 per month. This amount has not increased since 2002.

> **I have recommended that the Ministry of Health and the health authorities ensure that the full costs seniors pay for residential care, including extra fees for services, supplies or other benefits, as well as other reasonable expenses that seniors have an obligation to pay, are considered when assessing their eligibility for hardship waivers. (R127)**
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> **I have also recommended that the Ministry of Health immediately conduct a review of the amount that can be claimed for general living expenses on applications for hardship waivers and make necessary changes, and review and update the list of allowable expenses every three years. (R128)**

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Income Splitting and Residential-Care Rates

Income splitting is a strategy of shifting income from a higher income earner to a lower income earner in order to reduce the overall tax paid by the family. In October 2006, the federal government announced that it would allow couples to split pension income as of 2007. While the tax benefits and programs that are calculated based on the total income of both spouses ("family income") are not affected by the split, the costs of any benefits or programs that are calculated based on the income of a single spouse can be affected. Eligibility for subsidized residential care and the rate that eligible people pay for that service is calculated based on the after-tax income of only the person who is applying for or receiving the care and therefore is affected by an income split.

While income splitting results in lower residential care rates for spouses with higher earnings, it has the opposite effect for those with lower earnings. Given that this is not widely known, the health authorities should ensure that those who are applying for placement in a subsidized residential care facility are informed that income-splitting arrangements affect the rates charged.

> **I have recommended that the Ministry of Health and the health authorities work together to provide information for the public on how income splitting can affect the residential care rate that seniors are required to pay. (R129)**

Use of the *Mental Health Act* to Admit Seniors to Residential Care Involuntarily

A senior can be admitted to residential care in one of two ways: with consent, or as an involuntary patient under the *Mental Health Act.*[99] The vast majority of seniors in residential care are there by their own consent.[100] However, in the course of our investigation, we learned that in 2010/11 there were at least 100 seniors living in residential care facilities across British Columbia who were there as involuntary patients under the *Mental Health Act.*

The purpose of the *Mental Health Act* is to allow treatment of patients who require protection and care because they have mental disorders. The *Mental Health Act* was rewritten in 1964 and the provisions that apply to these situations have remained largely unchanged over the past 50 years. Section 22 of the Act allows directors of mental health facilities to admit someone to a mental health facility and detain that person for up to 48 hours for the purposes of examination and treatment. That period can be extended beyond the original 48 hours if the director obtains

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[99] A legal representative must be authorized to make personal care decisions to consent to a person's admission to residential care facility.

[100] Consent must be provided by a senior who has the capacity to consent to his or her own admission, or by a person who has legal authority to consent to the admission.

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a second medical certificate. Directors can only admit a person involuntarily if they have received a medical certificate completed by a doctor who has examined the person. The physician must have certified that the person:

- has a mental disorder[101]
- requires treatment in or through a mental health facility[102]
- requires care, supervision and control to prevent substantial mental or physical deterioration, or for the protection of the person or others
- cannot be admitted as a voluntary patient[103]

Section 37 of the *Mental Health Act* also authorizes a director to release a patient "on leave" into the community without affecting the legal status of the involuntary detention.[104] A person who is put on leave and transferred to a residential care facility continues to receive treatment, but in a residential care facility instead of a mental health facility. When this happens, the practice in all the health authorities is to charge the person on extended leave a residential care fee.

While involuntary detention has serious impacts on a person's civil liberties, in the exceptional cases where seniors require protection and cannot consent to admission, and there is no one else who will do so on their behalf, it may be necessary for health authorities to involuntarily admit seniors to a mental health facility and then transfer the senior to residential care. The *Mental Health Act* is the only available statute that allows this. However, given the serious implications of involuntarily admitting seniors to residential care, and the fact that the *Mental Health Act* was not enacted for this express purpose, we expected that the Ministry of Health and the health authorities would have created procedures to guide directors of mental health facilities in their use of section 22 of the Act. We found that this is not the case. Neither the ministry nor the health authorities have established procedures in this area.

> **I have recommended that the Ministry of Health ensure that seniors' civil liberties are appropriately protected by working with the health authorities to develop a clear, province-wide policy on when to use sections 22 and 37 of the *Mental Health Act* to involuntarily admit seniors to mental health facilities and then transfer them to residential care. (R130)**

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[101] Section 1 of the Act defines "person with a mental disorder" as "a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability (a) to react appropriately to the person's environment, or (b) to associate with others." *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.

[102] Section 1 defines "treatment" as safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment. *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 1.

[103] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22.

[104] *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 37.

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Also, the provincial government has an option that would deal with care facility admissions on a comprehensive basis. Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act (HCCFAA)* would create a process allowing a substitute decision-maker, as defined in the Act, to consent to the admission of an adult who is not capable of making an informed decision to enter a care facility.[105] Bringing Part 3 of the *HCCFAA* into force could reduce the instances in which health authorities use the *Mental Health Act.* In the "Consenting to Admission" section of this report I recommended that the ministry take the necessary steps to bring Part 3 of the *HCCFAA* into force.

Charging Fees to Involuntary Patients

We also learned during our investigation that all the health authorities charge residential care fees to patients who have been involuntarily admitted to a mental health facility or psychiatric unit and then put on extended leave and transferred to a residential care facility. While the *Mental Health Act* has been in place in its current form since 1964, it has not been possible to determine when this particular practice began.

We examined the legislative authority for this practice and found it to be unclear. A patient involuntarily admitted to a provincial mental health facility does not have to pay fees while detained there.

It is therefore inconsistent and unfair to charge fees to seniors who have been involuntarily admitted to a mental health facility and then — also involuntarily — put on extended leave in residential care facilities.

From the perspective of health authorities, these seniors are home and community care clients, because they are receiving care in residential care facilities and health authorities are allowed to charge fees for home and community care. However, this rationale ignores the fact that these seniors are involuntary patients who have been detained in residential care facilities under the authority of the *Mental Health Act.*

Unlike other seniors in residential care, seniors who are involuntarily in residential care under the *Mental Health Act* are there against their will, have not agreed to pay the fees, are not at liberty to leave, and may have treatment imposed on them.

> **I have recommended that the health authorities stop charging fees to seniors they have involuntarily detained in mental health facilities under the *Mental Health Act* and then transferred to residential care facilities. (R131)**
>
> **I have also recommended that the Ministry of Health develop a process for seniors who have paid fees for residential care while being involuntarily detained under the *Mental Health Act* to apply to the ministry to be reimbursed for the fees paid. (R132)**

[105] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181.

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Quality of Care

The quality of care that seniors receive in residential care facilities is the most significant concern for residents and their families.

Quality care is care that is compassionate, timely, responsive, skilled and professional. It promotes the safety, independence, dignity and overall well-being of residents by ensuring that their physical, social, emotional, spiritual and cultural needs are being met. Without strong, enforceable minimum standards for each area of care, the operators and staff of residential care facilities, however well intentioned, may fall short of providing quality care.

There are four essential aspects of residential care: suitable and well-maintained accommodation, adequate professional care that meets the health and hygiene needs of residents, satisfying and nutritious meal services, and a program of activities that meets the social, recreational and cultural needs of residents and enhances their quality of life. The minimum standards for these services are set by the *Residential Care Regulation* and vary from detailed and prescriptive requirements to outcome-based measures. For example, in relation to accommodation, section 27 of the Regulation goes into great detail and states that single-bed rooms must have at least 11 square metres of usable floor space for those who require mobility aids, and at least 8 square metres of usable floor space for those who do not require the aids.

However, such specific, objective standards are generally lacking for the other three major aspects of residential care. For example, the regulations on professional care and recreation under the *Community Care and Assisted Living Act* offer only outcome-based criteria that are non-quantifiable and not subject to objective evaluation. Specifically, with respect to activities, the *Residential Care Regulation* requires an operator to designate an employee to "organize and supervise physical, social and recreational activities for persons in care."[106] The regulations made under the *Hospital Act* do not specify specific standards for these four aspect of care.

The government has chosen to use prescriptive standards for some aspects of care and outcome-based standards for most others. This shift toward outcome-based standards is in keeping with the trend of the past 20 years. The *Adult Care Regulations,* which came into force in 1980 and applied to licensed residential care facilities, contained specific and quantifiable staffing standards. The current *Residential Care Regulation* requires only that "the employees on duty are sufficient in numbers … to meet the needs of persons in care and assist persons in care with activities of daily living. … In a manner consistent with the health, safety and dignity of persons in care."[107]

In addition to these regulations, the ministry and health authorities have established some policies and practices to guide the delivery of care. Again, however, these policies and practices contain only subjective, outcome-based criteria. While providing operators with some level of flexibility is

[106] *Residential Care Regulation*, B.C. Reg. 96/2009, s. 45.

[107] *Residential Care Regulation*, B.C. Reg. 96/2009, s. 41.

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reasonable and useful, relying strictly on subjective, outcome-based criteria means that operators, health authorities and the ministry do not have to meet specific benchmarks for the various areas of care.

Our full report (Volume 2) examines a number of areas where quality of care has concerned seniors and their families including bathing frequency, dental care, help with going to the bathroom, call-bell response times, meal preparation and nutrition, recreation programs, and culturally appropriate services. In this summary, we highlight three areas: bathing frequency and help with going to the bathroom, and meal preparation and nutrition.

Bathing Frequency and Help with Going to the Bathroom

In hearing the concerns of seniors and their families about the quality of certain services and aspects of care provided in residential care facilities, bathing frequency was mentioned often.

Maintaining personal hygiene is important for a person's physical and mental well-being. Both seniors and their families complained to us that seniors in residential care facilities, many of whom are incontinent, were not able to bathe often enough.

While the *Residential Care Regulation* requires facility operators to ensure that "the employees on duty are sufficient in numbers … to meet the needs of persons in care and assist persons in care with activities of daily living," it does not specify how often residents must be bathed.[108] It is common in residential care facilities in British Columbia for residents to receive one tub bath a week. This contrasts with Ontario's regulations, which require that all residents receive at least two baths or showers each week.

Bathing is a good example of an area of care where specific minimum standards could be established and where doing so would benefit seniors and their families.[109]

Timely assistance with going to the bathroom is another major concern for seniors in residential care facilities and their families. One person we heard from noted that "due to staffing levels the residents are toileted at specific times only, so for my mother … if she needs to go to the bathroom outside of her times she ends up going into the diaper as she cannot possibly hold out." At another facility we visited, staff identified a problem providing this type of help in a timely way. The director of care said she would like to have a team of people devoted to providing assistance with going to the bathroom.

[108] *Residential Care Regulation,* B.C. Reg. 96/2009, s. 42.

[109] *Long-Term Care Homes Regulation,* Ontario Reg. 79/10, s. 33.

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Individual health authority practices vary when it comes to this area, but the degree of concern expressed suggests that greater efforts need to be made to improve practice in this area. Any standard developed should apply equally to facilities governed by the *Hospital Act,* where no such requirements are currently in effect.[110]

Meal Preparation and Nutrition

Among the concerns we heard most often during our investigation were those about the quality of food, food choices, methods of food preparation, and availability of staff to assist seniors with eating. The *Residential Care Regulation* contains a number of requirements for menu planning, nutrition, meal preparation and service. Specifically, the Regulation states that menus must provide "a variety of foods" that account for "the nutrition plan of each person in care. … The food preferences and cultural background of the person in care, seasonal variations in food, and the texture, colour and matters that affect food safety, taste, and visual appearance".[111]

The Regulation also requires meals to contain "at least three food groups as described in *Canada's Food Guide*." Operators are also supposed to ensure that "persons in care have sufficient time and assistance to eat safely and comfortably."[112]

We found that food-related practices differ among individual facilities. In British Columbia some facilities cook meals on-site and others bring in prepared food — in some cases from as far away as Toronto — and simply reheat or "re-therm" it on site. In contrast, in Ontario, every facility must have "an organized food production system" on-site.[113] That system must be supported by a full-time cook, food service workers, a dietician and a nutrition manager, all of whom meet the minimum training qualifications specified in the regulations.[114]

Similar variations are apparent when it comes to providing assistance with eating. Most health authorities do not have specific policies on assistance with eating, but instead expect this to be addressed in individual care plans and through various types of non-binding guidelines and educational programs for staff.

As is the case with the other aspects of care discussed in this section, the *Hospital Act* and its regulations do not even have the same requirements about food service or meal preparation as those currently in the *Community Care and Assisted Living Act (CCALA)* and its *Residential Care Regulation*.

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[110] *Residential Care Regulation,* B.C. Reg. 96/2009, s. 42.

[111] *Residential Care Regulation,* B.C. Reg. 96/2009, s. 62(2).

[112] *Residential Care Regulation,* B.C. Reg. 96/2009, s. 62.

[113] *Ontario Long-Term Care Homes Regulation,* Ontario Reg. 79/10, s. 72(1).

[114] *Ontario Long-Term Care Homes Regulation,* Ontario Reg. 79/10, ss. 74-77.

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To ensure fair and equitable treatment for seniors in residential care, specific, measurable and enforceable standards should be in place to cover key aspects of care.

I have recommended that, after consulting with the health authorities, facility operators, seniors and their families, the Ministry of Health establish specific and objectively measurable regulatory standards that apply to key aspects of care in all residential care facilities, including:

- **bathing frequency**
- **dental care**
- **help with going to the bathroom**
- **call-bell response times**
- **meal preparation and nutrition**
- **recreational programs and services**
- **provision of culturally appropriate services**

I have recommended that the ministry take these steps by April 1, 2013.(R133)

I have also recommended that the Ministry of Health and the health authorities, in cooperation with facility operators, collect available data on call-bell response times and utilize this data in setting objective standards for reasonable response times. (R134)

Restraints

Like all adults, seniors in residential care have the right to be treated in a manner that promotes their health, safety, dignity and personal freedom. Regardless of the circumstances or the method used, restraining someone reduces that person's individual liberty and affects his or her dignity.

Given the gravity of this consequence, it is vital that all types of restraints are used to the least degree necessary. Restraints should be used only when necessary to protect the health and safety of the person being restrained, other residents or employees. No restraints should ever be used to discipline or coerce residents or for the convenience of facility staff.

Did You Know?

Environmental restraints, such as the use of secure building units with electronic exits that require access codes, also constitute a form of restraint. Seniors can lawfully be accommodated in secure units only if they or their legal representatives have consented in writing and where the restraint is documented in the resident's care plan.

Source: *Residential Care Regulation*, B.C. Reg. 96/2009.

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The *Residential Care Regulation* defines a "restraint" as "any chemical, electronic, mechanical, physical or other means of controlling or restricting a person in care's freedom of movement in a community care facility, including accommodating the person in care in a secure unit."[115]

Legislative Protection for Seniors

There are no legislated requirements in the Hospital Act *that limit the use of restraints in private hospitals or extended care facilities.*

The use of restraints is another area where the level of protection for seniors varies, depending on which of the two regulatory frameworks applies to the facility in question.

Under the *CCALA,* the *Residential Care Regulation* allows the use of a restraint only when all of the following conditions are met:

- it is necessary to protect the resident or others from serious physical harm
- it is as minimal as possible, and
- the safety and physical and emotional dignity of the resident is monitored throughout the use of the restraint and assessed after its use

In addition, the regulation requires that operators document the type of restraint used; the reason for its use; the alternatives considered, implemented or rejected; the duration and monitoring of the restraint; the result of any reassessment of its use; and employees' compliance with applicable requirements.

The *Residential Care Regulation,* which applies only to those facilities licensed under the *Community Care and Assisted Living Act (CCALA),* places significant limits on the use of restraints and includes requirements for reporting and documenting their use. These conditions do not apply to facilities governed by the *Hospital Act*.

> **I have recommended that the Ministry of Health take the necessary steps to ensure that the *Community Care and Assisted Living Act's* standards for the use of restraints apply to all residential care facilities in the province. (R135)**

When Restraints Can Be Used

Operators can restrain a resident only in an emergency or with written consent of the resident or his or her legal representative and the medical or nurse practitioner who is responsible for the resident's care.

[115] *Residential Care Regulation,* B.C. Reg. 96/2009, s. 1.

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Before restraining a person with consent, the following requirements must also be met: any alternatives to the restraint must have been used already or considered and rejected; the staff person administering the restraint must be trained in restraint use and monitoring; and the use of the restraint, its type and the duration of its use must be documented.

The Regulation requires operators to reassess the need for the restraint at least once within 24 hours after it is first used. After 24 hours, written consent for continued use of the restraint is required from both the resident (or his or her agent) and the practitioner overseeing his or her care. If this consent is not available, use of the restraint must end after 24 hours.

According to the Regulation, the emergency use of a restraint is a reportable incident, meaning that the operator must immediately notify the resident or his or her contact person, the medical or nurse practitioner responsible for the resident's care, a medical health officer, and any funding program involved in the resident's care. We asked each of the health authorities to provide us with a list of all reportable incidents that occurred in their region from April 1, 2008, to March 31, 2011. During this period, the emergency use of restraints was reported four times to the Fraser Health Authority, four times to the Vancouver Coastal Health Authority, 16 times to the Interior Health Authority, once to the Northern Health Authority and 74 times to the Vancouver Island Health Authority (VIHA). VIHA believes the higher number may result from the efforts it had made to educate operators about the requirement to report emergency restraints.

While section 74 of the *Residential Care Regulation* provides that a licensee may restrain a person in care in an emergency, it does not define "emergency." Schedule D of the Regulation does define "emergency restraint" for the purpose of identifying a reportable incident. For Schedule D, an emergency restraint is any use of a restraint in an emergency. This definition is circular and unhelpful.

> **I have recommended that the Ministry of Health define "emergency" and the circumstances in which an operator is permitted to restrain a resident without consent. (R136)**

Chemical Restraints

Residents with dementia may wander, shout and suffer from disturbed sleep. These symptoms negatively affect the health of those who suffer from them and increase the demands on facility staff responsible for their care. They may also create safety issues for other residents.

Doctors may prescribe treatment to reduce the disruptive symptoms of dementia for the benefit of the affected patient. In these circumstances, medication is prescribed for a therapeutic benefit, such as to help a patient sleep.

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However, when medication is either prescribed or administered for the purpose of controlling behaviour — beyond any therapeutic benefit — it is used as a restraint. In practice, this can be a difficult distinction to make, because in both cases, medication is used to control behaviour. The problem is further complicated by the fact that drugs used to treat dementia symptoms may be prescribed on an "as needed" basis. This means it is up to facility staff to exercise discretion in deciding when medication should be administered. Currently, the Ministry of Health does not have a province-wide policy to guide the use of chemical restraints or medication prescribed on an "as needed" basis in care facilities.

The use of medication as a chemical restraint is subject to the *Residential Care Regulation*. Except in the case of an emergency, the use of a chemical restraint requires prior written consent from the resident (or his or her representative) and from the doctor or nurse responsible for the resident's care. As with other types of restraints, the use of medication as a restraint is governed by the conditions outlined above, such as the requirement for reassessment after 24 hours.

During our investigation we heard from people who were concerned that the use of antipsychotic drugs in residential care facilities were being used to restrain residents and had become a routine way of coping with restless and anxious residents.

The use of antipsychotic drugs in residential care facilities is an on-going issue. The Ministry of Health initiated a review of the use of antipsychotic drugs in residential care facilities throughout British Columbia. The results were made public in December 2011. Its recommendations include a review of section 73(2) of the *Residential Care Regulation* to determine whether it provides appropriate protections as well as education and greater oversight and monitoring in this area.

> **I have recommended that the Ministry of Health complete a review on the use of antipsychotic drugs in residential care facilities and make the report available to the public. (R137)**
>
> **I have also recommended that the Ministry of Health work with the health authorities, resident and family councils and other stakeholders to develop a province-wide policy to guide facility operators and staff members on the appropriate use of chemical restraints. (R138)**

Administering Medication

Administering medication is one of the important services provided in residential care facilities in British Columbia. According to the *Residential Care Regulation* under the *Community Care and Assisted Living Act*, operators must ensure that residents are only given medication that has been prescribed or ordered by a nurse or physician.[116] Operators must also keep a medication

[116] *Residential Care Regulation,* B.C. Reg. 10/2010, s. 70(1).

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administration record for each person in their care, showing the date, amount and time of any medication administered. As well, operators must have written policies and procedures concerning the medication monitoring of a person in care.[117]

Consent

Before medication or any other form of health care is provided to a senior in a residential care facility, the health care provider (which includes a physician, nurse or other person licensed to provide health care) must obtain informed consent to the care.[118] The only exception is in an emergency. According to the *Health Care (Consent) and Care Facility (Admission) Act (HCCFAA),* the consent to health care, including administration of medication, can be oral, written or inferred from conduct.[119]

In order for the consent to be valid, the health care provider must give the senior who will be taking the medication the information a reasonable person would require to understand the reason for the medication and to make a decision. This includes information about the condition for which the medication is proposed, the nature, risks and benefits of the medication, and any alternatives to it.

Seniors have the right to give, refuse or, on an ongoing basis, revoke consent on any grounds.[120] When deciding whether a senior is incapable of giving, refusing or revoking consent to health care, a health care provider must base that decision on whether or not the senior demonstrates that he or she understands the information given by the health care provider. If a senior is not able to understand the proposed medication or communicate a choice, the health care provider must seek and obtain substitute consent.

Substitute consent is given by a substitute decision-maker, who must be a person with legal authority to make decisions on behalf of the senior. A senior who is unable to give consent may already have a legal guardian or representative who can make health care decisions on his or her behalf. When no such person has been appointed, the *HCCFAA* establishes a process for health care providers to select a "temporary substitute decision-maker." That person is chosen from a ranked list of people (defined in the Act) who are related to the person who is unable to give consent. If no one on that list of people is available, the health care provider must choose a person approved by the public guardian and trustee, which can include a member of the public guardian and trustee's staff.

[117] *Residential Care Regulation,* B.C. Reg. 10/2010, s. 78(2), s. 85(2)(h).

[118] *Health Care (Consent) and Care Facility (Admission) Act,* R.S.B.C. 1996, c. 181, s. 5(1), 12(1).

[119] *Health Care (Consent) and Care Facility (Admission) Act,* R.S.B.C. 1996, c. 181, s. 9(1).

[120] *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 6.

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Determining a senior's capacity to give consent and obtaining informed consent to administer medication are crucial to respecting the autonomy of that person to make informed decisions about his or her own health care. Yet there is no legal requirement for health care providers in British Columbia to document that the capacity of a person in care to give consent has been considered or assessed, or that informed consent has been obtained from a person in care or his or her substitute decision-maker. Furthermore, the Ministry of Health does not require health care providers to fully document that informed consent was obtained, or to seek reconfirmation of informed consent as time goes on, including verifying that informed consent has been obtained and is still valid before administering medication. I believe improved documentation requirements would lead to greater transparency and accountability in this area.

I have recommended that the Ministry of Health take the necessary steps to amend the *Health Care (Consent) and Care Facility (Admission) Act* so that health care providers administering medication in residential care facilities are legally required to document:

- **that they have considered whether a person in care is capable of providing informed consent**
- **who provided informed consent**
- **when informed consent was provided**
- **how informed consent was provided**
- **the duration of consent (R139)**

I have also recommended that the Ministry of Health take the necessary steps to establish legal requirements for operators to:

- **ensure that facility staff verify from the documentation that informed consent has been obtained and is still valid before administering medication**
- **require facility staff to document their verification of consent prior to administering medication. (R140)**

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Antipsychotic Medications and *Pro re nata* Prescriptions

Antipsychotics are a class of psychotropic medications that have a tranquilizing effect. They are primarily used to manage psychosis.[121] Some studies indicate that antipsychotics may impair cognitive and emotional functioning, and may cause significant physical side effects.[122] In residential care facilities, antipsychotics can be administered on a *pro re nata* (PRN) basis to manage symptoms of dementia such as aggression and anxiety. *Pro re nata* means "as needed" or "as the situation arises."

Because these medications are prescribed to be taken as required as opposed to on a routine basis, the decision about when to administer PRNs is up to registered nurses and licensed practical nurses in a facility. However, neither the *Community Care and Assisted Living Act* nor the *Hospital Act* contains any specific legally enforceable standards around the prescription and administration of PRN medication in residential care facilities.[123]

To ensure patient safety and assist staff in deciding when and how to administer PRN medications, prescriptions should clearly describe the target symptoms they are intended to treat, how frequently the dose can be given, the maximum daily doses that cannot be exceeded, and when the prescription must be reviewed to determine whether it is still necessary. In addition, prescriptions for PRN medications should be properly documented and regularly reviewed at the facility level.[124]

> **I have recommended that the Ministry of Health take the necessary steps to create legally enforceable standards for the use of medications administered on an as-needed basis in all residential care facilities, including for prescribing, administering, documenting and reviewing their use. (R141)**

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[121] Merriam Webster Online, "Antipsychotic"<http://www.merriam-webster.com/dictionary/antipsychotic?show=0&t=1312906771>.

[122] Juan Fransisco Artaloytia et al,"Negative Signs and Symptoms Secondary to Antipscyhotics: a Double-Blind, Randomized Trial of a Single Dose of Placebo, Haloperidol, and Risperidone in Healthy Volunteers," 2006 Am J Psychiatry, 163:3 <http://ajp.psychiatryonline.org/cgi/reprint/163/3/488>; Lon S. Schneider et al, "Efficacy and Adverse Effects of Atypical Antipsychotics for Dementia: Meta-analysis of Randomized, Placebo-Controlled Trials," 2006 Am J Geriatr Psychiatry, 14:3 <http://davidhtaylormd.com/wp-content/uploads/191.pdf>; Health Canada, "Drugs and Health Products: Atypical Antipsychotic Drugs and Dementia — Advisories, Warnings and Recalls for Health Professionals," 22 June 2005 < http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/_2005/atyp-antipsycho_hpc-cps-eng.php>.

[123] The College of Pharmacists bylaw includes requirements regarding PRN medications that are binding on pharmacists.

[124] Ontario Ministry of Children and Youth Services, *Standards of Care for the Administration of Psychotropic Medications to Children and Youth in Licensed Residential Settings,* February 2009, 9.

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Staffing Levels

Two aspects of staffing affect the quality of care provided in residential care facilities. One is the number of staff or hours of care. The other is who delivers that care and the level of training and qualifications they have.

Staffing levels can be measured by either the number of staff hours or the number of direct care hours. Measuring the hours that staff provide direct care is more precise than measuring the number of staff hours because it accounts for the fact that not all staff provide direct care, and that even those who do also have other duties to perform. This approach — measuring direct care hours — is generally the one taken in British Columbia.

Legislated Requirements

There are no legislated requirements for the minimum number of staff who must be on duty at any given time in a residential care facility, or for the number of direct care hours that must be provided to each resident a day. There is also no legislated requirement on the type or mix of staff who must be on duty.

Instead, for facilities licensed under the *Community Care and Assisted Living Act (CCALA)* and the *Residential Care Regulation*, a number of "outcome-based" staffing requirements are set out, some in the Act and some in the Regulation. The latter, for example, requires operators to assist people in care with the activities of daily living (including eating, mobility, dressing, grooming, bathing and personal hygiene) in a manner consistent with residents' health, safety and dignity. Operators are also required to ensure that the employees on duty are, at all times, sufficient in number, training and experience and organized in an appropriate staffing pattern to meet the needs of people in care.[125]

[125] The Act also requires operators to only employ people of good character. The Regulation also requires operators to:

- obtain, for each person employed in a facility, a criminal record check; character references; a record of work history; copies of any diplomas, certificates or other evidence of training and skills; and evidence that a person has complied with the province's immunization and tuberculosis control programs
- only employ people of good character, who have the personality, ability and temperament to work with people in care; and
- only employ people who have the training and experience and demonstrate the skills necessary to carry out the duties assigned

The regulation requires operators on an ongoing basis to:

- only continue to employ people who provide evidence of continued compliance with the province's immunization and tuberculosis control program
- regularly review the performance of their staff to ensure that employees meet the requirements of the regulation and demonstrate the competence required for their duties
- ensure that their employees do not carry out duties they are not competent to perform

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The decisions about how to meet these standards are left up to facility operators. For example, some operators choose to have a registered nurse available on-site 24 hours a day, even though the regulation does not require this. For extended care hospitals or private hospitals licensed under the *Hospital Act*, no similar staffing level requirements apply.

While we understand that outcome-based requirements offer operators useful flexibility, subjective requirements such as these are difficult to monitor and enforce.

The outcome-based approach used in residential care is quite different from the one the ministry uses to regulate child care facilities, which are also licensed under the *CCALA*. We found this difference interesting, given that both types of facilities care for people who are vulnerable. For example, the ministry sets specific, measurable staff-to-children ratios for child care facilities. In addition, the *Child Care Licensing Regulation* specifies how many of each type of staff are required (for example, educators and assistants).

Direct Care Hours Provided in British Columbia

While the province has not established a legislated minimum number of direct care hours that must be provided per resident per day, the health authorities do track and analyze this information. The table below shows the average number of direct care hours provided in residential care facilities in 2008 and 2011. The staff included in these figures are registered nurses, registered psychiatric nurses, licensed practical nurses and care aides.

Table 6 – Daily Hours of Direct Care Provided per Resident, 2008 and 2011

Health authority*	2008[1]	2011
FHA	2.40	2.72
IHA[2]	2.80	2.85
NHA	2.80	2.98
VCHA	Not available[3]	2.54
VIHA	2.52	3.19[4]

* Fraser Health Authority (FHA); Interior Health Authority (IHA); Northern Health Authority (NHA); Vancouver Coastal Health Authority (VCHA); Vancouver Island Health Authority (VIHA)

[1] The source of the information for 2008 is a Ministry of Health Services fact sheet dated May 2008.

[2] The IHA defines "direct care" as nursing care delivered by RNs, LPNs and RCAs.

[3] The VCHA reported that the 2008 level would have been lower than the 2011 level but were unable to provide specific figures.

[4] This figure includes nursing and allied care.

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Progress

In February 2009, six months after we started our investigation, the provincial government began using the number of care hours as a measure of the adequacy of care, but stopped short of establishing an enforceable standard. The minister issued a directive to the health authorities requiring them to create a three-year plan to address a number of issues, including staffing levels and educational standards.

The ministry also asked the health authorities to describe how they would achieve a staffing level of 3.36 direct care hours per resident per day. All of the health authorities indicated that they could not achieve that target without additional resources.

Additional resources became available as the new residential care rate structure took effect in January 2010. However, even with the additional revenue, none of the health authorities achieved a staffing level of 3.36 direct care hours per resident per day in 2011.[126]

I have recommended that the Ministry of Health take the necessary steps to establish:

- **the mix of registered nurses, licensed practical nurses and care aides staff (direct care staff) necessary to meet the needs of seniors in residential care**
- **the minimum number of direct care staff required at different times**
- **the minimum number of care hours that direct care staff provide to each resident each day to meet their care needs (R142)**

I have also recommended that once specific minimum staffing standards have been established, the Ministry of Health develop a monitoring and enforcement process to ensure that they are being met and report publicly on the results on an annual basis. (R143)

Access to Visitors

Having opportunities to visit with friends and family is tremendously important for seniors in residential care facilities, who understandably can suffer from loneliness. During our investigation we heard from people who felt that facility operators or staff were unnecessarily and unfairly restricting visitors.

The right of seniors in residential care to receive visitors is clearly set out in the *Residential Care Regulation,* which applies to facilities licensed under the *Community Care and Assisted Living Act,* and in the Residents' Bill of Rights, which applies to all residential care facilities. The *Residential Care Regulation* requires operators to ensure that those in care may receive visitors of their choice at

[126] After introducing the new rate structure, the ministry required each health authority to submit a plan outlining how it would spend the new money over the next four years (2009/10 to 2012/13).

any time and communicate with them in private, subject only to an operator's need to maintain the health, safety and dignity of people in care. The Residents' Bill of Rights, passed in December 2009, states that seniors have the right "to receive visitors and to communicate with visitors in private."

While these rights exist, restrictions on visitor access are allowed in certain limited circumstances. For instance, the *Residential Care Regulation* provides discretion to facility operators to determine when a visitor's conduct undermines "the health, safety and dignity of all persons in care." However, we noted that the ministry has not developed any policy to guide the exercise of this discretion.

I have recommended that the Ministry of Health work with the health authorities to:

- **develop policies and procedures that protect the legislated rights of seniors in residential care to receive visitors**
- **provide the necessary direction to operators on the circumstances in which any limitation or restriction may be permitted and the process to be followed (R144)**

Services for Residents with Dementia

"Dementia" describes a variety of symptoms that result from diseases that affect the brain. Common symptoms of dementia are the impairment of memory, orientation, comprehension, learning capacity, judgment, reasoning and ability to communicate. Other symptoms include changes in mood and behaviour, and changes in a person's ability to complete daily activities.

Number of People Affected

In Canada, there were 403,622 seniors living with dementia in 2008. In 2008, 55 per cent of those with dementia who were 65 years of age or more were living in their own homes with either no formal support (22 per cent) or home support (33 per cent). The remaining 45 per cent lived in long-term care facilities.[127]

Best Practice: Pilot Project — Licensed Dementia Housing Vancouver Island Health Authority

During our investigation, we visited a privately owned and operated facility where all beds were subsidized by VIHA as part of a pilot project. All of the beds in this facility were for people with dementia who were in good physical health and able to walk independently, but who, because of their cognitive limitations, could no longer live safely in their own homes or assisted living facilities. These dementia patients do not require the high level of nursing care that residential care homes provide to residents with physical limitations. An evaluation of this pilot project indicated that it provided better quality care for people living with dementia at a cost lower than the cost of providing residential care.

[127] Alzheimer Society of Canada, *Rising Tide: — The Impact of Dementia on Canadian Society,* 2010, 20. We did not find statistics on the number of people with dementia in B.C.'s residential care facilities.

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In 2007, the Ministry of Health worked with stakeholders to develop the B.C. Dementia Service Framework.[128] The goal was a comprehensive set of recommendations of practice, to guide the provision of dementia care and to support health authorities and other service providers to plan, prioritize and implement service improvements.[129]

Despite the time and work invested in developing the framework, we found that the ministry has not established standards, policies, services and training that are specific to dementia care.

> **I have recommended that the Ministry of Health build upon its own Dementia Service Framework and work with the health authorities to:**
>
> - **develop a provincial policy to guide the delivery of dementia care in residential care facilities**
> - **ensure that all residential care staff receive ongoing training in caring for people with dementia. (R145)**

End-of-Life Care

"End-of-life care" describes the specialized clinical and support services required by those who are approaching death. This term encompasses both hospice and palliative care. Hospice care is intended to improve the quality of life, both physically and mentally, for those who are in the last stages of a terminal illness. Hospice services can be provided in a facility, hospital, hospice centre or a patient's home. Palliative care is treatment that is provided specifically to alleviate a person's suffering, rather than to cure a disease or condition.

End-of-Life Care in Residential Care Facilities

Seniors who are close to death have particular and unique needs, so the provision of end-of-life care is distinct from that of day-to-day residential care. More privacy and flexibility with daily routines are needed in the provision of appropriate end-of-life care. Counselling services, pain and symptom management and compassionate nursing care should be planned and coordinated in a way that respects the dignity and choices of seniors who are nearing death.

Every year, about 25 per cent of all deaths in British Columbia occur in residential care facilities.[130]

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[128] The framework was developed with representatives from the Ministry of Health Services, the health authorities, the Alzheimer Society of BC, the Centre for Applied Research in Mental Health and Addiction, and Impact BC.

[129] Ministry of Health, B.C. Dementia Service Framework, September 2007, 12.

[130] Ministry of Health, *A Provincial Framework for End-of-Life Care*, May 2006, 9 <http://www.health.gov.bc.ca/library/publications/year/2006/framework.pdf>.

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In British Columbia, there are no legislated requirements for facility operators providing end-of-life care to seniors. Nor does the Ministry of Health's *Home and Community Care Policy Manual* include any references to end-of-life care for seniors in residential care. However, the ministry did publish *Model Standards for Continuing Care and Extended Care Services* in 1999, which does contain some guidance on end-of-life care, as well as *a Provincial Framework for End-of-Life Care* in 2006.[131] The framework recognizes that end-of-life care can be delivered at home, in a hospital or hospice, or in a residential care facility. With regard to the last option, the framework states that the facility's regular services must be supplemented so that quality end-of-life services are provided to residents — including services such as access to specialized medications and equipment similar to those available to patients participating the BC Palliative Care Benefits Program.[132]

The BC Palliative Care Benefits Program supports people who are in the late stages of a life-threatening illness and wish to receive palliative care at home.[133] The program provides required medications, supplies and equipment to these patients at no cost. Seniors in residential care are not eligible for this program, but as the ministry's framework states, facility operators are expected to provide them with benefits similar to those offered under the plan.

The principles set out in the ministry's 2006 policy framework are comprehensive and could form the basis for an effective system of end-of-life care. It is useful to have such a framework and for the ministry to recognize that the unique needs of end-of-life patients can be met in a variety of settings.

What is lacking, however, is an assurance that consistently high-quality end-of-life care will be available to seniors in all residential care facilities, regardless of the legislation that applies. In order to achieve this, the ministry needs to develop detailed standards for end-of-life care and require the health authorities to monitor the adequacy of the care provided.

We reviewed the information that the Ministry of Health and the health authorities make available to the public about residential care and found that none of them provide adequate information about the benefits and services that people receiving end-of-life care in residential care facilities are entitled to receive.

Although the framework states that facility operators should provide seniors who are at the end of their lives with access to medications and equipment similar to the access made available through the BC Palliative Care Benefits Program, the ministry has not monitored the services that residents are actually receiving. Nor has the ministry ensured that all seniors who receive palliative care have access to the same pharmaceutical benefits.

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[131] Ministry of Health, *Model Standards for Continuing Care and Extended Care Services*, April 1999.

[132] Ministry of Health, *A Provincial Framework for End-of-Life Care*, May 2006, 9 <http://www.health.gov.bc.ca/library/publications/year/2006/framework.pdf>.

[133] Ministry of Health Services, *BC Palliative Care Benefits Program*, patient information sheet, December 2009.

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I have recommended that the Ministry of Health work with the health authorities to develop standards for the provision of end-of-life care in residential care facilities that, at minimum, are equal to the services and benefits available under the BC Palliative Care Benefits Program, and that the ministry work with the health authorities to make information publicly available about the end-of-life care services and benefits available in residential care. (R146, R147)

Complaints

Residential care facilities provide 24-hour care to seniors who need professional nursing care and supervision. Given the nature of this care, the number of the people who receive it, and their vulnerability, there will always be challenges in ensuring appropriate and timely support and service delivery.

Complaints are a sign of this reality and are an important mechanism for identifying when problems occur and how to resolve them.

Complaining to Facilities

In many cases, raising concerns or complaints directly with the facility that is providing the care is the most effective and efficient way to resolve them. Under the Residents' Bill of Rights, seniors in residential care have the right to access a "fair and effective process to express concerns, make complaints or resolve disputes within the facility."[134] The Residents' Bill of Rights, which came into force in December 2009, applies to all residential care facilities, regardless of the legislation that governs them. For seniors in facilities governed by the *Hospital Act*, this is the only legislated requirement on complaints processes.

Operators must also ensure that a person in care is not subject to retaliation as a result of anyone expressing a concern, and that concerns and disputes are responded to promptly. As well, operators are required to record complaints and how they were addressed.

Outcome-based regulations allow operators to determine how these requirements will be achieved, provided whatever they implement meets the test of being "fair, prompt and effective." Operators may appreciate this degree of flexibility, but it results in wide variations in the complaints processes that are in effect at facilities across the province.

By comparison, Ontario's *Long-Term Care Homes Act* establishes specific requirements for complaints processes in "long-term care homes," which are that province's equivalent to facilities in British Columbia licensed under the *Community Care and Assisted Living Act (CCALA)*.

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[134] Residents' Bill of Rights, *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, Schedule 7, s. 1(3)(d) <http://www.health.gov.bc.ca/ccf/pdf/adultcare_bill_of_rights.pdf>.

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The Act requires that operators investigate and resolve all the written or oral complaints they receive about the care of a resident or the operation of their home within 10 business days. If a complaint includes an allegation of harm or risk of harm, the investigation must begin immediately. Operators must respond in writing to the person who complained, and include an explanation of what was done to resolve the complaint or why the operator believes it is unfounded.

A further requirement in Ontario — one that goes far beyond what is required by the *CCALA* — is that operators immediately forward any written complaints they receive to the director of the Ministry of Health and Long-Term Care.[135] As well, operators who investigate an allegation of abuse or neglect must report the results to the ministry's director.

British Columbia has no similar specific, legislated requirements for operators of residential care facilities.

> **I have recommended that the Ministry of Health require all operators of residential care facilities to:**
>
> - **investigate all complaints they receive**
> - **complete investigations within 10 business days of receiving a complaint**
> - **inform complainants in writing of the outcome of their complaint**
> - **inform complainants of what they can do if they are not satisfied with the operator's response**
> - **keep detailed and specific records of complaints and how they were handled**
> - **review the complaints they have received every quarter in order to determine whether there are areas where improvements can be made (R148)**

Complaining to Health Authorities

People who are not satisfied with how a facility handled their complaint or who, for whatever reason, do not want to complain directly to a facility, can complain to their regional health authority. The options for doing so depend on whether the facility in question is licensed under the *CCALA* or governed by the *Hospital Act.* Another factor that makes a difference is whether the care is subsidized or not.

[135] *Long-Term Care Homes Act,* S.O. 2007, s. 22.

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Community Care Licensing Offices

Community care licensing offices are staffed by licensing officers who are responsible for ensuring that residential care facilities (and child care facilities) licensed under the *CCALA* meet the requirements of that Act and its Regulation. Anyone who is concerned that a *CCALA* facility is not meeting those requirements can complain to one of these offices.

Under section 15 of the *CCALA,* medical health officers must investigate every complaint that alleges that a residential care facility licensed under the Act is not fully meeting the legislated requirements. In practice, medical health officers delegate their authority to licensing officers who are employees of the health authorities.

Public Information

We reviewed the health authority websites and found that they provide varying degrees of information about the complaints that licensing offices can deal with and their processes for doing so. While we found the information they provide to be generally useful, we also concluded that there is room for improvement on all health authority websites.

Number of Complaints Received

Given the number of licensed residential care facilities and the number of people receiving care in them, the health authorities have received very few licensing complaints. For example, the total number of licensing complaints received by Northern Health in between 2004/05 and 2010/11 works out to less than one per facility and in 2007/08, Northern Health received no licensing complaints at all about the 12 licensed facilities in its region. In 2009/10, Fraser Health, Interior Health, Northern Health and VIHA had a combined total of 12,205 residential care beds, yet licensing staff in those regions only received 242 complaints — a rate of just under two complaints per 100 residents. We could not factor licensing complaints made to Vancouver Coastal Health into these calculations, as the health authority could not provide us with this information.

Communicating with Complainants

When reviewing the ministry's draft manual on licensing investigations, we found very few requirements in it about communicating with the person who actually made the complaint. For example, the manual states that when licensing officers have concluded an investigation, they should provide their preliminary findings to the affected facility operator and allow him or her to respond before forwarding recommendations to the regional medical health officer. There are no similar requirements for informing complainants at the conclusion of investigations. In fact, the manual specifies that licensing officers should not provide information to anyone other

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than the operator, the ministry's director of licensing, and the funding body. The ministry's website also states that complainants "will not be provided with follow up information regarding the outcome of the investigation."[136]

We asked the health authorities about this. Fraser Health, Northern Health, Vancouver Coastal Health and VIHA told us that the only way people other than the director of licensing, the operator and the funding body can get information about the outcome of a licensing investigation is to request the investigation report under the *Freedom of Information and Protection of Privacy Act (FOIPPA)*. This is the case even for people who complain about services that they or their family member received. Since 2010, Interior Health has required licensing staff to verbally advise complainants of the outcome of its complaint investigations, although written information must be requested through the *FOIPPA* process.

Our office reviewed the licensing complaints for three *CCALA* facilities in each of the five health authorities for the period July 1, 2007, to July 1, 2009. Of the 41 complaints received about these 15 facilities, 19 were from residents, family members or advocates; 9 were from staff; and 13 were from a facility manager.[137] In only 8 of the 28 complaints made by residents, family members, advocates or staff could we find clear evidence that complainants had been notified of the outcome of an investigation.

In order to meet the test of being effective, a complaints process must include a requirement to provide complainants with clear and detailed reasons for decisions made about each complaint.

Timeliness

There are no legislated time limits or provincial policy guidelines on time limits for completing licensing investigations. Fraser Health and VIHA both have a target for licensing officers to complete investigations within 60 days.

Recourse

The Community Care Licensing Branch within the Ministry of Health describes itself as the provincial steward of all the community care licensing programs run by the regional health authorities. Despite this role, the ministry has not established a formal process through which someone who is dissatisfied with a licensing investigation, or with the care provided at a licensed facility, can complain to the branch directly.

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[136] Ministry of Health, "Complaints"<http://www.health.gov.bc.ca/ccf/complaints.html>.

[137] These complaints were about the facility that he/she was managing. The *Residential Care Regulation* requires a licensee to report to the medical health officer if there is an allegation of abuse or neglect. A facility manager can act on behalf of a licensee in making this report.

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Patient Care Quality Offices

Patient care quality offices (PCQOs) can respond to complaints about the "care quality" in residential care facilities, regardless of the legislation that governs those facilities, their form of ownership or whether the resident in question is receiving subsidized care. A person who is unhappy with how a PCQO has handled his or her complaint can ask the regional patient care quality review board (PCQRB) to review it. Both of these processes were created when the *Patient Care Quality Review Board Act* took effect in October 2009.

Who Can Complain

Patient care quality offices are limited to accepting complaints from the person receiving care or from a person on their behalf. For residential care, this means that PCQOs can accept complaints only from a resident, his or her legal representative or someone authorized to act as his or her agent. They cannot accept anonymous complaints, or complaints from staff, volunteers or others (including friends) who are not authorized to act on behalf of someone who is actually receiving care.

In order to be effective, a complaints process must be flexible enough to respond to the needs of the people it is expected to serve. Given that disease, cognitive impairment and other factors prevent many seniors in residential care from complaining themselves, for the PCQO process to be effective, it needs to accept complaints from a broader range of people. The ministry appears to have recognized this by allowing resident and family councils to complain to PCQOs, even when they are not acting on behalf of a particular senior. So far, however, this is being done informally, as resident and family councils are not officially recognized as being included in the legal definition of those who can complain to PCQOs.

Public Information

In order to be effective, a complaint process must also provide a clear explanation of the complaints that will be accepted and how they will be handled. None of the patient care quality offices do this.

While the provincial government's express purpose in establishing the PCQOs was to create a consistent process across British Columbia for responding to complaints about the quality of health care, we received inconsistent information from the health authorities about the complaints their PCQOs will and will not accept. For example, when we asked the health authorities whether their PCQOs can process complaints about the actions or decisions of medical health officers and licensing officers, their answers varied. Fraser Health, Northern Health and Vancouver Coastal Health said no, but Interior Health said yes. VIHA said that its PCQO would only be able to process such a complaint if it were about care quality. When we asked the Ministry of Health about this, staff explained that complaints about the actions or decisions of licensing officers and medical health officers are not considered to be "care quality" complaints.

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The patient care quality review boards (PCQRBs) are doing a better job of providing clear information on the complaints they will deal with. The joint website for the PCQRBs includes a clear description of the type of complaints that they will review and how they are handled.

Comparison of the Community Care Licensing and Patient Care Quality Office Complaints Processes

We compared the effectiveness of the patient care quality offices (PCQOs) and the community care licensing offices in responding to complaints about care and services in residential care. While each system has advantages and disadvantages, on the whole we found that the community care licensing offices are in a better position to respond to complaints about residential care than the PCQOs. The latter are limited in jurisdiction, in who they can accept complaints from and what they can do to respond to complaints. By comparison, the community care licensing offices have much broader jurisdiction, can accept complaints from anyone and have broad investigative and enforcement powers and staff trained to conduct inspections.

However, the PCQO process does have some procedural advantages. For instance, the PCQOs can respond to complaints about residential care facilities licensed under the *CCALA* or governed by the *Hospital Act*; the PCQOs must process complaints within 30 days; and the PCQOs are required to inform complainants of the outcome of their complaint within 10 business days of completing their process.

It would be simpler and more effective to designate one single agency in each health authority to be responsible for responding to complaints about all residential care facilities. Combining the positive procedural aspects of the PCQO process with the investigative and enforcement authority of the community care licensing offices would result in a single complaints process at the health authority level that is simplified, accessible, effective and better able to respond to the unique needs of people in residential care.

I have recommended that the Ministry of Health establish the community care licensing offices as the single process for responding to all complaints about residential care, and:

- **extend the jurisdiction of community care licensing offices to all residential care facilities**
- **ensure that patient care quality offices refer any complaints they receive about residential care to community care licensing offices**
- **require community care licensing offices to inform complainants in writing of the outcome their complaint**
- **ensure that consistent and comprehensive information about the role of community care licensing offices is publicly available**
- **establish a right of review or appeal from a decision of community care licensing to the provincial director of licensing or the patient care quality review boards or other appropriate agency (R149)**

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Monitoring

Monitoring is the ongoing process of observing and checking to determine whether care, safety and service delivery standards are being met. Monitoring is carried out through inspections, complaint investigations and review of reportable incidents. The April 2011 version of the Ministry of Health's *Home and Community Care Policy Manual* states that "health authorities are required to use performance data to measure and monitor improvements in quality of care and health outcomes for home and community care clients."[138]

Enforcement is the application of one or more corrective measures when standards are not met. The purpose of enforcement is to address operational gaps, discourage poor performance and promote compliance.

While the Ministry of Health is responsible for the oversight and regulation of all residential care facilities in the province, it is the health authorities that directly carry out most monitoring and enforcement activities.

Monitoring Facilities Licensed Under the *Community Care and Assisted Living Act*

Role of the Director of Licensing

The director of licensing in the Ministry of Health is the head of the community care licensing program. This person oversees the services that are provided to the more than 19,000 people who live in the province's 246.5 licensed community care facilities. The director is a statutory decision-maker who is appointed by order of the Minister of Health. Section 4 of the *CCALA* provides the director of licensing with many powers, including the power to specify policies and standards of practice for community care facilities, and to carry out or order the investigation of a reportable incident or a matter affecting the health or safety of a person in care. The director has exercised these powers a total of 20 times between 2004-2011.

We found that, since April 2004, the director has required a health authority to report on the operation of a licensed community care facility a total of five times, and to report on a licensing program a total of three times. On four occasions, the director inspected or ordered the inspection of the books, records or premises of a community care facility or required a health authority to audit the operations of a facility. The director has, on one occasion, ordered the investigation of a reportable incident or a matter affecting the health and safety of residents. The director has specified policies or standards of practice on four occasions since 2004 and on three occasions

[138] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Performance Management: General Description, 3.A.

has issued orders considered necessary to ensure the health and safety of facility residents. The ministry is now developing provincial policies to guide and support the licensing activities undertaken by the health authorities.

We found that while the ministry requires the health authorities to provide monthly reports about a variety of information, it does not regularly collect or track information about complaints received, inspections conducted or enforcement action taken against residential care operators across the province. The ministry could not tell us, for example, how often in the past eight years health authorities had suspended or cancelled a residential care facility's licence.

Effective stewardship and oversight of programs requires effective monitoring, including the collection and analysis of relevant and timely information about those programs.

> **I have recommended that the Ministry of Health finalize its provincial community care licensing policies by October 1, 2012 and establish a process for reviewing and updating them every three years. (R150)**
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> **I have recommended that the director of licensing require community care licensing offices to report to the ministry quarterly on the number of:**
>
> - **residential care complaints received**
> - **investigations and inspections conducted**
> - **exemptions granted**
> - **enforcement actions taken**
> - **facility closures and disruptions occurring**
> - **reportable incidents occurring (R151)**
>
> **I have also recommended that the director of licensing issue a public annual report on the community care licensing program. (R152)**

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Role of Medical Health Officers and Licensing Officers

Every health authority has medical health officers who are appointed by the Lieutenant-Governor-in-Council but who work for the health authorities and are often directly responsible to the health authorities' CEOs.[139] The primary duties of medical health officers are outlined in the *Public Health Act* but they also exercise authority under other acts. Medical health officers are also responsible to the provincial health officer for the quality of their work.

Specific responsibilities of medical health officers, as laid out under section 15 of the *CCALA*, include investigating every application for a licence to operate a community care facility, every complaint about the operation of an unlicensed community care facility, and every complaint about a licensed facility not complying with the Act, the regulations or the terms of the facility's license. Medical health officers are also responsible for inspecting community care facilities.

In practice, medical health officers delegate most of these duties to licensing officers, who are employees of the health authority. Licensing officers are responsible for monitoring health and safety conditions in child care facilities and adult residential care facilities. Both types of facilities are licensed under the *CCALA*.

Provincial Training for Licensing Officers

The ministry has not established standard credentials for licensing staff. According to the ministry, many licensing officers who inspect residential care facilities have backgrounds in early childhood education, nursing, social work or environmental health.

The ministry also has no standardized provincial training programs for licensing officers and no requirements that its licensing officers have any training in geriatrics.

Although the ministry sees training as the responsibility of each health authority, it is considering developing a provincial training program for licensing staff.

> **I have recommended that the Ministry of Health develop and implement provincial training standards and minimum education and experience requirements for community care licensing officers that will allow them to appropriately respond to complaints about residential care facilities. (R153)**

[139] *Public Health Act,* S.B.C. 2008, c. 28, s. 71.

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Exemptions from the *Community Care and Assisted Living Act* and *Residential Care Regulation*

While operators are required to comply with all the applicable terms of the *CCALA* and the *Residential Care Regulation*, facility operators may apply for and be granted an exemption under certain conditions.[140]

Section 4 of the Regulation states that an operator can apply to a medical health officer for an exemption. Section 16 of the Act states that a medical health officer can grant an exemption if he or she is satisfied that doing so will not result in any increased risk to the health and safety of those in care. In practice, medical health officers often delegate this power to licensing officers.[141]

Section 50 of the *Residential Care Regulation* — one of the sections subject to exemption — states that, except in emergencies, a resident (or his or her representative) must consent to be transferred to another residential care facility.[142] According to section 50, if residents are being transferred the operator must either obtain each resident's consent or apply to the medical health officer for an exemption. Other than in emergencies (in which case section 50 does not apply and consent is not required) it is difficult to imagine circumstances in which a medical health officer or licensing officer would be justified in granting an exemption from the requirement to obtain a resident's consent to transfer.

Test for Granting an Exemption

"In our view, the words used in section 16 of the Act — no increased risk to the health and safety of persons in care — set an obviously high test for the granting of an exemption."

Source: *BG and FS v. Fraser Health Authority and Valleyhaven Guest Home*, 2008, Community Care and Assisted Living Appeal Board Decision 5, at para. 24.

I have recommended that the Ministry of Health take steps to amend the *Residential Care Regulation* so that medical health officers no longer have the authority in non-emergency situations to grant facility operators exemptions from the legal requirement to obtain consent before transferring a resident to another facility. (R154)

[140] Facilities that were licensed on or before August 1, 2000, do not have to comply with the following sections of the *Residential Care Regulation*: accessibility (s. 14(2)), emergency equipment (s. 20), bedroom occupancy (s. 25(2)), bedroom floor space (s. 27), bedroom windows (s. 28(2) and (3)), bathrooms (s. 32), dining areas (s. 33(b)), lounges and recreation facilities (s. 34(1) and (2)), and outside activity areas (s. 26(1)(a) and (b)).

[141] Schedule A of the Regulation lays out the sections for which exemptions may not be granted. An exemption cannot be granted to any of the following provisions of the Act: ss. 1, 2, 5, 6, 7(1)(a)(b) and (d), 18(2) and (3), 22. An exemption cannot be granted to any of the following provisions of the Regulation ss.1, 2, 12, 37, 46, 52, 54(2), 55, 73, 74(2), 76, 77, 89.

[142] This is section 50 of the Regulation. It does not apply to people who have been placed in a residential care facility after being put on extended leave from a mental health facility under the *Mental Health Act*.

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During our investigation, we were able to obtain information from each of the health authorities about the exemption requests that they had granted. However, the Ministry of Health could not provide us with a provincial total, as it does not require health authorities to inform it when exemptions are granted. This means the ministry does not have information on either the overall number of exemption requests or the requirements that are being exempted.

It is, however essential for the ministry to know the circumstances under which exemptions to its legislation are being granted. It is also important for the ministry to know if a large number of exemptions from certain sections of the Act or Regulation are being granted, for this might signal that the intent of government policy is being avoided or that a review of the Act or Regulations is required.[143]

I have recommended that the Ministry of Health require medical health officers to report publicly every year on:

- **the number of requests they and their delegates receive for exemptions from the requirements of the *Community Care and Assisted Living Act* or the *Residential Care Regulation***
- **the reason for the requests**
- **the outcomes of those requests (R155)**

Inspections in Facilities Licensed under the *Community Care and Assisted Living Act*

Inspections are one of the ways that licensing officers monitor operators' compliance with legislation, standards and policies.

Section 9 of the *Community Care and Assisted Living Act* (*CCALA)* requires operators to make their facilities available at all times for inspection by the provincial director of licensing and the regional medical health officer. Section 15(c) of the Act requires medical health officers to inspect all *CCALA*-licensed residential care facilities that are operating in the region to which they are appointed, although those powers are often delegated to licensing officers who are also employees of the health authority.

The Act does not specify the type or frequency of inspections that must be conducted. Inspections may be unannounced or scheduled.

Licensing officers assign two types of ratings when they inspect licensed residential care facilities: hazard ratings and inspection priority level ratings.

[143] Requests for exemptions from notice requirements and appeals of these decisions are discussed later on in this section, Facility Closures and Significant Changes.

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Hazard Ratings

The hazard rating of a facility is based on the results of a particular inspection and the analysis of those results by licensing staff. In effect, a hazard rating is like a snapshot of a facility's situation at the time of inspection.

At the conclusion of an inspection, the licensing officer or medical health officer assigns a low, medium or high hazard rating to the facility. The hazard rating, which is based on the officer's findings and observations of the conditions, becomes part of the inspection report. It is a short-term rating that becomes one of many factors that licensing officers consider when determining the longer-term inspection priority level for each facility.

As of March 31, 2011, all licensed facilities in the Northern Health Authority had a low hazard rating compared to 91 per cent in the Fraser Health Authority. The Vancouver Coastal and Interior Health authorities could not provide us with this information.[144]

Inspection Priority Levels (Risk Ratings) and Routine Inspection Frequencies

Inspection priority level ratings are longer-term and broader than hazard ratings. When assigning inspection priority levels, licensing officers use an evaluation tool developed by the Ministry of Health. The tool, designed to account for a facility's past and current record of compliance, is used to assign points to each facility and rate it as having a low, medium or high inspection priority.

When calculating these levels, licensing officers focus on six categories of concern, including the effectiveness of management, the physical plant of the facility, and hazard ratings. Inspection priority levels are typically updated after a routine inspection is conducted.

In all health authorities except Northern Health, how often a facility is scheduled for routine inspections is determined by the facility's inspection priority level. However, even within the other four health authorities, the frequency of inspections that is triggered by inspection priority level differs. For example, all licensed facilities ranked low risk in the Fraser, Interior, and Vancouver Coastal health authorities are inspected at least once every 12 months. Similar facilities in the Vancouver Island Health Authority need to be routinely inspected once every 18 months.

The Northern Health Authority bases its inspection frequencies for facilities on the hazard ratings assigned by licensing officers. If a facility is given a high hazard rating during an inspection, the licensing officers should conduct a follow-up inspection within three months. If a facility receives a moderate hazard rating, staff should conduct a follow-up inspection within six months.

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[144] Interior Health plans to discontinue its use of hazard ratings with an information upgrade in early 2013. Vancouver Coastal Health does not assign hazard ratings and the Vancouver Island Health Authority discontinued assigning hazard ratings in 2010.

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The Ministry of Health's director of licensing began working with the health authorities in 2008 to develop a new assessment tool to determine inspection priority levels. The ministry anticipates that the health authorities will begin using the new tool in 2012/13.

Ombudsperson's Review of Inspection Files

Each of the five health authorities maintains records of routine and follow-up inspections of facilities licensed under the *CCALA*. These records, available on each health authority's website, list the violations that staff observed during the inspection and provide brief explanations of the standards that were not met.

The inspection priority levels and the hazard ratings of facilities are not included in the posted information. The Ministry of Health's director of licensing told us that once the new risk assessment tool is implemented, the inspection priority level of each facility will likely be included in the posted reports.

As already discussed, the required frequency of inspection depends on each facility's inspection priority level. However, each health authority sets its own policy on the minimum frequency at which inspections should be conducted for the various levels of priority.

To determine how often inspections of residential care facilities had been carried out, we reviewed a random sample of posted inspection reports for 30 adult residential care facilities in each health authority. All reports were for the period January 2008 to June 2010.

For the four health authorities whose inspection targets were once every 12 months, we determined that Vancouver Coastal Health met its annual goal for 80 per cent of the 30 sampled facilities and Interior Health for 67 per cent of its 30 sampled facilities. By comparison, Fraser Health met its target for only 43 per cent of its 30 sampled facilities, and Northern Health for only 23 per cent of its sampled facilities.[145]

While the Vancouver Island Health Authority (VIHA) has set a less demanding target, it met its target of one inspection every 18 months for only 40 per cent of the facilities we reviewed.

In the absence of provincial policies to guide inspections, the health authorities have developed different schedules for conducting inspections and different approaches to assigning hazard ratings. This inconsistency in approach is concerning because all seniors in care should benefit from the same level of oversight and protection.

[145] Fraser Health reported that its inspection objectives are based on a fiscal year. Our file review methodology was to determine the date the sampled facility had a routine inspection and then to determine whether the following routine inspection occurred within the health authority's target, for example, within 12 months for the Fraser, Interior and Vancouver Coastal health authorities.

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I have recommended that the Ministry of Health establish provincial standards for inspection frequencies, hazard ratings, and inspection priority levels for residential care facilities. (R156)

Scheduled Inspections

The Ministry of Health's draft provincial licensing policy states that inspections can be unannounced or scheduled. Unannounced inspections capture the facility during its usual routine, and are the standard practice for other regulatory inspections such as bylaw enforcement or occupational safety. Scheduled inspections are sometimes appropriate, especially if the licensing officers need to spend a significant amount of time with facility staff.

While most inspections are scheduled, all the health authorities told us that they sometimes conduct unannounced inspections.[146] Four of five health authorities conduct nearly all inspections during normal business hours when most facility staff are on duty (8:30 to 5:00, Monday to Friday). The Northern Health Authority is the only one that regularly conducts inspections outside normal business hours.

Given that residential care facilities operate on a 24-hour basis, it is important for licensing staff to conduct scheduled and unscheduled inspections during all times that care is provided, including evenings, weekends and overnight.

I have recommended that the Ministry of Health require the health authorities to conduct a set number or percentage of unscheduled facility inspections and inspections outside of regular business hours. (R157)

Inspections in Facilities Governed by the *Hospital Act*

All the inspection practices discussed in the preceding pages apply only to facilities licensed under the Community Care and Assisted Living Act. However, 101.5 residential care facilities in the province are instead governed by the Hospital Act. Of these, 77.5 are extended care hospitals and 24 are private hospitals. The 9,827 residents in these facilities make up 34 per cent of the total provincial population of residential care facilities.

Inspection of Extended Care Hospitals

The majority of extended care hospitals are owned and operated by the health authorities. Extended care hospitals can be inspected either by hospital inspectors appointed by the Ministry of Health or by certain health authority staff.

[146] For Fraser Health, unscheduled inspection is preferred.

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Section 40 of the *Hospital Act* authorizes the Minister of Health to appoint inspectors for public and private hospitals. The assistant deputy minister of the ministry's Health Authorities Division is the chief hospital inspector under the Act. A number of ministry staff are also designated as hospital inspectors and may conduct inspections when required to by the chief hospital inspector.

The ministry could not provide us with records of inspections of extended care hospitals by appointed hospital inspectors. It did give us a list of 50 inspectors, but the list was outdated. Some people on it were no longer government employees and others no longer worked for the ministry. Furthermore, the individuals on the list had very diverse backgrounds and experience, and included assistant deputy ministers, directors, policy analysts and health information analysts. The ministry was unable to provide us with a list of inspections conducted by these employees or to confirm whether all of them were actively involved in inspections.

> **I have recommended that the Ministry of Health ensure that its list of appointed provincial hospital inspectors is current and that everyone on that list is trained to inspect residential care facilities. (R158)**

We also found that the ministry has not delegated the authority to inspect extended care hospitals to the health authorities. However, because most extended care hospitals are owned and operated by health authorities, health authority staff do have access to them. Most health authorities have established quality review and monitoring processes for the extended care facilities they own and operate, but these processes do not address the same issues as inspections conducted on *CCALA*-licensed facilities, nor are these processes conducted with any regularity.

Inspection of Private Hospitals

The Ministry of Health delegated the authority to inspect private hospitals to the health authorities in 1997. The ministry also requires health authorities to have service agreements with private hospitals and expects the health authorities to inspect them.

In 2003, the ministry sent a letter to the health authorities reminding them of their authority to inspect private hospitals with which they had service agreements. In November 2005, the ministry wrote to the health authorities to again remind them of their power to inspect private hospitals with which they had service agreements. The letter also stated it was the government's intention to shift the regulation of private hospitals from the *Hospital Act* to the *CCALA,* but, in the interim, it was important for the health authorities to ensure the health and safety of private hospital residents by conducting inspections.

On January 4, 2007, the assistant deputy minister of the ministry's Health Authorities Division sent letters to the CEOs of all the health authorities explaining that proclamation of section 12 of the *CCALA* — to make facilities governed by the *Hospital Act* subject to the *CCALA* — had been

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further delayed but was expected to occur later in 2007. He noted that until then, the health authorities should continue to inspect private hospitals "with the same rigour and regularity" as facilities licensed under the *CCALA* are inspected.

Health Authority Inspections of Extended Care and Private Hospitals

None of the health authorities have conducted regular inspections of the residential care facilities governed by the *Hospital Act* between 2002-2007. In 2007, the Vancouver Coastal Health Authority began such inspections. In 2008, two other health authorities began using the following review processes:

- Fraser Health conducted 13 "transitional reviews". The reviews in 2008 focused on eight areas, including nutrition and food services, medication, and staffing.[147]
- Interior Health implemented a "regional quality site review process" to review residential care facilities governed by the *Hospital Act.* Since 2008, the health authority has reviewed the majority of its extended care facilities. It also conducted a review of the region's sole private hospital in 2009.

Oversight by the Ministry of Health

Although hospital inspectors from the Ministry of Health have the authority to inspect residential care facilities governed by the *Hospital Act,* the ministry has no records of any inspections occurring and could not tell us whether ministry staff had conducted such inspections since 2002.

While the ministry reminded the five health authorities of their authority to inspect private hospitals in 2003 and 2007, it did not require them to confirm that they were actually doing so. In fact, none of the health authorities, in that period, were required to provide any information including copies of inspection reports or schedules to the ministry.

In February 2009, the Ministry of Health directed all the regional health authorities to develop a three-year plan for the monitoring and inspection of those facilities. The directive indicated that the health authorities were to report to the ministry quarterly on the inspections conducted, the results of those inspections and any further actions required.

The directive, however, did not result in additional inspections of facilities under the *Hospital Act* or in the development of comprehensive three-year plans. Rather, all the health authorities indicated that they planned to continue with their existing monitoring practices. It does not appear that the ministry has taken further steps to enforce implementation of the directive or to itself ensure

[147] In 2010, Fraser Health reviewed 9 of the 12 private hospitals and reviewed all extended care facilities during the 2010/11 fiscal year.

that residential care facilities under the *Hospital Act* are being inspected. Consequently, almost one-quarter of vulnerable seniors continue to live in private and extended care hospitals that are not inspected in the same manner as *CCALA* facilities.

I have recommended that the Ministry of Health require health authorities to provide it with information on all inspections conducted on residential care facilities that are governed under the *Hospital Act* on a quarterly basis. (R159)

I have also recommended that the Fraser, Interior, Northern and Vancouver Island health authorities inspect all residential care facilities governed under the *Hospital Act* in the same manner and with the same frequency as they inspect residential facilities licensed under the *Community Care and Assisted Living Act* commencing immediately. (R160)

Posting Inspection Results

Since November 2008, most health authorities have posted on their websites the results of routine and follow-up inspections of residential care facilities that are licensed under the *CCALA*. Vancouver Coastal, as the only health authority with an active inspection program for *Hospital Act* facilities, has not included these inspection reports on its website. However, Vancouver Coastal has indicated it ensures that written inspection reports for facilities under that legislation are posted on a wall of the relevant facility.

We asked the Ministry of Health whether it had considered requiring inspection reports for residential care facilities governed by the *Hospital Act* to be made available to the public. In February 2009, the ministry told us that it did not plan to do this because it still intends to implement section 12 of the *CCALA*. The ministry explained that when this happens, residential care facilities currently governed by the *Hospital Act* will be made subject to the *CCALA* and will then be required to post inspection results.[148]

The ministry currently has no timeline for implementing section 12 of the *CCALA*.

I have recommended that the Ministry of Health ensure that the health authorities promptly post the results of inspections of residential care facilities governed under the *Hospital Act* on their websites. (R161)

[148] Director of Home and Community Care Services, letter to the Office of the Ombudsperson, 23 February 2009, 4.

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Reportable Incidents

One of the most important tools for monitoring residential care facilities licensed under the *Community Care and Assisted Living Act (CCALA)* is the incident reporting process.

Schedule D of the *Residential Care Regulation* lists and defines 20 events, behaviours and actions that constitute a reportable incident. When a resident in a *CCALA* facility is involved in a "reportable incident," section 77 of the Act requires the operator to immediately notify that person's representative or contact person, as well as the medical practitioner or nurse practitioner responsible for the person's care, the regional medical health officer and the program that provides funding for the resident, if applicable. The operator must also complete an Incident Report Form and send it to the health authority's community care licensing office immediately.[149]

The list of reportable incidents has been drafted to capture inappropriate behaviour by just about anyone who could interact with seniors in residential care facilities, including staff, volunteers and others who may be present. However, the definition of each incident of abuse — emotional, financial, physical or sexual — has been drafted specifically to exclude abusive behaviour perpetrated by another resident, unless the behaviour results in the need for emergency medical treatment or hospitalization.[150] The Ministry of Health's director of licensing issued a standard of practice under section 4 of the *CCALA,* effective September 1, 2011, aimed at correcting this gap. The standard of practice clarifies that aggressive behaviour by a person in care towards another person in care is always reportable. The rationale for excluding aggressive behaviour and abuse by another resident from the list of reportable incidents in regulation is not clear, as the recent standard of practice highlights.

Reportable Incidents

- *aggressive or unusual behaviour*
- *attempted suicide*
- *choking*
- *death*
- *disease outbreak*
- *emergency restraint*
- *emotional abuse*
- *fall*
- *financial abuse*
- *food poisoning*
- *medication error*
- *missing or wandering person*
- *motor vehicle injury*
- *neglect*
- *other injury*
- *physical abuse*
- *poisoning*
- *service delivery problem*
- *sexual abuse*
- *unexpected illness*

[149] "Immediately" is not defined in the Act or Regulation.

[150] Under the Regulation, there is a requirement to report "aggressive or unusual behaviour," which is defined as "aggressive or unusual behaviour by a person in care towards other persons, including another person in care, which has not been appropriately assessed in the care plan of the person in care." "Other injuries" must also be reported — that is, any injury to a person in care that requires emergency attention by a doctor or nurse or transfer to a hospital.

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We received complaints about facility operators failing to report incidents, and about the response of licensing staff to incidents that were reported. During our investigation, we looked at how 15 different *CCALA*-licensed facilities handled reportable incidents between July 1, 2007, and July 1, 2009. We observed inconsistent documentation practices, delays in the reporting of incidents to physicians and family members, and delays in reporting to the licensing offices. The lengths of the delays varied from several days to several weeks. In one case, it took an operator three weeks to report an incident to the licensing office.

In addition, one of the key differences between facilities licensed under the *CCALA* and those governed by the *Hospital Act* is that the latter facilities are not legally required to report reportable incidents. This is a serious shortcoming in the oversight that applies to these facilities. Only one health authority, Vancouver Coastal Health, has developed a reporting process for *Hospital Act* facilities that is similar to the process required by the *CCALA*.

While it is commendable that Vancouver Coastal Health has established this reporting process, it is a policy, which does not have the force of law.

> **I have recommended that the Ministry of Health take the necessary steps to require operators of residential care facilities governed under the *Hospital Act* to report reportable incidents in the same manner as facilities licensed under the *Community Care and Assisted Living Act*. (R162)**
>
> **I have recommended that the Ministry of Health take the necessary steps to include abuse by residents against other residents in the list of reportable incidents in the *Residential Care Regulation*. (R163)**
>
> **I have also recommended that the Ministry of Health, working with the health authorities, develop a process to evaluate operator compliance with the requirement to report incidents in accordance with the *Residential Care Regulation*. (R164)**

Enforcement

Options Available under the *Community Care and Assisted Living Act*

Inspection and monitoring systems are only effective when they are backed up by the ability to apply consequences for non-compliance. In the residential care context, the goal of enforcement is to ensure that facility operators comply with the applicable laws, regulations and policies so that care is provided at an acceptable level. Regulatory schemes generally involve a variety of enforcement mechanisms, including voluntary compliance agreements, warnings, tickets with associated fines, and for the most serious cases, the power to suspend an operation temporarily or permanently cancel a licence.

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In British Columbia, the *Community Care and Assisted Living Act (CCALA)* sets out enforcement options that can be applied to operators of facilities licensed under that Act. Section 13(1) of the Act says that if a medical health officer believes that a facility operator has not complied with the Act or its Regulation, or has broken other relevant provincial or federal laws or has contravened a term or condition of the facility's licence, the medical health officer can suspend or cancel the licence, attach terms or conditions to the licence, or vary the existing terms and conditions of the licence.

Similarly, the Minister of Health can appoint an administrator to operate a facility for a set period under section 23 of the *CCALA* if he or she has reasonable grounds to believe that a resident's health or safety is at risk.

Under section 33 of the *CCALA*, a person who contravenes sections 5, 6, 18(2) or (3) or 26(1) of the Act, or a term or condition attached to a licence, commits an offence. Licensing officers may recommend to prosecutors that charges be laid for contravening one of these sections or a term or condition attached to a licence. If a person is charged in court and found to have committed an offence, that person may be subject to a fine of up to $10,000.

Since 2004, no charges have been laid against operators of residential care facilities under the *CCALA.*

We asked the health authorities how often they use enforcement options under the *CCALA.* In the seven-year period from 2002/2003 to 2009/2010, all five health authorities took formal enforcement action on residential care facilities a combined total of 41 times. While we understand the necessity to be fair when taking any enforcement action and the importance of trying to obtain voluntary compliance, it is clear that the health authorities, with the exception of Interior Health and Fraser Health, have rarely used enforcement options beyond written warnings.

Since 2002/03, the health authorities have attached conditions to residential care facility licences 35 times, 19 of which were in the Interior Health Authority. The types of conditions attached to licences in these instances included requiring a facility to develop a plan to ensure appropriate care, requiring a facility to improve its documentation, temporarily suspending a facility's ability to admit new residents, and requiring a facility to increase the hours of its on-site manager. Only two health authorities, Northern Health and Fraser Health, have suspended or cancelled a licence.

The Ministry of Health has delegated to the boards of the health authorities its authority to appoint an administrator. A health authority board has appointed an administrator to a residential care facility in British Columbia on three occasions since the *Community Care and Assisted Living Act*

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(CCALA) came into force: Northern Health, Interior Health and VIHA have each done so once.[151] We asked VIHA to provide us with its records on licensing complaints and investigations for this facility that led to the appointment of the administrator.

Appointment of an Administrator

Between 1997 and 2003, VIHA licensing officers conducted seven investigations in response to complaints. In December 2002, VIHA substantiated a complaint that two staff had abused a resident by pouring water on her to prompt her to remove her clothing. No conditions were attached to the facility licence.

Eleven complaints about the facility were made to VIHA in 2004. Although all the complaints related to contraventions of the *CCALA*'s requirements, again no conditions were attached to the facility's licence.

In March 2005, VIHA received a complaint about several incidents. The investigation concluded that incidents of neglect had taken place, and facility staff failed to properly administer medication. There were delays in reviewing nutrition plans and failures to report incidents. Licensing also had conerns about documentation practices and communication. After investigating, it attached a set of conditions to the facility's licence, including suspending admissions for four months.

In July 2007, the operator notified the facility that there would be a change in its contracted care provider, and shortly thereafter licensing staff received complaints about substandard care. VIHA investigated and found a number of incidences of non-compliance.

VIHA inspected the facility 66 times between March 2004 and September 2007. On 31 of those occasions the result was a high hazard rating. Following the 2007 investigation, VIHA licensing concluded it had lost confidence in the operator's ability to run the facility safely and in accordance with legislative requirements. Given the risks to residents that resulted from the deficiencies, VIHA licensing recommended that an administrator be appointed for a minimum of six months beginning in October 2007.

A review of the events that led to the appointment of an administrator at the facility shows that there were problems with the facility that should have caused VIHA to pursue action sooner than they did. It did not attach conditions to the facility's licence until almost one year after a pattern of problems first emerged. It was clear after the second formal investigation in 2005 that the operator had failed to address concerns raised. Another 29 months passed before an administrator was appointed to take over the operation of the facility.

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[151] The appointments by Northern Health and Fraser Health were both made in 2006. The appointment by VIHA was made in 2007.

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Despite regular inspections, major issues with safety and service quality persisted over a prolonged period. When serious concerns about safety and service quality arise, it is ultimately the ministry's responsibility to ensure that those concerns are addressed quickly and effectively. The ministry must be able to monitor problems and work with the health authorities to ensure that operators fully comply with legislated minimum standards of care.

The principle of progressive enforcement is sound, but when services are being delivered to vulnerable people who require 24-hour care, it is critical that progressive enforcement be applied in a timely manner.

Other Enforcement Options to Consider under the *Community Care and Assisted Living Act*

Other jurisdictions have different enforcement options in their legislation. In Ontario, for example, penalties for non-compliance with legislated requirements include the reduction or withholding of the operator's provincial funding.[152] Other jurisdictions use administrative penalties to enforce compliance with the law. In California, the California Department of Public Health is responsible for licensing, regulating and inspecting nursing homes. If necessary, the department can impose a fine of between $100 and $100,000 on operators who violate state laws and regulations.

While the *Community Care and Assisted Living Act (CCALA)* allows for operators who commit an offence to be charged and fined, licensing officers do not have the authority to impose fines themselves. Instead, they can only recommend to Crown prosecutors that an operator be charged with an offence.

There are other regulatory frameworks in British Columbia where decision-makers can issue penalties or tickets for non-compliance. For example, a drinking water protection officer can impose a fine of $575 for failure to comply with the water monitoring requirements in the *Drinking Water Protection Act.* Likewise, a park ranger can impose a fine of $200 on a person who consumes liquor in a public place, which contravenes section 40(1) of the *Liquor Control and Licensing Act.*

Research by the provincial Attorney General's office has outlined the benefits of including administrative penalties as part of a regulatory framework.[153] Enforcement frameworks that allow for the issuing of tickets and fines can be an effective and quick response to regulatory non-compliance. They can also reduce the need for, and thus the cost of, further enforcement.

In addition, allowing medical health and licensing officers to impose administrative penalties could offer the following key benefits:

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[152] Ontario Ministry of Health and Long-Term Care, "Reports on Long-Term Care Homes" <http://www.health.gov.on.ca/english/public/program/ltc/27_pr_faq.html>.

[153] Ministry of Attorney General, Administrative Justice Office, "Administrative Monetary Penalties: A Framework for Earlier and More Effective Regulatory Compliance — A Discussion Paper," 2008.

- It would create a middle option in the present system of enforcement. Currently the health authorities can seek only voluntary compliance or take formal action on a licence.
- It would provide a solution in situations where the health authority itself is the facility operator and must consider whether to attach conditions to its own licence.

In particular, the option of issuing tickets with attached fines would give the health authorities more flexibility in their efforts to achieve compliance.[154]

The rules and standards established under the *CCALA* were created to protect vulnerable people. Ensuring that actual harm does not occur to seniors in residential care is an essential element of the *CCALA* enforcement system. Consequently, it would be useful for the health authorities to have a more flexible and effective range of enforcement options available to them.

> **I have recommended that the Ministry of Health develop a policy to guide community care licensing officers on how and when to apply progressive enforcement measures. I have also recommended that the ministry take the steps necessary to expand the enforcement options available under the *Community Care and Assisted Living Act* and create a system of administrative penalties that can be applied to facility operators who do not comply with legislative and regulatory requirements. (R165, R166)**

Options Available under the *Hospital Act*

Very limited enforcement options are available under the *Hospital Act*. The options for taking action against operators of public extended care hospitals are particularly limited.

> **I have recommended that the Ministry of Health take the steps necessary to ensure that residential care facilities governed by the *Hospital Act* are subject to the same range of enforcement measures as those licensed under the *Community Care and Assisted Living Act*. (R167)**

Closing, Downsizing and Renovating facilities

The process of being placed and moving into a residential care facility can be extremely stressful for seniors and their families. However, once such a move is completed and seniors have time to settle in and adapt to new routines, many of them adjust to their new surroundings and benefit from the regular care and monitoring they receive there.

[154] Ministry of Attorney General, "Administrative Monetary Penalties," 2008, 9.

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Given how unsettling the transition to residential care can be, it is not surprising that seniors and their families have many concerns when decisions are made to close facilities, make significant operational changes (for example, renovate), or transfer seniors for reasons not related to their health and safety.

Ministry Policy on Resident Moves

The Ministry of Health has a policy that applies to all situations in which subsidized residents have to move because their existing care facility is being renovated or closed.[155] The policy came into effect on April 1, 2011, applies whether the facility in question is licensed under the *CCALA* or governed by the *Hospital Act.*

However, the policy does not apply to situations where residents have to move because a health authority has decided to reduce its funding of beds at a facility even though these moves affect residents the same way as moves made for any other reason.

> **I have recommended that the Ministry of Health's policy of caring for residents during facility renovations and closures apply to residents who are required to move as a result of a funding decision. (R168)**

Protection for Seniors in Facilities Licensed under the *Community Care and Assisted Living Act*

Seniors in facilities licensed under the *CCALA*, compared with seniors in facilities governed by the *Hospital Act,* do have more protection and avenues of recourse when operators close those facilities. However, we found that these legal requirements were not always observed or enforced. During our investigation, for example, we received complaints about facility operators who did not follow the notice requirements for closure of a CCALA facility and did not request an exemption from these requirements. One complaint we investigated was of a health authority who tried to close a facility without the required notice. We also looked into complaints about a facility closing some of its beds and converting others to a special care unit without notifying the regional medical health officer.

Section 9 of the *Residential Care Regulation* requires operators to give written notice to their health authority's medical health officer 12 months before permanently or temporarily closing a residential care facility. It also requires operators to notify the medical health officer in writing 120 days before reducing, expanding or altering the accommodation or service they provide, and to get the written approval of the medical health officer before doing so. Nothing in the Regulation requires that notification be given to residents and their families at the same time.

[155] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Movement of Clients — Facility Closures or Renovations, 6.J, 1.

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Section 16 of the *CCALA* authorizes medical health officers to exempt an operator from requirements of the Act and most of the Regulation, including the notice requirement in section 9 of the Regulation. However, before granting an exemption, the medical health officer must be satisfied that doing so will not increase the risks to residents' health and safety. In addition, the medical health officer may attach terms and conditions to an exemption and may suspend, cancel or vary an exemption that was granted earlier.

These notification and approval requirements apply even when it is the health authority itself that owns and operates a facility and is notifying or requesting approval from its own medical health officer.

Section 16 of the *CCALA* allows a resident, agent, spouse, relative or friend of a resident to appeal a medical health officer's decision to grant an exemption. Such appeals are made to the Community Care and Assisted Living Appeal Board. Appeals must be filed within 30 days of when the decision was made. Merely submitting an appeal does not suspend the operation of an exemption. An applicant can request that the board issue a stay of the decision pending the outcome of the appeal. The board may decide, on request, to grant a stay of the decision if board members are satisfied that doing so would not risk the health and safety of the people in care.

Community Care and Assisted Living Appeal Board (CCALAB)

The CCALAB hears appeals of licensing, regulation and certification decisions regarding community care and assisted living facilities and early childhood educators. This includes decisions made by a medical health officer to exempt an operator from complying with a requirement under the Act or Regulation.

In reviewing these decisions, the CCALAB can look at new information, in addition to what information was available when the decision was first made.

The CCALAB has the authority under the Community Care and Assisted Living Act *to confirm, reverse or vary a decision, or send the decision back for reconsideration with or without instructions.*

Source: Community Care and Assisted Living Appeal Board <http://www.ccalab.gov.bc.ca/index.asp>.

Notifying the Medical Health Officer

Section 9(1) of the *Residential Care Regulation* states that an operator must not suspend, temporarily or permanently, operation of a residential care facility unless the operator has given notice to a medical health officer at least one year before the suspension begins. However, from the complaints we investigated, it was clear that the practice around notification of changes in the nature of operations is inconsistent. While health authorities are aware of the notification requirements, the processes they require facility operators to follow vary.

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Another issue is that section 9(2) of the *Residential Care Regulation* requires that a medical health officer be given notice at least 120 days before an operator decides to reduce, expand, or substantially change the nature of the accommodation or services provided by a facility. However, there is no further definition — either in the regulation or in policy — of what constitutes a "substantial change" in accommodation or services. This creates the potential for uncertainty among operators about when notice is required, and leads to inconsistent compliance with the 120-day notice requirement.

I have recommended that the Ministry of Health:

- **define what a "substantial change in operations" is for the purpose of the notice requirements in sections 9(1) and 9(2) of the *Residential Care Regulation***
- **include large-scale staff replacement in the definition**
- **review on a regular basis the steps health authorities are taking to ensure that operators comply with these requirements (R169)**

I have also recommended that the Ministry of Health work with the health authorities to develop safeguards to ensure that seniors in residential care are not adversely affected by large-scale staff replacement. (R170)

Notifying Residents and Families

While the *Residential Care Regulation* requires facility operators to notify their regional medical health officer when they plan operational changes or closures, it does not require operators to notify residents and families. However, the ministry's *Home and Community Care Policy Manual* says that the health authorities must develop local policy and procedures that ensure timely communication with the resident and an opportunity for follow-up discussion of questions and concerns.

The policy also indicates that residents be given a "reasonable time frame" in which to plan for their relocation.[156] However, neither the ministry policy nor health authority policies define what that means.

In my view, it is both reasonable and fair for residents and families to be notified as soon as possible after an operator decides that it wants to close beds or a facility and gives the required notice to the regional medical health officer. It is also fair and reasonable that employees and contracted staff be given the same amount of notice.

[156] Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Movement of Clients — Facility Closures or Renovations, 6.J.

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I have recommended that the Ministry of Health take the necessary steps to amend the Residential Care Regulation to require facility operators to notify residents, families and staff promptly of a decision to:

- **close, reduce, expand or substantially change the operations at their facility**
- **transfer residents from their facility because of funding decisions (R171)**

Exemptions to the Notice Requirements

During our investigation, we became concerned that some operators were being allowed to close facilities with less than one year's notice without seeking an exemption from the notice requirement. We found this to be the case for both facilities that were owned and operated by health authorities and those that were privately owned. For example, of the seven residential care facilities closed in the Fraser health region between 2004 and 2010, three closed within less than a year of the medical health officer being notified, and with no exemption being sought.

It is important that health authorities ensure that facility operators apply for an exemption when they are not able to meet the notice requirement. As well as being a legal requirement, the exemption process provides an important safeguard to protect individual residents. The Regulation requires that medical health officers grant exemptions only when they are satisfied that doing so will not increase the risk to residents' health and safety. When operators bypass the requirement to apply for an exemption, this safeguard is not triggered. Furthermore, the medical health officer's decision on the exemption request can be appealed to the Community Care and Assisted Living Appeal Board. If operators do not apply for exemptions, the medical health officer does not make a decision, and so there is nothing that can be appealed.

Consulting Residents about Exemption Requests

Facility operators are not currently required by regulation or policy to inform residents, families, staff or anyone else that they have asked a medical health officer for an exemption from the notice requirements. This means that those who will be affected by the outcome of an exemption decision will have limited, if any, opportunities to provide input before the decision becomes final.

Section 16 states that the medical health officer must be satisfied that there will be *no* increased risk to the health and safety of people in care (emphasis added). This is a very high threshold for granting exemptions. It means that if, on the balance of probabilities, the medical health officer believes that there will be *any* increased risk to the health and safety of residents as a result of reducing the notice period, he or she should not approve the exemption request.

However, nothing in the Regulation requires the medical health officer to seek the views of residents, their families or facility staff before deciding the request. This absence may result in medical health officers making decisions without considering how, from the perspective of residents and families, issuing the exemption might result in an increased risk to residents' health and safety.

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It is also contrary to a decision of the Community Care and Assisted Living Appeal Board, which affirmed the importance of considering input from affected residents and families in *BG and FS v. Fraser Health Authority and Valleyhaven Guest Home*.[157]

This situation improved in June 2009, when the Ministry of Health established provincial guidelines for the closure of residential care facilities. These guidelines specify that operators must consult with families and include evidence of that consultation when requesting an exemption to the notice requirements.[158] While this is a useful step, I think that residents and their families should have their views considered directly by the decision makers, the medical health officers rather than presented by operators.

I have recommended that the health authorities ensure that seniors and their families are:

- **informed when an operator of a residential care facility licensed under the *Community Care and Assisted Living Act* requests an exemption from the Act or Regulation's requirements**
- **informed of how they can provide input to the medical health officer before such a decision is made**
- **notified promptly of the medical health officer's decision**
- **informed about how to appeal a decision to the Community Care and Assisted Living Appeal Board (R172)**

Giving Notice of Exemption Decisions

Decisions that medical health officers make on exemption requests can be appealed to the Community Care and Assisted Living Appeal Board. In practice, however, there are few opportunities to exercise this right, since no one is legally required to inform residents and family members that such a decision has been made. Under section 29(3) of the *CCALA,* these decisions can be appealed within 30 days of the decision by a person in care, or that person's agent, representative, spouse, relative or friend.

In order to exercise their right to appeal, those in care (and those who represent or support them) must be promptly notified when a medical health officer has issued an exemption to the notice requirements, and must be informed that the decision can be appealed to the Community Care and Assisted Living Appeal Board.

I have recommended that before deciding on exemption requests, medical health officers consider input from residents and their families who will be directly affected by the decision on whether granting an exemption would result in an increased risk to health and safety. (R173)

[157] *BG and FS v. Fraser Health Authority and Valleyhaven Guest Home et al.*, 2008, BCCCALAB 5, at para. 30.
[158] Ministry of Health Services, *Provincial Guidelines for Closure of Residential Care Facilities*, 11 June 2009.

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Independence of Medical Health Officers

Many health authorities own and operate residential care facilities. In the course of planning how to care for the needs of the regional population, health authorities may conclude that it is necessary to close one of their facilities or otherwise change its operations. If they do, then — as for any other residential care facility operator — the *Residential Care Regulation* requires the health authority to notify the regional medical health officer of these plans and to request an exemption from the notice requirements if it would like to reduce the notice period.

When a health authority requests an exemption from the requirements, it is the health authority's own medical health officer who handles that request. This is a current legal requirement, although a medical health officer can choose to delegate this decision, including to a suitable person not directly connected with the health authority. This is also the usual procedure followed, even though medical health officers and particularly Chief Medical Health Officers are often either a member of a health authority's executive team or are required to report directly to a member of that team who may be the person making the request to them. Given these circumstances, medical health officers who are asked to decide exemption requests from their own employer are put in a very difficult position and may not be perceived as independent or impartial by the people directly affected by the decision.

To ensure public confidence, decision-makers must not only act impartially but also be seen to be acting impartially. The employment relationship between the health authorities who request exemptions and the medical health officers who must decide these requests puts an undesirable and unnecessary burden on the health authorities' own medical health officers.

Because medical health officers are responsible for making important decisions about all facility operators, it is important for these individuals to have a degree of visible separation from the health authorities they regulate when they are making decisions involving their own health authorities' requests for exemptions.

Currently, there are no guidelines to assist medical health officers in dealing with the challenges of deciding exemption requests submitted by their own employer. Section 68 of the *Public Health Act* gives the provincial health officer the power to set standards for medical health officers and to review their compliance with those standards. Under that authority, the provincial health officer could establish clear guidelines and standards that would set out when a medical health officer can make decisions and how, in these circumstances, he or she can seek an alternative decision-maker to fulfill that role.

> **I have recommended that the Ministry of Health work with the provincial health officer to create policies and procedures that provide for alternative decision-making processes when medical health officers are asked to consider exemption requests under the *Community Care and Assisted Living Act* from their own health authority. (R174)**

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I have also recommended that the Ministry of Health, in discussion with the health authorities, the provincial health officer and other interested stakeholders, consider the broader issues raised by health authorities monitoring, evaluating and enforcing standards against themselves and whether an independent public health agency that is responsible for monitoring and enforcement in residential care facilities is a viable and desirable alternative. (R175)

Protection for Seniors in Facilities Governed by the *Hospital Act*

The requirements that apply when facilities governed by the *Hospital Act* are going to be closed, downsized or otherwise disrupted are minimal and vary from one health authority to another.

Despite the fact that some health authorities have proactively and voluntarily adopted protocols that seek to align the operations of *Hospital Act* facilities with *Community Care and Assisted Living Act (CCALA)* requirements, no legally binding notice requirements apply to closures or substantial changes to the operation of *Hospital Act* facilities. This would only change if section 12 of the *CCALA* were brought into force.

I have recommended that the Ministry of Health take all necessary steps to ensure that the notice and appeal requirements regarding facility closures, downsizing and renovations and other substantial changes that apply to facilities licensed under the *Community Care and Assisted Living Act* also apply to facilities governed by the *Hospital Act.* (R176)

Consultation Meetings

Consultation Meetings

In addition to consulting with the organizations listed below, ombudsperson staff met with a number of individuals and government agencies, including the Public Guardian and Trustee, Treasury Board staff and the Seniors' Healthy Living Secretariat.

Alzheimer Society of B.C.

Association of Advocates for Care Reform

BC Association of Community Response Networks

BC Care Providers Association

B.C. Government and Service Employees' Union

BC Health Coalition

BC Psychogeriatric Association

BC Seniors Advocacy Network

Beacon Community Services

British Columbia Nurses Union

Burquitlam Care Society

Canadian Centre for Policy Alternatives

Central Care Home Family Council

Concerned Friends, Ontario

Council of Seniors Citizens Organizations

Cowichan Lodge Auxilliary

Denominational Health Association

Diamond Geriatrics

Elder College

Gerontology Research Centre, Simon Fraser University

Hospital Employees' Union

Nanaimo Seniors Village Family Council

National Pensioners and Seniors Citizens Federation

North West Regional Hospital District, Terrace

New Horizons Family Council (Campell River)

Old Age Pensioners Organization – Sooke Branch

Pederson Elder Health

Qmunity

Ridge Meadows Seniors Society

Saanich Peninsula Hospital Family Council

South Island Health Coalition

Terraceview Family Council

UBC Centre for Health Services Policy and Research

UBC Centre for Research on Personhood with Dementia

UBC Division of Palliative Care

UBC Geriatric Psychiatry Program

UVic Centre on Aging

Vancouver Coastal Administrators Council

Vancouver Cross Cultural Seniors Network Society

Vancouver Island Association of Family Councils

Ombudsperson Site Visits

Ombudsperson Site Visits

Fraser Health Authority

Abbotsford
Bevan Lodge
Menno Home
Menno Hospital
Menno Terrace East

Burnaby
The New Vista Society

Chilliwack
Valleyhaven Guest Home

Coquitlam
Burquitlam Lions Care Center

New Westminster
Queen's Park Care Centre

Surrey
Carelife Fleetwood
Czorny Alzheimer Centre

Interior Health Authority

Armstrong
Pioneer Square

Kamloops
Pine Grove Lodge
Poderosa Lodge
Ridgeview Lodge

Kelowna
Cottonwood Extended Care
Sun Pointe Village
Three Links Manor

Penticton
Village by the Station

Summerland
Summerland Seniors Village

Northern Health Authority

Prince George
Alward Place
Jubilee Lodge
Laurier Manor
Prince George General Hospital
Prince George Hospital Acute Care
Gem Unit, Prince George General Hospital
Parkside Care Home
Transition Unit, Prince George General Hospital

Terrace
Terraceview Lodge

Vancouver Coastal Health Authority

Richmond
Minoru Residence
Rosewood Manor

Vancouver
Mount St. Joseph Hospital
St. Jude's Anglican Home
Three Links Care Society
Yaletown House

North Vancouver
Churchill House
Crofton Manor
Louis Brier Home and Hospital

Lynn Valley Care Centre

Ombudsperson Site Visits

Vancouver Island Health Authority

Brentwood Bay
Brentwood House

Campbell River
New Horizons Community of Care

Duncan
Cowichan Lodge
Sunridge Place

Ladysmith
The Lodge on 4th

Nanaimo
Nanaimo Seniors Village

Port Alberni
Heritage Place
Echo Village

Saanichton
Saanich Peninsula Hospital

Victoria
Beacon Hill Villa
Central Care Home
Mount St. Mary Hospital

Findings and Recommendations

Home and Community Care

Planning Framework

F1: The Ministry of Health does not track and report publicly on the funding allocated to and expended on home and community care services and the results achieved.

R1: The Ministry of Health report publicly on an annual basis in a way that is clear and accessible:

- the funding allocated to home and community care services by each health authority
- the funds expended on home and community care services in each health authority
- the planned results for home and community care services in each health authority
- the actual results delivered by home and community care services
- an explanation of any differences between the planned results and the actual results

Difficulties in Obtaining Information

F2: The Ministry of Health and the health authorities were unable to provide consistent and reliable data about home and community care services.

R2: The Ministry of Health work with the health authorities and other stakeholders to identify key home and community care data that should be tracked by the health authorities and reported to the ministry on a quarterly basis.

R3: The Ministry of Health include the reported data in an annual home and community care report that it makes publicly available.

Collecting, Managing and Reporting Information

F3: In 2005, the Ministry of Health identified that it needed a new data reporting system to collect and manage home and community care information, but the new system is not yet fully operational.

R4: The Ministry of Health ensure that all health authorities are reliably reporting all the information required by the minimum reporting requirements (MRR) by May 31, 2012.

Findings and Recommendations

F4: None of the health authorities met the December 1, 2009, deadline the Ministry of Health set for them to switch to the new MRR system.

R5: The health authorities ensure that the MRR system is fully operational in their regions by May 31, 2012.

F5: The process selected by the Ministry of Health to move to the MRR system allowed gaps in the reporting of information required by the ministry.

R6: The Ministry of Health, when developing a new information management system, ensure that the new system is fully operational before allowing information reported under the old system to be discontinued.

Assessment Process

F6: The health authorities are not ensuring that all seniors are assessed for Home and Community Care services within two weeks of referral as set out in Ministry of Health policy.

R7: The health authorities ensure that seniors are assessed for home and community care services within two weeks of referral.

F7: The Interior Health Authority and the Vancouver Coastal Health Authority do not track the length of time seniors wait to be assessed for home and community care services.

R8: The Interior Health Authority and the Vancouver Coastal Health Authority track the length of time seniors wait to be assessed for home and community care services.

F8: The Ministry of Health and the health authorities do not have an adequate program in place to ensure that seniors and their families are informed of the availability of home and community care services and the opportunity to have their eligibility for subsidized services assessed.

R9: The Ministry of Health work with the health authorities and other stakeholders to develop a program to ensure that:

- all seniors and their families are informed of the availability of home and community care services
- all seniors and their families are informed that they can meet with health authority staff to determine what supports are available to them

Findings and Recommendations

Information about Assessments Provided to Clients

F9: It is unreasonable for Fraser Health Authority, Interior Health Authority, Vancouver Island Health Authority, and Vancouver Coastal Health Authority to require seniors to submit a freedom of information request in order to obtain a copy of their own home and community care assessment, and it is unreasonable for Northern Health Authority to not provide seniors a copy of a requested assessment.

R10: The health authorities offer seniors copies of their home and community care assessments. In any case where health authorities believe that providing the complete assessment would harm a senior's health, they should provide an edited copy.

Fees and Fee Waivers

F10: The Ministry of Health and the health authorities do not consistently provide seniors receiving subsidized care with clear information about the availability of fee reductions or waivers.

R11: The Ministry of Health and the health authorities include information about how to apply for fee reductions and waivers when they mail fee notices to clients who receive subsidized home and community care services, and look for other opportunities to make this information accessible in a timely manner to those who need it.

F11: The health authorities are not consistently tracking the number of fee reduction applications they receive, approve and deny.

R12: The health authorities track the number of fee reduction applications they receive, approve and deny, and report this information to the Ministry of Health to assist the ministry in evaluating the capacity of seniors to pay home and community care fees.

F12: The Ministry of Health has not established a time limit within which health authorities must respond to fee reduction applications.

R13: The Ministry of Health establish a reasonable time limit within which health authorities must decide and respond in writing to fee reduction applications.

Findings and Recommendations

Sponsored Immigrants

F13: The Ministry of Health did not have authority to use a separate and distinct process to determine the rates that sponsored immigrants had to pay for home and community care services between March 31, 1997, and April 1, 2011.

R14: The Ministry of Health establish a process that permits any sponsored immigrants charged home and community care fees between March 31, 1997, and April 1, 2011, to apply to the ministry for a review of the fees paid and, where appropriate, a reimbursement for excess fees paid.

Patient Care Quality Offices and Review Boards

F14: The patient care quality offices (PCQOs) are only able to process care quality complaints that are made by or on behalf of a particular person who received care and this prevents them from responding to broader care quality issues.

R15: The Ministry of Health take the steps necessary to ensure that PCQOs can respond to a broader range of complaints, including complaints from resident and family councils.

F15: The Ministry of Health has not provided specific direction to the patient care quality offices (PCQOs) on the steps they should follow in processing care quality complaints.

R16: The Ministry of Health provide specific direction to the PCQOs on the steps they should follow in processing care quality complaints.

R17: After the PCQOs and patient care quality review boards (PCQRBs) have been operational for five years, the Ministry of Health review their complaint-handling processes and implement any improvements identified in the course of this review.

F16: The Ministry of Health has not established a policy on when PCQRBs should treat requests for reviews as urgent.

R18: The Ministry of Health develop and make public a clear policy to guide the PCQRBs on when they should treat review requests as urgent.

Findings and Recommendations

F17: The health authorities' PCQOs do not consistently:

- provide information to the public about which complaints they will consider
- document the process they use when responding to complaints
- provide written reasons to complainants at the end of a review
- record whether complainants were advised of their option to take their complaints to the regional patient care quality review board

R19: The health authorities provide clear and consistent information to the public on how the PCQOs respond to complaints and the complaints they will consider.

R20: The health authorities ensure that PCQOs carefully document the steps taken in response to a complaint as set out in the ministerial directive.

R21: The health authorities ensure that PCQOs inform all complainants in writing about the outcome of their complaint.

Need for Advocacy and Support

F18: The Ministry of Health has not ensured that seniors and families have access to adequate assistance and support to navigate the complex home and community care system and bring forward concerns and complaints.

R22: The Ministry of Health establish a program to provide support for seniors and their families to navigate the home and community care system and bring forward concerns and complaints by January 2013.

Education and Training

F19: The Ministry of Health has not ensured that all institutions offering training for community health workers are using its approved new curriculum.

R23: The Ministry of Health work with the Ministry of Advanced Education to require all institutions offering training for community health workers to use the approved new curriculum commencing in September 2013.

Findings and Recommendations

Registration

F20: The Ministry of Health does not require care aides and community health workers at home support agencies, assisted living residences and residential care facilities that do not receive public funding to register with the BC Care Aide & Community Health Worker Registry.

R24: The Ministry of Health, by January 2013, require care aides and community health workers at all home support agencies, assisted living residences and residential care facilities to register with the BC Care Aide & Community Health Worker Registry.

F21: The Ministry of Health does not require applicants to the BC Care Aide & Community Health Worker Registry to disclose whether they have ever been subject to formal disciplinary action by a health care employer.

R25: The Ministry of Health require applicants to the BC Care Aide & Community Health Worker Registry to disclose whether they have ever been disciplined or terminated by a health care employer on the grounds of abuse, and establish a process for evaluating whether it is appropriate to allow registration.

Criminal Record Checks

F22: The Ministry of Health has not taken adequate steps to ensure that employers of home support agencies and private hospitals that do not receive public funding obtain criminal record checks on persons who work with vulnerable adults as a condition of employment.

R26: The Ministry of Health, in consultation with the Ministry of Solicitor General, take all necessary steps by June 2013 to ensure that all persons who work with vulnerable adults in home support agencies and private hospitals are required to obtain criminal records checks as a condition of employment.

Reporting and Responding to Allegations of Abuse and Neglect

F23: The Ministry of Health does not require care staff to report information indicating seniors receiving home support, assisted living or residential care services are being abused or neglected.

R27: The Ministry of Health take the necessary steps to require staff providing care to seniors to report information indicating that a senior is being abused or neglected to the regional health authority.

Findings and Recommendations

F24: The Ministry of Health does not require operators of facilities governed under the *Hospital Act* to report incidents of abuse and neglect of residents.

R28: The Ministry of Health take the necessary steps to require operators of residential facilities governed under the *Hospital Act* to report instances of abuse and neglect of residents.

F25: The health authorities do not track the number of reports of abuse and neglect they have investigated or the number of support and assistance plans they have implemented in response to investigations of abuse and neglect.

R29: The health authorities track the number of incidents of abuse and neglect investigated in their region and the number of support and assistance plans implemented in response to their investigations of these reports.

F26: The Ministry of Health does not require service providers to notify the police of an incident of abuse or neglect that may constitute a criminal offence.

R30: The Ministry of Health require service providers to immediately notify the police of all incidents of abuse and neglect that may constitute a criminal offence.

R31: The Ministry of Health work with the health authorities to develop provincial guidelines on when service providers should report incidents of abuse and neglect to the police.

Protecting Seniors in Care from Financial Abuse

F27: The Ministry has not ensured that seniors who receive home support services or live in assisted living residences have the same legal protection from financial abuse as those who live in residential care facilities.

R32: The Ministry of Health take the steps necessary to ensure that seniors who receive home support services or live in assisted living residences have the same level of legal protection from financial abuse as those who live in residential care facilities.

Findings and Recommendations

Protecting Those Who Report Concerns

F28: The Ministry of Health has not ensured that there is comprehensive legal protection from adverse consequences for anyone, including staff, who makes a complaint in good faith about home and community care services.

R33: The Ministry of Health take the necessary steps to provide comprehensive legal protection from adverse consequences for anyone, including staff, who makes a complaint in good faith about home and community care services.

Home Support

Changes in Home Support Policy

F29: The Ministry of Health has not analyzed whether the home support program is meeting its goal of assisting seniors to live in their own homes as long as it is practical and in their and their families' best interests.

R34: The Ministry of Health

- analyze whether the current home support program is meeting its goal of assisting seniors to live in their own homes as long as it is practical and in their and their families' best interests, and make any necessary changes
- evaluate the home support eligibility criteria to ensure that they are consistent with program goals, and make any necessary changes
- analyze the benefits and costs of expanding the home support program up to the cost of providing subsidized residential care when it is safe and appropriate to do so
- report publicly on the results of this analysis and evaluation by October 2013

Assessment, Eligibility and Access

F30: The Ministry of Health has not ensured that time allotments for home support activities are adequate and consistent across the province.

R35: The Ministry of Health work with the health authorities to develop a consistent province-wide process for determining adequate time allotments for home support activities.

F31: The Ministry of Health has not established a time frame within which seniors are to receive home support services following an assessment.

R36: The Ministry of Health set a time frame within which eligible seniors are to receive subsidized home support services after assessment.

Findings and Recommendations

F32: The health authorities do not consistently track and report the time it takes for seniors to receive home support services after assessment.

R37: The health authorities track the time it takes for seniors to receive home support services after assessment and report the average and maximum times that eligible seniors wait to receive subsidized home support services to the ministry quarterly.

R38: The Ministry of Health report annually to the public on the average and maximum times that eligible seniors wait to receive subsidized home support services after assessment.

Cost of Receiving Services

F33: It is unfair for the Ministry of Health to treat seniors without earned income differently than seniors with earned income for the purposes of capping monthly fees for home support services at $300 per month.

R39: The Ministry of Health take the steps necessary to extend the $300 monthly cap to seniors who do not have earned income so that they are treated the same way as those seniors who do have earned income.

Continuity of Care

F34: While continuity in staffing is recognized as important in home support services, the Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority do not incorporate this principle in their policies, service agreements and performance measures on a regular and consistent basis.

R40: The Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority include the principle of continuity in home support in their policies, service agreements and performance measures.

The Choice in Supports for Independent Living Program

F35: The Ministry of Health has not ensured that the Choice in Supports for Independent Living (CSIL) application process is standard across the province and that clear information about the CSIL program is provided to seniors and their families.

R41: The Ministry of Health establish a standard CSIL application process and ensure that clear and accessible information about that application process is made available by the health authorities.

Findings and Recommendations

Quality of Care

F36: The Ministry of Health has not exercised its power under section 4(4) of the *Continuing Care Act* to establish specific quality of care standards for home support services.

R42: The Ministry of Health exercise its power under section 4(4) of the *Continuing Care Act* to establish clear, specific and enforceable quality of care standards for home support services, including the type and level of care to be provided, minimum qualifications and training for staff, complaints processes and procedures for reportable incidents.

R43: The Ministry of Health require health authorities to provide information about these standards to home support clients.

Complaints

F37: The Interior Health Authority does not include a requirement in its contracts for home support providers to have clearly defined complaints processes.

R44: The Interior Health Authority require all of its contracted service providers to have a clearly defined complaints process.

F38: The health authorities do not have a requirement in their contracts for home support providers to inform residents and families about how to complain about home support services and to report to the health authorities about the number, type and outcomes of complaints received.

R45: The health authorities require their contracted home support providers to inform residents and families about how to complain about home support services and report to the health authorities on the number, type and outcomes of complaints received once per quarter.

F39: The health authorities do not keep track of complaints about home support that are made to case managers.

R46: The health authorities develop and implement methods for tracking complaints made to case managers about home support.

F40: The Ministry of Health has not ensured that all seniors who receive home support services have access to the same complaints processes.

R47: The Ministry of Health ensure that all seniors who receive home support services have access to the same complaints processes, regardless of how they pay for the services.

Findings and Recommendations

F41: The health authorities do not provide clear and consistent information for seniors and their families about how they can complain about home support services and how the health authorities will handle complaints.

R48: The Ministry of Health and the health authorities work together to develop and provide clear and consistent information for seniors and their families on how they can complain about home support services and how the health authorities will handle those complaints.

Monitoring and Enforcement

F42: The health authorities do not have clear and consistent processes for monitoring the quality of home support services provided directly by health authority staff or by contractors, or for enforcing any applicable standards.

R49: The Ministry of Health work with the health authorities to establish clear and consistent processes to monitor the quality of home support services provided directly by health authority staff or by contractors, and to enforce any applicable standards.

F43: The reporting requirements in the service agreements used by the Interior Health Authority and Vancouver Island Health Authority are too general to effectively monitor contracted home support services.

R50: The Interior Health Authority and Vancouver Island Health Authority adopt more specific reporting requirements in their service agreements to more effectively monitor contracted home support services.

Assisted Living

The Office of the Assisted Living Registrar

F44: The Ministry of Health's practice of contracting with the Health Employers Association of BC to staff the Office of the Assisted Living Registrar is incompatible with the role of that office as an impartial overseer of assisted living.

R51: The Ministry of Health stop contracting with the Health Employers Association of BC to staff the Office of the Assisted Living Registrar and instead staff all positions with permanent employees of the ministry.

Findings and Recommendations

F45: The assisted living registrar has not delegated the investigative powers she has under the *Community Care and Assisted Living Act* to her staff.

R52: The assisted living registrar delegate the investigative powers she has under the *Community Care and Assisted Living Act* to any of her staff who require those powers.

Cost of Receiving Services

F46: It is unfair and unreasonable for the Ministry of Health to give health authorities and facility operators until April 1, 2013, to comply with its policy on benefits and allowable charges in assisted living because this allows operators to charge fees for benefits that are included in the assessed client rate.

R53: The Ministry of Health require health authorities and assisted living operators to comply with its policy on benefits and allowable charges immediately rather than by April 1, 2013. If this results in an unexpected financial inequity for certain operators, the ministry take steps to resolve this inequity in a fair and reasonable manner.

The Legal Definition of Assisted Living

F47: There is no statutory basis for the Ministry of Health's practice of allowing operators to provide prescribed services at the support level.

R54: If the Ministry of Health believes that the practice of allowing operators to provide prescribed services at the support level is useful, the ministry take steps to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act* so that it provides a statutory basis for doing so.

R55: If the Ministry of Health decides to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act,* it ensure that any changes in service delivery practices maintain a clear distinction between the services provided in assisted living residences and those provided in residential care facilities.

R56: If the Ministry of Health decides to revise the definition of "assisted living residence" in the *Community Care and Assisted Living Act* to allow operators to provide additional services, it must ensure this is accompanied by increased oversight, monitoring and enforcement.

Findings and Recommendations

Availability of Information

F48: The health authorities have not yet fully complied with the February 2009 Minister of Health's directive that requires them to make specific information about assisted living publicly available.

R57: The health authorities fully comply with the February 2009 Minister of Health's directive immediately.

F49: The Ministry of Health has not ensured that adequate information is publicly available in an accessible format that allows seniors and their families to plan and make informed decisions about assisted living.

R58: The Ministry of Health ensure that the health authorities make the following additional information available to the public by June 1, 2012:

- the basic services available at each assisted living facility in their region and their costs, as well as the type and costs of any other services available at each facility
- billing processes for each assisted living residence in their region
- the care policies and standards for each assisted living residence in their region

Section 26(3) *Community Care and Assisted Living Act*

F50: The Ministry of Health has not established a legally binding process to guide decisions made by assisted living operators under section 26(3) of the *Community Care and Assisted Living Act* about the decision-making capacity of assisted living residents.

R59: The Ministry of Health create a legally binding process with appropriate procedural safeguards for determining whether assisted living applicants and residents have the required decision-making capacity.

R60: If the Ministry retains the test in section 26(3) of the *Community Care and Assisted Living Act,* it provide more specific direction on the meaning of the phrase "unable to make decisions on their own behalf."

R61: The Ministry of Health ensure that assisted living applicants and residents have access to an independent process through which decisions about capacity made under section 26(3) can be reviewed.

Findings and Recommendations

Exceptions to the Eligibility Requirements

F51: The Ministry of Health does not have the legal authority to recognize relationships other than spousal relationships when dealing with the exceptions to the provision of the *Community Care and Assisted Living Act* that requires assisted living residents to be able to make their own decisions.

R62: The Ministry of Health take the steps necessary to broaden the exception in section 26(6) of the *Community Care and Assisted Living Act* to include a wider range of relationships.

The Placement Process

F52: The Ministry of Health has not established a time frame within which seniors are to receive assisted living services following an assessment.

R63: The Ministry of Health set a time frame within which eligible seniors are to receive subsidized assisted living services after assessment.

F53: The Ministry of Health does not track and report the time it takes for seniors to receive assisted living services after assessment.

R64: The Ministry of Health require the health authorities to report the average and maximum times that eligible seniors wait to receive subsidized assisted living services to the ministry quarterly.

R65: The Ministry of Health report annually to the public on the average and maximum time that eligible seniors wait to receive subsidized assisted living services after assessment.

F54: The health authorities' practices vary widely in the length of time they give people to move into a subsidized assisted living unit after it has been offered, and on the consequences of declining an offered unit.

R66: The Ministry of Health work with the health authorities to a develop a clear and consistent provincial policy that provides reasonable time frames for moving, has the flexibility to respond to individual circumstances and sets out:

- how long a person has to accept an offered placement in an assisted living residence
- how long a person has to move into an assisted living unit once it has been offered
- any consequences of declining an offered of placement

Findings and Recommendations

The Exit Process

F55: The Ministry of Health policy that requires operators to provide additional support to residents during the exit process results in operators providing more than the maximum two prescribed services for an undefined time frame.

R67: The Ministry of Health take the steps necessary to provide facility operators with the legal authority to offer additional support to assisted living residents during the exit process.

R68: The Ministry of Health establish reasonable time frames for completing the exit process for assisted living residents.

Quality of Care

F56: The Ministry of Health has not established legally binding standards for key areas in assisted living such as staffing, residents' rights, food safety and nutrition, emergencies, record management and assistance with activities of daily living.

R69: The Ministry of Health, after consulting with stakeholders, establish legally binding minimum requirements for assisted living residences in key areas, including:

- staffing
- residents' rights
- food safety and nutrition
- emergencies
- record management
- assistance with activities of daily living

R70: The Ministry of Health provide clear and accessible information to residents on the standards assisted living operators are required to meet.

Complaints

F57: The Fraser Health Authority, Interior Health Authority and Northern Health Authority have not yet fully complied with the minister's directive.

R71: The Fraser Health Authority, Interior Health Authority and Northern Health Authority fully comply with the minister's directive by:

- in the case of FHA, providing direct contact information for the OALR
- in the case of IHA, including a description of the complaints processes and direct contact information for the PCQRB and OALR, and
- in the case of NHA, providing a description of the complaints process and direct contact information for the OALR

Findings and Recommendations

F58: Assisted living operators are not required by law to have a process for responding to complaints.

R72: The Ministry of Health take the necessary steps to establish a legal requirement for assisted living operators to have a process for responding to complaints, and to establish specific standards for that process.

F59: The health authorities do not ensure that operators provide clear and comprehensive information to assisted living residents on how to complain about the care and services they receive.

R73: The health authorities ensure that by September 30, 2012, all assisted living operators are providing residents with clear and comprehensive information on how to complain about the care and services they receive, including where to take complaints about services provided by contractors.

F60: The health authorities do not track complaints about assisted living that are made to case managers.

R74: The health authorities develop and implement a process for tracking complaints made to case managers about assisted living.

F61: The complaints process used by the Office of the Assisted Living Registrar does not:

- establish time limits for responding to complaints
- include an established process for investigating complaints
- require its staff to provide the person who complained with written information on the outcome of its investigation and any further actions they can take
- require its staff to monitor whether operators implement the action it has recommended to resolve complaints

R75: The Ministry of Health revise the complaints process used by the Office of the Assisted Living Registrar to include:

- time limits for responding to complaints
- an established process for investigating complaints
- a requirement that complainants be informed in writing of the outcome of their complaint and any further actions they can take

Findings and Recommendations

R76: The Ministry of Health take the necessary steps to establish a right of review or appeal from decisions or complaints made to the Office of the Assisted Living Registrar.

R77: The Ministry of Health develop a process for monitoring whether operators implement the actions it recommends through the Office of the Assisted Living Registrar to resolve complaints, and taking further action if they do not.

F62: It is unfair that all assisted living residents do not have access to the same complaints processes.

R78: The Ministry of Health take the steps necessary to expand the powers of the Office of the Assisted Living Registrar so that it has the authority to respond to complaints about all aspects of care in assisted living from all residents.

R79: The Ministry of Health review the structure of the Office of the Assisted Living Registrar with the goal of ensuring that it has the necessary support to fulfill this expanded role.

F63: The overlapping jurisdiction of the Office of the Assisted Living Registrar and the patient care quality offices and the different approaches the health authorities take to resolve this overlapping authority leads to inconsistencies in how similar complaints are dealt with and is confusing for those who want to complain about assisted living.

R80: The Ministry of Health take the necessary steps to ensure that the patient care quality offices refer all complaints about assisted living to the Office of the Assisted Living Registrar.

R81: The Ministry of Health establish a mechanism that allows the Office of the Assisted Living Registrar to share the results of its complaints with the home and community care sections of the health authorities on a timely basis.

F64: The Ministry Responsible for Housing, currently part of the Ministry of Energy and Mines, has not ensured that assisted living residents benefit from equal or greater legal protection afforded other, less vulnerable, tenants.

R82: The Ministry Responsible for Housing take the steps necessary to better protect assisted living residents by bringing the unproclaimed sections of the *Residential Tenancy Act* into force by January 1, 2013, or by developing another legally binding process to provide equal or greater protection by the same date.

Findings and Recommendations

R83: The Ministry of Health, in consultation with the Ministry Responsible for Housing, consider whether to expand the jurisdiction of the Office of the Assisted Living Registrar to deal with complaints and disputes about tenancy issues in assisted living.

R84: If the Ministry of Health decides not to include complaints about tenancy within the jurisdiction of the Office of the Assisted Living Registrar, the ministry must require the Office of the Assisted Living Registrar to automatically refer tenancy issues to the agency that has the power to resolve them.

Monitoring

F65: Assisted living operators are not legally required to report serious incidents.

R85: The Ministry of Health take the necessary steps to legally require assisted living operators to report serious incidents to the Office of the Assisted Living Registrar, the representative of the person in care, the person's doctor and the funding program.

F66: The list of serious incidents developed by the Ministry of Health for assisted living residences is less comprehensive than the list of reportable incidents for residential care facilities under the *Community Care and Assisted Living Act.*

R86: The Ministry of Health review the current list of serious incidents applicable to assisted living residences and expand it.

F67: The Ministry of Health does not have a formal process to monitor operators' compliance with serious incident reporting.

R87: The Ministry of Health develop a formal process to monitor operators' compliance with serious incident reporting requirements and ensure appropriate enforcement action is taken.

F68: It is ineffective and inadequate for the Ministry of Health to rely on responding to complaints and serious incident reports as its main form of oversight for assisted living residences.

R88: The Ministry of Health develop an active inspection and monitoring program for assisted living, including:

- a regular program for inspecting existing facilities
- more frequent announced and unannounced inspections of facilities it receives complaints about
- a risk-rating system for assisted living residences
- publicly available inspection reports

Findings and Recommendations

F69: Currently less than 11 per cent of assisted living residences were inspected by the Office of the Assisted Living Registrar to ensure they meet the requirements of the *Community Care and Assisted Living Act* for registration before they were registered.

R89: The Office of the Assisted Living Registrar develop and implement a program to conduct inspections of assisted living residences before they are registered.

F70: The assisted living registrar has insufficient authority to obtain information needed to conduct effective investigations.

R90: The Ministry of Health take the necessary steps to expand the authority of the assisted living registrar to obtain information from all relevant parties, including employees, operators of assisted living residences, residents, contractors and others with information about incidents under investigation.

F71: The performance management approaches and practices, including the implementation of processes in the Ministry of Health's Performance Management Framework for Assisted Living, differ among the health authorities.

R91: The Ministry of Health work with the health authorities to standardize performance management processes for assisted living, and adopt the best practices within each health authority provincially.

R92: The Ministry of Health make information it obtains under the Performance Management Framework for Assisted Living publicly available on an annual basis.

Enforcement

F72: The Office of the Assisted Living Registrar is heavily dependent on an informal enforcement process and has only used its formal enforcement powers on two occasions in seven years.

R93: The Ministry of Health review the Office of the Assisted Living Registrar's enforcement program to ensure that it has adequate resources and more power to actively ensure compliance with required standards.

Findings and Recommendations

Residential Care

Regulating Residential Care — Two Approaches

F73: The Ministry of Health's decision to maintain two separate legislative frameworks for residential care has resulted in unfair differences in the care and services that seniors receive and fees they pay.

R94: The Ministry of Health harmonize the residential care regulatory framework by January 1, 2013, by either:

- taking the necessary steps to bring section 12 of the *Community Care and Assisted Living Act* into force or
- taking other steps to ensure that the same standards, services, fees, monitoring and enforcement, and complaints processes apply to all residential care facilities

(If this option is chosen, the Ministry of Health should also amend the definitions in the *Hospital Act* to accurately reflect the fact that extended care hospitals and private hospitals provide complex care.)

R95: Until the regulatory framework for residential care is standardized, the Ministry of Health require the health authorities to include residential care facilities governed under the *Hospital Act* in their inspection regimes and report the results of those inspections on their websites.

R96: The Ministry of Health ensure that harmonizing the residential care regulatory framework does not result in any reduction of benefits and services for residents in any residential care facility.

Funding

F74: The Ministry of Health and the health authorities' decisions on residential care funding are primarily guided by past funding levels and the amount of money allocated by the health authorities for each program area, rather than an evaluation to determine whether the residential care budget in each health authority is sufficient to meet the needs of its population.

R97: The Ministry of Health working with the health authorities conduct an evaluation to determine whether the residential care budget in each health authority is sufficient to meet the current needs of its population.

Findings and Recommendations

F75: The health authorities' current processes for determining the funding needs of individual facilities do not adequately account for or address historical funding differences or how the care needs of residents vary among facilities.

R98: The Ministry of Health work with health authorities to remedy any historically based anomalies in funding by establishing a consistent method to determine the funding requirements of residential care facilities. The Ministry ensure the process takes into account the care needs of residents, actual costs, capital expenses and taxes.

R99: The Fraser Health Authority, the Interior Health Authority and Vancouver Island Health Authority establish a three-year review cycle for determining the funding needs of individual facilities.

Eligibility Criteria

F76: The Ministry of Health has two unreasonable conditions of eligibility for a subsidized bed in a residential care facility:

- that seniors have to accept a placement in an unknown residential care facility and move in within 48 hours of when a bed is offered
- that seniors have to agree to pay the applicable room rates and other permissible facility charges before knowing the amount of those costs

R100: The Ministry of Health remove the two unreasonable conditions of eligibility for a subsidized bed in a residential care facility.

Assessment Process

F77: The Ministry of Health does not require the health authorities to ensure that seniors who believe a placement they've been offered is inappropriate have the opportunity to raise their concerns and have them considered.

R101: The Ministry of Health work with the health authorities to ensure that seniors who believe an offered placement is inappropriate have an adequate opportunity to raise their concerns and have them considered.

Findings and Recommendations

F78: It is unfair for the Ministry of Health and the health authorities to tell seniors they can transfer to a residential care facility they prefer after accepting admission to the first appropriate bed without also informing them:

- they will be considered lower priority for transfer to their preferred facility once they have accepted the first appropriate bed
- how long it is likely to take to transfer to their preferred facility

R102: The Ministry of Health require the health authorities to inform seniors that they will be considered lower priority for transfer to their preferred facility once they have accepted the first appropriate bed, and how long it is likely to take to transfer to their preferred facility.

F79: The Ministry of Health and health authorities' residential care placement policies and practices do not incorporate seniors' choices and preferences.

R103: The Ministry of Health require the health authorities to ask seniors who are waiting to be placed in residential care facilities to identify their three preferred facilities and accommodate those preferences whenever possible.

F80: It is unfair for the health authorities to penalize seniors who pay for a non-subsidized bed while waiting for a subsidized bed by assigning them a lower priority on waiting lists for that reason.

R104: The health authorities stop penalizing seniors who pay for a non-subsidized residential care bed while waiting for a subsidized bed by assigning them a lower priority on their waiting lists for that reason.

F81: The health authorities do not provide seniors and their families with information on how long eligible seniors can expect to wait for initial placement in subsidized residential care and for transfer to their preferred facility.

R105: The health authorities provide clear information to seniors and their families on how priorities are determined for seniors waiting for initial placement in a subsidized residential care bed when the senior is waiting in acute care, at home, in assisted living and in a non-subsidized residential care facility.

R106: The health authorities provide clear information to seniors and their families on how priorities are determined for seniors waiting to transfer to their preferred residential care facility.

Findings and Recommendations

R107: The health authorities track and publicly report every year on:

- the average and maximum times seniors wait for initial placement from acute care, home and assisted living, and from non-subsidized residential care
- the average and maximum times seniors wait to be transferred to their preferred facility
- the percentage of seniors in residential care who are placed in their preferred facility immediately and within one year of their initial placement

Waiting Times for Placement

F82: The Ministry of Health has not established a time frame within which seniors are to receive residential care services following an assessment.

R108: The Ministry of Health set a time frame within which eligible seniors are to receive subsidized residential care services after assessment.

R109: The health authorities track the time it takes for seniors to receive residential care after assessment and report the average and maximum times to the ministry quarterly.

R110: The Ministry of Health report annually to the public on the average and maximum time that eligible seniors wait to receive subsidized residential care services after assessment.

F83: The Northern Health Authority does not track the length of time seniors wait in hospitals for residential care before being transferred to a residential care facility.

R111: The Northern Health Authority track the length of time seniors wait in hospitals for residential care before being transferred to a residential care facility.

F84: The Ministry of Health and the health authorities do not track the extra costs that result from keeping seniors who require residential care in acute care hospital beds.

R112: The health authorities:

- track the extra costs that result from keeping seniors who require residential care in acute care hospital beds and report these extra costs to the Ministry of Health on a quarterly basis
- report the length of time that seniors occupy acute care beds while waiting for placement to the Ministry of Health on a quarterly basis

R113: The Ministry of Health report publicly every year on the length of time and the extra costs that result from keeping seniors who require residential care in acute care hospital beds.

Findings and Recommendations

Seniors in Hospital Waiting for Transfer to Residential Care

F85: It is unfair for the Ministry of Health to permit health authorities to charge seniors for hospital stays that extend beyond 30 days after they have been assessed as needing residential care when they have to remain in hospital because of the unavailability of appropriate residential care beds.

R114: The Ministry of Health ensure that the health authorities stop charging seniors assessed as needing residential care but who remain in hospital for longer than 30 days because of the unavailability of appropriate residential care beds.

Consenting to Admission

F86: The Ministry of Health has not provided adequate direction to the health authorities about when to conduct an assessment of a senior's capacity to consent to admission to a residential care facility or what to do when a senior does not have this capacity.

R115: The Ministry of Health take the necessary steps to bring into force Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act,* and in the interim provide health authorities with direction on when and how to conduct an assessment of a senior's capacity to consent to admission.

F87: The Ministry of Health has not provided adequate direction to the health authorities on the process to be followed by operators in obtaining written consent-to-admission to residential care facilities.

R116: The Ministry of Health work with the health authorities and service providers to develop a standard consent-to-admission form for residential care facilities.

Moving In

F88: It is unreasonable for the Ministry of Health and the health authorities to require that all seniors move into a residential care facility within 48 hours of when a bed is offered, particularly when they have not had a reasonable amount of time to plan for the move.

R117: The Ministry of Health develop a policy that is more flexible regarding the length of time allowed to move into a facility when a bed is offered, and provides a reasonable amount of time to plan for the move.

Findings and Recommendations

F89: It is unreasonable for the health authorities to move a senior into a residential care facility when the operator does not have adequate information and a reasonable amount of time to prepare for the new arrival.

R118: The health authorities work together with facility operators to develop a list of standard information about any new resident to be provided to the facility by the health authority a reasonable amount of time before a resident is scheduled to move in.

F90: It is unfair for the health authorities to make seniors reapply for services if they have declined the first residential care bed offered but still want a residential care placement.

R119: The health authorities stop making seniors reapply for services if they decline the first residential care bed offered but still want a residential care placement.

F91: It is unreasonable that the health authorities do not inform people of their right to request an exception to the requirement to move into a facility within 48 hours of when a bed is offered.

R120: The health authorities inform seniors of their right to request an exception to the requirement to move into a facility within 48 hours of when a bed is offered.

What Seniors Pay for Subsidized Residential Care

F92: The Ministry of Health has stated that the amount seniors pay for residential care should not exceed the actual cost of accommodation and hospitality services, but has not ensured that this is the case.

R121: The Ministry of Health work with the health authorities to develop a process for accurately calculating the costs of accommodation and hospitality services for each residential care facility that provides subsidized residential care, and ensure that seniors receiving subsidized residential care do not pay more than the actual cost of their accommodation and hospitality services.

F93: The Ministry of Health has not taken steps to address the unfairness to seniors who had to pay room differentials between January 1, 2010, and October 1, 2010, even though they had not requested a superior room.

Findings and Recommendations

R122: The Ministry of Health establish a process for people to apply to the ministry for a review of the fees paid if they believe they were unfairly charged room differentials between January 1, 2010, and October 1, 2010.

F94: The Ministry of Health has approved spending plans submitted by the health authorities that devote a portion of the revenue to expenses not related to care, despite public assurances that the money would be spent to improve care.

R123: The Ministry of Health provide further and more detailed public information on how the additional revenue generated by the new residential care rate structure is being spent and what improvements to care have resulted in each facility.

F95: Despite the increased revenue generated by the new residential care rate structure, the Interior, Fraser, Vancouver Coastal and Vancouver Island health authorities are not planning to meet the Ministry of Health's guideline of providing 3.36 direct care hours by 2014/15.

R124: The Ministry of Health together with the Interior, Fraser, Vancouver Coastal and Vancouver Island health authorities ensure that each health authority, at a minimum, meets the ministry's guideline of providing 3.36 daily care hours by 2014/15.

F96: The variation in charges for items and services at different facilities is unfair, particularly as seniors often cannot choose the facility in which they are placed.

R125: The Ministry of Health establish a process to review the fees at different facilities and take all necessary steps to ensure that they are consistent and that this action does not result in increases in fees for seniors in residential care.

F97: It is unfair and unreasonable for the Ministry of Health to give health authorities and facility operators until April 1, 2013, to comply with its new policy on benefits and allowable charges in residential care because this allows operators to charge fees for benefits already included in the resident fee.

R126: The Ministry of Health require health authorities and facility operators to comply with its policy on benefits and allowable charges immediately rather than by April 1, 2013. If this results in an unexpected financial inequity for certain operators, the ministry take steps to resolve this inequity in a fair and reasonable manner.

Findings and Recommendations

F98: When considering applications for hardship waivers, the Ministry of Health does not ask for or consider information about other reasonable expenses that seniors have an obligation to pay.

R127: The Ministry of Health and the health authorities ensure that the full costs seniors pay for residential care, including extra fees for services, supplies or other benefits, as well as other reasonable expenses that seniors have an obligation to pay, are considered when assessing their eligibility for hardship waivers.

F99: It is unreasonable that the Ministry of Health has not increased the amount that can be claimed for general living expenses on applications for hardship waivers since 2002.

R128: The Ministry of Health immediately conduct a review of the amount that can be claimed for general living expenses on applications for hardship waivers and make necessary changes, and review and update the list of allowable expenses every three years.

F100: The health authorities do not provide adequate information to seniors on how income splitting can affect the residential care rate that they are required to pay.

R129: The Ministry of Health and the health authorities work together to provide information for the public on how income splitting can affect the residential care rate that seniors are required to pay.

Use of the *Mental Health Act* to Admit Seniors to Residential Care Involuntarily

F101: The health authorities' use of sections 22 and 37 of the *Mental Health Act* to involuntarily admit seniors to mental health facilities and then transfer them to residential care is done without clear provincial policy to ensure that the *Mental Health Act* is used as a last resort and that seniors are not unnecessarily deprived of their civil liberties.

R130: The Ministry of Health ensure that seniors' civil liberties are appropriately protected by working with the health authorities to develop a clear, province-wide policy on when to use sections 22 and 37 of the *Mental Health Act* to involuntarily admit seniors to mental health facilities and then transfer them to residential care.

Findings and Recommendations

F102: It is unfair for the health authorities to charge fees to seniors they have involuntarily detained in mental health facilities under the *Mental Health Act* and then transferred to residential care facilities.

R131: The health authorities stop charging fees to seniors they have involuntarily detained in mental health facilities under the *Mental Health Act* and then transferred to residential care facilities.

R132: The Ministry of Health develop a process for seniors who have paid fees for residential care while being involuntarily detained under the *Mental Health Act* to apply to the ministry to be reimbursed for the fees paid.

Quality of Care

F103: The Ministry of Health has not established specific and objectively measurable standards for key aspects of residential care, including:

- bathing frequency
- dental care
- help with going to the bathroom
- call-bell response times
- meal preparation and nutrition
- recreational programs and services
- provision of culturally appropriate services

R133: After consulting with the health authorities, facility operators, seniors and their families, the Ministry of Health establish specific and objectively measurable regulatory standards that apply to key aspects of care in all residential care facilities, including:

- bathing frequency
- dental care
- help with going to the bathroom
- call-bell response times
- meal preparation and nutrition
- recreational programs and services
- provision of culturally appropriate services

The Ministry take these steps by April 1, 2013.

Findings and Recommendations

F104: The Ministry of Health and the health authorities have not collected data on call-bell response times or established standards for reasonable response times.

R134: The Ministry of Health and the health authorities, in cooperation with facility operators, collect available data on call-bell response times and utilize this data in setting objective standards for reasonable response times.

Restraints

F105: Fewer regulatory safeguards apply to the use of restraints in residential care facilities governed by the *Hospital Act* than in facilities licensed under the *Community Care and Assisted Living Act*.

R135: The Ministry of Health take the necessary steps to ensure that the *Community Care and Assisted Living Act*'s standards for the use of restraints apply to all residential care facilities in the province.

F106: The Ministry of Health permits operators to restrain residents without consent in an emergency, but has not defined what constitutes an emergency.

R136: The Ministry of Health define "emergency" and the circumstances in which an operator is permitted to restrain a resident without consent.

F107: The Ministry of Health has not yet completed an investigation of the increased use of antipsychotic drugs in residential care facilities.

R137: The Ministry of Health complete its review on the use of antipsychotic drugs in residential care facilities and make the report available to the public.

F108: The Ministry of Health has not developed a province-wide policy to guide the use of chemical restraints in all residential care facilities.

R138: The Ministry of Health work with health authorities, resident and family councils and other stakeholders to develop a province-wide policy to guide facility operators and staff members on the appropriate use of chemical restraints.

Findings and Recommendations

Administering Medication

F109: The Ministry of Health does not require health care providers who are responsible for obtaining informed consent to administering medication in residential care to document:

- that they have considered whether a person in care is capable of providing informed consent
- who provided informed consent
- when informed consent was provided
- how informed consent was provided
- the duration of the consent

R139: The Ministry of Health take the necessary steps to amend the *Health Care (Consent) and Care Facility (Admission) Act* so that health care providers administering medication in residential care are legally required to document:

- that they have considered whether a person in care is capable of providing informed consent
- who provided informed consent
- when informed consent was provided
- how informed consent was provided
- the duration of the consent

F110: The Ministry of Health does not require operators whose staff administer medication to verify that informed consent has been obtained and is still valid before administering medication.

R140: The Ministry of Health take the necessary steps to establish legal requirements for operators to:

- ensure that facility staff verify from the documentation that informed consent has been obtained and is still valid before administering medication
- require facility staff to document their verification of consent prior to administering medication

F111: The Ministry of Health has not established specific and legally binding procedures to guide the use of medications administered on an as-needed basis in all residential care facilities.

R141: The Ministry of Health take the necessary steps to create legally enforceable standards for the use of medications administered on an as-needed basis in all residential care facilities, including for prescribing, administering, documenting and reviewing their use.

Findings and Recommendations

Staffing Levels

F112: The Ministry of Health has not established clear, measurable and enforceable staffing standards for residential care facilities.

R142: The Ministry of Health take the necessary steps to establish:

- the mix of registered nurses, licensed practical nurses and care aides (direct care staff) necessary to meet the needs of seniors in residential care
- the minimum number of direct care staff required at different times
- the minimum number of care hours that direct care staff provide to each resident each day to meet their care needs

R143: Once specific minimum staffing standards have been established, the Ministry of Health develop a monitoring and enforcement process to ensure they are being met, and report publicly on the results on an annual basis.

Access to Visitors

F113: The Ministry of Health and the health authorities have not provided necessary direction to operators to ensure that the legislated rights of seniors in residential care to receive visitors are respected.

R144: The Ministry of Health work with the health authorities to:

- develop policies and procedures that protect the legislated rights of seniors in residential care to receive visitors
- provide the necessary direction to operators on the circumstances in which any limitation or restriction may be permitted and the process to be followed

Services for Residents with Dementia

F114: The Ministry of Health has not developed a planned approach to the delivery of care and services to seniors in residential care who suffer from dementia.

R145: The Ministry of Health build upon its own BC Dementia Service Framework and work with the health authorities to:

- develop a provincial policy to guide the delivery of dementia care in residential care facilities
- ensure that all residential care staff receive ongoing training in caring for people with dementia

Findings and Recommendations

End-of-Life Care

F115: The Ministry of Health has not established standards for the provision of end-of-life care in residential care facilities, and has not ensured that seniors in residential care facilities have access to the same services and benefits available to seniors in the community under the BC Palliative Care Benefits Program.

R146: The Ministry of Health work with the health authorities to develop standards for the provision of end-of-life care in residential care facilities that, at minimum, are equal to the services and benefits available under the BC Palliative Care Benefits Program.

F116: Neither the Ministry of Health nor the health authorities make adequate information available to seniors and their families about the benefits and services that people receiving end-of-life care in residential care facilities are entitled to receive.

R147: The Ministry of Health work with the health authorities to make information publicly available about the end-of-life care services and benefits available in residential care.

Complaints

F117: The Ministry of Health has not established specific, legislated requirements that residential care facility operators have to meet when responding to complaints about the care they provide.

R148: The Ministry of Health require all operators of residential care facilities to:

- investigate all complaints they receive
- complete investigations within 10 business days of receiving a complaint
- inform complainants in writing of the outcome of their complaint
- inform complainants what they can do if they are not satisfied with the operator's response
- keep detailed and specific records of complaints and how they were handled
- review the complaints they have received every quarter to determine whether there are areas where improvements can be made

F118: There is no single process available to seniors in all residential care facilities that provides a simple, accessible, comprehensive, timely and effective mechanism for responding to complaints about all aspects of care.

Findings and Recommendations

R149: The Ministry of Health establish the community care licensing offices as the single process for responding to all complaints about residential care and:

- extend the jurisdiction of community care licensing offices to all residential care facilities
- ensure that patient care quality offices refer any complaints they receive about residential care to community care licensing offices
- require community care licensing offices to inform complainants in writing of the outcome their complaint
- ensure consistent and comprehensive information about the role of community care licensing offices is publicly available
- establish a right of review or appeal from a decision of community care licensing to the provincial director of licensing or the patient care quality review boards or other appropriate agency

Monitoring

F119: The Ministry of Health has not developed adequate provincial community care licensing policies in a timely manner.

R150: The Ministry of Health finalize its provincial community care licensing policies by October 1, 2012 and establish a process for reviewing and updating them every three years.

F120: The director of licensing in the Ministry of Health does not collect sufficient data on the monitoring and enforcement activities of the health authority community care licensing offices to allow her to effectively exercise her role as head of the provincial licensing program.

R151: The director of licensing require community care licensing offices to report to the Ministry quarterly on the number of:

- residential care complaints received
- investigations and inspections conducted
- exemptions granted
- enforcement actions taken
- facility closures and disruptions occurring
- reportable incidents occurring

R152: The director of licensing issue a public annual report on the community care licensing program.

Findings and Recommendations

F121: The Ministry of Health has not developed provincial training standards and minimum education and experience requirements for community care licensing officers.

R153: The Ministry of Health develop and implement provincial training standards and minimum education and experience requirements for community care licensing officers that will allow them to appropriately respond to complaints about residential care facilities.

F122: It is unreasonable that medical health officers and their delegates, in non-emergency situations, have the authority to exempt residential care operators from the legal requirement to obtain consent before transferring a resident to another facility.

R154: The Ministry of Health take steps to amend the *Residential Care Regulation* so that medical health officers no longer have the authority in non-emergency situations to grant facility operators exemptions from the legal requirement to obtain consent before transferring a resident to another facility.

F123: Medical health officers and their delegates are not required to inform the Ministry of Health when they grant residential care operators an exemption from the requirements of the *Community Care and Assisted Living Act* or the *Residential Care Regulation.*

R155: The Ministry of Health require medical health officers to report publicly every year on:

- the number of requests they and their delegates receive for exemptions from the requirements of the *Community Care and Assisted Living Act* or the *Residential Care Regulation*
- the reason for the requests
- the outcomes of the requests

F124: The health authorities conduct regular inspections of residential care facilities at varying frequencies and use different processes to calculate hazard ratings and determine schedules for follow-up inspections.

R156: The Ministry of Health establish provincial standards for inspection frequencies, hazard ratings, and inspection priority levels for residential care facilities.

F125: It is unreasonable for health authorities to conduct mainly scheduled inspections, conduct them during regular business hours and base their evaluations and hazard ratings on those inspections because residential care facilities operate 24 hours a day, seven days a week.

Findings and Recommendations

R157: The Ministry of Health require all the health authorities to conduct a set number or percentage of unscheduled facility inspections and inspections outside of regular business hours.

F126: The Ministry of Health's list of appointed provincial hospital inspectors is outdated.

R158: The Ministry of Health ensure that its list of appointed provincial hospital inspectors is current and that everyone on that list is trained to inspect residential care facilities.

F127: The Ministry of Health has not taken reasonable steps to ensure that residential care facilities under the *Hospital Act* are being properly inspected.

R159: The Ministry of Health require health authorities to provide it with information on all inspections conducted on residential care facilities that are governed under the *Hospital Act* on a quarterly basis.

F128: Since 2007, only the Vancouver Coastal Health Authority has been conducting residential care facility inspections of *Hospital Act* facilities. Between 2002 and 2007, the health authorities did not conduct residential care facility inspections of *Hospital Act* facilities.

R160: The Fraser, Interior, Northern and Vancouver Island health authorities inspect all residential care facilities governed under the *Hospital Act* in the same manner and with the same frequency as they inspect residential facilities licensed under the *Community Care and Assisted Living Act* commencing immediately.

F129: The health authorities do not post the results of inspections of residential care facilities governed under the *Hospital Act* on their websites.

R161: The Ministry of Health ensure that the health authorities promptly post the results of inspections of residential care facilities governed under the *Hospital Act* on their websites.

F130: The Ministry of Health does not require facilities governed under the *Hospital Act* to report incidents that are defined as "reportable" in the *Community Care and Assisted Living Act*.

R162: The Ministry of Health take the necessary steps to require operators of residential care facilities governed under the *Hospital Act* to report reportable incidents in the same manner as facilities licensed under the *Community Care and Assisted Living Act.*

Findings and Recommendations

F131: The Ministry of Health has not yet taken the required steps to ensure that reports of incidents of abuse by residents against other residents are included in the list of reportable incidents in the *Residential Care Regulation*.

R163: The Ministry of Health take the necessary steps to include abuse by residents against other residents in the list of reportable incidents in the *Residential Care Regulation*.

F132: The health authorities have not taken adequate steps to ensure that all operators of residential care facilities report reportable incidents promptly and consistently.

R164: The Ministry of Health working with the health authorities develop a process to evaluate operator compliance with the requirement to report incidents in accordance with the *Residential Care Regulation*.

Enforcement

F133: The health authorities do not use the full range of enforcement tools that are available to them under the *Community Care and Assisted Living Act*.

R165: The Ministry of Health develop a policy to guide community care licensing officers on how and when to apply progressive enforcement measures.

F134: The Ministry of Health has not ensured that there is a full range of administrative penalties available to the health authorities to use in enforcing the requirements of the *Community Care and Assisted Living Act*.

R166: The Ministry of Health take the steps necessary to expand the enforcement options available under the *Community Care and Assisted Living Act* and create a system of administrative penalties that can be applied to facility operators who do not comply with legislative and regulatory requirements.

F135: The Ministry of Health has not ensured that facilities governed by the *Hospital Act* are subject to the same range of enforcement measures as those that are licensed under the *Community Care and Assisted Living Act*.

R167: The Ministry of Health take the steps necessary to ensure that residential care facilities governed by the *Hospital Act* are subject to the same range of enforcement measures as those licensed under the *Community Care and Assisted Living Act*.

Findings and Recommendations

Closing, Downsizing and Renovating Facilities

F136: The Ministry of Health's policy on caring for residents during facility closures and renovations does not apply to residents who are required to relocate as the result of a funding decision.

R168: The Ministry of Health's policy on caring for residents during facility renovations and closures apply to residents who are required to move as a result of a funding decision.

F137: The Ministry of Health has not defined what a "substantial change in operations" is for the purpose of the notice requirements in sections 9(1) and 9(2) of the *Residential Care Regulation.*

R169: The Ministry of Health:

- define what a "substantial change in operations" is for the purpose of the notice requirements in sections 9(1) and 9(2) of the *Residential Care Regulation*
- include large-scale staff replacement in the definition
- review on a regular basis the steps health authorities are taking to ensure operators comply with these requirements

F138: The Ministry of Health has not ensured that there are safeguards in place to protect seniors in residential care from the lack of continuity of care during large-scale staff replacements.

R170: The Ministry of Health work with the health authorities to develop safeguards to ensure that seniors in residential care are not adversely affected by large-scale staff replacement.

F139: The Ministry of Health has not taken adequate steps to ensure that operators are required to notify residents, families and staff promptly when closing, reducing, expanding or substantially changing a facility, and when transferring residents from a facility because of funding changes.

R171: The Ministry of Health take the necessary steps to amend the *Residential Care Regulation* to require facility operators to notify residents, families and staff promptly of a decision to:

- close, reduce, expand or substantially change the operations at their facility
- transfer residents from their facility because of funding decisions

Findings and Recommendations

F140: When a medical health officer is considering a facility operator's request for an exemption to the notice requirements of the *Residential Care Regulation*, health authorities are not required to ensure that residents and their families are:

- notified of the operator's request
- notified of whether the medical health officer granted the exemption
- advised of their right to appeal the medical health officer's decision

R172: The health authorities ensure that seniors and their families are:

- informed when an operator of a residential care facility licensed under the *Community Care and Assisted Living Act* requests an exemption from the Act or Regulation requirements
- informed of how they can provide input to the medical health officer before such a decision is made
- notified promptly of the medical health officer's decision
- informed about how to appeal a decision to the Community Care and Assisted Living Appeal Board

F141: When a medical health officer is considering whether to grant a facility operator's request for an exemption from the requirements of the *Community Care and Assisted Living Act*, the medical officer is not required to consider input from people who will be directly affected by the decision.

R173: Before deciding on exemption requests, medical health officers consider input from residents and their families who will be directly affected by the decision on whether granting an exemption would result in an increased risk to health and safety.

F142: When a medical health officer considers a request for exemption from the provisions of the *Community Care and Assisted Living Act* submitted by the same health authority that employs him or her, the medical health officer does not have the necessary independence from the requesting institution to ensure confidence in the decision-making process.

R174: The Ministry of Health work with the provincial health officer to create policies and procedures that provide for alternative decision-making processes when medical health officers are asked to consider exemption requests under the *Community Care and Assisted Living Act* from their own health authority.

Findings and Recommendations

R175: The Ministry of Health, in discussion with the health authorities, the provincial health officer and other interested stakeholders, consider the broader issues raised by health authorities monitoring, evaluating and enforcing standards against themselves, and whether an independent public health agency that is responsible for monitoring and enforcement in residential care facilities is a viable and desirable alternative.

F143: It is unfair that when facilities governed by the *Hospital Act* close, downsize or renovate, or make other substantial changes, seniors who live in those facilities do not have the same notice and rights of appeal as seniors who live in facilities licensed under the *Community Care and Assisted Living Act.*

R176: The Ministry of Health take all necessary steps to ensure that the notice and appeal requirements regarding facility closures, downsizing and renovations and other substantial changes that apply to facilities licensed under the *Community Care and Assisted Living Act* also apply to facilities governed by the *Hospital Act.*

Authority Responses

911895

Ms. Kim S. Carter
Ombudsperson
756 Fort St
PO Box 9039 Stn Prov Govt
Victoria BC V8W 9A5

Dear Ms. Carter:

Thank you for the opportunity to review the findings and recommendations in your second report on seniors' services, *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*. I am responding on behalf of the Honourable Michael de Jong, QC, Minister of Health.

Your report examines a range of important services BC seniors may receive through BC's health care system, specifically home support, assisted living and residential care services. These services represent a small part of the broad range of services and programs provided by government and community organizations aimed at supporting older adults to achieve better health outcomes, remain active and independent, and continue to contribute their skills, knowledge and experience to their communities. While increased age is a significant factor in the likelihood of a person having one or more chronic diseases, it is also true that most adults, including seniors, effectively manage their own health conditions in partnership with their family physician and with the support of family and friends.

For seniors who find themselves in need of health services, it is important that we ensure that the majority of those needs are met with high quality community based health services, and that if needed, they are able to access hospital and residential care services in a timely and appropriate manner.

Approximately 13 percent of all 676,000 BC residents over the age of 65 receive home and community care services with just over 5 percent residing in residential care facilities. Approximately 10 percent of seniors receive home health and assisted living services. As you point out in your report, the population of BC residents over 65 is expected to increase significantly over the next 20 years, resulting in larger numbers of people requiring support to manage health conditions. As the numbers of seniors and their needs changes, the variety of housing options and community based services must also change and innovate to support the best possible quality of life. Preparing for an aging population is a shared responsibility, involving many government ministries and agencies, local and federal governments, the business sector, community organizations, families and friends. In spite of these challenges, the province remains committed to working with patients and families as partners in building the best system of support in Canada for our older citizens.

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Authority Responses

The BC health system is one of our most valued social programs – virtually every person in the province will access some level of health care or health service during their lives. Good health is a fundamental component of a happy and productive life. Although the aging process brings changes to our lives, evidence clearly shows that there are actions individuals can take to reduce their risk of chronic health conditions that can significantly impact their quality of life. For those who have a chronic health condition, much can be done in the early stages to reduce adverse events and slow progression of the condition. Working with the family physician and supportive health services, are foundational to achieving improved health outcomes and improving the experience of care for seniors. The Ministry of Health (the Ministry) has a number of strategies underway to achieve this – across the health continuum, from prevention through to end of life.

In 2010/11, government spent $16.15 billion on health care services, with seniors accounting for approximately 54 percent of total health care expenditures. In its current Service Plan, the Ministry has committed to a broad innovation and change agenda for the health care system, focused on four key strategic priorities:

- Effective health promotion, prevention and self management;
- The majority of British Columbians' health needs will be met by high quality primary and community based health care and support services;
- British Columbians will have access to high quality hospital and residential services when needed; and
- Improved innovation, productivity and efficiency in the delivery of health services to seniors.

Since your first report, BC has accomplished much to improve the range and quality of services and care for seniors. A Residents' Bill of Rights was incorporated into both the *Community Care and Assisted Living Act* and the *Hospital Act* in 2009, to make clear the rights of seniors in residential care facilities. The Ministry and health authorities are monitoring compliance as part of their inspection and monitoring processes. In collaboration with the Ministry of Public Safety and Solicitor General, important changes have been made to expand scope of *Criminal Records Review Act* (CRRA), and to extend protections for vulnerable seniors.

The Provincial Home and Community Care Policy Manual has been completely updated and is now available to the public. The revised policy manual supports greater consistency in the provision of home and community services in straightforward language, and will be reviewed and updated on a regular basis to ensure its provisions reflect the best practices in care. Family councils in residential care facilities have been supported with stakeholder sessions and educational materials to assist councils and facility operators in establishing successful relationships. The Ministry and health authorities regularly engage with health service providers and community organizations through a variety of provincial leadership tables and working groups.

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Authority Responses

In your report, you mentioned the Auditor General's 2008 Report, *Home and Community Care: Meeting Needs and Preparing for the Future.* As recommended by the Auditor General, the Ministry now takes a more integrated approach to health service planning and has implemented a balanced score card framework to ensure alignment between capacity and outcomes. The Ministry has adopted a population based planning approach that considers the needs of priority patient groups across the health continuum, rather than within individual service silos, and is currently leading the way in integrating the work of family physicians and community health teams across the province.

Integrated Primary and Community Care recognizes that the population in each community and their health service needs are diverse, and therefore services must be designed in a manner that meets legislative and regulatory requirements, but also allows for flexibility and innovation at the community level. To date more than 19 communities have begun the process of engaging physicians, patients, health providers, municipalities and community groups to discuss health priorities, and establish plans to meet the needs of their unique urban centres, rural and remote communities. All health care service redesign will be based on clinical evidence, best practice and research-supported guidelines and standards. Results will be evaluated using the Institute for Healthcare Improvement's Triple Aim framework, balancing improved health outcomes, patient and provider experience, and cost sustainability.

The extent of your report and large number of findings and recommendations is significant and the services it addresses are extremely important to the public, health authorities and the Ministry. The findings and recommendations reflect a number of key themes that we fully support and strive to reflect through our policies and practices. These include accessibility, consistency, continuity, accountability, transparency, choice and respect. The Ministry and the health authorities are fully committed to taking actions to ensure consistency in quality of care across the continuum of seniors' services, access to information about services, monitoring and enforcement, and processes for dealing with concerns and complaints.

Our immediate priorities will be to improve administrative fairness and access to information within the current legislative and regulatory framework. This will help to ensure all seniors who receive home and community care services have easy access to an integrated system for receiving, hearing and acting on concerns or complaints by seniors or their families and caregivers. We recognize the need for timely response to concerns or complaints and the need for greater navigational support as the care options are often unique to a senior's and caregiver situation.

The Ministry will also ensure all seniors, their families and others have easier access to comprehensive information about the range of services and care options provided in their communities and those services that are publicly subsidized. We will also make it easier for all seniors to easily access personal information about their assessment, eligibility and other information collected and retained by providers of services and care.

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Authority Responses

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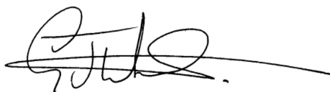
The Ministry, together with health authorities, continues to fully evaluate the unprecedented number of very specific recommendations in the report to determine the feasibility of implementation and benefits to the system. The Ministry and health authorities have agreed that the Ministry will take the lead for the recommendations directed to all the health authorities in order to ensure the assessment of these recommendations is done consistently and reflect provincial direction. Each health authority will, of course, provide their own response to your report and the recommendations directly pertaining to them.

In its comprehensive evaluation, the Ministry is applying the same criteria it would use in the evaluation of any proposed change that impacts the public and requires significant investment of resources to successfully implement. These criteria include: verification that the information and assumptions underlying the recommendation are accurate; determining the requirements for legislative and regulatory change; assessing the time required for successful implementation; confirming alignment of the recommendation with government and Ministry strategic directions; determining fiscal implications and where additional evidence is needed to support a recommendation, undertake consultation and additional research to gather the needed information.

Many of the recommendations do require consultation and joint analysis with other ministries, municipalities or agencies, and would strongly benefit from direct input from seniors, caregivers, physicians and other primary health care professionals. In addition, there are a number of recommendations that should be considered in the context of new collaborative approaches and models of care that we, in BC, are actively examining and prototyping.

The Ministry is committed to continue its examination of the Ombudsperson's findings and recommendations and will proceed with implementing those that will immediately contribute to improving the provision of services and care to seniors. The Ministry plans to regularly report publicly on its progress on improving services and care to the seniors of BC.

Sincerely,



Graham Whitmarsh
Deputy Minister

pc: Honourable Michael de Jong, QC

Authority Responses

fraserhealth Better health. Best in health care.

January 11, 2012 *(revision to Dec. 23, 2011 letter)*

Ms. Kim S. Carter **via email**
Ombudsperson
Province of British Columbia
947 Fort Street
PO Box 9039 Stn Prov Govt
Victoria, BC V8W 9A5

Dear Ms. Carter:

Re: Report on "The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)"

Thank you for the opportunity to review and respond to your report "*The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)".* Fraser Health is committed to providing *Better health, Best in health care* to the individuals in our communities, including to those seniors we serve. We share a mutual goal for the provision of quality care to seniors and recognize the efforts your team has made to gain an understanding of the health care system supporting seniors. We appreciated the opportunity to review and make factual clarifications to your report, and thank you for your consideration of these.

The Home and Community Care sector in British Columbia is multifaceted, and your report highlights some of the intricacies and challenges in serving a diverse group of individuals age 19 and over with a complex array of healthcare needs. While your report focuses on those services provided in Assisted Living, Residential Care, and Home Support, Fraser Health provides Home and Community Care services more broadly than in these three areas. Every day Fraser Health provides care and service to almost 9,200 clients and residents in Assisted Living and Residential Care, and almost 15,000 clients in the community who receive 220,000 professional visits annually, and 170,000 hours of home support monthly.

Last year Fraser Health, the fastest growing health authority in British Columbia, spent more than $2.5 billion dollars on health care services, with seniors accounting for almost 55% of total healthcare services utilized.

British Columbia is considered a leader in the development of an integrated community-based health system, building on evidence and leading practices in a number of jurisdictions. In Fraser Health's current service plan, the health authority has a broad innovation and change agenda laid out by the Ministry of Health:

Fraser Health Authority
Office of the President and CEO

Suite 400, Central City Tower
13450 102nd Avenue
Surrey, BC
V3T 0H1 Canada

Tel (604) 587-4625
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www.fraserhealth.ca

Authority Responses

The public health system must continually drive improvement in innovation, productivity and efficiency to ensure the health system is affordable and effective for British Columbians to ensure

- *Effective health promotion, prevention and self management.*
- *That the majority of health needs are met by high quality primary and community based health care and support services*
- *Access to high quality hospital and residential services when needed*
- *Improved innovation, productivity and efficiency in the delivery of health services to seniors.*

Fraser Health is pleased to lead in several areas of seniors care, including in the implementation of a Residential Care Delivery Model and funding methodology that has standardized and made transparent the funding allocation to the residential care sector. The Residential Care Delivery Model, and additional funding of almost $20 million dollars to the sector, made it possible to see the highest increase in direct care hours (those hours of care provided to each resident each day by a multidisciplinary team) across the province in 2010, and further increases expected in 2011.

Our "Home is Best" strategies to support individuals in their own home as they recover from an acute care stay are recognized provincially and nationally as leading practice. Fraser Health is leading in the development of collaborative practices with General Practitioners, and includes prototypes that provide enhanced supports in the residential care and community sector. We continue to strive to develop innovative and effective strategies to meet the needs of our fast-growing, aging population.

"The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)" report is very broad, and the large number of findings and recommendations are unprecedented. The report deals with an extremely important health care sector in Fraser Health and in the communities we serve. We appreciate and thank you for highlighting the leading practices in Fraser Health in your report, as well as those of other health authorities. We are committed to sharing our leading practices and extending them where possible, and to incorporating the leading practices from other areas of the province. Fraser Health recognizes the value of working together in addressing the nuances and uniqueness of British Columbia's senior's needs, whether in a rural or urban setting, and incorporating the cultural diversity across the province.

Health authorities have worked collaboratively with the Ministry of Health to review *"The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)"* content, findings and recommendations. The report includes recommendations directed to the Ministry of Health, all health authorities, and three recommendations specifically directed to Fraser Health. The Ministry of Health and health authorities have agreed that the responses to these recommendations must be consistent and require provincial direction; therefore, the Ministry of Health will address these twenty-eight recommendations in its response. Fraser Health response is limited to those findings and recommendations that apply specifically to our health authority. Please find attached as Appendix A our response to your specific recommendations to Fraser Health in a table format. Additionally, Fraser Health has provided, in a separate document, a fulsome response to your report addressing the closure of the temporary bed capacity at Newton Regency summarized in your *"Best of Care"* report.

Authority Responses

Fraser Health accepts the three recommendations directed specifically to Fraser Health. Additionally, we are committed to fully engage in a collaborative working relationship with the Ministry of Health and other health authorities to establish standardized systems and processes for the remaining findings and recommendations in your report, as directed by the Ministry of Health. Again, thank you for your interest in the care of seniors, and for your recognition of Fraser Health's leading practices in many areas of the Home and Community Care sector.

Sincerely,

Dr. Nigel Murray
President and Chief Executive Officer

NJM/tls

Cc: Barbara Korabek, Vice President, Clinical Programs
Heather Cook, Executive Director, Residential Care and Assisted Living Program
Lynda Foley, Executive Director, Home Health and End of Life Program
Tim Shum, Director, Licensing

Authority Responses

APPENDIX A

Finding and Recommendation	Health Authority Specific Response	Comment
F4 – R5 *The health authorities ensure that the MRR system is fully operational in their regions by May 31, 2012.*	All Health Authorities	Recommendation Accepted. Fraser Health Authority accepts this recommendation. Planning is in place to ensure compliance on or before May 31, 2012.
F57 – R71 *The Fraser Health Authority, Interior Health Authority, Northern Health Authority and Vancouver Coastal Health Authority fully comply with the minister's directive by, in the case of FHA, providing direct contact information for the OALR.*	FHA, IHA, NHA, VCHA	Recommendation Accepted. Fraser Health Authority will adjust its website information to reflect this recommendation.
F129 – R161 *The Fraser, Interior, Northern and Vancouver Island health Authorities inspect all residential care facilities governed under the Hospital Act in the same manner and with the same frequency as they inspect residential facilities licensed under the Community Care and Assisted Living Act commending immediately.*	FHA, IHA, NHA, VIHA	Recommendation Accepted. Fraser Health Authority will collaborate with the MOH and other health authorities to develop an implement a standardized and consistent approach to the inspection of residential facilities governed under the Hospital Act.

Authority Responses

Interior Health

Corporate Administration
Interior Health Authority
#220 – 1815 Kirschner Road
Kelowna, B.C. V1Y 4N7
Web: www.interiorhealth.ca

Dr. Robert Halpenny
President & Chief Executive Officer
Phone: (250) 862-4205
Facsimile: (250) 862-4201
e-mail: robert.halpenny@interiorhealth.ca

January 11, 2012

Ms. Kim Carter
Office of the Ombudsperson
947 Fort Street
PO Box 9039 Stn. Prov. Govt
Victoria, BC V8W 9A5

Dear Ms. Carter:

The Interior Health Authority (IHA) would like to thank you for the opportunity to review and respond to the findings and recommendations contained in the report "*The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*".

Your report has provided IHA with valuable information as well as many observations about the current state of some of the health care services that seniors access in the British Columbia interior. These observations will be used to guide actions to improve the experiences of both individuals and families as Interior Health endeavours to improve the delivery of services for seniors and subsequent health outcomes. We assure you that the provided recommendations are being taken seriously and wish to acknowledge the partnership and leadership required with the Ministry to ensure appropriate changes are grounded in policy and research.

While the majority of the recommendations require collaborative work between the Ministry of Health and the Health Authorities, this letter will respond to those recommendations specific to Interior Health. We would also like to acknowledge the importance of working closely with the Ministry and our service partners to ensure seniors have access to a range of supports and health care services that are delivered in supportive environments and offer optimal quality of life.

Last year, IHA spent $1.7B on health care services, with seniors accounting for approximately 54% of total services utilized. British Columbia is considered a leader in the development of an integrated community based health system, building on evidence and leading practices in a number of jurisdictions. In IHA's current service plan, the Health Authority has a broad innovation and change agenda laid out by the Ministry:

> *The public health system must continually drive improvement in innovation, productivity and efficiency resulting in affordability and effectiveness for British Columbians, to ensure:*
>
> - *Effective health promotion, prevention and self management*
> - *That the majority of health needs are met by high quality primary and community based health care and support services*

Authority Responses

- *Access to high quality hospital and residential services when needed*
- *Improved innovation, productivity and efficiency in the delivery of health services to seniors*

Since 2009, Interior Health has been focusing on improving seniors care through the examination and implementation of a revised staffing framework that is founded on the principle of equity in access to services and is based on standardized funding and allocated direct and allied care hours model.

In addition, quality investments in residential services, clinical practice initiatives related to access and flow through the health system, improved access to Interior Health service information by seniors, and guidelines to support the consistent use of home support and assisted living, combined with a number of key Ministry initiatives on the horizon, demonstrates our commitment to improving care for seniors.

The extent of the report "*The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*" and the large number of findings and recommendations are unprecedented and address an extremely important focus for our Health Authority and the communities we serve. We thank you for recognizing leading practices in Interior Health and we are committed to collaborating with the Ministry of Health and other BC health authorities to address the nuances and uniqueness of BC's senior rural, urban, and remote populations and the cultural diversity in our communities.

Health Authorities have worked collaboratively with the Ministry to carefully examine the report content, findings and recommendations. Most of the findings and recommendations requiring a response are directed to all Health Authorities. As well, there were a number directed to the Ministry. The Ministry and Health Authorities have agreed that the responses to these recommendations must be consistent and require provincial direction, therefore, the Ministry will address these twenty-eight recommendations. The Interior Health response is limited to those findings and recommendations that apply specifically to our Health Authority and is included in the attachment to this letter. Please find attached as Appendix A, our response to your specific recommendations to the Interior Health Authority.

Interior Health would like to thank you for your efforts in improving seniors' care in British Columbia and for the inclusion of leading practice within your report for all Health Authorities. A collaborative approach is essential in sharing and spreading leading practice within the Home and Community sector across the province in order to ensure that the best system to support seniors care is in place.

Sincerely,

Dr. Robert Halpenny
President & Chief Executive Officer

Authority Responses

Appendix A

Interior Health Authority Response to Recommendations contained in Ombudsperson report, "*The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*"

Home and Community Care

Ombudsperson Recommendation 8:
The Interior Health Authority and the Vancouver Coastal Health Authority track the length of time seniors wait to be assessed for home and community care services.

IHA Response:
This recommendation is not accepted as the finding is incorrect for Interior Health. Interior Health will continue to work with Ministry of Health to meet Ministry requirements for tracking length of wait time for home and community care services.

Home Support

Ombudsperson Recommendation 40:
The Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority include the principle of continuity in home support in their policies, service agreements and performance measures.

IHA Response:
This recommendation is accepted and IHA will collaborate with other health authorities and the Ministry on the establishment of a policy and amend existing contract language to reflect content of this policy.

Ombudsperson Recommendation 44:
The Interior Health Authority and Vancouver Island Health Authority require all of their contracted service providers to have a clearly defined complaint process.

IHA Response:
This recommendation is accepted and IHA will collaborate with the other Health Authorities to explore leading practices and incorporate findings into standardized contract language surrounding complaint process with all contract renewals.

Ombudsperson Recommendation 50:
The Interior Health Authority and Vancouver Island Health Authority adopt more specific reporting requirements in their service agreements in order to more effectively monitor contracted home support services.

IHA Response:
This recommendation is accepted and IHA will collaborate with other Health Authorities to establish common reporting requirements and include in future RFPs.

Authority Responses

Assisted Living

Ombudsperson Recommendation 71:
The Fraser Health Authority, Interior Health Authority, Northern Health Authority and Vancouver Coastal Health Authority comply with the Minister's directive and provide information on how to complain about assisted living services to the public.

IHA Response:
This recommendation is not accepted as the finding is incorrect. This information is made available to the public on the Interior Health webpage.

Residential Care

Ombudsperson Recommendation 160:
The Fraser, Interior, Northern and Vancouver Island Health Authorities inspect all residential care facilities governed under the Hospital Act in the same manner and with the same frequency as they inspect residential facilities licensed under the Community Care and Assisted Living Act commencing immediately.

IHA Response:
This recommendation is accepted and Interior Health with collaborate with the other Health Authorities and the Ministry of Health to achieve consistency related to Hospital Act inspections.

Authority Responses

Office of the President & CEO
#600 – 299 Victoria Street
Prince George BC V2L 5B8

January 10 2012

Your File: 08-87413

Carly Hyman
Ombudsperson
947 Fort Street
P O Box 9039
Stn Prov Govt
Victoria, BC
V8W 9A5

Via Fax: 250-387-0198

Re: Northern Health Response - Draft Report *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*

Thank you for your letter of January 6, 2012, advising of the numbering issue in respect to the Findings and Recommendations. We would like to take this opportunity to resubmit our responses from December 22, 2011 with the corrected numbering sequence.

In respect to Finding #57 and Recommendation #71, we will also take this opportunity to revisit our previous response within the context of the modified findings.

Your report provides us with valuable observations and information about some of the health care services that seniors access in the Northern Health region. These observations will be used to guide Northern Health's actions to improve individual and family care experiences and health outcomes for seniors.

We also know that your observations are equally important to the Ministry of Health. We have reviewed the recommendations provided to Northern Health and note the areas where you believe greater consistency is required across the province. Northern Health is working with the other health authorities and with the Ministry to carefully examine this report's findings and recommendations. Where a provincially consistent response and provincial direction is required, the Ministry of Health will be providing the response.

Last year, Northern Health spent $6.48M on health care services, with about 50% of this allocated to services for seniors. The Ministry of Health has been working with the health authorities to implement a broad innovation and change agenda:

> *The public health system must continually drive improvement in innovation, productivity and efficiency to ensure the health system is affordable and effective for British Columbians to ensure*
> - *Effective health promotion, prevention and self management.*
> - *That the majority of health needs are met by high quality primary and community based health care and support services*
> - *Access to high quality hospital and residential services when needed*

Authority Responses

- *Improved innovation, productivity and efficiency in the delivery of health services to seniors.*

Northern Health is in the process of implementing an integrated primary health care approach to serving seniors. Our approach involves improving services to seniors through collaboration between family physicians, Northern Health care team members, and non profit organizations. This type of work is key to addressing the unique needs of seniors in urban, rural and remote populations, and the cultural diversity present in northern communities. We are also improving the availability of information for seniors so they have a better understanding of options available to them and how to access services when required.

The Northern Health response is attached and is limited to those findings and recommendations that apply specifically to Northern Health. Northern Health accepts all 4 recommendations.

Northern Health is committed to improving the services we provide to seniors living in Northern British Columbia in collaboration with physicians and community based organizations. Our continuing efforts will include serious consideration of all the recommendations you have made in partnership with the other health authorities and the Ministry of Health.

Yours sincerely,

Cathy Ulrich
President & Chief Executive Officer

Attach. – Appendix 1

cc: Dr. Charles Jago – Board Chair, Northern Health
Suzanne Johnston – Vice President, Clinical Programs & Chief Nursing Officer
Tim Rowe - Executive Lead, Elderly Services

Authority Responses

Appendix 1:

Response to Northern Health Specific Recommendations contained in Ombudsperson Seniors Care Report – Part 2

Home Support

Ombudsperson Recommendation 40:
The Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority include the principle of continuity in home support in their policies, service agreements and performance measures.

NHA Response:
Yes, NHA will collaborate with other Health Authorities and the Ministry on the establishment of a policy that addresses the principle of continuity in home support.

Assisted Living

Ombudsperson Recommendation 71:
The Fraser Health Authority, Interior Health Authority, Northern Health Authority and Vancouver Coastal Health Authority comply with the minister's directive by:

- In the case of NHA, providing a description of the complaints process and direct contact information for the OALR.

NHA Response:
Yes, NHA will ensure full compliance with the requirements of the minister's directive to ensure information is available on the Northern Health webpage at: www.northernhealth.ca,specifically, Home and Community Care/Complaints & Compliments.

Residential Care

Ombudsperson Recommendation 111:
The Northern Health Authority track the length of time seniors wait in hospitals for residential care before being transferred to a residential care facility.

NHA Response:
Yes, Northern Health will refine our current tracking system to ensure accuracy and timeliness of information regarding the length of time seniors wait in hospitals for residential care before being transferred to a residential care facility.

Authority Responses

<u>Ombudsperson Recommendation 160:</u>
The Fraser, Interior, Northern and Vancouver Island Health Authorities inspect all residential care facilities governed under the Hospital Act in the same manner and with the same frequency as they inspect residential facilities licensed under the Community Care and Assisted Living Act commending immediately.

NHA Response:
Yes, Northern Health will collaborate with the other Health Authorities and the Ministry of Health to achieve consistency related to Hospital Act inspections.

Authority Responses

President & Chief Executive Officer
#1100, 601 West Broadway
Vancouver BC V5Z 4C2
Tel: 604-875-4721
Fax: 604-875-4750

January 11, 2012

Ms. Kim S. Carter
Ombudsperson
Province of British Columbia
P.O. Box 9039 STN Prov Govt
Victoria, BC V8W 9A5

Dear Ms Carter:

Re: Vancouver Coastal Health's Response to Draft Report "The Best of Care: Getting It Right for Seniors in British Columbia (Part 2): File 08-87413

Thank you for your correspondence of January 6, 2012 in which you identified an inadvertent clerical error in the numbering of findings and recommendations in the draft report *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*. Per your letter, we appreciate the opportunity to revise our December 23rd response to include reference to the amended numbering. Attached please find an amended Appendix A which reflects your renumbering (e.g. previous F58-R72 has been amended to be F57-R71).

We also appreciate your review of our comments on Finding 57 (previously 58) and Recommendation 71 (previously 72), and your finding that F57 and R71 do not apply to Vancouver Coastal Health as we have fully met the requirements. We appreciate your consideration to amend our December 23 2011 letter to remove reference to this finding and recommendation. In order to fully capture the exchange of information and preserve transparency, we have elected to leave our response in its original form, to reflect the manner in which that requirement had been met. We greatly appreciate your offer to address this revision in your introduction to the Report, once it is finalized.

With respect to Finding 7 and Recommendation 8, we appreciate the clarification of your understanding as outlined on pages 2 and 3 of your letter. While VCH does have data available to track wait times in a different way, we currently do not report average wait time for assessment and number of seniors waiting for an assessment. We respectfully have left our response unaltered from our December 23rd letter.

We thank you once again for the opportunity to provide factual clarification to the VCH related findings and recommendations and for the thoroughness of your approach.

Authority Responses

Yours sincerely,

David N. Ostrow, MD, FRCPC
President & Chief Executive Officer

Attachment

cc: Graham Whitmarsh, Deputy Minister, Ministry of Health
Dr. Jeff Coleman, Vice President, Regional Programs and Service Integration
Dr. Patricia Daly, Vice President Public Health and Chief Medical Officer
Shannon Berg, Executive Director, Home and Community Care

Authority Responses

APPENDIX A (AMENDED)

Finding and Recommendation	Health Authority Specific Response	Comment
F4-R5 The health authorities ensure that the MRR system is fully operational in their regions by May 31 2012	All Health Authorities	Recommendation Accepted. In fact, VCH is now compliant with the Ministry requirements for MRR
F7-R8 The IHA and the VCHA track the length of time seniors wait to be assessed for home and community care services	VCHA and IHA	Recommendation not accepted as the finding is incorrect. VCH does, in fact, track the length of time clients (including seniors) wait to be assessed for home and community care services. All people who are referred to home and community care services are prioritized based on the urgency of their need, and we track how often the client is seen within the priority time frame attached to their referral (e.g. 24 hours, 48 hours, 72 hours, within 2 weeks, etc.)
F57-R71 The FHA, IHA, NHA and VCHA comply with the minister's directive and provide information on how to complain about assisted living services to the public.	FHA, IHA, NHA and VCHA	Recommendation not accepted as the finding is incorrect. All AL sites have been directed to provide tenants with information about how to make complaints and how contact the Office of the Assisted Living Registrar. This information is posted at the sites. It is also contained on the VCH website at http://www.vch.ca/your_stay/patient_care_quality_office/submit_feedback_about_your_care, and in the VCH Assisted Living Handbook.

Authority Responses

December 23, 2011 Ref # 12868

Ms. Kim Carter
Ombudsperson, Province of British Columbia
756 Fort Street
PO Box 9030 Station Provincial Government
Victoria BC V8W 9A5

Dear Ms. Carter:

Re: Draft Report - *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*

I am responding to your letter dated October 28, 2011 regarding the draft report *The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)*. I appreciate the opportunity to respond to the draft report and its recommendations as we consider this an opportunity to improve services for seniors within the health authority as well as at a system level.

The Vancouver Island Health Authority (VIHA) shares your commitment to the provision of high quality seniors' care. As the health authority with the largest proportion of seniors in British Columbia, seniors care is a key strategic priority. VIHA's recently finalized Seniors Service Excellence Strategy identifies key areas of focus, including health promotion and prevention; emphasis on primary and community based services; education and learning for both health care providers and seniors; and accessible, sustainable services.

I also note our health authority has made significant accomplishments since the first Ombudsperson Report was released. Achievements include the full integration of seniors' medical and mental health care services; the streamlining of intake for specialty services; the implementation of a common approach to assessment and care planning, enhanced partnerships with physician and community providers; and increased emphasis on practice excellence and research.

I am pleased your report recognizes leading practices in VIHA with respect to seniors' care, and that you fully support sharing best practices among health authorities so our clients can benefit from innovation and best practices developed in BC health authorities and elsewhere.

Collaboration among the health authorities has guided our response to your recommendations. VIHA has worked with the other health authorities and the Ministry of Health to review *Best of Care (Part 2)* content, findings and recommendations. We have agreed that responses to findings and recommendations directed to all health authorities and the Ministry would benefit from a consistent provincial direction. Therefore, the Ministry will address the report's 28 recommendations in its own response. VIHA's response is limited to those findings and recommendations that apply specifically to our health authority.

Our response to the VIHA-specific recommendations is attached and we request that our submission be included as an appendix to the final report when it is released. VIHA accepts all recommendations directed to it. It should be noted that recommendation 45 no longer applies

Authority Responses

as per the revised version of the report received December 19, 2011 based on the factual clarification we submitted in November.

You have also requested VIHA provide a response to the Cowichan Lodge Case Study summary that will be included in the *Best of Care (Part 2)* report. With respect to the draft Case Study summary you provided, VIHA wishes to make one clarification on page 1, paragraph three, second line: The budget of the Vancouver Island Health Authority was not reduced. In fact, VIHA (and all the BC health authorities) have received annual budget increases for over a decade. What occurred in 2008 was that VIHA's anticipated budget allocation increase for the 2008/09 fiscal year was less than originally anticipated. This resulted in unanticipated cost pressures.

I acknowledge and appreciate the effort that has gone into developing your report on the closure of Cowichan Lodge. I would note that VIHA has accepted all of the recommendations where we have a statutory ability to do so. These recommendations have been implemented and will be adhered to in the event of future facility closures.

Finally, VIHA acknowledges that the closure of Cowichan Lodge was not managed in an ideal manner. We sincerely regret the impact the decision – and our initial efforts to close this facility within a shortened period – had on residents, their families, our staff and the community in general. Since the closure was first announced three and half years ago, VIHA has made significant changes to our processes, policies and procedures around facility closures. These are in addition to the new guidelines issued by the Ministry of Health.

VIHA will participate fully with the Ministry and other health authorities to address the remaining findings and recommendations in the *Best of Care (Part 2)* report. We are committed to working collaboratively in the best interests of our seniors province wide.

Sincerely,

Howard Waldner
President and Chief Executive Officer

cc. Catherine Mackay, Executive Vice-President & Chief Operating Officer
Marguerite Rowe, Executive Director, Continuing Health Services

Attachments *Recommendations Specific to VIHA*
Schedule C-1 – Appendix A

Authority Responses

Recommendations Specific to VIHA

Home & Community Care

Ombudsperson Recommendation 5:

The health authorities ensure that the MRR system is fully operational in their regions by May 31, 2012.

VIHA Response:
VIHA accepts the recommendation. Planning is in place to ensure compliance on or before May 31, 2012.

Home Support

Ombudsperson Recommendation 40:

The Interior Health Authority, Northern Health Authority and Vancouver Island Health Authority include the principle of continuity in home support in their policies, service agreements and performance measures.

VIHA Response:
VIHA accepts the recommendation and will collaborate with other health authorities and the Ministry of Health on the establishment of a policy and amendments of existing contract language to reflect content of this policy.

Ombudsperson Recommendation 44:

The Interior Health Authority and Vancouver Island Health Authority require all of their contracted service providers to have a clearly defined complaints process.

VIHA Response:
In the revised version of the Report received December 19, 2011 it is noted that this recommendation is no longer directed to us based on our factual clarification.

Ombudsperson Recommendation 50:

The Interior Health Authority and Vancouver Island Health Authority adopt more specific reporting requirements in their services agreements in order to more effectively monitor contracted home support services.

VIHA Response:
VIHA accepts this recommendation and will collaborate with other health authorities to establish common reporting requirements. Common reporting requirements will be included in future Requests for Proposals, leading to new service contracts with providers.

It should be noted that VIHA currently collects indicator data as part of its Home Support Service Agreement based on a performance indicator template. The template which is attached

Authority Responses

for reference (**Schedule C-1 – Appendix A**) may be useful in establishing common reporting requirements.

Residential Care

Ombudsperson Recommendation 160:

The Fraser, Interior, Northern and Vancouver Island Health authorities inspect all residential care facilities governed under the Hospital Act in the same manner and with the same frequency as they inspect residential facilities licensed under the Community Care and Assisted Living Act commencing immediately.

VIHA Response:
VIHA accepts this recommendation and will collaborate with the other health authorities and the Ministry of Health to achieve consistency related to Hospital Act inspections.

Schedule C-1 – Appendix A

Home Support Performance Management Framework

Data Entry Template

VANCOUVER ISLAND health authority

		YEAR 1				YEAR 2			
		Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar	Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
a-1	# of **NEW** referrals refused by the Service Provider								
a-2	total # of **NEW** referrals during the reporting period								
a									
b-1	# of personnel immunized								
b-2	# of personnel								
b	**Immunization Rate of Personnel**								
c-1	# of scheduled service hours								
c-2	# of delivered service hours								
c-3	# of service hours delivered by "out source" provider(s)								

Authority Responses

Schedule C-1 – Appendix A

VANCOUVER ISLAND health authority

Home Support Performance Management Framework

Data Entry Template

		YEAR 1				YEAR 2			
		Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar	Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
c-4	# of scheduled **Service Hours** not delivered to **Clients** as a result of **Client** absence, short notice, cancellation, illness or otherwise								
c	**% of Scheduled Service Hours undelivered due to client**								
	% of scheduled Service Hours delivered by Out Source								
d-1	# of scheduled **Service Hours** not delivered to Clients as a result of **Personnel** shortages (not delivered by either Beacon or out sourced)								
d	**% of Scheduled Service Hours undelivered due to Staff:**								
e-1	# of new personnel hired during reporting period								
e-2	# of personnel leaving the workforce during reporting period								
e	**Personnel turnover rate in reporting period**								
f-1	# of personnel who have completed a performance plan in the previous 12 months								

Authority Responses

Schedule C-1 – Appendix A

Home Support Performance Management Framework

Data Entry Template

VANCOUVER ISLAND health authority

		YEAR 1				YEAR 2			
		Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar	Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
f-2	total # of personnel								
f	**% personnel compliance with Performance Plan**								
g-1	# of visits								
g-2	# of Overnight Shifts 10 for 12								
g-3	# of Live-in Shifts 13 for 24								
g-4	# of Unique Clients								
g-5	# of Client Starts								
g-6	# of Clients Ends								
g-7	# of Clients Disabled								
g-8	# of Clients Section 2's (excluded from Special Needs)								

Authority Responses

Schedule C-1 – Appendix A

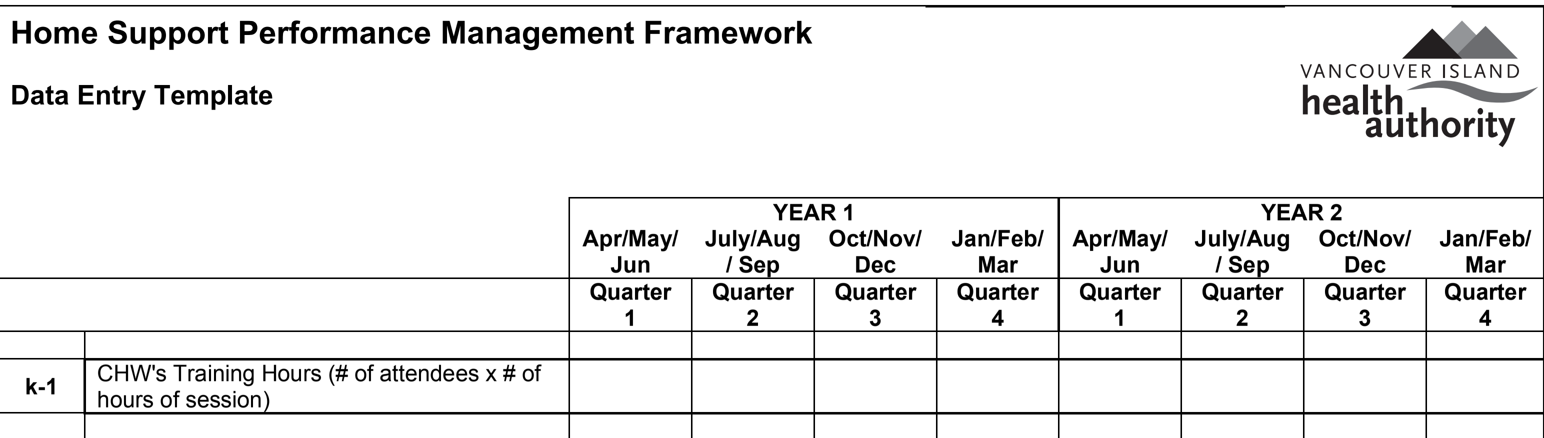
Home Support Performance Management Framework

Data Entry Template

VANCOUVER ISLAND health authority

		YEAR 1				YEAR 2			
		Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar	Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
g-9	# of Clients Palliative								
g-10	# of Clients Dementia								
g	**Utilization Information**								
h-1	Total # of Risk 1 Incidents								
h-2	Total # of Risk 2 Incidents								
h-3	Total # of Risk 3 Incidents								
h-4	Total # of Risk 4 Incidents								
h-5	Total # of Risk 5 Incidents								
i-1	# of C-Diff Clients								
i-2	# of MRSA Clients								
j-1	# of Client Complaints Escalated to Management								

Authority Responses



Schedule C-1 – Appendix A

Home Support Performance Management Framework

Data Entry Template

VANCOUVER ISLAND health authority

		YEAR 1				YEAR 2			
		Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar	Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	Quarter 2	Quarter 3	Quarter 4
k-1	CHW's Training Hours (# of attendees x # of hours of session)								

Vancouver Island Health Authority response to
recommendations of the Ombudsperson's
The Best of Care: Getting it Right for Seniors in British Columbia (Part 2) *report*

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Authority Responses

DEC 1 2 2011

Kim Carter
Ombudsperson
Province of British Columbia
PO Box 9039 Stn Prov Govt
Victoria BC V8W 9A5

Dear Ms. Carter:

Thank you for your October 28, 2011 letter in which you identify tenancy issues in your upcoming report entitled "The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)." I appreciate the opportunity to comment.

The Province's residential tenancy laws are built on a foundation of balancing the rights and responsibilities of landlords and tenants. In conventional tenancies, issues are straightforward. The provincial government requires landlords and tenants to enter into a contract at the start of the tenancy that establishes the expectations on both sides. The Province, in consultation with associations for landlords and tenants, established the conditions for ending a tenancy and a process for resolving disputes.

Since the Inter-Ministerial Supportive Housing Review Committee published its report in 1999, we have sought an appropriate administrative structure to address tenancy contracts that include components on personal and health services. Although the *Tenancy Statutes Amendment Act* (2006) contained provisions addressing Assisted Living residences, as you have noted, these have never been proclaimed.

The Residential Tenancy Branch, (RTB), began consultation with stakeholders on the implementation of the Assisted Living provisions of the *Residential Tenancy Act* in September 2006. Both tenant and landlord stakeholders raised sufficient concern that the province decided not to bring the provisions into force. This decision was formalized in early 2007.

The RTB approached stakeholders and offered to work with them to develop some new processes in the absence of the legislation. This work continued until 2008, when the project was no longer funded.

.../2

Ministry of
Energy and Mines
and Minister Responsible for Housing

Office of the Minister

Mailing Address:
PO Box 9060 Stn Prov Govt
Victoria BC V8W 9E2

Authority Responses

-2-

The plan had been to pilot a dispute resolution panel project, with RTB providing support and coaching for panel members. There was also a proposal to develop a shared tenancy agreement, based on the *Residential Tenancy Act*. Although the panel pilot did not take place, a new standard Resident Occupancy Agreement was developed by the British Columbia Seniors Living Association and is being used by the majority of Assisted Living providers.

This standard Resident Occupancy Agreement addresses a key issue identified by consumers and consumer advocates – notice of a rent increase. The shared tenancy agreement separates the accommodation component from parking fees, pet fees, storage locker fees, and Assisted Living fees. It establishes a requirement that the Assisted Living residence provider give the tenant 90 days notice in writing prior to increasing accommodation fees. This is similar to the three months' notice provision in the *Residential Tenancy Act*, gives certainty to both landlord and tenant, and establishes a common understanding that fees might increase with less notice if a tenant requires additional health services.

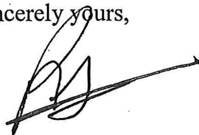
I applaud industry for responding to a consumer issue without government intervention. By inserting this clause into the standard Resident Occupancy Agreement, industry has laid out the process for rent increases and given tenants access to the courts to resolve disputes should they believe their Resident Occupancy Agreement has been breached.

The RTB has a process in place to assist the Office of the Assisted Living Registrar, through which the Office of the Assisted Living Registrar refers tenancy issues to the RTB, and the RTB deals informally with clients. The RTB receives about a dozen of these referrals each year. While no formal process exists, the informal process has proven very effective at addressing problems as they arise.

In 2010, the provincial government decided that the responsibility for Assisted Living tenancies should rest with the Ministry of Health, since health conditions prompt someone to move from independent living to an Assisted Living residence. The province intends to repeal the provisions of the *Tenancy Statutes Amendment Act* (2006) relating to Assisted Living once the Ministry of Health has established a program. In the interim, the informal arrangement between the Office of the Assisted Living Registrar and RTB will continue, and RTB will provide whatever support it can during the transition.

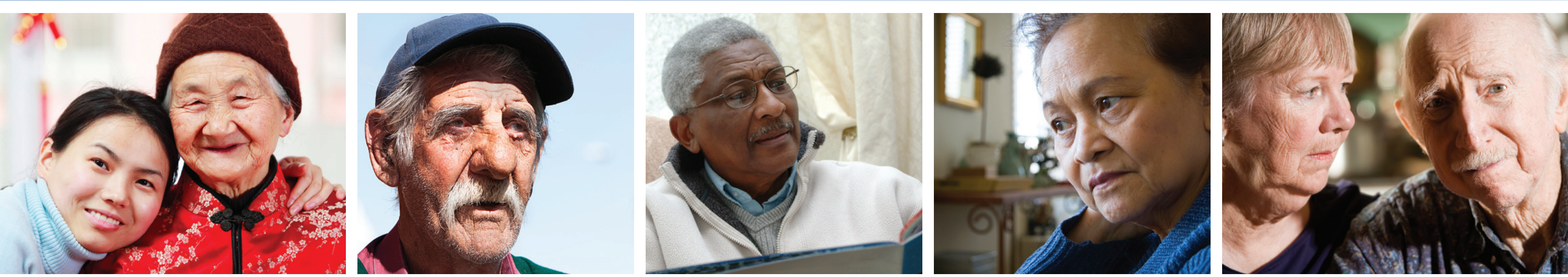
I would like to thank you again for the opportunity to inform you of the progress that has been made in addressing tenancy issues in Assisted Living residences.

Sincerely yours,



Rich Coleman
Minister Responsible for Housing

Notes



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