

THE BEST OF CARE:

GETTING IT RIGHT FOR SENIORS
IN BRITISH COLUMBIA (Part 2)

REPORT | VOLUME 2



ombudsperson
B.C.'s Independent Voice For Fairness

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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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Residential Care

Program Overview

Description of Services

- 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 and typically receive care by trained caregivers. They are provided with meal service, medication administration, personal assistance with daily activities including bathing and dressing, laundry, housekeeping, and social and recreational services.

Service Delivery

- Subsidized residential care services are part of the provincial home and community care program, which is overseen by the Ministry of Health and delivered by the health authorities.
- In some cases, subsidized services are delivered directly by health authority employees, and in other cases by non-profit or for-profit agencies under contract with a health authority.
- Residential care is provided in three types of facilities: community care facilities, extended care hospitals and private hospitals.
- Seniors who can afford to do so can also arrange to receive these services directly from a private provider.
- One hundred and twelve, or 32 per cent of residential facilities are owned and operated by the health authorities. The remaining 236 or 68 per cent are operated by private operators.

Number of People Served

- In 2009/10, 38,411 clients received residential care services in British Columbia. As of September 2011, there were 26,491 publicly subsidized residential care beds.

Legislation

- Seventy-one per cent of residential care beds are in facilities licensed under the *Community Care and Assisted Living Act* and the *Residential Care Regulation* that accompanies it. The Act and the Regulation set the mandatory minimum health and safety standards in these facilities, as well as the requirements for staffing, food service, medication administration and other matters.²⁹⁸
- The remaining 29 per cent of beds are in either extended care hospitals or private hospitals, both of which are governed by the *Hospital Act*.

²⁹⁸ The *Residential Care Regulation* took effect in October 2009, replacing the former *Adult Care Regulations*. This was the first major revision of these regulations since they were rewritten in 1980.

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Cost of Providing Services

- The Ministry of Health estimates the average monthly cost of operating a residential care bed at approximately \$6,000. Facility operators who operate facilities with 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.

Cost of Receiving Services

- In January 2010, the province implemented a new rate structure for subsidized residential care. Under this new 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.²⁹⁹

²⁹⁹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates for Specific Services, 7.B.2.

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Regulating Residential Care — Two Approaches

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 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*.

Table 24 – Senior 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 facilities¹	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 a 0.5 of a *CCALA* facility and 0.5 of a *Hospital Act* facility.

Table 25 – Residential Care Facilities and Beds under the *CCALA* and *Hospital Act*, 2010/11

Health authority*	CCALA		Hospital Act					
	Total facilities ¹	Number of beds	Total facilities	Number of beds	Private hospitals	Private hospital beds	Extended care hospitals	Extended care hospital beds
FHA	63.0	5,785	27.0	2,949	12.0	1,267	15.0	1,682
IHA	67.0	4,241	17.0	1,399	1.0	96	16.0	1,303
NHA	11.5	765	12.5	357	1.0	124	11.5	233
VCHA	39.5	4,234	23.5	3,032	9.0	1,111	14.5	1,921
VIHA	65.5	4,140	21.5	2,090	1.0	130	20.5	1,960
Total²	246.5	19,165	101.5	9,827	24.0	2,728	77.5	7,099

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

¹ Includes facilities with no beds subsidized by the health authorities, but licensed under the *CCALA* and therefore regulated by the licensing departments of the health authorities.

² Each health authority, except for the Fraser Health Authority, has facilities with both *CCALA* beds and *Hospital Act* beds. These facilities were counted as 0.5 of a *CCALA* facility and 0.5 of a *Hospital Act* facility.

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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. Before 2002, residential care facilities provided four different levels of care: intermediate care 1, 2 or 3 and extended care. Facilities were designed to serve specific levels of need, and this was also reflected in the services and user charges.³⁰⁰ One of the outcomes of the 2002 changes was the elimination of the four levels of care and the adoption of a new policy under which everyone in subsidized residential care was identified as in need of “complex care.”

Despite this, 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. The *Hospital Act* has changed very little in the past 50 years. Its principal focus has always been the regulation of public hospitals that provide acute, extended and rehabilitation care. At the same time, the Act has continued to regulate private and extended care 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 “requiring extended care at a higher level than that generally provided in a private hospital licensed under Part 2.”³⁰¹ Today, however, all hospitals governed by the *Hospital Act* currently provide care to “complex care” patients.³⁰² This fact is inconsistent with the definition set out in Part 2 and needs to be addressed. Ministry policy also perpetuates this inaccuracy. With the introduction of the new model in 2002, residents in extended care were no longer considered to have higher care needs than those in private hospitals, as everyone was then defined as in need of “complex care.” This continues to be the case, and some provisions of the *Hospital Act* are now dated and redundant.

Despite the elimination of the different levels of care in 2002, the government has not 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*.

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, may often not know which legislation 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 which govern the care provided.

In the course of our investigation, we identified many differences between facilities licensed under the *CCALA* and those governed by the *Hospital Act*. The following are some of those key differences:

³⁰⁰ Ministry of Health, briefing document, 2005.

³⁰¹ *Hospital Act*, R.S.B.C. 1996, c. 200, s. 1.

³⁰² In the Ministry of Health’s revised *Home and Community Care Policy Manual*, effective April 1, 2011, the complex care designation and its associated categories have been eliminated. To be admitted to residential care, seniors must now be assessed as being in need of 24-hour professional nursing supervision, having care needs that cannot be met in their home or community, being at significant risk in their current living situation, and having an urgent need for residential care services.

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- *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. (The Vancouver Coastal Health Authority is the only exception. It has been inspecting facilities under the *Hospital Act* regularly since September 2007.)
- Health authorities are required to post inspection reports of *CCALA* facilities on their websites but are not required to post inspection reports of residential care facilities under the *Hospital Act* on their websites.
- The *Residential Care Regulation* sets care standards for *CCALA* facilities on hygiene, recreation opportunities, emergency preparedness, nutrition and the administration of medication. There are no legislated care standards for *Hospital Act* facilities.
- Facilities licensed under the *CCALA* must meet detailed physical standards for bedrooms, bathrooms, temperature and lighting.³⁰³ *Hospital Act* facilities are not subject to these specific regulated physical requirements.
- Facilities licensed under the *CCALA* are required to provide most residents with separate bedrooms and are permitted to house a maximum of 5 per cent of residents in double-occupancy rooms.³⁰⁴ *Hospital Act* facilities do not have to provide separate bedrooms, and there is no regulated limit on the number of residents who can share a room.
- *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.
- The majority of extended care hospitals are either beside or adjoining general hospitals and so may have greater access to medical equipment and supplies at a lower cost than private hospitals and facilities under the *CCALA*.
- The *Hospital Act* requires private hospitals to have a superintendent who is either a medical practitioner or registered nurse living on-site. *CCALA* facilities are required only to ensure that either a medical or nurse practitioner can be contacted in an emergency.
- 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.
- Residents in extended care facilities are provided with oxygen at no extra cost because it is included in the budget of extended care facilities. Residents of *CCALA* facilities or private hospitals must either pay for oxygen themselves or apply for coverage to the provincial Home Oxygen Program.

³⁰³ Facilities licensed prior to August 1, 2000, need not meet these requirements, as per section 94(2) of the *Residential Care Regulation*.

³⁰⁴ Facilities licensed prior to August 1, 2000, need not meet these requirements, as per section 94(2) of the *Residential Care Regulation*.

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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.³⁰⁵ 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*.

New *Hospital Act* facilities can be created only 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.

In June 2009, the ministry told us:

There would not be any circumstances where the Ministry would designate a new residential care facility under the *Hospital Act*; these would be licensed under the *CCALA*. Replacement beds have been designated under the *Hospital Act*, but not new facilities.³⁰⁶

Despite this assurance from the ministry, new residential care facilities have been designated under the *Hospital Act*. 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*. In addition, replacement beds continue to be designated under the *Hospital Act* in both the Vancouver Coastal and Fraser health authorities. The designation of new facilities and replacement beds under the *Hospital Act* means that rather than minimizing the problems associated with having two different regulatory regimes for residential care, the ministry and the health authorities have allowed the problem to continue.

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 has not yet completed the steps necessary to do so.

While the *CCALA* was passed in 2002 and the majority of it came into force in May 2004, section 12 has not yet been proclaimed. According to the Ministry of Health, section 12 is intended to bring the regulation of all residential care facilities under one piece of legislation, meaning that private hospitals and extended care hospitals and beds would be under the *CCALA*. As a result, there would be one system of monitoring and inspection for all facilities and

“[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.

³⁰⁵ Ministry of Health, *Home and Community Care Policy*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

³⁰⁶ Director of Home and Community Care, letter to the Office of the Ombudsperson, 8 June 2009.

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consistency in user fees and benefits. According to the ministry's statements soon after the Act came into force, proclaiming section 12 would "ensure that all vulnerable persons in residential care facilities are provided with the best possible protection to their health, safety and well-being."³⁰⁷ Still, more than nine years since the Act was passed, section 12 has not yet been proclaimed.

In January 2004, the Ministry of Health began a project to examine the implications of implementing section 12. The aim of the project was to identify the policy and financial challenges that would result from implementation and recommend ways to resolve them.

The ministry identified several significant financial issues, particularly for extended care hospitals, that it needed to resolve in order for the change to have a minimal impact on costs for residents, health authorities and the ministry. 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. The ministry identified the following financial implications of these issues:

- The write-off of prepaid capital advances would require \$24 million from the ministry's operating budget.³⁰⁸
- The loss to operators of \$1.6 million in revenue from room differential charges would put pressure on the ministry to supply the operators with extra funding. (See "Residential Care Rate Structure" later in this section.)
- The additional oversight costs, including the cost of more licensing staff for health authorities, were estimated at approximately \$0.9 million per year.

Pharmacy Services

Health authorities are currently responsible for providing pharmacy services in extended care hospitals. Most pharmacy services are provided by the hospital pharmacies. Health authorities pay for these services through the global funding they receive from government. When facilities move under section 12, extended care residents would no longer receive pharmacy services from hospital pharmacies. Their medications would be funded through PharmaCare's Plan B, which applies to people in CCALA facilities. The PharmaCare Plan B drug list is not as comprehensive as the hospital drug list. The key difference is that Plan B does not fund over-the-counter drugs and some other medications (such as Tylenol), which are currently provided through hospital pharmacies.

³⁰⁷ Ministry of Health, information bulletin, 5 October 2005.

³⁰⁸ According to the Ministry of Health, the health authorities receive capital funding from the ministry in the form of restricted capital grants (formerly prepaid capital advances), approved by the Treasury Board and the Minister of Finance, to build acute care and other facilities. Generally, there is no requirement to pay off the unamortized balance of these funds unless the facility is disposed of or sold while an unamortized balance still remains. Ministry documents from 2007 show that seven facilities that would lose their designation as hospitals if section 12 were to be implemented are currently included in the government reporting entity (GRE). Four are operated by societies as stand-alone extended care facilities with prepaid capital advances totalling approximately \$24.8 million. Once these facilities are moved under the *CCALA* and lose their hospital designation, they will have to be removed from the GRE. This would require government to write off the remaining balances of the prepaid capital advances. New extended care facilities that are not health authority owned and operated would not be eligible for restricted capital grants.

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- Some former *Hospital Act* facilities would have to pay property taxes, creating additional cost pressures.³⁰⁹
- The health authorities would have to transfer about \$16 million to the ministry for pharmacy and diagnostic services that they would no longer be providing directly to residents, some of which would instead be covered by PharmaCare.

Proclaiming section 12 would affect 101.5 facilities and their 9,827 residents that are now governed by the *Hospital Act*. It would mean that these residents would receive the same approach to residential care as those who live in facilities licensed under the *CCALA* and be protected under the same legislation.

At the time this report was released, more than nine years since the Act was passed, the provincial government did not have a plan or time frame for the implementation of section 12.

Conclusion

During our investigation, we found that seniors and their families were generally unaware of the two different regulatory approaches in effect at residential care facilities and how each facility's services, benefits and oversight were affected by them. This is not surprising given that it is often difficult to obtain information about the legal rules that apply to a particular facility.

Maintaining the differences in the standards, user fees, benefits, oversight and complaints processes that result from the two regulatory approaches might make sense if there were different levels of care provided at the differently regulated facilities, and if people had a choice about which one to go to. Before 2002, this was the case. Facilities did offer different levels of care and seniors could put their names on the waiting lists of their chosen ones. This has not been true for more than eight years. Now all facilities provide complex care, and seniors who are applying for placement in a subsidized residential care bed are expected to accept the first one that is offered to them.

Since all seniors in residential care need 24-hour support and care and are therefore vulnerable, it is important that they all be protected by the same level of oversight and procedural safeguards. This includes public reporting of inspection results, which should be required for all types of residential care facilities. It is also important that seniors who require this level of care not have to cope with widely varying charges, benefits and services depending on the type of residential care facility in which they are placed.

The ongoing discrepancies between the two regulatory approaches means that seniors and their families must continue to cope with inconsistencies in standards, services, benefits and oversight that are difficult to explain or understand. If the government chooses to continue to maintain the two regulatory regimes, it should ensure that residents in *Hospital Act* facilities are protected by the same standards afforded under the *Residential Care Regulation*, and that *Hospital Act* facilities are subject to the same active oversight and inspection requirements.

³⁰⁹ When extended care hospitals move from being governed by the *Hospital Act*, they will lose the property tax exemption they have under the *Community Charter* as a result of being designated a hospital. According to documents from the Ministry of Health, a number of extended care facilities would maintain property tax exemptions under other provisions; however, 10 facilities that would lose their property tax exemptions will have to apply to municipalities for permissive tax exemptions.

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However, we believe that making all residential care facilities subject to the *CCALA* would be a better course. If it chooses to do so, the ministry should ensure that the harmonization process does not result in the reduction of existing benefits and services for residents in any residential care facility.

The Ombudsperson finds that

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 the fees they pay.

The Ombudsperson recommends that

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

Funding for subsidized residential care comes from two main sources: the provincial government and monthly payments from residents (or their families). The provincial government provides health authorities with an overall amount of money each year, which the health authorities then assign in ways that allow them to meet their service obligations. In addition to residential care, these obligations include funding hospitals, mental health services, other home and community care programs, public health protection, environmental health and other services. Once health authorities decide how much of their overall budgets to spend on residential care, they decide how much funding to provide to each facility in their region.

The cost of operating a residential care bed is approximately \$6,000 per month or \$200 per day.

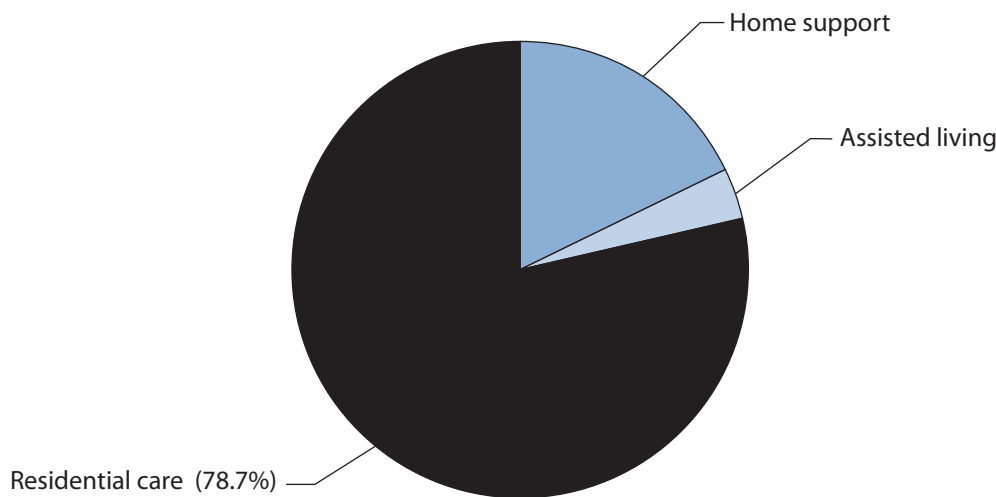
Source: Ministry of Health, "Home and Community Care Residential Care Facilities," fact sheet.

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According to the Ministry of Health, the total cost of operating a residential care bed is approximately \$6,000 per month or \$200 per day.³¹⁰ Depending on their incomes, subsidized residents currently pay between \$894 and \$2,932 per month of that cost.³¹¹

Those who are not assessed as requiring the level of care needed to receive subsidized residential care, or who are waiting for a subsidized bed to become available and can afford to do so, may choose to purchase residential care privately and pay the full cost of their care.

Figure 5 – Allocation of Home and Community Care Budget, 2008/09



Provincial Government Decisions and Responsibilities

The Ministry of Health decides the total annual funding for each health authority. To do this, 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. (For further information about this process, see the description of the population needs-based funding model in the Home and Community Care section of this report.) The ministry establishes the policies, directives and expectations that guide how health authorities use the funds the ministry provides.³¹² The Ministry of Health also sets the rates that subsidized residential care facility residents will pay.³¹³ The rate structure usually results in subsidized residents paying 80 per cent of their after-tax income.

³¹⁰ Ministry of Health, "Home and Community Care Residential Care Facilities," fact sheet, undated.

³¹¹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates for Specific Services, 7.B.2.

³¹² Ministry of Health, *Revised 2011/2012-2013/2014 Service Plan*, May 2011, 6.

³¹³ The rate structure ordinarily results in subsidized residents paying 80 per cent of their after-tax income.

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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.

Health Authority Decisions and Responsibilities

Overall Spending on Residential Care

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. The percentage of the overall home and community care budget that each health authority spent on residential care ranged from 70 per cent

in the Vancouver Coastal Health Authority to 83 per cent in the Interior Health Authority.

Since the percentage of each health authority budget spent on residential care varies from one authority to another, we were interested in how these funding decisions were made. 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. Health authorities 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
- the potential for increased costs

We asked the health authorities to provide us with the number of publicly subsidized residential care beds that were operating in each health authority from 2002 to 2011. In addition, we asked the health authorities for information about how they funded residential care over the same period. Some of the health authorities were not able to provide us with figures for all years. The information provided is

Pre-2002 Care Levels

Personal Care (PC): For seniors who were independently mobile with or without mechanical aids, required minimal assistance with the activities of daily living and required non-professional supervision and/or assistance.

Intermediate Care 1 (IC1): For seniors who were independently mobile with or without mechanical aids, required moderate assistance with the activities of daily living and required daily professional care and/or supervision.

Intermediate Care 2 (IC2): For seniors who required heavier care and/or supervision and additional care time over and above IC1 level.

Intermediate Care 3 (IC3): For psycho-geriatric clients with severe behavioural problems on a continuing basis and seniors who required a heavier level of physical care involving considerably more staff time than at the IC1 or 2 level but who were not eligible for extended care.

Extended Care: For seniors with severe chronic disabilities who required 24-hour-a-day professional nursing services and continuing medical supervision, but did not require acute care.

Source: Ministry of Health, "Home and Community Care Redesign," fact sheet.

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summarized in the following two tables. The health authorities also told us that between 2002 and 2009 their residential care funding decisions were influenced by the Ministry of Health's implementation of the provincial government's goal set in 2001 to develop 5,000 new "intermediate and long-term care" beds by 2006, a goal that was later adjusted to be implemented in 2008.³¹⁴

In 2001, the phrase "intermediate and long-term care" referred to the four categories of care in which seniors required higher levels of care and supervision. The government brought the concept of assisted living into its home and community care program in 2002 and then actually put it into effect in 2004. Before 2004, those who lived in assisted living would have been in a residential care facility identified as having intermediate care levels 1 and 2.

Table 26 – Number of Publicly Subsidized Residential Care Beds, 2002/03 to 2010/11

Health authority*	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
FHA	7,539	7,256	7,138	7,227	7,327	7,457	7,607	7,543	7,564
IHA ¹	Not provided	Not provided	Not provided	4,304	4,515	4,786	5,112	5,175	5,279
NHA	1,044	944	948	956	1,000	1,011	1,017	1,095	1,101
VCHA	6,605	6,998	6,731	6,641	6,730	6,710	6,708	6,560	6,702
VIHA	4,803	4,707	4,629	4,704	4,777	4,939	5,287	5,261	5,293
Total	-	-	-	23,832	24,339	24,903	25,731	25,634	25,939

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

¹ IHA data includes short-term beds.

³¹⁴ This goal was incorporated into the provincial government's planning for seniors care in 2001. A news release issued on November 4, 2002, by the Ministry of Health quoted the Minister of State for Intermediate, Long-Term and Home Care as stating, "Working with the private and non-profit sector, we will develop another 5,000 intermediate and long-term care units by 2006." Ministry of Health Services, "New Community Care Act to Strengthen Protection," news release, November 4, 2002. In a backgrounder released on February 9, 2005, the provincial government stated that "by 2008, government will achieve its goal of adding 5,000 beds to the inventory inherited in 2001." Ministry of Health Services, "Backgrounder on Seniors' Housing and Care," February 9, 2005.

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Table 27 – Health Authority Funding (\$) for Residential Care, 2002/03 to 2010/11

Health authority*	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
FHA	328,623,000	330,580,000	328,898,000	330,601,000	342,871,000	366,535,000	394,764,000	379,700,000	444,756,455
IHA	238,604,966	243,128,745	214,906,018	214,115,601	251,671,577	271,062,258	291,782,921	305,068,397	331,908,518
NHA	52,570,988	51,752,238	51,774,173	54,178,978	63,459,002	63,220,838	66,612,868	53,759,394	81,113,000
VCHA	324,793,832	333,179,340	323,610,835	345,921,897	369,551,668	385,320,780	403,579,531	410,331,388	424,846,636
VIHA	261,536,693	253,290,599	245,374,208	263,341,843	269,070,000	283,184,000	313,374,349	322,564,228	334,546,660
Total	1,206,129,479	1,211,930,922	1,164,563,234	1,208,159,319	1,296,623,247	1,369,322,876	1,470,113,669	1,471,423,407	1,617,171,269

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

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 this same period, the funding that the Ministry of Health provided to the health authorities increased by an even larger amount — 42 per cent.³¹⁵ 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 2009/10.³¹⁶ The total number of subsidized residential beds also decreased.³¹⁷ There were 1,748 fewer subsidized residential care beds in 2010/11 than there were in 2005/06.

We found the decrease in residential care beds surprising, given that there has been an increase in both the overall population of seniors and the number of seniors assessed as requiring complex care since 2002. For further information, see the Background section of this report. We expected that these population trends would have prompted an increase in the number of subsidized residential care beds and in the percentage of the health authorities' budgets that was spent on residential care, but this was not the case.

It is important that the Ministry of Health be accountable for residential care planning and budgeting decisions. One way to enhance the ministry's accountability is to ensure that the public is informed about how funding changes over time and whether the planned results are appropriately supported on an ongoing

³¹⁵ This calculation is based on figures found in the ministry's annual service plans for 2002/03 and 2009/10. Ministry of Health, *2002/03 Annual Service Plan Report*, 55 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2002_2003/hs/hs.pdf>; Ministry of Health, *2009/10 Annual Service Plan Report*, 28 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2009_2010/hs/hs.pdf>.

³¹⁶ This is based on figures found in the ministry's annual service plans for 2002/03 and 2009/10. Ministry of Health, *2002/03 Annual Service Plan Report*, 55 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2002_2003/hs/hs.pdf>; Ministry of Health, *2009/10 Annual Service Plan Report*, 28 <http://www.bcbudget.gov.bc.ca/Annual_Reports/2009_2010/hs/hs.pdf>.

³¹⁷ The authors of *Continuing Care Renewal or Retreat: BC Residential and Home Health Care Restructuring 2001-2004* conclude that as a result of the closure of 26 publicly funded residential care facilities from 2001 to 2004, 2,529 residential care beds were lost. During the same period, 1,065 subsidized assisted living beds were created. This resulted in a net loss of 1,464 residential care and subsidized assisted living beds from 2001 to 2004. Marcy Cohen et al., *Continuing Care Renewal or Retreat: BC Residential and Home Health Care Restructuring 2001-2004* (Ottawa: Canadian Centre for Policy Alternatives, 2005), 5 <http://www.policyalternatives.ca/sites/default/files/uploads/publications/BC_Office_Pubs/bc_2005/continuing_care.pdf>.

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basis by adequate funding. As recommended in the Home and Community Care section of this report, the Ministry of Health should publicly report the forecasted budget and actual money spent on residential care services by each of the health authorities on a yearly basis.

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.³¹⁸

This approach is problematic because the seniors who are in residential care today generally have higher and more complex needs than those who were in residential care 10 years ago. This shift began in 2002, when the provincial government introduced the need for "complex care" as a condition of admission to a subsidized residential care bed.

When the ministry introduced the new complex care criteria for residential care in 2002, health authorities confirmed to us that they did not request or require facility operators to submit new proposals for their contracts. The contracts that existed then allowed the health authorities to change the terms of service and the health authorities expected operators to adapt to the new conditions. Residential care facilities that had previously served residents with lower care needs were expected to provide higher levels of care with the same funding. This created funding disparities among the residential care facilities based on the level of care they had provided prior to 2002. Because funding is based on the previous year's budget, these disparities still continue.³¹⁹ It is predictable that these funding disparities end up affecting the services that operators can provide to the residents of those facilities, though in some cases outside sources of funding, such as that from foundations, help even things out.

Form of Ownership

In the course of 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). We sought information from the health authorities on how they funded public and privately owned facilities. As is apparent in the following table, 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. In the Northern Health Authority, there is only one privately operated facility. These differences in the average daily per-bed funding result in significant monthly amounts. For example, given the difference in the average daily per-bed funding

³¹⁸ In November 2011, the FHA told us that it had implemented a Care Delivery Model and Funding Methodology in January 2010, which adjusted historical funding and established standards to ensure future funding is allocated equitably.

³¹⁹ Starting in 2007/2008, VIHA implemented a standardized funding model for residential care services.

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provided by the Vancouver Island Health Authority, it would be typical for a publicly owned facility with 50 residential care beds to receive approximately \$44,000 more in funding each month than a privately owned facility with the same number of subsidized residential care beds.

Table 28 – Average Daily Per-Bed Funding for Public and Privately Owned Residential Care Facilities, 2010/11

Health authority* ¹	Form of ownership	
	Public	Private
FHA ²	\$170.08	\$182.83
IHA	\$200.15 ³	\$190.15
NHA	\$205.04	\$184.50
VCHA	\$190.54	\$185.14
VIHA ⁴	\$221.10	\$191.61 ⁵

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

¹ The FHA, IHA, VCHA and VIHA data include the funds paid by residents. The NHA has not indicated whether this data also includes the residents' contributions.

² In the FHA, privately owned (for-profit and not-for-profit) facilities receive funding for property costs.

³ In the IHA's public facilities this includes pharmacy funding of \$9.62 for *Hospital Act* beds.

⁴ In November 2011, VIHA reported that this amount includes funding for facilities with higher staffing levels due to specialized services.

⁵ VIHA estimated its average daily per-bed funding in publicly owned facilities, because it centralizes some non-direct care costs such as administrative support and supplies.

All the health authorities except the Vancouver Coastal Health Authority (VCHA) said that they use different processes for deciding the funding for facilities they own versus ones owned by non-profit or for-profit agencies. The VCHA stated that its decision process is now the same for both types of facilities, but acknowledged that it was different in the past, which stemmed from the two different acts and sets of requirements that residential care facilities can be subject to. The VCHA said that while these differences have not yet been fully resolved, it believes it can address them over time by providing additional funding when it becomes available.

The Fraser Health Authority (FHA) and the Vancouver Island Health Authority (VIHA) attributed the differences in their regions to historical funding patterns. VIHA and the Interior Health Authority (IHA) explained that the facilities that are owned by the health authority fall under the *Hospital Act*, which means that medication and other costs are higher. In addition, the IHA said that staff at all its facilities are unionized, so salary and benefit costs are higher than they generally are at privately owned facilities where staff are often not unionized. Similarly, the Northern Health Authority (NHA) said that the one privately owned facility in its region is funded at a lower rate because it is only partially unionized whereas the public facilities are completely unionized.

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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 for the Ministry of Health to require the health authorities to publicly report the amount of funding they provide to each facility in their region — a recommendation we made in *The Best of Care (Part 1)* but that has not yet been implemented.

Operating Costs

Operating costs are another factor that affects the funding health authorities provide to individual facilities. These costs differ, depending on the legislation that facilities are governed by. For example, extended care facilities that are regulated by the *Hospital Act* receive an 83 per cent rebate for the federal portion of the harmonized sales tax (HST) and 58 per cent for the provincial portion.³²⁰ Non-profit private hospitals and non-profit facilities regulated by the *Community Care and Assisted Living Act (CCALA)* receive only a 50 per cent rebate on the federal portion of this tax and 57 per cent on the provincial portion.³²¹

The treatment of property taxes also differs depending on which act governs. Under the *Community Charter*, extended care facilities are automatically exempt from property taxes, while private hospitals and *CCALA* facilities are not. Local governments make case-by-case decisions on whether to exempt private hospitals and *CCALA* facilities on an annual basis, so some of these facilities may have to pay property taxes while others do not.

Pharmacy costs are higher in extended care hospitals because those facilities are required to provide medications and supplies to residents at no cost. At *CCALA* facilities, residents either pay their own pharmacy costs or rely on PharmaCare. Further information about pharmacy costs and service is discussed above in “Differences between *Hospital Act* Facilities and Community Care Facilities.”

Health authorities have taken different approaches to reconciling these differences in operating costs when they make facility funding decisions. For example, the FHA does not adjust the funding it provides to facilities based on the size of their tax rebate or whether they are exempt from property taxes. VIHA does adjust for the tax rebate when deciding funding for the facilities it owns, but not for those owned by other agencies. VIHA also provides funding so that most of the non-profit facilities it contracts with can pay their property taxes if they are not exempt. For other facilities, VIHA provides the same or greater amount based on the 60th percentile of reported costs. For newer private facilities, the daily amount paid by VIHA includes the property tax amount based on costs submitted in response to a Request for Proposal.

The NHA takes a more systematic and comprehensive approach to adjusting funding based on the differences in operating costs for *CCALA* and *Hospital Act* facilities. The NHA explained that when it does annual budget reviews, it examines actual costs and spending in detail and reconciles any differences between the funding it provides for facilities governed by the *Hospital Act* and those governed by the *CCALA*. The NHA is perhaps in a better position to take this systematic approach because it owns and operates all but one residential care facility in its region.

³²⁰ The HST combines a 5 per cent federal tax and a 7 per cent provincial tax.

³²¹ Government of British Columbia, “Rebates for Public Bodies” <http://www.hstinbc.ca/making_your_choice/faqs/rebates-for-municipalities%2C-universities%2C-public-colleges%2C-school-authorities%2C-hospital-authorities%2C-charities-and-qualifying-non-profit-organizations/>.

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Care Needs of Residents

Before the Ministry of Health's revised *Home and Community Care Policy Manual* took effect on April 1, 2011, health authorities had to assess seniors as in need of complex care in order to place them in a subsidized residential care bed. The previous policy manual listed five categories of complex care, although most health authorities did not appear to recognize these distinct categories for funding purposes. These five categories of complex care are described in more detail under "Eligibility Criteria" in this section of the report.

While all seniors must meet these requirements in order to be placed in a subsidized residential care bed, this does not mean that in reality all seniors in residential care need exactly the same level of care.

The NHA accounts for different staffing levels for seniors with different care needs in its funding. It aims to provide a minimum of 2.8 hours of direct care per day for all residents and 3.5 hours of direct care per day for residents who need palliative, dementia or psychogeriatric care. VIHA also accounts for staffing levels in its funding formula, but does not relate staffing levels to the care needs of residents. VIHA's goal is to provide 3.24 direct care hours per day for each resident.

With the exception of the NHA, the health authorities do not factor in any differences in the level of care needed by residents when making facility funding decisions. Some health authorities, however, have developed other ways to respond to the special care needs of seniors in residential care. For example, VIHA has a policy on "added care dollars," which sometimes allows it to provide additional short-term funding to facilities to provide more support for seniors who have just entered residential care after being at home or in the hospital. The IHA told us that in the past, it has provided some extra funding in order to relieve the pressures caused by the increasingly complex care needs of seniors and that it distributed this funding to all the residential care facilities in its region. In November 2011, the IHA reported it recently formalized a guideline and budget for added care that is intended to provide additional short-term funds to assist in stabilizing the care needs of seniors entering residential care.

Conclusion

The Ministry of Health relies primarily on past funding levels to make current funding decisions. After reviewing the health authorities' prior and current budget submissions, the ministry makes incremental adjustments based on the predicted needs of the general population.

The health authorities, in turn, also rely on past funding levels and contractual agreements when deciding on the funding for individual residential care facilities. The Northern Health Authority conducts annual reviews of the funding needs of its individual facilities. The Fraser Health Authority, Interior Health Authority, Vancouver Island Health Authority and Vancouver Coastal Health Authority have no ongoing or formal process that allows for input from individual facility operators before the health authorities determine the distribution of funds. These health authorities may consider any change in circumstances that facility operators present, but they do not have a standard method for determining the actual funding requirements of individual facilities. A facility with a disproportionate number of residents with high care needs, such as

Best Practice — Budget Review

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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dementia or palliative or psychogeriatric needs, may be eligible for enhanced funding, but only on an ad hoc basis. In order to ensure that all facilities receive the funding they need to address the care needs of their residents, it is necessary to use an objective and standard method to evaluate these needs on an ongoing basis. This would also make the system more responsive, transparent and accountable.

The existing approach is still failing to address historical funding inequities between different types of facilities that originated in 2002.³²² When the need for complex care was included in the eligibility criteria for residential care, some facilities found that they had to provide higher levels of care with the same amount of money. In addition, facilities that are privately owned continue to be funded differently from those that are publicly owned. These disparities no longer have any basis in current policy, yet they are perpetuated by using past decisions as the starting point for current funding decisions. In addition, the health authorities do not consistently account for variations in operating costs such as tax rebates and exemptions when funding facilities.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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, Interior Health Authority and Vancouver Island Health Authority establish a three-year review cycle for determining the funding needs of individual facilities.

³²² Starting in 2007/2008, VIHA implemented a standardized funding model for residential care services.

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Eligibility and Assessment

The ministry's *Home and Community Care Policy Manual* includes the following list of typical characteristics of seniors who are eligible for residential care. Seniors who are eligible for subsidized residential care are likely to:

- have severe behavioural problems on a continuous basis
- be cognitively impaired, ranging from moderate to severe
- be physically dependent, with medical needs that require professional nursing care and a planned program to retain or improve functional ability
- be clinically complex, with multiple disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or specialized skilled care³²³

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 Resident 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.

Eligibility Before April 1, 2011

Before the release of this revised policy manual, the eligibility criteria required that a health authority assess a senior as having “complex care” needs before the senior could qualify for a subsidized residential care bed.³²⁴ The health ministries and health authorities used the term “complex care” to refer to the higher levels of resources needed to meet the specialized requirements of people who are generally, though not always, seniors. This criterion had been in place since April 2002.

There were five categories of complex care:³²⁵

- **Group A:** People who have severe behavioural problems on a continuous basis. They may or may not be independently mobile.
- **Group B:** People with cognitive impairment, ranging from moderate to severe, but whose behaviour is socially appropriate. People who may or may not be independently mobile with assistance.

³²³ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

³²⁴ Ministry of Health, *Home and Community Care Policy Manual*, July 2007, Residential Care Services: Access to Residential Care: Residential Care Admission Criteria, 6.B.2.

³²⁵ Ministry of Health, *Home and Community Care Policy Manual*, July 2007, Residential Care Services: Access to Residential Care: Residential Care Admission Criteria, 6.B.4.

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- **Group C:** People who have cognitive impairment, ranging from moderate to severe and whose behaviour is socially inappropriate. People who may or may not be independently mobile with assistance.
- **Group D:** People who are physically dependent but cognitively intact, with medical needs that require professional nursing, and whose conditions require planned programs to retain or improve their functional abilities.
- **Group E:** People who are clinically complex. For example, people with multiple disabilities or medical problems that require professional nursing care or who have complex medical conditions that require monitoring and specialized care.

Although the above five categories were removed from the ministry's policy manual in April 2011, many aspects of these categories are now reflected in the revised manual as being the typical characteristics of seniors who are eligible for residential care.

Current Eligibility Criteria

The policy manual now 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 in 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 caregiver³²⁶

These criteria are all about 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.

Finally, 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 (the health authority must ensure that a senior's capacity to provide informed consent for admission to a facility has been assessed, and he or she has consented in writing to be admitted)³²⁷
- agree to occupy the bed offered within 48 hours of being notified of its availability unless alternative arrangements are approved by the health authority
- agree to pay the assessed client rate and any other permissible facility charges³²⁸

³²⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

³²⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: General Description and Definitions, 6.A.

³²⁸ 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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Under the existing policy and practices, seniors either have to accept the bed they are offered or risk having their names removed from the waiting list. Many of the seniors and family members we spoke to during our investigation believed that they did not have any choice but to accept the bed offered, because they could not afford to pay for a private facility. A senior's consent to placement in an appropriate but non-preferred facility may not be truly voluntary if he or she is only consenting in order to avoid losing a place on the waiting list. Seniors are also told that they can put their name on a list for transfer, which makes it easier to accept a non-preferred bed. However, as discussed later in this section, once a senior accepts a placement, transfer may take a long time.

Analysis

In *The Best of Care (Part 1)*, we discussed the lack of consistent and easily available information about residential care options and the problems this creates for seniors and their families. One problem is that since the ministry policy says seniors must agree to take an offered bed within 48 hours, seniors often have to make these very important decisions without adequate information.

In response to *The Best of Care (Part 1)*, the ministry revised its policy so that health authorities are now required to make “information about their residential care services, including care philosophy, services, programs, facility descriptions, contact information and photographs” easily available to the public.³²⁹ While this is a step in the right direction, the ministry's new policy does not cover all of the information that we said should be available, nor does it ensure that the information is provided in one easily accessible place. As a result, seniors may still be required to make hasty decisions without adequate information. Under these circumstances, we believe it is unreasonable for the ministry to make it a condition of eligibility that seniors agree to accept a placement in an unknown residential care facility within 48 hours of when it is offered.

It is also unreasonable to make it a condition of eligibility that seniors agree to pay all applicable and permissible facility charges. As we have already noted, there are two different acts that govern residential care facilities, and 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 and so may not realize that the facility they just agreed to move to will charge them for some of their medications while another nearby facility may not. Given that information about which act applies to a particular facility is not easily available, it is particularly unfair that seniors must agree to pay all applicable and permissible facility charges without knowing the amount of these costs.

For example, requiring seniors to accept the first appropriate bed they are offered as a condition of eligibility means that if a senior later turns down a placement, the health authority could determine that the senior is no longer eligible despite his or her care needs. Seniors who are in need of subsidized residential care are vulnerable and have urgent care needs. As a result, seniors and their families are likely to agree to the conditions of placement, even if they feel it is not in their best interests.

³²⁹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: General Description and Definitions, 6.A.

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The Ombudsperson finds that

- 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

The Ombudsperson recommends that

- R100. The Ministry of Health remove the two unreasonable conditions of eligibility for a subsidized bed in a residential care facility.

Assessment Process

According to Ministry of Health policy, seniors who are seeking any type of home and community care service, including residential care, must be assessed by their regional health authority before those services can be provided. Ministry policy requires health authorities to assess each senior who seeks services and to develop a care plan.

According to the ministry's home and community care policy, the assessment process should include:

- a visit with the senior
- confirmation of the senior's eligibility for home and community care services
- identification of the senior's health goals and ability to achieve those goals with the assistance of caregivers
- identification of the risk of adverse health outcomes if the senior or caregiver remains in the current situation
- identification of options and available resources in the community
- identification of the senior's health status and the development of a care plan
- identification of appropriate community health services, including home and community care services
- collaboration with other members of the senior's health care team³³⁰

The Ministry of Health requires the health authorities to use the interRAI, an assessment tool developed by gerontology researchers, to assess all seniors applying for placement in subsidized residential care. The interRAI is described in more detail under Assessment in the Home and Community Care section of Volume 1 of this report.

³³⁰ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Access: Assessment, 2.D.

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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. For example, a person who was put on the waiting list for a particular facility in March would have been offered a bed before a person who was put on that list in April, regardless of each person's condition or care needs. This process did not allow people who had more urgent care needs to be given higher priority for a subsidized bed. Placement in residential care since 2002 has been based on a system of priority access for people with higher needs as established by the assessment process administered by health authorities and is commonly referred to as the "first available bed" or "first appropriate bed" process. (While "first available and appropriate bed" was the term used originally, the Ministry of Health now prefers the term "first appropriate bed," as explained under "Residential Care Access Policy—First Appropriate Bed" below.)

The residential care placement process is challenging for health authorities to manage. In the course of our investigation, we heard from people who had concerns about the fairness and transparency of placement processes for residential care, the length of time seniors spend waiting for placement, and how health authorities managed their waiting lists. Such concerns make it essential that the process be as transparent and clear as possible. The transparency of the process could improve by ensuring that seniors and their families receive regular updates while they are waiting for placement and have access to information about waiting lists and how placement decisions are made.

Identification of Preferred Facilities

Given the current diversity of residential care facilities in British Columbia, it is even more 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. Facilities can be operated by health authorities or by non-profit or for-profit organizations. Facilities range from those that are brand new and have only private rooms to older buildings in which up to four residents share a room. Residential care facilities are governed by the *Community Care and Assisted Living Act (CCALA)* or the *Hospital Act*. As we have seen, having two regulatory approaches results in different standards and oversight requirements. A residential care facility may be a senior's last home in British Columbia, and it is essential that this place is where their care needs are met and where he or she feels comfortable and safe.

Some seniors and family members we spoke to during our investigation told us that they were not asked to identify any preferred facilities during the assessment process. Others said that health authority staff told them that they had to accept the first available bed, and did not explain that a placement also needs to be considered appropriate. The complaint we received from Sandra is an example of these types of concerns. (The names below have been changed to protect confidentiality.)

Sandra and Beryl's Story

Sandra's mother, Beryl, was in the early stages of Alzheimer disease and had been in an assisted living residence for two years when the Vancouver Island Health Authority (VIHA) decided that she needed more care than could be provided to her there.

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Sandra was surprised by the plan to move her mother to a residential care facility. In addition to not understanding why her mother could not stay where she was, Sandra had not known that Beryl would have to accept the first bed offered and that once she did so, her family would have a very short time to move Beryl to her new home.

At the time that the decision to move Beryl to residential care was made, her family was not asked to identify the facility where they would prefer to see her live. Health authority staff offered Beryl a placement in a residential care facility where she would share a room with three others.

When Sandra toured the facility, she found it unsuitable because it seemed that the other residents in the room were in more advanced stages of dementia than her mother. Sandra was very concerned when the health authority's case manager told her that if the family did not accept the placement and move Beryl within 48 hours, she would not be able to stay in her assisted living residence — and she would go to the bottom of the waiting list for placement in a residential care facility.

Sandra quickly looked for private residential care beds, but her mother's income made this option impossible to afford. Her mother's monthly income was only \$1,800 and the least expensive private bed Sandra could find cost \$5,000 per month.

It was only after Sandra contacted the case manager's supervisor that she learned her mother could move to the first available bed in one facility and then ask to be put on the waiting list for transfer to her preferred facility. Although Sandra was not keen to move her elderly mother twice, she did find this information useful.

In the end, Sandra did not need to decide whether to accept the offered placement because the operator of the residential care facility also thought that the placement was inappropriate for Beryl's needs. Only after Sandra complained to our office did VIHA offer to place Beryl at a different facility, and Beryl's family accepted this offer on her behalf.

Sandra and Beryl's story is an example of a situation in which a family was not asked to identify their preferred residential care facility, was offered a placement that they did not consider appropriate, and was not provided with all relevant information before being asked to make an important decision.

Nothing in the *CCALA*, the *Residential Care Regulation* or the *Hospital Act* establishes a process for seniors who require residential care to choose where they want to live. The Ministry of Health's revised *Home and Community Care Policy Manual* states that health authorities should ensure that a senior eligible for residential care be given "the opportunity to identify a preferred facility or location."³³¹ During the first two and a half years of our investigation, before this new policy came into effect, the ministry did not require health authorities to ask seniors to indicate a preferred facility.

The ministry explained that its new policy does not specify how many preferred facilities health authorities should ask seniors to identify, as local options may vary by area. The ministry does not track, nor does it require the health authorities to track, the percentage 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 in this regard vary. The Fraser Health Authority and 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.

³³¹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Access to Services, 6.D.

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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.

In contrast, under Ontario's *Long-Term Care Homes Act*, a person who has been determined to be eligible for long-term care can apply for admission to one or more residences of choice.³³² Seniors in Ontario do not apply directly to the facility even though they can apply to their preferred residence. Applications for admission are made by seniors through a "placement co-ordinator" who serves as a connection between the licensee and the senior.

Section 46(1) of Ontario's Act states that consent for admission must be informed and voluntary. Researchers have argued that this regulatory approach recognizes choice as an essential element of the residential care system; and that determining what is in a person's best interests "cannot, and should not, be done by a third party based on issues unrelated to the person."³³³

Although choice is one of the core values chosen by the provincial government in its 2011/12-2013/14 strategic plan, British Columbia's current approach to identifying and accommodating seniors' placement preferences, does not give the same weight to the choice of seniors, and does not "afford citizens the opportunity to exercise self determination."³³⁴

Residential Care Access Policy — The First Appropriate Bed

The Ministry of Health's Residential Care Access Policy sets in place a process where seniors who are eligible for subsidized residential care must 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" placement, it does state that "health authorities are responsible for determining the appropriate long-term residential care services to meet the client's needs."³³⁵ During the assessment process, health authorities are supposed to ensure that clients will agree to accept the first appropriate bed, even when a bed is not in their preferred facility or location. Previously, seniors were expected to accept the "first available and appropriate bed." In the ministry's policy manual of April 2011, the word "available" was removed.³³⁶ The current system still does not formally recognize resident choice as a factor in determining what is appropriate.

We investigated the following complaint about the way the Vancouver Coastal Health Authority applied the first appropriate bed policy. (The names below have been changed to protect confidentiality.)

³³² *Long-Term Care Homes Act*, S.O. 2007, c. 8, s. 44(1).

³³³ Jane E. Meadus and Judith A. Wahl, *Transfer from Hospital to Long-Term Care: Reframing the Ethical Debate from the Patient's Perspective* (Toronto: Advocacy Centre for the Elderly, 2008), 4 <<http://www.ancelaw.ca/appimages/file/ACE%20-%20Ethical%20Issues%20&%20First%20Available%20Bed%20Policies%20-%202008.pdf>>.

³³⁴ Province of British Columbia, *Strategic Plan 2010/11-2012/13*, March 2010, 6.

³³⁵ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Long-Term Service Needs Determination, 6.C.

³³⁶ 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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Linda and Julia's Story

Linda was very close to her stepmother, Julia. Shortly after Linda's dad passed away, Julia had a massive stroke. She was admitted to Vancouver General Hospital, which is within the jurisdiction of the Vancouver Coastal Health Authority (VCHA). The stroke affected Julia's speech and the left side of her body. It was determined that she would need to be admitted to residential care upon discharge from the hospital.

Julia's family preferred that she be placed in a residential care facility in New Westminster because it was just down the street from Linda's home, which would allow her to visit Julia regularly. The facility was within the Fraser Health Authority. The VCHA contacted the Fraser Health Authority (FHA) to see if Julia could be placed in her preferred facility or another one in the same area, but there were no beds available in the area at that time. At this point, the VCHA placed Julia in one of its own facilities at the University of British Columbia (UBC), on the west side of Vancouver. Julia's name was put on the transfer list for her preferred facility in New Westminster.

The distance between Linda's house and UBC was approximately 30 km, making it very time-consuming for Linda to visit her step-mother. The situation worsened when Linda fell ill and was unable to make the trip to UBC. Linda was concerned about the effect that her absence would have on Julia's condition, especially since she was the only family member who had regular contact with her.

Linda contacted our office to complain about Julia's placement. She believed that the VCHA should have made a greater effort to place Julia in a facility in the Fraser Health Authority. In response to our enquiries, the VCHA informed us that its policy was to place seniors in the "first available and appropriate bed" if a bed is not available in the preferred facility. When we asked the VCHA about the meaning of "appropriate" within this policy, we were told that geographic location is one of the factors considered. We questioned whether the bed in which Julia was placed was appropriate given how far it was from her closest family member. In an effort to resolve the complaint, we requested that the VCHA follow up with the FHA to facilitate a transfer to a facility closer to Linda.

As a result of our investigation, the VCHA contacted the FHA to request a bed in New Westminster. This time, after waiting six months on the transfer list, Julia was successfully placed in a bed in her preferred facility. As this facility was so close to Linda's house, she was now able to visit Julia regularly.

Julia and Linda's story shows that a health authority's definition of appropriate placement can differ markedly from that of a patient or family. This can be attributed in part to the lack of a definition of "appropriate" in the provincial policy. Without a consistent and clear understanding of how the appropriateness of a placement is determined, seniors' preferences may not be given sufficient weight. In addition, as illustrated by this story, there should be a process in place that seniors and their families can access if they disagree with the appropriateness of a placement.

The Ombudsperson finds that

F77. The Ministry of Health does not require the health authorities to ensure that seniors who believe a placement they have been offered is inappropriate have the opportunity to raise their concerns and have them considered.

The Ombudsperson recommends that

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.

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Management of Waiting Lists

Since 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're 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. It is important that there be a transparent and publicly available process for prioritizing access to subsidized residential care beds.

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 initial placement.

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. Some health authorities use a software program to allocate beds to seniors and regularly rotate between admissions from hospitals, the community and transfers from other residential care facilities. In contrast, other health authorities maintain separate waiting lists for placements from hospitals, the community and other facilities and allocate beds on a more ad hoc or adaptable basis. There is no province-wide approach to managing waiting lists. While this may help health authorities respond to local conditions, it may also lead to inconsistent treatment.

We asked the health authorities what they do when they have multiple people with equal needs and levels of urgency who require a subsidized residential care bed. They said they consider a number of factors in these cases, including seniors' preferences and clinical needs. The Fraser Health Authority also considers how long each patient has been on the waiting list. The Vancouver Coastal Health Authority will offer the placement to the person whom it believes is the most appropriate fit for the placement, based on language, culture, familiarity with the facility, and location. If all these factors are roughly equal, the Vancouver Coastal Health Authority uses the length of time each person has been on the waiting list as the determining factor.

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.

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Transfers to Preferred Facilities

Seniors who refuse the first appropriate bed offered to them may lose their place on the waiting list. The ministry's *Home and Community Care Policy Manual* requires health authorities to equitably manage residents' transfer from the first bed that was available to a bed in their preferred facility.³³⁷

Given that the average length of stay in residential care for seniors is approximately 24 months, it is important that transfers occur quickly.³³⁸ However, in the cases we looked at during our investigation, 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 is because seniors who are already in subsidized residential care beds are assessed as receiving good care and are generally considered to be lower priority for placement than those who are in hospitals or living at home. The length of the average waiting time means that for some seniors the opportunity to choose their preferred facility may be illusory. Information on waiting times to transfer to preferred facilities is also not consistently tracked by the health authorities.

Transfer from a Non-Subsidized Bed

Seniors who need residential care wait an average of one to three months, and sometimes much longer, before they are offered a placement. A non-subsidized bed is usually much more available, so seniors (or their families) who can afford to do so sometimes choose to pay for non-subsidized beds, especially when they believe care is urgently needed. Meanwhile, they continue to wait for a subsidized placement. Due to 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 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 in 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. Roy's story illustrates some of the concerns we heard about this practice. (The names below have been changed to protect confidentiality.)

Roy's Story

Roy had been the primary caregiver for his wife, Alice, for six years. Alice suffered from Alzheimer disease and had been receiving home support services from the Vancouver Island Health Authority (VIHA). As Alice's health deteriorated, her case manager assessed her and determined that she was eligible for a subsidized bed in a residential care facility.

³³⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Access to Services, 6.D.

³³⁸ The average length of stay for seniors in residential care in 2008/09 was 28.3 months in the Fraser Health Authority, 19.5 months in the Interior Health Authority, 38 months in the Vancouver Coastal Health Authority and 23.2 months in VIHA. The NHA was unable to provide this information, instead referring us to the Ministry of Health.

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Since there was no subsidized bed available at the time, Roy decided to temporarily pay the full cost of a bed at the facility of his choice. He did so on the understanding that, according to the ministry policy, access to subsidized beds is determined by need rather than by the length of time a person has spent waiting. The facility Roy chose had both subsidized and non-subsidized beds. VIHA staff had told Roy that the average waiting time for a subsidized bed at that facility was 12 to 16 months.

After a year, Roy became increasingly concerned about Alice's position on the waiting list for a subsidized bed and his ability to continue paying for her bed, which cost about \$6,250 per month. He had noticed that people who did not appear to be nearly as ill as Alice were being placed in subsidized beds in that facility. He worried that his decision to pay for his wife's bed privately had affected her position on the waiting list. He also believed that Alice would have been placed in a subsidized bed in that facility sooner if she had remained at home.

Based on the information we collected, Roy's concerns were justified. VIHA's assessment of "urgency" and "need" is partly based on the care a person is currently receiving. Because Alice was receiving good care while in the bed that Roy was paying for privately, her need for placement in a subsidized bed was no longer as urgent. It seemed to Roy that he would have to fully exhaust his financial resources in order for Alice's case to be considered a high priority for placement in a subsidized bed. 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 because his or her income is too high.

When we investigated Roy's complaint, VIHA told us that, in general, it considers clients who are already receiving residential care to be at lower risk than similar clients who are not receiving that level of care. VIHA also told us that it gives higher priority to clients who are living in the community and have been assessed as requiring "emergency" or "urgent" placement and to those who are waiting in hospitals for placement when that hospital is in an over-capacity situation.

As a result of our investigation, VIHA looked at this situation again and placed Alice in a subsidized bed. By that time, however, Roy had paid for Alice's non-subsidized bed for 18 months, which cost more than \$100,000.

Through our investigation of Roy's complaint, we learned that it was standard practice in all the health authorities to assign a low priority to clients such as Alice who are already receiving residential care.

Alice waited 18 months to be transferred from a non-subsidized to a subsidized bed. If she had been able to remain at home, her waiting time for a subsidized bed probably would have been much shorter. But Roy cared deeply for his wife and wanted her to receive the best of care. He was unable to continue as his wife's primary caregiver and chose to pay for a non-subsidized bed, which ended up exhausting the couple's savings. If VIHA had been clearer with Roy about the likely timing for Alice's placement and the effect that paying for a non-subsidized bed would have on her priority on its waiting list, he would have had the information he needed on which to base his decisions about her care. He might, for example, have chosen to instead pay for more home support services in order to keep her at home until she was offered a subsidized placement. Roy felt frustrated that he hadn't received clear information from the health authority about how his decision might affect his wife's position on the waiting list.

While Alice was eventually placed in a subsidized bed, Roy's complaint, as well as a similar one we investigated, led us to inquire into the waiting times for transfer from non-subsidized to subsidized beds. As a result, we obtained statistics for the comparative waiting times for beds in two residential care facilities. In Alice's facility, the average waiting times for placement or transfer to a subsidized bed were as follows:

- seniors in acute care hospitals waited two months for placement
- seniors living in their own homes waited two months for placement

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- seniors who had selected the facility as their preferred facility waited 13 months for transfer
- seniors in a non-subsidized bed in the same facility waited 18 months for transfer

For the other facility, in a different health region, the waiting times were as follows:

- seniors in acute care hospitals waited three weeks for placement
- seniors living in their own homes waited two months for placement
- seniors who had selected the facility as their preferred facility waited 12 months for transfer
- seniors in a non-subsidized bed in the same facility waited 23 months for transfer

It is clear that the health authorities prioritized placement for seniors in hospitals or at home over seniors who were waiting to be transferred to their preferred facility or from a non-subsidized to a subsidized bed. This may occur even when seniors have serious care needs, and is consistent with what the health authorities told us about how they manage their waiting lists for residential care.

The ministry's revised *Home and Community Care Policy Manual* says the health authorities must inform seniors and their families about how they manage their residential care waiting lists.³³⁹ 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, since at this point the health authorities only track overall waiting times and do not track how those differ depending on seniors' circumstances, accurate information is not readily available.

The Ombudsperson finds that

- 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

The Ombudsperson recommends that

- 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.

³³⁹ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: General Description and Definitions, 6.A.

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The Ombudsperson finds that

F79. The Ministry of Health and health authorities' residential care placement policies and practices do not incorporate seniors' choices and preferences.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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 or 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.

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

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. The Northern Health Authority (NHA) 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 regional 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's list grew by 102 people, or 21 per cent; and Vancouver Coastal's list grew by 21 people, or 11 per cent. In comparison, Vancouver Island Health Authority's waiting list stayed virtually the same (falling by 1 person, a change of less than 1 per cent).

The NHA 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 29 – 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 because of an information system upgrade that made the data unavailable.

We also asked the health authorities for information about their shortest, longest and average waiting times for placement in 2008/09, 2009/10 and 2010/11. As shown in the following table, the average waiting time varied across the province in each of the three fiscal years.

Table 30 – Days Waited for Placement in Subsidized Residential Care, 2008/09, 2009/10 and 2010/2011

Health authority*	Number of days (2008/09)			Number of days (2009/10)			Number of days (2010/2011)		
	Shortest	Longest	Average	Shortest	Longest	Average	Shortest	Longest	Average
FHA	10	61	22	15	58	32	15	135	40.5
IHA	0	1,012	70	0	762	68	0	1,099	71
NHA	Not available	Not available	Not available	Not available	Not available	72	Not available	Not available	93
VCHA	0	1,868	35	0	398	31	0	650	37
VIHA	1	1,561	98	1	1,729	109	1	1,120	92

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

The FHA's average wait for placement in a residential care facility was 22 days in 2008/09, and increased to 40.5 days in 2010/11. The IHA's average waiting time increased slightly from 70 days in 2008/09 to 71 days in 2010/11. The NHA's average waiting time grew from 72 days in 2009/10 to 93 days in 2010/11. The VCHA's average waiting time also increased slightly from 35 days in 2008/09 to 37 days in 2010/11. VIHA's average waiting time declined in the same time period, from 98 days in 2008/09 to 92 days — approximately three months — in 2010/11. The longest wait during these three fiscal years was in 2008/09, where it was reported a person waited more than five years for placement.

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The NHA could not provide us with complete information because the data had been reported through the ministry's continuing care information management system (CCIMS) system, which reported that this data has never been available in the NHA. The NHA told us that the information would be available from the Ministry of Health.

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. The ministry explained the rationale for choosing 30 days as the baseline for measurement:

Home and Community Care's Residential Access Policy (April 2002) states only clients with complex care needs are to be admitted to residential care facilities. With the implementation of this policy, it is expected that residential care beds will be available in a timely manner for those high-needs clients that require the 24-hour professional services provided in a residential care facility. Thirty days is the maximum wait advised for these complex care needs (based on clinical experience).³⁴⁰

The following table contains the 2009/10 information that health authorities reported to the ministry on the number and percentage of people admitted within 30 days of assessment.

Table 31 – People Admitted to Residential Care within 30 Days of Assessment, 2009/10 and 2010/11

Health authority*	2009/10		2010/11	
	Total admitted	Number (and %) admitted within 30 days	Total admitted	Number (and %) admitted within 30 days
FHA	1,987	1,275 (64)	2,569	1,618 (63)
IHA	1,689	850 (50)	1,738	814 (47)
NHA	279	49 (18)	312	89 (29)
VCHA ¹	Not available	Not available	1,779	1,151 (65)
VIHA	1,482	1,302 (88)	1,905	579 (30)

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

¹ For two of the three health service delivery areas, the VCHA was not able to provide information to the ministry on the percentage of people admitted to residential care within 30 days in 2009/10.

As illustrated by these tables, there is still considerable work to be done to ensure seniors who require 24-hour professional services are provided access to residential care within the 30-day maximum waiting time advised by the Ministry of Health. We are concerned by the high number of seniors who are waiting more than 30 days for placement. In 2010/11, in

"Thirty days is the maximum wait advised for these complex care needs (based on clinical experience)."

Source: Ministry of Health, Management Information Branch, Percentage of HCC Clients Admitted to RC within 30 Days, June 2010, cover page.

³⁴⁰ Ministry of Health Services, Management Information Branch, "Percentage of HCC Clients Admitted to RC within 30 Days," June 2010, cover page.

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three health authorities less than half of those awaiting transfer to residential care were admitted within 30 days. Although the ministry's revised home and community care policy now requires health authorities to "monitor" clients who are waiting for admission to residential care, this is not an adequate substitute for placement within 30 days. Seniors who are assessed as requiring subsidized residential care are vulnerable and in need of 24-hour care — their care needs are urgent. While those seniors waiting in hospitals have their needs met, acute care is much more costly than residential care and does not provide a number of the services, such as social and recreational activities, that exist in residential care facilities.

A shortage of residential care beds throughout the province is the most obvious cause of the sometimes lengthy waiting times for placement in residential care from community and from acute care. Waiting times vary across the province and within each health authority. Tracking waiting times would help identify which areas of the province are in greatest need of additional residential care beds. Such information would also assist the health authorities to be more effective and efficient in their long-range planning.

It is important to monitor the percentage of people who are placed in a subsidized residential care bed within 30 days of being assessed as eligible, and the ministry's February 2009 directive is a step in that direction. However, the directive has not yet resulted in a reduction of the waiting times for placement in residential care. In fact, since the ministry issued the directive, the average waiting time for placement has increased in the Fraser, Interior and Vancouver Coastal health authorities. Waiting times have decreased only in the Vancouver Island Health Authority. While it is impossible to know what happened in the Northern Health Authority in 2008/09 (as the NHA was unable to provide this information), the average waiting time has increased from March 31, 2010, to March 31, 2011. In order to improve the timeliness of access to residential care, the ministry should formally adopt 30 days as the maximum acceptable waiting time for placement and continue to monitor and publicly report on the performance of the health authorities against this standard. Setting clear targets for the maximum time that seniors should wait to be transferred to residential care would allow the ministry to track the performance of health authorities in reducing waiting times. Moreover, seniors and their families would then know how long they could reasonably expect to wait to be admitted to a residential care facility, and this would help them make better decisions.

The Ombudsperson finds that

F82. The Ministry of Health has not established a time frame within which seniors are to receive residential care services following an assessment.

The Ombudsperson recommends that

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.

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Waiting Times for Transferring Seniors from Hospital to Residential Care

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 when seniors wait in hospitals for a subsidized residential care bed to become available. In addition to the higher costs, the beds that waiting seniors occupy are not available for other patients.

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

Except for the Northern Health Authority, each of the health authorities provided us with figures from 2010/11 on their average and longest waiting times for transfer from hospital to residential care. (Although this information is tracked for acute care, it is not made available to the public.) The health authorities also provided figures on the total number of people who were waiting to be transferred from hospital to residential care on March 31, 2011.

Table 32 – Transfers from Hospital to Subsidized Residential Care, 2010/11

Health authority*	Average number of days waited	Longest waiting time (days)	Number of people waiting on March 31, 2011
FHA	19	26	87
IHA	38	303	61
NHA ¹	Not available	Not available	Not available
VCHA	24	518	83
VIHA	25	274	71

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

¹ The NHA reported that this information was captured through the continuing care information management system (CCIMS) system and was stored with the Ministry of Health.

On March 31, 2011, the total number of people waiting to be transferred from hospitals to residential care was at least 302. Waiting times varied, with the longest time being nearly 1.5 years.

We learned that the Ministry of Health does not track the length of time seniors wait in hospitals for transfer to residential care facilities and has not established time limits for this. The ministry said that when implementation of its minimum reporting requirements (MRR) system is eventually completed, it will have

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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consistent data on clients' access to different services and on the locations in which clients receive services. We understand this to mean that when the transition to the MRR system is complete, the ministry will be able to track how long seniors wait in hospitals to be transferred to a subsidized residential care bed.

Without such important information, the ministry cannot know the additional costs involved in keeping seniors in acute care beds while they wait for a subsidized residential care bed. The Ministry of Health told us that the daily cost for an acute care bed varies according to a number of factors, including the facility in which the patient is being treated and the nature of the services being provided. For billing purposes, the ministry stated that the cost of treatment for seniors in an acute care bed ranges between \$826 and \$1,968 per day. This can be compared to the cost of providing residential care, which is estimated at approximately \$200 per day.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

Residential Care

Seniors in Hospital Waiting for Transfer to Residential Care

As mentioned previously, 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, if they can be supported, and wait for an appropriate 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.

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. Research on patients in these circumstances indicates that lengthy hospital stays may contribute to medical complications and lower seniors' ability to cope independently.³⁴¹ In addition, 30 days after being assessed as requiring residential care, health authorities charge seniors who are waiting in hospital the same rate they would pay in a residential care facility, even though they are not receiving that 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*. People also thought that it was unfair to do so given that seniors are not receiving residential care services and that seniors in these circumstances are in hospitals only because of the lack available residential care beds. We received the following complaint from Doreen, who had to pay for her husband's hospital stay while he was waiting for a residential care bed to become available. It illustrates some of the issues that seniors face when they have to wait in hospital for a residential care bed. (The names below have been changed to protect confidentiality.)

Doreen and Frank's Story

When Doreen first contacted our office, her husband Frank was in the hospital waiting to be transferred to a residential care facility. There was a shortage of residential care beds in their northern community. Frank spent a total of 86 days in the hospital before he was eventually transferred to a residential care facility in a community that was a 90-minute drive from where Doreen lived.

Under the Hospital Insurance Act Regulations, health authorities are allowed to charge fees to anyone who is still in the hospital 30 days after being assessed as requiring a "different level of care." People who are in this situation pay the same rates as those who are in residential care facilities, even though they do not receive this level of service.

Frank was assessed as requiring residential care 14 days after he entered the hospital. He could not be discharged to his home because his care needs were more than Doreen could safely provide. Frank was in the hospital for a total of 86 days. He was charged for 42 of those, which is the time he spent in the hospital over the 30-day limit after he was assessed as requiring residential care. Frank was charged at a rate based on his after-tax income. However, Doreen was concerned about their ability to pay these fees. She eventually applied for and received a hardship waiver, which meant that the rate was reduced.

Doreen did not think it was fair that Frank was being charged the residential care rate for his hospital stay because he was not receiving residential care services. The Northern Health Authority (NHA) acknowledged that Frank did not receive the full range of residential care services while he was in the hospital.

³⁴¹ A. S. Ostry et al., "Choosing a Model of Care for Alternate Level Care Patients: Caregivers' Perspectives with Respect to Staff Injury," *Canadian Journal of Nursing Research* 2004; 36: 142-157.

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Doreen was frustrated that she was billed for her husband's hospital stay given that the shortage of beds meant there was nowhere else for him to go. In an effort to resolve the complaint, our office suggested that the NHA refund Doreen for the fees it charged Frank, but the NHA refused to do so.

Authority to Charge Fees

Most people believe that the *Canada Health Act* protects them from being charged for medically necessary care, including stays in the hospital — and this was certainly true of the seniors and families that we spoke to. The *Canada Health Act* is federal legislation that establishes the conditions under which the provinces are allowed to charge user fees to patients. Compliance with the Act is a condition of receiving health care funding from the federal government.

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, drugs, biologicals and related preparations 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, neither the ministry nor the health authorities currently separate out the costs of accommodation and meals in hospitals from the costs of the rest of the services seniors in hospital receive and so it is impossible to determine whether the amounts charged are in compliance with the *Canada Health Act*.

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. This fee is equal to 80 per cent of the senior's income, as long as he or she is left with \$325 per month. The resulting fee is usually a rate that ranges between \$898 and \$2,932 per month, depending on the person's income. However, there is a hardship provision for people who may be unable to pay the residential care rate. The ministry considers the rate the senior pays to be a contribution towards the cost of accommodation and hospitality fees. Seniors who refuse to be discharged from a hospital to a residential care facility can be charged an even higher rate — the same rate charged to hospital patients from outside British Columbia, which ranges from \$1,500 to \$3,000 per day.

While it is legal to charge seniors for the costs of accommodation and meals while they wait in hospitals to be transferred to residential care, we considered whether it is fair to do so. Seniors in this situation do not receive the full range of residential care services, and the reason they are waiting in these less than ideal circumstances is because of the shortage of available beds. Since the ministry has said that 30 days is the maximum time seniors should have to wait for placement, we concluded that it is unfair for health authorities to charge seniors for their hospital stay when they wait longer than 30 days after assessment for a bed to become available.

Residential Care

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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 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.

Neither the *Community Care and Assisted Living Act (CCALA)* nor the *Hospital Act* contains any specific provisions on the admissions process or on how to obtain consent for admission to a residential care facility. While legislation does not provide much guidance on the admissions process for residential care, there is more detailed guidance in ministry policy. Until April 1, 2011, ministry policy required only that health authorities authorize the admission of clients to residential care facilities and that clients agree to admission.³⁴² During our investigation, we observed inconsistencies in how facilities obtained this agreement, with some, but not all, requiring consent in writing. Not requiring written consent can lead to problems. For example, in one complaint we investigated, a senior was admitted to a bed in a facility that he disliked. However, the senior believed he was in the facility against his will and maintained that because he had not consented to admission, he should not have to pay the fees. The health authority reported that he had verbally agreed to the admission but was not able to provide a record of that verbal consent. The health authority said its practice was to accept verbal consent to admission to subsidized residential care facilities and that this was consistent with the ministry's policy.

On the other hand, problems can arise even when some form of written consent does exist. In our investigation, we saw examples of the misuse of admissions documentation. In one case, a facility operator relied on forms from another facility as proof of a person's consent to admission to his facility. In another case, a facility operator relied on a term in an admissions agreement as proof that a person had authorized future medical treatment.

The ministry's revised policy states that health authorities must 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."³⁴³ The ministry's revised policy is a positive step, as it is important

³⁴² Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Short-Term Service Needs Determination, 6.B.

³⁴³ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: General Description and Definitions, 6.A.

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to have a process for ensuring that a person's consent to admission is properly obtained and documented. However, as the revised policy is currently written, the health authorities are individually responsible for developing a process for ensuring written consent. This creates a risk that each of the health authorities may take different approaches to this task. The ministry should develop a standard form to be used in the admissions process that clearly outlines what seniors who consent to admission to a residential care facility are agreeing to when they sign it.

Like the requirement to obtain written consent, the requirement to assess capacity to consent prior to admission is new. The ministry told us that the requirement to assess the capability to consent was included in its revised policy in anticipation of Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* coming 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. 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. Under Part 3, substitute decision-makers would be required to act in the best interests of the person being considered for admission and would have to consult with that person and his or her family or friends who asked to participate in the decision. The substitute decision-maker would have to consider the person's previously expressed wishes, whether he or she would benefit from admission, and whether another viable option was available. Part 3 would also require health care facilities, at the time of admission, to provide patients with a proposal that clearly outlined the care to be provided. Patients or their substitute decision-makers would be able to accept or reject this care proposal.

The ministry's decision to create this policy in the absence of the legislative framework that the enactment of Part 3 would provide is not fully consistent with the legal principle of presumption of capability. Many seniors who are admitted to residential care are entirely able to consent to admission and do not require assessment for this purpose. There should be a fair process for determining whether a senior's ability to consent actually needs to be assessed.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

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 in turn creates pressure on seniors and their families to move into a facility within a very short period when a vacant bed has been offered.

Time Allowed for Moving In

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.³⁴⁴ Although the policy permits exceptions to allow for longer move-in times under certain conditions, health authority policies do not specify how clients can request an exception. Consequently, the option to seek an exception is little known and infrequently used.

We heard from seniors and families who found that the 48-hour 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:

A client who is awaiting placement in residential care (and their family) will have had discussions with case management staff about the options for placement, and will have urgent needs requiring residential care. It is exceptionally rare that the decision to move to residential care occurs without a fairly lengthy period of consideration and discussion. A client with an urgent need for supervised residential care would thus be expected to occupy the bed when it becomes available in a reasonable, prompt period of time.

One Family's Experience

"In my mother's case, the bed was accepted on Friday and my mother was required to move from VGH [Victoria General Hospital] to the facility at 10 a.m. the following Monday. The facility did not have an appropriate mattress for my mother (resulting in a significant increase in her pain levels) and the facility did not receive my mother's meds (including pain meds) until 6 p.m. Monday."

Source: Respondent, Ombudsperson's questionnaire.

³⁴⁴ 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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There are, at any point in time, a number of individuals with a similar urgent need for placement, and it would be unreasonable to expect that a health authority would hold a bed empty for a long period of time while a client or family considered their options, rather than offer the bed to another client in need who is prepared to accept it. As the policy states, there are provisions to make alternative arrangements with the health authority.³⁴⁵

While such a scenario may represent the ideal circumstances, often events will unfold in other ways. In many cases, these decisions and the follow-up steps may have to be made during times of crisis and on short notice. For example, a senior in hospital may be told unexpectedly that he or she cannot go home and must move into residential care as soon as possible. There is no guarantee of when a placement offer will be made, so people cannot plan ahead with certainty. Not everyone has healthy spouses or nearby children who are available, willing and able to help with a move on short notice.

We received complaints from people who didn't have a lengthy period of discussion and consultation in order to prepare themselves for their move. Families with whom we spoke also said that it is difficult to plan for a move when you do not know where or when a senior will be moving.

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

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

Challenges for Operators — Lack of Information about New Residents

In the course of our investigation, we also heard from a number of facility operators who were concerned that they did not always receive enough information about incoming residents from health authorities. Operators need this information in order to develop care plans that meet the particular needs of new residents — and they must be able to address those needs as soon as seniors arrive in their facilities. When this information is not available this can be challenging for operators given that they may find out who their next resident will be only 48 hours in advance. In the Northern Health Authority, interRAI client assessment information is available to residential care managers and operators who are part of the health authority. (Further information on care planning is in the Home and Community Care section of this report.)

Operators told us that prior to 2002, they managed their own waiting lists. As a result, they had access to better and more timely information about the needs of incoming residents and were in a better position to plan for their care.

To provide the best care and avoid problems in the critical transition phase, it is important that facility operators and staff learn as much as possible about a new resident prior to admission. Effective management of underlying medical conditions, diet limitations, past behavioural concerns and other issues requires full and complete information. In its absence, it is unfair to expect facility operators to be able to effectively meet their care obligations.

³⁴⁵ Ministry of Health, letter to the Office of the Ombudsperson, 8 June 2009.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

Although people who can afford to do so may choose to pay for residential care with their own resources, the majority of people who require residential care have to rely on public subsidies to cover a portion of these costs. The Ministry of Health has estimated the average monthly cost of a residential care bed at approximately \$6,000.

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.³⁴⁶ The ministry estimates that the average cost of accommodation and hospitality services to be \$2,932 per month, so that is 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.

In general, 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.

From the ministry’s perspective, the following key principles underlie the co-payment structure:

- The cost of residential care is shared between the province and the resident.
- No person will be denied a placement in a facility due to the inability to pay.
- Residents should have enough disposable income after paying the co-payment to meet their basic personal needs.
- Residential care clients should not pay more than the accommodation costs (accommodation costs include accommodation and hospitality services, such as meals, laundry and housekeeping).³⁴⁷

³⁴⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates for Specific Services, 7.B.2.

³⁴⁷ Director of Home and Community Care, letter to the Office of the Ombudsperson, 9 March, 2010, 2-3.

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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 \$325 left over each month.³⁴⁸ The new structure replaced a system in which residents were assigned one of 11 income-based rate codes and paid a corresponding daily amount. Fees under the previous rate structure ranged from \$31 to \$74 per day. This translates to between \$940 and \$2,260 per month. Under the former system, seniors with the lowest incomes retained a minimum of \$230 each month.

According to the ministry, previous changes to the residential care structure occurred in 1993, 1997 and 2003. In the ministry's view, the income test and rate structure that had been in effect since 2003 did not accurately reflect the actual cost of accommodation, despite annual increases to adjust for inflation. The ministry said that the previous formula resulted in low-income residents paying proportionately more of their incomes than those who were better off. The ministry stated that the new rate structure is intended to introduce equity into the system, and is based on fairness and affordability for both clients and taxpayers.

The new rate structure is calculated on a monthly basis, with fees ranging from \$898 to \$2,932 per month, or \$30 to \$96 per day. Fees are adjusted annually (as they were under the previous system), based on the formula in the *Hospital Insurance Act Regulations* and *Continuing Care Fees Regulation*, and are tied to cost of living increases calculated by Statistics Canada.

The minimum monthly rate of \$898 under the new rate structure was arrived at by subtracting \$275³⁴⁹ from the maximum monthly Old Age Security (OAS)/Guaranteed Income Supplement (GIS) benefit (the rate for singles not earning any income). The OAS/GIS benefit is the sole monthly income for many seniors in British Columbia. This formula resulted in a rate reduction for the lowest income seniors. The minimum rate is scheduled to be adjusted every year on January 1, and began on January 1, 2011.

The maximum co-payment rate of \$2,932 per month is significantly higher than the previous maximum charge of \$2,260 per month. It is set to increase annually based on the percentage increase in the consumer price index (CPI) for the 12-month period ending August 31 of the previous year, starting in January 2012.

According to the Ministry of Health, the maximum charge is meant to represent the full cost of accommodation. In October 2009, the former Health Services Minister delivered a presentation on residential care, in which he stated that since the late 1970s, "residential care has been cost-shared between

³⁴⁸ 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.

³⁴⁹ 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.

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province and client” and that “health authorities provide care, with co-payments [from clients] for room and board.”³⁵⁰ The minister also stated that one of the benefits of the new rate structure is that “100 per cent of care costs will continue to be paid for by the province.”³⁵¹

In 2007, the ministry reviewed the cost of accommodation in a limited sample of residential care facilities across the province and concluded that costs had been consistently underestimated. In a question-and-answer document about the new rate structure, dated October 21, 2009, and posted to the ministry’s website, the ministry explained that under the former rate structure, accommodation costs for seniors who could afford to pay more were heavily subsidized.

In practice, however, the maximum co-payment is based on the average cost of accommodation in residential care facilities across the province. This means that in some facilities the actual cost of accommodation will be more than the maximum co-payment, and in others it will be less. This is a problem because the ministry has stated that a key principle of the residential care rate structure is that a resident’s co-payment should not exceed the cost of his or her room and board.

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

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

How Seniors Were Affected by the Rate Change

As of January 1, 2010, the new rate structure resulted in a decrease for residents who have after-tax annual incomes below \$14,579. The ministry estimated that 25 per cent of residents would either experience no change or a decrease of between \$1 and \$45 per month. The remaining 75 per cent of residents experienced a rate increase. Rate increases were phased in over a two-year period for existing residential care residents as well as for those approved for placement in a residential care facility before January 2010. Fifty per cent

³⁵⁰ Minister of Health Services, “Residential Care: Rate Structure for Residential Care Clients,” presented 8 October 2009, 5.

³⁵¹ Minister of Health Services, “Residential Care: Rate Structure for Residential Care Clients,” presented 8 October 2009, 10.

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of the increase was effective in January 2010, with the remaining applied on January 1, 2011. Those who previously paid the maximum rate of \$74.30 per day (\$2,260 monthly) paid \$2,596 monthly for 2010, and then a maximum of \$2,932 beginning in January 2011. For seniors in this income range, this is an increase of \$672 per month or \$8,064 per year. Seniors who were approved for residential care after January 1, 2010, paid the full increase immediately.

After January 2010, we received several complaints about the new rates. Seniors complained about not having enough money to meet basic living expenses as a result of the rate increase. They also complained about inadequate notice of the rent increase. Spouses complained that as a result of the rate increase, they were left with insufficient funds to pay household expenses.

Insufficient Residual Income

We asked the ministry how it determined that \$275 was enough residual income to meet the basic personal care needs of seniors living in residential care facilities. The ministry told us the residual income was increased from \$230 to \$275 and that this was a cabinet decision.³⁵² According to the ministry, it intends to review the minimum residual income every three years with a view to ensuring this amount leaves sufficient income to cover seniors' personal expenses. The next review is scheduled for the 2012/13 fiscal year, which begins April 1, 2012.³⁵³

According to the ministry, the \$275 residual income available to residents is intended to pay for personal expenses such as toiletry items, hair cuts, newspapers and over-the-counter medications. When asked whether there was consideration given to the amount of money residents spend for "chargeable extras" on a monthly basis, the ministry said that it had considered this matter and concluded that \$275 per month would meet residents' personal care needs. Despite the ministry's assertion that \$275 is an adequate amount, we reviewed all ministry documentation related to the rate increase and found no evidence that the ministry had analyzed this figure or totalled residents' potential monthly costs, such as Medical Services Plan (MSP) premiums, medicines and other personal items.

Room Differential Charges

The number of people per room is one of the main factors that affects the quality of life for residents, and until recently, the cost of care. After January 1, 2010, we also received complaints from people who were paying an extra fee or "room differential" for a private or semi-private room. They told us that after paying the room differential, they had no money left for their other living expenses.

Since August 2000, all newly licensed facilities under the *Community Care and Assisted Living Act (CCALA)* have been required to provide private bedrooms for residents at no additional charge. 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. However, in our investigation we found that the health authorities continued to allow facilities that were licensed before August 1, 2000, and facilities governed by the *Hospital Act* to have more rooms with multiple residents and to charge residents an extra fee called

³⁵² Order In Council 644, (2009) BC Gazette 20 (s. 6 *Continuing Care Act*); Order In Council 645, (2009) BC Gazette 20 (s. 29 *Hospital Insurance Act*).

³⁵³ In December 2011, the Ministry of Health announced that the minimum amount available to residents each month had increased to \$325 to accommodate a Guaranteed Income Supplement (GIS) increase of \$50 announced by the federal government in July 2011.

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a “room differential” if residents in these facilities wanted a semi-private or private room.³⁵⁴ Because the *Hospital Act* and its regulations do not have similar room requirements as the *CCALA*, we observed that these facilities often had two- and four-bed rooms. For semi-private rooms in facilities licensed before August 2000, the extra fee was at least \$6 per day (\$180 per month). For private rooms, the fee was at least \$9 per day (\$270 per month).³⁵⁵

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 with a six-bed 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 visited, every resident had to pay a room differential of either \$6 or \$9 per day (\$2,190 or \$3,285 per year).

In 2007, the ministry estimated that the annual revenue from room differentials in residential care facilities across British Columbia was \$10.18 million. At the time, the ministry identified the charging of room differentials as an inequity that should be remedied. However, the ministry did not take steps to address this issue until January 31, 2010. As a result, seniors in residential care facilities continued to pay different amounts for private and semi-private rooms, resulting in some people paying an extra \$6 or \$9 per day above their assessed residential care rate.

Effective January 31, 2010, ministry policy on benefits and allowable charges for residential care allowed room differentials to be imposed only where the health authority determined a room was “demonstrably superior,” and a resident requested the preferred accommodation in writing and then occupied the room. In addition, facility operators were required to provide the resident or the resident’s representative with information about which rooms had been approved as preferred accommodation, the approved charge for superior rooms, and options for rooms without a room differential. As a result of this policy, no residents were supposed to be charged a room differential without specifically requesting a superior room. However, after this policy came into effect, we continued to receive complaints that room differentials were charged to clients who did not request the preferred accommodation in writing. According to the health authorities, the practice of charging room differentials, except in accordance with the new policy, was phased out between February and October 2010.

The health authorities told us that room differentials were not discontinued in all of their public and private residential care facilities until October 2010. To make matters worse for residents who were already paying room differentials, in January 2010, the ministry’s new residential care rate structure came into effect resulting in higher rates for 75 per cent of people receiving residential care. After the new residential care rate came into effect, people who were being charged room differentials complained to our office that after paying the room differential, they had little or no money left for personal expenses. People were referred to the hardship waiver process but the health authorities did not consider the room differential as an expense in this process. The “Benefits and Allowable Charges” section of the ministry’s April 2011 *Home and Community Care Policy Manual* states that standard accommodation is an included benefit of residential care,

³⁵⁴ In November 2011, VIHA reported that the room differentials were discontinued at its facilities effective September 1, 2010.

³⁵⁵ Ministry of Health, *Home and Community Care Policy Manual*, January 2010, Financial Management: Client Charges — Residential Care, 8.B.

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and makes no mention of preferred accommodation or room differential charges.³⁵⁶ However, the ministry has indicated that compliance with this new policy on benefits and allowable charges is not required until April 1, 2013. Since the previous policy has been repealed, there is currently no policy in effect to prohibit facility operators from charging room differentials.

We investigated these complaints and found that before the room differential policy was revised, many seniors were charged a \$6 or \$9 daily room differential for semi-private and private rooms. Some of these people were charged because they had requested a private room. Others were required to pay a room differential because they had been placed into a private room or semi-private room under the first available bed policy. Because residents paid these charges out of pocket, they found that most of their residual income was being applied to these fees. Since a private room costs \$270 per month, clients receiving the minimum \$275 residual monthly income would have only \$5 left over to pay for personal expenses.³⁵⁷

The change in the residential care rate structure resulted in an additional financial burden for some residents — in particular, residents who were already paying room differentials. Before the ministry changed the residential care rate structure, it was aware that there were inequities and inconsistencies in how operators charged room differentials. The ministry should have anticipated this result and taken steps to resolve the issue of room differentials before it changed the residential care rate structure, or 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. Since seniors were given no choice as to whether they wanted to use their residual income for this purpose, they should be given an opportunity to apply to the ministry for reimbursement of the room differential fees paid during the period from January to October 2010.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

³⁵⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Benefits and Allowable Charges, 6.F.

³⁵⁷ In December 2011, the Ministry of Health announced that the minimum amount available to residents each month had increased to \$325 to accommodate a Guaranteed Income Supplement (GIS) increase of \$50 announced by the federal government in July 2011.

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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. The ministry said that the new rate structure was fairer because low-income seniors would pay less and those who were better off would pay more. It also stated that the extra revenue generated by decreasing the subsidy to those who were better off would be invested in improving the care provided to all seniors in residential care.³⁵⁸

The former Minister of Health Services stated publicly on at least two separate occasions 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.³⁵⁹ 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. He repeated on May 25, 2010, that “all of those dollars — and that was the commitment we made ... — will be returned to the residential care sector in the form of improving care and safety quality for those individuals that are in residential care facilities.” The minister indicated that the extra revenue would be distributed to facilities based on need and would be aimed at increasing the number of care hours in those facilities that were then providing fewer than the average care hours.

Following the implementation of the new residential care rates, the former Minister of Health Services stated that the increased revenue would be distributed to residential care facilities on the basis of need, with the goal of raising the level of care provided in all facilities to “the same higher level.”

Source: Minister of Health Services, British Columbia Legislative Assembly, Hansard, 25 May 2010 <<http://www.leg.bc.ca/hansard/39th2nd/H00525p.htm>>.

“Health authorities will be required, as I mentioned, to use the increased revenues raised to directly improve care. Those will be things like increasing the hours of client care provided to clients, hiring more nursing and care aide staff to provide more care to residents, addressing higher care needs of clients now being admitted to facilities, or providing rehabilitation staff to support the complex care needs of clients now being admitted.”

— Minister of Health Services, June 2010

Source: BC Care Providers Association, *Care Quarterly*, Spring/Summer 2011, 9. <<http://www.bccare.ca/pdf/2011-Spring-Summer-Newsletter.pdf>>.

After introducing the new rate structure, the Ministry of Health Services required every health authority to submit estimates of its actual revenues and spending by March 15, 2010, and to account for how it would spend the new money over the next four years (2009/10 to 2012/13). The ministry confirmed that it would not approve use of the new money to cover general operating costs or to meet increased cost pressures resulting from the introduction of the harmonized sales tax (HST). The ministry identified the following five initiatives as spending priorities that it would support:

³⁵⁸ Ministry of Health, *Questions and Answers on the New Residential Care Rate Structure*, 21 October 2009 <<http://www.health.gov.bc.ca/hcc/pdf/ResCareRateStructureQandAs.pdf>>.

³⁵⁹ Minister of Health Services, British Columbia Legislative Assembly, Hansard, 19 October 2009 1217 <<http://www.leg.bc.ca/hansard/39th2nd/H91019p.htm>> and 25 May 2010 5741 <<http://www.leg.bc.ca/hansard/39th2nd/H00525p.htm>>.

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- increasing the number of direct care hours provided per resident by nurses, care aides and other health care workers
- supporting education and the use of evidence-based tools to improve and maintain the competencies of professional and non-professional care staff
- providing specialized services and supports for distinct populations, such as those with dementia, acquired injuries or in need of palliative care
- acquiring non-capital equipment, such as specialized mattresses and rehabilitation supplies
- supporting recruitment and retention initiatives³⁶⁰

The ministry specifically advised the Fraser Health Authority (FHA) and the Vancouver Coastal Health Authority (VCHA) that they should prioritize increasing direct care hours.³⁶¹

In the course of preparing their plans, the health authorities asked for the ministry's consent to use a portion of the new money to offset the impact of eliminating room differentials in keeping with ministry policy required by a January 31, 2010 ministry policy. Despite its public assurances that all of the additional revenue would be directed to improving care, the ministry allowed contracted facilities to use the new money to make up for the loss of room differentials and confirmed it in letters sent to health authorities.

The Ministry of Health provided the health authorities with a framework to assist in the development of their three-year 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 hours of direct care provided per day per resident, of which 3.00 hours was to be of nursing and 0.36 was to be of allied, or supporting, care.³⁶² The ministry indicated that this number of direct care hours was a “guide for health authorities to aspire to.”³⁶³

The health authorities reported to the ministry that they planned to use the revenue from the rate increase in the following ways.

The FHA planned to spend 84 per cent of the new revenue on staffing, with the remaining 16 per cent going to a combination of non-capital equipment for privately owned facilities and to offset the loss of revenue from room differentials in publicly owned facilities (6 per cent). The FHA indicated that it would increase the total direct care and allied care hours to 86 per cent of the 3.36 hour target by 2012/13, up from 78 per cent in 2009/10.³⁶⁴

³⁶⁰ Home and Community Care Program, Ministry of Health, “Analyses of Health Authority Investment of Revenues from Revised Residential Care Client Rates,” internal report, 30 March 2010, 3.

³⁶¹ Home and Community Care Program, Ministry of Health, “Analyses of Health Authority Investment of Revenues from Revised Residential Care Client Rates,” internal report, 30 March 2010, 3.

³⁶² Home and Community Care Program, “Costing Assumptions #3 for the Proposed Staffing Framework for Residential Care Facilities,” 11 August 2009, 1.

³⁶³ Home and Community Care Program, “Residential Care Staffing and Reporting Tool Frequently Asked Questions,” internal document, 3.

³⁶⁴ Allied care (or clinical support) staff include aides, social workers and other health professionals providing physical therapy, occupational therapy and recreation therapy.

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The Interior Health Authority (IHA) intended to spend 56 per cent of the new money on staffing. Its plan did not specify how it would spend the remaining 44 per cent. In its approval letter to IHA, the ministry said that it “provisionally approves” the plan, but also expressed concern that the plan did not explain how the funding would be used past year one. The ministry requested that the IHA submit detailed investment plans for year two after which it would “review and communicate approval of the revised plans.”³⁶⁵

The Northern Health Authority (NHA) planned to spend 75 per cent of the new revenue on staffing, with the remaining 25 per cent invested in education and equipment for its own facilities. The NHA’s plan showed daily direct care hours increasing from 3.66 in 2009/2010 to 3.72 in 2010/2011 and then falling to 3.57 for the next two years. It is unclear why the NHA projected that daily direct care hours would decrease in 2011/12 and 2012/13 given that it plans to invest 75 per cent of the new money on staffing.

While the NHA predicts the average number of direct care hours provided in 2012/13 to be below 2009/10 levels, its projections for all three years still exceed the ministry’s guideline of 3.36 direct care hours per resident.

The initial plan submitted by the VCHA used 12 per cent of the new money to cover increases in basic operating costs, which contradicted the ministry’s directions. While the VCHA’s plan devoted 48 per cent of the increased revenues to staffing, daily direct care hours were not projected to change at all over the three-year period, even though the ministry had instructed the VCHA to make increasing direct care hours a priority. As a result, the ministry did not approve the VCHA’s original plan. In its revised plan, the VCHA directed 69 per cent of the increased revenue to staffing and aimed to increase the direct care hours from 2.81 in 2009/10 to 2.95 by 2011/2012. The remaining funds were to be used for education (3 per cent), specialized services (8 per cent), non-capital equipment costs (3 per cent) and the removal of room differentials (17 per cent).

In its first plan, the Vancouver Island Health Authority (VIHA) intended to use the new money to offset a decrease of \$13 million in its base budget from 2010/11 to 2011/12, and did not specify which of the ministry’s priorities it was targeting. Although the plan devoted 86 per cent of the increased revenue to staffing, it specified that this would be used to “sustain” daily direct care hours as well as address other needs. VIHA planned to spend the remaining 14 per cent of the new money on education and non-capital equipment in privately owned facilities. Its plan actually projected a decrease in direct care hours over the three-year period, even though VIHA was already below the ministry’s guideline. The ministry rejected this plan. In its revised plan, VIHA directed 73 per cent of the new money to sustaining or increasing staffing levels and to increasing the average daily direct care hours from 3.11 in 2009/10 to 3.18 in 2010/11. VIHA planned to spend the remaining revenue on education (3 per cent) and non-capital equipment costs (4 per cent), and on measures aimed at compliance with the ministry’s new policies on room differentials and chargeable extras (20 per cent).

The table below shows the number of total daily direct care hours projected in the three-year plans submitted by each health authority. Even with increased revenue, none of the health authorities except NHA plan to meet the ministry’s guideline of 3.36 of daily direct care hours per resident by 2012/2013. (For actual direct care hours provided, see “Direct Care Hours in British Columbia” later in this section.)

³⁶⁵ In November 2011, the Interior Health Authority told us that it submitted an updated plan for year two in December 2010, which directed 53 per cent of the increased revenue to increased staffing levels, 15 per cent to additional staffing for specialized populations, 5 per cent to lost room differential revenue, and 27 per cent to educational/clinical leadership. The plan also included a one-time delayed savings of \$2.4 million to be spent on non-capital specialized equipment.

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Table 33 – Projected Daily Direct Care Hours Compared with Ministry Guideline (3.36 Hours), 2009/10 to 2012/13

Health authority*	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)

Analysis

In January 2010, the new residential care rate structure took effect, causing the rates of 75 per cent of residential care residents to increase. The rate increase was phased in over two years for existing residents, and for those who had been approved for placement before January 2010. Some of the increases were significant. For instance, the rate for seniors who had been paying the previous maximum rate (\$2,260 per month) went up by \$336 in January 2010 and a further \$336 in January 2011, resulting in a 30 per cent increase in their rate since December 2009.

The ministry stated that all of the extra revenue generated from the rate increase would be directed to improving care. It also stated that the new rate structure would benefit clients by increasing staffing levels and the number of care hours provided in residential care facilities. Given such information and the additional revenue generated by the rate increase, it was reasonable for seniors to expect to see an increase in the amount of care being provided in their facilities.

The three-year spending plans submitted and approved by the ministry show that the health authorities plan to spend a portion of the new money on non-care initiatives, such as the elimination of room differentials. For example, VIHA plans to spend 20 per cent of its new money to cover these expenses. In addition, despite the additional revenue, the NHA projects a decrease in the number of average daily care hours provided per resident and VIHA projects only a slight increase. None of the health authorities plan to meet the ministry's guideline of providing 3.36 direct care hours per resident by 2012/2013, except the NHA, which plans to do so by reducing its total daily direct care hours. It is interesting to note that the NHA is the only health authority that plans to meet the ministry's staffing guideline and is also the only health authority that owns and operates almost all of the facilities in its region.

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The health authorities' plan to invest a significant portion of the increased revenue into staffing is a positive step that will benefit seniors. However, 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 surprising to see funding being devoted to non-care-related measures such as offsetting the impact of room differential elimination and complying with the ministry's policy on chargeable extras.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

Chargeable Extras

In addition to their co-payment, residents may also pay for a variety of items, services, programs or supplies that the facility operator offers for an additional fee. These extra charges can be for services and items ranging from oxygen supply to wheelchairs to cable service. However, depending on the facility, seniors may or may not have to pay these additional charges. Many seniors who had moved from one facility to another told us that they were surprised to learn that they had to pay extra for some services or items at their new facility that they had received without charge at their previous one. This seemed to be particularly common in cases where the former facility was owned by a health authority and governed by the *Hospital Act* and the new facility was privately owned and licensed under the *Community Care and Assisted Living Act (CCALA)*.

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We heard from one senior who was surprised to see an increase in his wife's residential care bill when she moved from one facility to another. The new facility was charging \$100 per month for incontinence supplies that had been provided free of charge at the previous facility. The "Benefits and Allowable Charges" section of the Ministry of Health's revised *Home and Community Care Policy Manual* states that incontinence supplies are a benefit included in the assessed client rate for residential care. However, as the ministry has decided to delay putting this section of its policy into effect until April 1, 2013, there is currently no prohibition against this practice.

Ministry Policy on Extra Charges

Between 2003 and 2005, a group called the Optional Goods and Services Working Group, which included representatives from health authorities, the BC Care Providers Association and the Tillicum and Veterans Care Society, provided input to the Ministry of Health on policies and practices related to extra charges in residential care facilities. Five years later, the ministry incorporated the input it received into a revision of chapter 8 of the *Home and Community Care Policy Manual*, which took effect on January 31, 2010.

This revised policy stated that the following residential care services and supplies were benefits that residents should receive for no extra charge,³⁶⁶ and health authorities were told to ensure that operators did not charge residents extra for these benefits:

- standard accommodation
- development and maintenance of a care plan that includes skilled care with professional supervision, a falls prevention plan, a bathing and skin care plan, and other routines to meet the unique needs of the resident
- clinical support services (rehabilitation, social work services)
- ongoing, planned physical, social and recreational activities, such as exercise and music programs, crafts and games
- meals or tube feeding, including a therapeutic diet if prescribed by the resident's physician
- meal replacements and nutritional supplements as specified in a care plan or as required by a physician
- routine laundry service for bed linens, towels, washcloths and clothing
- general hygiene supplies, including but not limited to soap, shampoo, toilet paper and special products required for bathing
- routine medical supplies, including but not limited to sterile dressing supplies, glucose strips, bandages, band-aids, syringes, catheters, disposable underpads for bed and chair use, disposable gloves, wound-care supplies and dressings
- equipment for the general use of all residents, such as lifts, bed alarms and specialized mattresses, and surveillance systems
- incontinence management as follows:
 - a toileting program, such as routine toileting for incontinence control, and, where necessary, a diapering service
 - underpads, briefs and inserts (reusable or disposable)
 - catheters (indwelling and straight), catheterization tray, drainage tubing and drainage bag,
 - disposable gloves

³⁶⁶ Ministry of Health, *Home and Community Care Policy Manual*, January 2010, Residential Care Services: Benefits and Allowable Charges, 8.B.

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- any other specialized services (such as specialized dementia or palliative care) that the service provider has been contracted to provide

In addition, health authorities had to ensure that operators did not charge administrative fees for services or supplies required by a senior's care plan.

The ministry's 2010 revised policy included items for which operators *could* charge residents extra. Health authorities were required to ensure that operators who offered these chargeable items did so at a reasonable cost that was at or below market rates and only on an optional basis. Operators were also required to explain the fees for chargeable items and to ensure that the client had agreed to pay the fees. The list of chargeable items includes:

- personal cable connection and monthly fee
- personal telephone connection and basic services
- nutritional supplements, when residents request a specific commercial brand rather than the brand provided by the operator
- personal newspapers, magazines and periodicals
- hearing aids and batteries
- personal transportation
- extra or optional craft supplies
- entertainment and recreational activities that are in addition to activities provided by the operator
- administration or handling fee, where reasonable, to perform a task or provide services that would normally be a resident's responsibility
- purchase or rental of equipment that is for the exclusive use of the resident
- companion services
- personal dry cleaning, or laundry service for items requiring special attention
- personal hygiene and grooming supplies that the resident chooses in preference to the general supplies provided by the operator

In April 2011, the ministry replaced the version of the *Home and Community Care Policy Manual* that took effect on January 31, 2010, with a revised manual, which is currently in effect. The new policy on benefits and allowable charges in residential care is substantially the same as the January 2010 policy. However, as of April 1, 2011, operators are not expected to comply with these requirements until April 1, 2013. This means that the current ministry 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 since January 2010. These charges may place a significant financial burden on seniors, who are left with as little as \$325 after paying their assessed rate for residential care. The fact that the ministry is allowing two years for health authorities to come into compliance with its policies demonstrates the weakness of policy as a standard-setting tool. It would be more difficult to change the rules on benefits and allowable charges if these were included in regulation.

In addition, the ministry acknowledged that there are inconsistencies in the items and services that facility operators charge clients for, and in the amounts charged. The following table, which is based on information the ministry provided, lists some of the items and services that are covered by the basic rate at some facilities but not at others. The table also shows the extra charges that may apply and how much these charges can vary from one facility to another.

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Table 34 – Chargeable Extras

Service or benefit	Current charges
Activities	
Entertainment or activity fee	From no charge to \$20 per activity or per month
TV services	From no charge to actual cost
TV set-up	From no charge to \$30 per hour
Bus outings	From no charge to \$10 an outing
Equipment	
Walkers — to rent or lease for personal use	From no charge to \$5 per month
Wheelchairs — to rent or lease for personal use	From no charge to \$25 per month
Scooters — storage and charging	From no charge to \$20 per month
Cleaning equipment	From no charge to \$30 per hour
Repairs to equipment	From no charge to \$30 per hour
Administration	
Administration fee (trust fund accounts)	From no charge to \$10 per month
Mail forwarding	From no charge to \$1 per item
Supplies	
Catheters	From no charge to actual cost
Disposable gloves	From no charge to actual cost
Special incontinence supplies	From no charge to actual cost, plus a 15 per cent supply charge
Oxygen	From no charge to actual cost
Test strips	From no charge to actual cost
Tissues	From no charge to actual cost
Direct Charges	
Dental-care provider	Varies
Dry cleaning	Varies
Foot care provider	Varies
Hairdressing	Varies
Physiotherapy/occupational therapy	From no charge to actual cost
Meals	
Guest meals	From \$6 to \$8
Special diets	From no charge to actual cost
Supplements	From no charge to actual cost
Clothing	
Labels	From no charge to \$75 for one-time labelling of all clothes
Repairs	Varies
Other Charges	

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Service or benefit	Current charges
Telephone and hook up	From no charge to \$20 per month
Wound dressing	From no charge to actual cost
Slings and tensor bandages	From no charge to actual cost

The above table includes several examples of services, supplies and benefits that, according to the ministry's own policy, should be provided without charge. These include:

- catheters (both for regular use and incontinence management)
- disposable gloves
- special diets and supplements when prescribed by a physician
- equipment such as walkers and wheelchairs

As the table illustrates, there is wide variation in how much facility operators actually charge residents for things like activities, equipment, programs and supplies. Charges may vary from zero to amounts that reflect the actual cost of the service.

Extended care hospitals are not permitted to charge extra for many of the services and items listed in the table because they are included in Part 1 of the *Hospital Act*. However, private hospitals that are governed by Part 2 of the *Hospital Act* and facilities that are licensed under the *CCALA* are not subject to the same restrictions on extra charging. 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. It also results in some seniors having to spend a portion of their residual \$325 on health-related goods and services that other seniors in other facilities do not have to pay for.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

Rate Reductions and Waivers

As discussed previously in this section, many seniors in residential care facilities, especially if their only or main source of income is government programs, can be left with only \$325 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. Given the long list of chargeable extras that seniors in some facilities must pay for (see the preceding table), it is easy to see how these costs could easily add up to more than \$325.

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. The ministry’s *Home and Community Care Policy Manual* explains how to do that.³⁶⁷ If approved, the reduction or waiver lasts for one year and seniors must reapply if it is still needed to prevent hardship. 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.

³⁶⁷ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Client Rates: Temporary Reduction of Client Rate, 7.D.

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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.

As a rule, health authorities calculate a resident’s potential reduced monthly rate by subtracting allowable expenses and general living expenses from his or her net income and then dividing by 12. Once an application has been assessed, the resident is notified in writing of the decision and provided with a copy of the application form completed by the health authority. If approved, the resident receives a temporary reduction for a period of one year. The resident is required to re-establish his or her eligibility for a waiver once per calendar year by submitting a new application one month before the expiry of the current temporary reduction.

The following tables shows sample calculations for a single resident with no spouse or dependant (scenario 1) and a resident with a spouse who continues to live at home (scenario 2).

Table 35 – Sample Rate Reduction Calculations

Income and expenses	Scenario 1: Single resident with no dependants (\$)	Scenario 2: Married resident with spouse living in family home (\$)
Net income	20,000	20,000
Monthly co-payment (based on 80% of net income)	1,333	1,333
Joint income	n/a	40,000
Monthly expenses		
MSP premiums	0	109
Life insurance (max. \$50 per person)	50	100
Prescription drugs and dental care	75	150
Medical equipment	250	300
Mortgage or rent		1,200
Property taxes		
Transportation (max. \$100)		100
Utilities		50
Telephone (max. \$30)		30
Prescribed special foods and dietary supplements		50
Monthly allowable expenses	375	2,089
Yearly allowable expenses	4,500	24,984
General living expenses		5,796

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Income and expenses	Scenario 1: Single resident with no dependants (\$)	Scenario 2: Married resident with spouse living in family home (\$)
Total allowable expenses	4,500	30,780
Yearly joint net income	20,000	40,000
Less total allowable expenses	-4,500	-30,780
	15,500	9,220
Divided by 12		
Reduced rate	1,292	768

The purpose of having a process that allows for fee reductions and waivers is to ensure that residents, their spouses and dependants do not suffer financial hardship as a result of paying for residential care. It is easy to understand how seniors on fixed incomes could find it difficult to afford maintaining the family home while also paying their spouse's residential care fees, even if those fees are subsidized. As the table above shows, seniors are limited in what they are able to claim as monthly expenses.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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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. The rate that eligible people pay for subsidized residential care is calculated based on the after-tax income of only the person who is applying for or receiving the care — and is therefore affected by an income split.

Seniors in residential care are charged up to 80 per cent of their after-tax income for residential care, as long as they have a minimum of \$325 left over each month. This results in rates between \$898 and \$2,932 per month. When a senior’s income goes up due to income splitting, this results in that person being charged a higher rate for residential care than he or she would have been charged if the income had not been 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 bed are informed that income-splitting arrangements can affect the rates charged.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

Seniors can be admitted to residential care in one of two ways: either with consent or as an involuntary patient under the *Mental Health Act*. The vast majority of seniors who are in residential care are there by their own consent. A senior must have the capacity to consent to his or her own admission or have a legal representative with the authority to consent to the admission. (Further information about the capacity to consent can be found under “Consenting to Admission to a Care Facility” in this section of the report.) In the course of our investigation, we learned that there were at least 100 seniors living in residential care facilities across British Columbia in 2010/11 who were there as involuntary patients under the *Mental Health Act*.

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The purpose of the *Mental Health Act* is to allow treatment of patients who require protection and care because they have mental disorders. The Act is meant to be protective but has significant impacts on the civil liberties of those it affects. A person who is an involuntary patient under the *Mental Health Act* is detained for the purpose of treatment and protection. These patients may have treatment imposed on them and they are not at liberty to leave a facility.

The Act does, however, allow a detained person to be released on extended leave into the community, including into a residential care facility. When this happens, the practice in all the health authorities is to charge these seniors fees. Seniors in this situation are paying up to 80 per cent of their after-tax income for residential care, as long as they have a minimum of \$325 left over each month. We received complaints about this practice during our investigation, including the following one from Murray, which illustrates some of the issues raised. (The names below have been changed to protect confidentiality.)

Murray and Joan's Story

Murray had been married for 50 years to his wife Joan, who suffered from dementia. He complained to our office after VIHA staff used the Mental Health Act to remove 80-year-old Joan from their home, admit her involuntarily to a mental health facility and then transfer her to a residential care facility. Murray thought it was unfair to hold Joan in the residential care facility against her will, impose treatment on her and charge her for being there.

At the time that Joan was admitted as an involuntary patient, she and Murray had been living in a makeshift suite in the home of one of their daughters. Since Joan had recently been discharged from the hospital, members of VIHA's Elderly Outreach Service (EOS) team had come to visit the couple. The EOS team assessed the suite as unsafe. They believed the couple's living environment put Joan at risk and that she should be moved to a residential care facility. Joan did not have the capacity to consent to admission to residential care and had not appointed a legal representative who could make that decision for her. Although not Joan's legal representative, Murray disagreed with VIHA.

VIHA's EOS doctor certified Joan under the Mental Health Act and admitted her to a mental health facility. Then, with the authorization of a second doctor, she was promptly put on extended leave and sent to a residential care facility. After VIHA transferred Joan to the residential care facility, it charged her fees for those services, including for over-the-counter medications not covered by PharmaCare.

We investigated Murray's complaint. With respect to his concerns about Joan's admission under the Mental Health Act we provided Murray with information about how a patient or a person acting on behalf of the patient can challenge the detention before an independent review panel. With respect to Murray's complaint about VIHA's practice of charging residential care fees to patients who have been involuntarily admitted to a mental health facility and then transferred to residential care, we concluded that it was unfair to charge Joan fees in these circumstances. In an effort to resolve the complaint, VIHA agreed to not charge fees to Joan and to review its practice.

In this case, Joan was not able to consent to her own admission to residential care and had not appointed a legal representative who could make that decision for her. Unlike health care decisions where the law establishes a process to appoint a temporary decision-maker when one has not been appointed in advance, the law does not establish a process for appointing a temporary decision-maker with authority to make a decision on a residential care admission. Murray opposed the admission but did not have authority to make a decision on Joan's behalf. Murray could have applied to the Supreme Court to be appointed Joan's "committee of person" in order to make the decision. However, the health authority believed that Joan was at risk and so they took the extraordinary step of admitting her on an involuntary basis under the *Mental Health Act*.

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Ideally, in these situations, the health authorities will work with seniors, their families and their legal representative to persuade them that consenting to admission is the best course of action. There are, however, extraordinary situations in which admitting a senior to residential care using the *Mental Health Act* is the only viable option that will allow for his or her protection. The Act allows for this when a doctor has determined that a senior needs treatment for a mental disorder, including dementia, and that he or she is incapable of safely living in the community and will not consent to admission.

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. As discussed above, 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
- requires treatment in or through a mental health facility
- 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 patient³⁶⁸

The period of detention and treatment can be extended up to a month beyond the original 48 hours if the director obtains a second medical certificate. If this happens, the director, or a medical practitioner instructed by the director, must examine the person at least once during this extended period. At the conclusion of this examination, the director must either discharge the person or confirm in writing that the person continues to suffer from the mental disorder upon which the original certificate was based.

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.³⁶⁹ 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 in a mental health facility.

An involuntary detention under section 22 results in a substantial loss of civil liberties, including freedom to leave the facility, and for this reason the *Mental Health Act* includes safeguards to ensure that a fair process is followed and peoples’ rights are respected. Section 25 of the Act allows a patient to challenge his or her detention before an independent review panel consisting of a lawyer, a medical practitioner and a third person. These hearings take place under strict and defined time limits that are set out in the *Mental Health Act* and the *Mental Health Regulation* that accompanies it.

Section 33 of the Act also allows patients (at either their request or that of those acting for them) to apply directly to the Supreme Court to challenge their involuntary detention. Although this option is available, it is rarely used since it is costly and time-consuming, and the review panel process is timely and free.

While it has serious impacts on civil liberties, 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 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

³⁶⁸ *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22.

³⁶⁹ *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 37.

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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.

Charging Fees to Involuntary Patients

We 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.

In investigating complaints about charging fees to patients that had been involuntarily admitted, we considered both the fairness of the practice and whether it is based on legislative authority.³⁷⁰ One of the issues we looked at is the fact that people involuntarily detained in provincial mental health facilities or inpatient units of hospitals cannot be charged fees. In addition, section 8.1 of the *Hospital Insurance Act Regulation* provides authority to charge a fee to a patient residing in a psychiatric unit of a hospital, but section 8.5 of the Regulation states that section 8.1 does not apply to those admitted involuntarily to a psychiatric unit under section 22 of the *Mental Health Act*. It is clear that a patient admitted involuntarily to either a provincial mental health facility or a psychiatric unit does not have to pay fees. While section 9 of the *Mental Health Act* authorizes cabinet to “prescribe daily charges for care, treatment, and maintenance provided in a provincial mental health facility,” cabinet has only done so for those who have been voluntarily admitted, not those involuntarily admitted.³⁷¹

Given that involuntary patients cannot be charged fees while they are in provincial mental health facilities or inpatient units of hospitals, it is inconsistent and unfair to charge fees to seniors who have been involuntarily admitted to a mental health facility and then involuntarily put on extended leave in residential care facilities. It is unfair to charge that person who would not otherwise be charged simply because a health authority has decided to transfer her or him to a residential care facility. The health authorities may be leaving themselves vulnerable to an argument that charging fees in these circumstances violates a person’s rights under section 7 of the Canadian Charter of Rights and Freedoms to “life, liberty and security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice” and to the right to the equal protection and equal benefit of the law without discrimination.³⁷²

We also considered whether health authorities have the legal authority to charge fees in these circumstances. When investigating Murray’s complaint, VIHA told us that people like Joan must pay the fees that are provided for by the *Continuing Care Act* and *Continuing Care Fees Regulation*. However, we questioned whether it is appropriate to apply this legislation to involuntary patients on extended leave under the *Mental Health Act*.

³⁷⁰ The Supreme Court of Canada has held that when the government charges fees, such a decision must be founded on clear and unambiguous legislative authority. *Re: Eurig Estate* [1998] 2 S.C.R. 565.

³⁷¹ *Mental Health Regulation*, B.C. Reg. 233/99, s. 4.

³⁷² Charter of Rights and Freedoms, Part I of the *Constitution Act*, 1982, Schedule B, c. 11, s. 7.

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The *Continuing Care Act* states that cabinet may define “continuing care” as one or more health care services provided “to persons with a frailty or with an acute or chronic illness or disability that do not require admission to a hospital as defined in section 1 of the *Hospital Act*.”³⁷³ The rates cabinet may prescribe in these circumstances apply only to people who are receiving “continuing care,” which under the Act is defined as people who “do not require admission to a hospital.”³⁷⁴

Given these definitions, we considered whether someone admitted involuntarily to a mental health facility under the *Mental Health Act* can be reasonably regarded as someone who does not require admission to a hospital. We concluded this is not the case. In order to use the *Mental Health Act* to involuntarily admit a person, a director of a mental health facility must deem that person to require “care, supervision and control in or through a designated facility to prevent the person’s or patient’s substantial mental or physical deterioration or for the protection of the person or patient or the protection of others.”³⁷⁵ Section 39.1 of the Act also makes it clear that even while on extended leave, these patients remain involuntarily detained through the designated facility and are treated as such. Certification under the *Mental Health Act* itself should be seen as evidence that a person requires admission to a hospital. Placing a person on extended leave is simply an extension of that admission and hospitalization. By this interpretation, a person who has been involuntarily admitted under the *Mental Health Act* and then put on extended leave in a residential care facility cannot be considered to be receiving continuing care and therefore should not be charged fees on that basis.

Conclusion

The *Mental Health Act* is protective legislation designed to ensure the safety and well-being of people with mental illnesses. Given the significant loss of personal liberties that results from involuntary admission and detention under the *Mental Health Act*, using this procedure to admit seniors to residential care should only be done when absolutely necessary to provide treatment and prevent harm. Since the use of section 22 of the *Mental Health Act* clearly results in the loss of liberty, it should only be used when a fair process is followed and peoples’ rights are respected. This requires clear guidelines to ensure that the *Mental Health Act* is used appropriately and in a way that respects seniors’ procedural and constitutional rights.

The provincial government has an option that would deal with care facility admissions on a comprehensive basis. If proclaimed, Part 3 of the *Health Care (Consent) and Care Facility (Admission) Act* 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 a care facility.³⁷⁶ Bringing Part 3 of the Act into force would likely reduce the instances in which health authorities use the *Mental Health Act*.

In my view, it is unfair for a government to involuntarily detain seniors, subject them to treatment and then charge them fees for that detention. This is especially true when there is no clear legislative authority for doing so. A senior who is detained in residential care is, in fact, the same as a person who is detained in a mental health facility. People detained in mental health facilities are not charged fees because that would contravene the *Hospital Insurance Act Regulation*. The only reason seniors are charged fees while detained in residential care is that health authorities have decided that being put on extended leave from a mental

³⁷³ *Continuing Care Act*, R.S.B.C. 1996, c. 70, s. 3.

³⁷⁴ *Continuing Care Act*, R.S.B.C. 1996, c. 70, s. 3.

³⁷⁵ *Mental Health Act*, R.S.B.C. 1996, c. 288, s. 22.

³⁷⁶ *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181.

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health facility allows for such a practice. Transferring a senior to a residential care facility after involuntarily admitting him or her to a mental health facility does not make it any fairer to charge that person for his or her detention.

We understand that from the perspective of the health authorities, these seniors are home and community care clients, because they are receiving care in residential care facilities. The 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*. All other seniors in residential care, it may be argued, have consented in some way to be there and to pay the required fees. This is not the case for seniors who are detained in residential care facilities under 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.

The Ombudsperson finds that

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 Act is used as a last resort and that seniors are not unnecessarily deprived of their civil liberties.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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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.

Four Aspects of 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 they vary from detailed and prescriptive requirements to more outcome-based measures. For example, in relation to accommodation, section 27 of the Regulation goes into great detail and states that single bedrooms for those who require mobility aids must have at least 11 square metres of usable floor space, and at least 8 square metres of usable floor space for those who don't need mobility aids. However, such specific, objective standards are generally lacking for the other three major aspects of residential care. As illustrated in the following table, the regulations on professional care and recreation under the *Community Care and Assisted Living Act (CCALA)* offer only outcome-based criteria that are non-quantifiable and not subject to objective evaluation. For example, with respect to activities, the *Residential Care Regulation* only requires an operator to designate an employee to “organize and supervise physical, social and recreational activities for persons in care.”³⁷⁷ The regulations under the *Hospital Act* do not establish standards for these four aspects of care.

Table 36 – Examples of Standards in the *Residential Care Regulation*

Aspect of care	Examples of standards set out in the <i>Residential Care Regulation</i>
Suitable accommodation	<p>For a bedroom occupied by one person who does not require a mobility aid: 8 m² usable floor space</p> <p>A licensee must provide, at no cost to the person in care, each person in care with bedroom furnishings, including a closet or wardrobe cabinet measuring at least 0.50 m²</p> <p>A licensee must ensure that all bathrooms have slip-resistant material on the bottom of each bathtub and shower</p>

³⁷⁷ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 45.

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Aspect of care	Examples of standards set out in the <i>Residential Care Regulation</i>
Professional care	<p>The licensee must designate an employee, qualified by training and experience, to</p> <ul style="list-style-type: none"> (a) supervise employees who provide care to persons in care, (b) coordinate and monitor the care of persons in care, and (c) manage unusual situations or emergencies <p>A licensee must ensure that, at all times, the employees on duty are sufficient in numbers, training and experience, and organized in an appropriate staffing pattern, to</p> <ul style="list-style-type: none"> (a) meet the needs of the persons in care, and (b) assist persons in care with activities of daily living, including eating, mobility, dressing, grooming, bathing and personal hygiene, in a manner consistent with the health, safety and dignity of persons in care
Satisfying meals	<p>A licensee must ensure that</p> <ul style="list-style-type: none"> (a) a morning meal is available between 7:00 a.m. and 9:00 a.m., (b) a noon meal is available between 11:45 a.m. and 1:00 p.m., (c) an evening meal is served after 5:00 p.m., and (d) snacks are provided at times that meet the needs of the persons in care <p>A licensee must ensure that persons in care have sufficient time and assistance to eat safely and comfortably</p>
Program of activities	<p>A licensee must</p> <ul style="list-style-type: none"> (a) designate an employee, qualified by training or experience, to organize and supervise physical, social and recreational activities for persons in care, (b) give the designated employee sufficient time away from other duties to carry out the activities, and (c) ensure that there is sufficient time for persons in care to participate in the activities <p>A licensee must</p> <ul style="list-style-type: none"> (a) provide persons in care, without charge, with an ongoing planned program of physical, social and recreational activities <ul style="list-style-type: none"> (i) suitable to the needs of the persons in care, and (ii) designed to meet the objectives of the care plans of the persons in care

The examples in the table above show that the government has chosen to use prescriptive standards for some aspects of care and outcome-based standards for most others. This shift towards outcome-based standards is in keeping with the trend of the past 20 years. Where governments have gradually shifted the focus of regulations in many areas away from detailed prescriptive requirements to more general “outcome-based” objectives. For example, the *Adult Care Regulations*, which came into force in 1980 and applied to licensed

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residential care facilities, contained specific and quantifiable staffing standards. The regulations specified the minimum length of time per day for each resident to receive personal care, depending on the level of care needed and the number of staff on duty at night, based on the number of residents.³⁷⁸

The *Adult Care Regulations* were amended in 1999, and these prescriptive requirements were replaced by outcome-based standards. The *Residential Care Regulation* that replaced the *Adult Care Regulations* in 2009 continued this trend and 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.”³⁷⁹

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

The care provided to seniors in residential care facilities is also guided by individual care plans, which are supposed to identify each senior’s preferences, abilities, goals, risk factors and longer-term needs. While care plans allow service providers to tailor the care they provide to the particular needs of residents, they are not substitutes for establishing minimum standards of care. If more specific standards were implemented, facility operators could, for example, be provided with the flexibility necessary to meet individual needs by having policies that allow for any exceptions to these standards to be agreed upon and detailed in care plans.

It became clear to us during our investigation that seniors and their families were particularly concerned about the quality of the following services and aspects of care provided in residential care facilities. It is important to note that facilities governed by the *Hospital Act* are not subject to the requirements discussed below.

Personal Care

Bathing Frequency

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, are not able to bathe often enough. It is common in many facilities for residents to have only one tub bath per week. We also learned that residents in some facilities can’t purchase additional baths because there are not

³⁷⁸ Requirements included a minimum of 30 minutes of individual personal care for residents whose care needs were designated at the personal care level, and a minimum of 60 minutes for residents designated at the intermediate care level. *Adult Care Regulations*, B.C. Reg. 536/80, s. 6(5)(f) and (g).

³⁷⁹ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 41.

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enough staff available to provide them. We heard from both seniors and staff that, in some cases, seniors had missed their weekly bath due to staff shortages.

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.³⁸⁰ This contrasts with the regulation under Ontario’s *Long-Term Care Homes Act*, which requires that all residents receive at least two baths or showers each week.³⁸¹

None of the health authorities we spoke to had policies on the number of baths residents should have each week.³⁸² When we asked them, they all said that the frequency of bathing is determined by the content of individual care plans. The Fraser Health Authority added that “the focus is not on specifying the number of baths ... but ensuring that the resident is clean.” Although the Interior Health Authority doesn’t have a policy on bathing, it stated that residents “should be washed daily and offered at least one bath per week.” The Northern Health Authority could not provide information on bathing frequency. The Vancouver Coastal Health Authority stated that residents generally receive one bath each week, unless a care plan calls for more frequent bathing. The Vancouver Island Health Authority (VIHA) does not have any policies on bathing frequency.

Bathing is a good example of an area of care where specific minimum standards could easily be established.

Dental Care

People who contacted us during our investigation identified oral health as a significant concern in residential care facilities. There are two aspects to the problem. The first is the challenge of maintaining and supporting proper daily oral hygiene routines for residents. The second is the difficulty of ensuring that seniors with limited mobility have regular access to the services of a dentist or dental hygienist.

Case Study: Bathing Frequency

The bath log showed many two-week lapses between baths for persons in care, with some residents having to wait as long as three weeks for a bath. Staffing shortages appeared to be the main reason for the lack of baths, as bath aides had been pulled to assist in general care duties on the floors. The operator acknowledged that a “staffing crisis” had existed, and that competing priorities resulted in baths not being completed. The lack of baths continued to be an issue for at least two months after assurances from facility management that they had addressed the issue.

Source: VIHA licensing investigation report.

³⁸⁰ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 42.

³⁸¹ *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, s. 33.

³⁸² The *Homes and Community Care Policy Manual* indicates that a care plan made under s. 81 of the *Residential Care Regulation* should include a skin care and bathing plan. It does not establish prescriptive minimum standards for the content of a bathing plan.

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In terms of daily oral hygiene practices, the *Residential Care Regulation* states that “a licensee must assist persons in care to maintain daily oral health.”³⁸³ However, we heard from several people who had concerns about the lack of supervision or assistance provided with brushing teeth and cleaning dentures. Staff who contacted us said they don’t always have time to assist with thorough daily oral hygiene. The failure to maintain proper daily oral hygiene routines can result in periodontal disease, which in turn may lead to infection and more serious health problems.

The responses the health authorities provided to our inquiries about dental care suggest that some health authorities have paid relatively little attention to this area from a policy perspective. Northern Health and VIHA did not provide any information about their policies on daily dental care. Vancouver Coastal Health stated that daily dental care is part of every resident’s individual care plan. Fraser Health provided us with a copy of its Integrated Oral Health Standard, which states that appropriate oral care will be provided or encouraged twice a day. Interior Health provided its Oral Care Policy and Guidelines, which state that each resident will be given the opportunity to perform oral care a minimum of twice a day, or as specified on his or her care plan, and that staff will assist residents who are unable to complete these tasks independently. Another concern is that even the health authorities that have oral hygiene policies did not identify how they are monitored. It is important to also note that facilities governed by the *Hospital Act* are not subject to any daily oral hygiene requirements.

In terms of being able to see a dentist or dental hygienist, the *Residential Care Regulation* states that “a licensee must encourage persons in care to be examined by a dental health care professional at least once every year.”³⁸⁴ None of the health authorities have policies on providing access to professional dental services. In view of the high correlation between poor dental health and some serious diseases and conditions, it is important that facility operators ensure that dental hygienists assess residents, develop oral care plans, instruct care aides on proper brushing techniques, provide on-site hygiene services and participate in case conferences. As is the case with daily oral hygiene requirements, the *Hospital Act* is silent regarding access to professional dental service.

Help with Going to the Bathroom

Timely assistance with going to the bathroom is a 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 on.” Another person who contacted us recalled the following incident:

When I asked to have my mom taken to the toilet, as I could see she needed to go, I was told that she would just have to wait ... as the staff did not have time to deal with it. During that ... stay my mother became incontinent and it was very painful to watch a once proud woman struggle with her natural urges until she just had to give in.

³⁸³ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 54(3)(b).

³⁸⁴ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 54(3)(a). Under the authority of the *Dental Hygienists Regulation*, dental hygienists are authorized to treat patients in a residential care facility even if they have not been examined by a dentist within the past year, as is normally required. This authority was expanded to include assisted living residences in April 2007.

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At another facility that 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.

The *Residential Care Regulation* does not specify how often or how seniors in residential care should be assisted with going to the bathroom. This is another example of how the outcome-based requirement for operators to ensure that “the employees on duty are sufficient in numbers, training and experience” to “assist persons in care with activities of daily living in a manner consistent with the dignity of the person” falls short.

By comparison, section 51 of the regulation under Ontario’s *Long-Term Care Homes Act* requires all facilities to have a continence care and bowel management program in place, and outlines detailed requirements aimed at promoting continence and maximizing independence.³⁸⁵

The Ministry of Health’s *Home and Community Care Policy Manual* does say that “incontinence management” is a benefit that should be provided to all residential care clients. This includes the provision of equipment such as disposable underpads and catheters, a program to manage bathroom needs, and an incontinence plan where necessary.³⁸⁶ However, the ministry does not expect the health authorities to fully comply with this policy until April 1, 2013.

In addition, the specifications are only set out as policy and do not have the force of regulation.

Individual health authority practices vary when it comes to this area. Interior Health has a short policy that is focused on maintaining maximum independence for residents by providing assistance when needed. Vancouver Coastal Health has a policy on “bowel function promotion and maintenance.” The other health authorities did not identify specific policies on providing bathroom assistance.

As with eating, going to the bathroom is one of the most basic of personal needs. Failing to respond to this need in a timely way offends human dignity. To ensure fair treatment, a specific standard should be established that balances the needs of seniors, the expectations of families and the capacities of facility operators. While setting standards in this area may be challenging, the degree of concern expressed to us 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*, as no such requirements are currently in effect.

Continence Care in Long-Term Care Homes in Ontario

In Ontario, every licensee of a long-term care home has to ensure, among other things, that

- *each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence*
- *each resident who is incontinent receives the assistance and support from staff to become continent or continent some of the time*
- *continence care products are not used as an alternative to providing assistance to a person to toilet*
- *there are a range of continence care products available and accessible to residents and staff at all times*
- *residents who require continence care products have sufficient changes to remain clean, dry and comfortable*

Source: *Long-Term Care Homes Act*, Ontario Reg. 79/10 s. 51.

³⁸⁵ *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, s. 51(c) and (e).

³⁸⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Residential Care Services: Benefits and Allowable Charges, 6.F.

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Call-Bell Response Times

Seniors in residential care often use call bells to alert staff when they need help or have urgent concerns.

A number of people complained to us that it regularly took 15 to 20 minutes before they were responded to when they used a call bell, and sometimes they were not responded to at all. One person said, “The bells are useless. They ignore it or tell me they have a big mess to clean up but they never come back.”³⁸⁷

Slow response times to call bells pose a danger to the safety of residents, who rely on these bells to alert staff to emergencies. The need for 24-hour nursing care is a condition of eligibility for subsidized residential care. Given this requirement, timely response to call bells is a critical aspect of the care provided to seniors in residential care facilities.

It is surprising, therefore, that neither the ministry nor the health authorities have established standards on acceptable response times to call bells. Technology enabling the measurement of call-bell response times is available, and some facilities are already using it. Without objective data, it is difficult to determine the extent of the problem. It would be useful for health authorities to collect objective data about actual response times and use it to support the development of appropriate standards and guidelines. Once this is done, compliance with these standards can be monitored.

Any standards or guidelines developed should apply equally to facilities governed by the *Hospital Act*, as no such requirements are currently in effect.

Meal Preparation and Nutrition

Concerns about the quality of food, food choices, methods of food preparation and the availability of staff to assist seniors with eating were among those we heard about most frequently during our investigation. The importance of satisfying and appealing meals as well as proper nutrition for seniors in care cannot be overstated. Research has shown that the incidence of malnutrition can be quite high in facilities, although it may often go undetected.³⁸⁸

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 and the nutrition needs, age, gender and level of activity of people in care
- the food preferences and cultural background of the people in care
- seasonal variations in food and
- the texture, colour and matters that affect food safety, taste and visual appeal³⁸⁹

Best Practice — Nutrition

The Vancouver Coastal Health Authority requires that residents be provided with fresh fruit and vegetable choices daily.

³⁸⁷ Respondent, Ombudsperson’s questionnaire.

³⁸⁸ Northern Health Authority, *Best Practices for Nursing Care of the Older Adult: Promoting Nutrition*, 1.

³⁸⁹ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 62(2).

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The Regulation also requires meals to contain “at least three food groups as described in *Canada’s Food Guide*.”³⁹⁰ In addition, it specifically requires operators to encourage residents to participate in various aspects of menu planning and food preparation. Operators are also supposed to ensure that “persons in care have sufficient time and assistance to eat safely and comfortably.” Another provision states that each person in care who has difficulty eating must receive personal assistance or supervision. Employees must be given “ongoing education respecting ... assisted eating techniques.”

Food-related practices differ among individual facilities. Many do not actually cook residents’ meals, but instead bring in prepared food — in some cases from as far away as Toronto — and simply reheat or “re-therm” it on-site. This practice limits the flexibility that facilities have to adapt to residents’ needs and preferences. In one facility we visited, staff told us that they had not even been able to order a second type of cookie as an alternative to the kind that residents received all the time. Another facility had a state-of-the-art kitchen that was not being used because food was brought in from off-site.

Food service is also provided in a variety of ways. Some facilities serve meals on hospital-style plastic trays, while others use regular dishes. Preparing food on-site and serving it on dishes provides a more home-like atmosphere for seniors.

However, these requirements are still considerably less specific than those that apply in Ontario. The regulation under Ontario’s *Long-Term Care Homes Act, 2007*, requires every facility to have “an organized food production system” on-site.³⁹¹ This 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 regulation.³⁹² No similar provision requiring on-site food production exists in any of British Columbia provincial regulations.

“Several of the residents require feeding at meal times. ... With only two aides available this is difficult.”

Source: Respondent, Ombudsperson’s questionnaire.

Health authority practices and policies also vary 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 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 contain any requirements on food service or meal preparation that parallel those in the *CCALA* and its *Residential Care Regulation*. This is a key difference in the requirements that apply to facilities licensed under the *CCALA* and those licensed under the *Hospital Act*. It is also a difference that can have a significant impact on residents’ quality of life, health and well-being. During our investigation we visited facilities under the *Hospital Act* that used the same food contract in residential care that was used in acute care. The result was a lack of flexibility in food choices and meals that were not home-like.

Food is a key factor in seniors’ quality of life and overall health. It is therefore important that seniors and their families be made aware of the food-related policies and practices in effect at a particular facility before they are required to accept a placement there. It is equally important for facility operators and staff to ensure that adequate assistance with eating is available.

³⁹⁰ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 62.

³⁹¹ *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, s. 72(1).

³⁹² *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, ss. 74–77.

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Recreational Programs

We also received complaints about the quantity and accessibility of the recreational programs offered in residential care facilities. One person noted that “residents complain of boredom, especially during the evenings and weekends, as there is reduced programming during these times.” Another person said that “most recreational programs are run in English, which is a concern given the ... number of non-English speaking residents.” A similar concern was expressed about seniors who need individual attention as, “given staffing resources, most recreation programs are group oriented and this ... excludes many residents with dementia.”

The *Residential Care Regulation* does not require facility operators to provide a specific number of hours of social and recreational programming. Instead, the Regulation states that operators must provide residents with an ongoing planned program of physical, social and recreational activities that is suitable to their needs and designed to meet the objectives of their care plans. Operators must provide this without additional charge and are also required to encourage residents to participate in these activities as well as those available in the community.³⁹³ In addition, they must “provide suitably equipped and comfortably furnished areas designated for recreational activities” and “designate an employee, qualified by training or experience, to organize and supervise physical, social and recreational activities for persons in care.”³⁹⁴

None of the health authorities have specific policies on required recreational activities for seniors in residential care. The lack of specific minimum standards on the quantity and variety of recreational activities that facility operators must offer leaves seniors and their families not knowing what services they can expect or are entitled to. This results in inconsistencies and leaves programs vulnerable in times of financial constraint.

No requirements concerning recreational programs apply to extended care facilities and private hospitals under the *Hospital Act*.

Recreation and Therapy Programs

“I was especially happy that an active life is one of the goals that [facility] has for their residents. The therapists are an important part of implementing this goal. Several times a week the therapists use their training and talents to engage the seniors and the research shows a clear connection with activities and the well-being of seniors. The therapists use music, art and horticulture to ‘exercise’ the residents’ remaining abilities. . . . The value of these programs cannot be overestimated. Who of us wants to just exist and spend our remaining days passively?”

It has been decided that the three therapy programs will be cut at the end of this month.”

Source: Respondent, Ombudsperson’s questionnaire.

³⁹³ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 55.

³⁹⁴ *Residential Care Regulation*, B.C. Reg. 96/2009, ss. 34 and 45.

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Culturally Appropriate Services

As is true for other adults in British Columbia, seniors in residential care facilities come from a variety of backgrounds and sometimes speak languages other than English. The cultural and communication needs of seniors from diverse backgrounds must be taken into account when planning for and providing residential care services.

For example, we received complaints that services in residential care facilities were not effective or accessible because of language barriers. In particular, one person who contacted us was concerned that “caregivers did not provide care in the resident’s own language ... which might add to the confusion already being experienced by those with dementia.” Serious safety concerns arise when staff are unable to communicate with residents or respond to their care needs. Particularly in emergencies, such as building evacuations or medical problems, staff need to be able to communicate effectively with residents.

Section 42(3) of the *Residential Care Regulation* requires operators to ensure that there are always employees on duty who can communicate effectively with all residents. The obligations noted under the *Residential Care Regulation*, however, do not apply to extended care facilities or private hospitals governed by the *Hospital Act*. In one extended care facility we visited, there were a large number of Mandarin-speaking residents, but the facility’s management told us there were no staff available at the time who spoke that language.

All residential care facilities should have to meet the same standard when it comes to ensuring that staff can communicate effectively with the residents.

Seniors in residential care often have limited access to information as a result of mobility and cognitive challenges, so it is also important that care plans, facility policies and the Residents’ Bill of Rights are provided in languages spoken by a significant portion of residents.

We also received complaints about the lack of culturally appropriate services and food available to seniors in residential care. For example, in one facility we visited, management had been trying — unsuccessfully — for more than three years to order certain food items that were preferred by the predominantly Chinese population there. The *Residential Care Regulation* states that facility operators must take the cultural backgrounds of residents into consideration when planning their meals and developing their care plans. While no such provision exists under the *Hospital Act* or its regulations, section 1 of the Residents’ Bill of Rights applies to all residential care facilities in the province. It states that a resident has the right to a care plan developed specifically for him or her and on the basis of his or her own unique abilities, social and emotional needs, and cultural and spiritual preferences.

Vancouver Coastal Health is the only health authority with a policy on providing culturally appropriate services in residential care facilities. Vancouver Coastal Health expects each facility operator to consider the need for culturally appropriate services and to include any cultural requirements in individual care plans.

In addition, we heard concerns from the lesbian, gay, bisexual and transgendered (LGBT) community about the needs of LGBT seniors. LGBT seniors can feel the need to hide their sexual orientation or gender in residential care in the absence of inclusive policies. This is exacerbated if residential care facilities take a narrow view or definition of family. It is important that residential care staff receive education and training to ensure that residential care facilities are inclusive and welcoming places for seniors and their families, regardless of their sexual or gender orientation.

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Conclusion

To ensure fair treatment for seniors in residential care, specific, measurable and enforceable minimum standards are needed for each area of care described here. These standards should reflect society's expectation that seniors in residential care will both have their basic needs met and be supported to live their final years with dignity.

The Ombudsperson finds that

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

The Ombudsperson recommends that

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.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

Using restraints on seniors in residential care is a sensitive issue for both facility operators and families. 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 be used to the least degree necessary. Restraints should only be used to protect the health and safety of the person being restrained, other residents and employees. They cannot be used to discipline or coerce residents, or for the convenience of facility staff.

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.”³⁹⁵ This includes:

- physical restraints — for example, tethers to keep a person from falling off a chair, or rails to prevent a person from falling out of bed
- chemical restraints — any use of medication to control behaviour for purposes other than therapeutic benefit
- environmental restraints — the modification of a person’s surroundings to restrict movement — for example, the use of secure building units with electronic exits that require access codes

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. 93/2009.

³⁹⁵ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 1.

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During our investigation, we received complaints about the use of restraints in residential care facilities. We heard from people who felt that restraints were used too often, and from family members who worried specifically about the use of chemical restraints. One of the concerns raised about chemical restraints was that some of the drugs used to treat dementia symptoms have sedative effects and are prescribed on an as-needed basis, making it possible to use them to control disruptive behaviour.

Legislated Protection for Seniors

The use of restraints is another area where we found the level of protection for seniors varies depending on which of the two regulatory frameworks applies to the facility in question. 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*, which has no such provisions on the use of restraints.

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

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
- the safety and physical and emotional dignity of the resident is monitored throughout the use of the restraint and assessed after its use

Operators are also not permitted to restrain a resident for the purpose of punishment or discipline, or for the convenience of employees.³⁹⁶

Health Authority Policies on the Use of Restraints

We asked the health authorities about their policies on restraints. For all the authorities except VIHA, we found that the policies mainly echo or reinforce the requirements of the *Residential Care Regulation*, which does not apply to residential care facilities governed by the *Hospital Act*. VIHA's policy on the use of restraints is more extensive than those of the other health authorities. VIHA describes the steps staff must follow when using restraints and timelines for monitoring and reassessment. VIHA also requires staff to fill out a monitoring form every time a restraint is used.

When Restraints Can Be Used

In addition to the requirements under the *Residential Care Regulation* described above, operators can restrain a resident only in an emergency or with the 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. Furthermore, before a person is restrained, the following requirements must also be met:

³⁹⁶ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 74(2).

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- alternatives to the restraint must have either been used already or considered and rejected
- the staff person administering the restraint must have been trained in alternatives to the use of restraints, determining when alternatives are most appropriate, and the use and monitoring of restraints
- the staff person must follow any instructions in the care plan respecting the use of restraints
- the use of the restraint, its type and the duration of its use must be documented in the person's care plan

The Regulation requires operators to reassess the need for the restraint at least once within 24 hours after it is first used. When a restraint is used for more than 24 hours, the operator must reassess the need for it at the time specified in the resident's care plan, or when specified by the person who gave consent, whichever is earlier.³⁹⁷ While not stated explicitly in the Regulation, this suggests that a person who is consenting to the use of a restraint can also specify its duration. As part of the reassessment, operators are required to consult with the person who agreed to the use of the restraint.

As well, if emergency use of a restraint goes beyond 24 hours, the facility operator must obtain written consent from both the resident (or his or her representative) and the medical or nurse practitioner overseeing his or her care. Again, although not specifically stated in the Regulation, it is reasonable to assume this means that in the absence of consent, the use of a 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). The non-emergency use of a restraint is not a reportable incident. VIHA believes the higher number of incidents reported in its region may result from the efforts it had made to educate operators about the requirement to report the use of 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. According to this definition, emergency restraint means "any use of a restraint that is not agreed to under section 74." Section 74 states that a restraint must not be used except in an emergency or if consented to in writing. For the purpose of Schedule D, an emergency restraint is any use of a restraint in an emergency. This definition is circular and unhelpful.

By failing to define the term "emergency," the Regulation leaves operators with considerable discretion determining what situations are emergencies and a distinct lack of direction on how to do this. If an operator determines that a situation is an emergency, the operator is authorized to restrain a resident without consent. Given that the use of a restraint on an adult without consent seriously infringes upon that adult's civil liberties, the authorization to do so ought to be carefully restricted by a clear and specific definition of emergency. Oxford Dictionaries Online defines an "emergency" as "a serious, unexpected, and often

³⁹⁷ *Residential Care Regulation*, B.C. Reg. 96/2009, s. 75(3)(a).

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dangerous situation requiring immediate action.” This provides a helpful starting point. However, it is also important to consider the specific context of restraint use in residential care facilities. Ontario’s *Long-Term Care Homes Act* does not use the term “emergency,” but instead refers to situations “when immediate action is necessary to prevent serious bodily harm to the person or to others.” This provides a more specific indication of the type of situation that may justify the use of a restraint that is not agreed to in writing beforehand.

The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

F106. The Ministry of Health permits operators to restrain residents without consent in an emergency, but has not defined what constitutes an emergency.

The Ombudsperson recommends that

R136. The Ministry of Health define “emergency” and the circumstances in which an operator is permitted to restrain a resident without consent.

Documentation

Any time a restraint is used, the operator is required to document its use in the resident’s care plan.³⁹⁸ The *Residential Care 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. It is important that all aspects of the use of restraints be carefully documented.

Ontario’s *Long-Term Care Homes Act* regulation serves as an example of how the documentation requirements under the *Residential Care Regulation* could be expanded. Under the Ontario regulation, operators must document:

- the circumstances that triggered the use of a restraint
- the alternatives considered and why they were deemed inappropriate

³⁹⁸ As of March 31, 2011, there were 28,992 residents in residential care in the province. It was beyond the scope of this investigation to review all care plans to see how carefully operators were documenting and recording the use of restraints.

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- who ordered the restraint
- any instructions that were part of the order
- the consent of the restrained person (or his or her substitute decision-maker)
- the person who applied the restraint
- when a restraint was applied
- all assessment, reassessment and monitoring activities, including the resident's response to the restraint
- each time the restraint was released or repositioned
- when a restraint was removed
- the post-restraint care offered³⁹⁹

These documentation requirements are important and useful, as they encourage facility operators and staff members to use restraints with awareness and caution. They also ensure that detailed records are available in the event that questions or concerns are raised.

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 (for example, so that the person may be able to sleep or rest). In these circumstances, medication is prescribed for a therapeutic benefit. 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 complicated by the fact that drugs used to treat dementia symptoms may be prescribed to be taken on an “as needed” basis. This means that it is up to facility staff to exercise discretion and decide when medication should be administered.

The use of medication as a chemical restraint is subject to the *Residential Care Regulation*. Except in the case of an emergency, using a chemical restraint requires prior written consent from the resident (or 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 complained about the use of antipsychotic drugs in residential care facilities. People who contacted us complained about the use of chemical restraints and were worried that the use of these drugs had become a routine way of coping with restless and anxious residents in the face of staffing pressures. The complaint we received from Brenda illustrates the type of concerns we heard about the use of chemical restraints in residential care. (The names below have been changed to protect confidentiality.)

³⁹⁹ *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, s. 110(7).

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Brenda's Story

Brenda's mother suffered from vascular dementia and anxiety. She lived in a residential care facility that was licensed under the Community Care and Assisted Living Act (CCALA). The facility has an admission and discharge agreement form that residents usually sign on admission stating that the person signing it agrees to accept "basic care" provided by the facility staff and attending physician.

The attending physician at the facility, who was Brenda's mother's family practitioner, prescribed an antipsychotic drug for Brenda's mother to take as needed for agitation. Between early April and mid-June 2009, it was regularly administered to Brenda's mother but the prescription and administration of the drug were not discussed with the family beforehand. Consequently, Brenda did not become aware of this until nearly two months after it was first administered.

She raised concerns to the community care licensing office that the prescription was being administered to her mother as a chemical restraint and that the facility did not inform the family. The licensing office found the facility was in non-compliance with section 8.4(5) of the Adult Care Regulations, as the nursing staff had failed to document one of the instances when the antipsychotic drug was administered on the medication administration record. As the antipsychotic drug had been prescribed and as Brenda's mother had not refused the treatment licensing concluded that the requirements of the Regulation were met. Our investigation into this matter continues.

This complaint illustrates the difficulty of distinguishing a chemical restraint from a prescribed treatment to alleviate the symptoms of dementia. As this is the case, the complaint also highlights the need for clearly documenting use of medications administered on an as needed basis. This documentation should specify how informed consent is obtained.

There is some evidence suggesting that the use of antipsychotic drugs in residential care facilities has recently increased. At a 2010 conference on residential care, Fraser Health reported that 35 per cent of its residential care clients were prescribed an antipsychotic drug.⁴⁰⁰ Vancouver Coastal Health reported an increase of 62 per cent in the use of antipsychotic medications between 2002 and 2007.⁴⁰¹ The ministry has not

Best Practice — Use of Restraints in Vancouver Island Health Authority

VIHA has a least-restraint policy that sets out acceptable and unacceptable restraint equipment and outlines alternatives to the use of restraints. VIHA has created guidelines for the use of chemical restraints that state that psychoactive medication is to be used only to treat medical symptoms, or in extraordinary circumstances to protect the patient or others from physical harm. The guidelines state that drugs are to be used as minimally as possible to achieve a defined therapeutic benefit. The guidelines outline the appropriate and inappropriate use of antipsychotic drugs, and state strongly that these drugs are not to be used to deal with symptoms that are limited to wandering, poor self-control, restlessness, anxiety, agitation and uncooperativeness.

Source: VIHA, letter to the Office of the Ombudsperson.

⁴⁰⁰ Centre for Healthy Living at Providence, remarks made at Improving Quality in Residential Care with Evidence: RAIs of Light? conference, 5-6 November 2010, Vancouver, B.C.

⁴⁰¹ Adil Virani and Gordon Tse, "An Atypical Dilemma: Using Antipsychotics in the Elderly," presented at Improving Quality in Residential Care with Evidence: RAIs of Light? conference, 5-6 November 2010, Vancouver, B.C.

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conducted any studies to determine the reasons for the increased use of antipsychotic drugs in residential care facilities. However, it has initiated a review of the use of antipsychotic drugs in residential care facilities in British Columbia.

The Ministry of Health initiated a review of the use of antipsychotic drugs in residential care facilities in 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.

Chemical restraints can look a lot like medical treatment because they can involve the same medications to produce the same results. As the line between using prescribed drugs for therapeutic purposes and merely for behaviour modification can be unclear, it is important to have a provincial policy that applies to all residential care facilities to add clarity and ensure consistency. Such a policy would provide guidance to facility operators and staff on how to distinguish between the use of medications for treatment and their use as a form of restraint. No such policy currently exists. Such a policy should be developed in consultation with the health authorities, medical professionals and representatives of residents and families, such as resident and family councils. VIHA's least-restraint policy, which provides guidelines for the use of chemical restraints, including a detailed description of the appropriate and inappropriate use of antipsychotic drugs, currently appears to be the best model in this area.

The Ombudsperson finds that

F107. The Ministry of Health has not yet completed an investigation of the increased use of antipsychotic drugs in residential care facilities.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

F108. The Ministry of Health has not developed a province-wide policy to guide the use of chemical restraints in all residential care facilities.

The Ombudsperson recommends that

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.

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Administering Medication

Administering medication is one of the important services provided in residential care facilities in British Columbia. The *Residential Care Regulation* establishes rules for administering medication in facilities licensed under the *Community Care and Assisted Living Act (CCALA)*. The Regulation requires licensees to appoint a medication safety and advisory committee in each facility. The committee must establish training for employees as well as policies and procedures regarding the storage, handling and administration of medication to people in care.⁴⁰² According to the regulation, operators must ensure that residents are only given medication that has been prescribed or ordered by a nurse or physician.⁴⁰³

Operators must also keep a medication 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 on the monitoring of a person in care's medication.⁴⁰⁴ No such requirements exist under the *Hospital Act* or *Hospital Act Regulation*.

The College of Physicians and Surgeons of British Columbia and the College of Registered Nurses of British Columbia have also established professional standards for physicians and registered nurses who prescribe and administer medication to people in care. Physicians and nurses must keep a clear record of any care or treatment they provide.⁴⁰⁵ The guideline for physicians on prescribing medication stipulates that the prescription of medication should be based on a face-to-face encounter with the patient. It also states that physicians should inform patients and their representatives of any information pertinent to the use of a medication and arrange for appropriate follow-up.⁴⁰⁶

The Medication Administration Practice Standard for registered nurses requires nurses to understand the side effects and interactions of medications, especially when dealing with off-label uses of medication.⁴⁰⁷ Registered nurses must also determine that all orders, labels and administration records are complete, and verify that the right dosage of medication is being provided for the right reason before administering it.⁴⁰⁸

⁴⁰² *Residential Care Regulation*, B.C. Reg. 10/2010, s. 68.

⁴⁰³ *Residential Care Regulation*, B.C. Reg. 10/2010, s. 70(1).

⁴⁰⁴ *Residential Care Regulation*, B.C. Reg. 10/2010, ss. 78(2) and 85(2)(h).

⁴⁰⁵ College of Physicians and Surgeons of British Columbia, Bylaws, revised 15 December 2010, 3-5(1); College of Registered Nurses of British Columbia, Practice Standard, "Documentation," Principles 1-4.

⁴⁰⁶ College of Physicians and Surgeons of British Columbia, Resource Manual, updated October 2009, "Prescribing Practices, Countersigning Prescriptions and Internet Prescribing."

⁴⁰⁷ College of Registered Nurses of British Columbia, Practice Standard, "Medication Administration," Principle 2, Applying Principles, 5.

⁴⁰⁸ College of Registered Nurses of British Columbia, Practice Standard, "Medication Administration," Principles 11, 3.

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Consent

Before medication or any other form of health care is provided to a senior in a residential care facility, the health care provider (who may be a physician, nurse or other person licensed to provide health care, such as a licensed practical nurse) must obtain informed consent to the health care.⁴⁰⁹ The only exception is in an emergency situation. The consent to health care, including medication, under the *Health Care (Consent) and Care Facility (Admission) Act (HCCFAA)* can be oral, written or inferred from the conduct of the resident.⁴¹⁰

In order for the consent to be valid, the health care provider must give the senior who will be taking the medication the information that a reasonable person would require to understand the reason for the medication and to make a decision, including information about:

- the condition for which the medication is proposed
- the nature of the medication
- the risks and benefits of the proposed medication that a reasonable person would expect to be told about
- any alternatives to the medication

The senior must also have the opportunity to ask questions and receive answers about the proposed medication. Seniors have the right to give, refuse or on an ongoing basis revoke consent on any grounds.⁴¹¹

Seniors are presumed to be capable of providing consent.⁴¹² 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. 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.

Substitute consent is necessary when a senior is not capable of giving or refusing consent. It is given by a substitute decision-maker who is 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.” This person is chosen from a ranked list of people (defined in the Act) who are related to the senior 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.

⁴⁰⁹ *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, ss. 5(1) and 12(1).

⁴¹⁰ *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 9(1).

⁴¹¹ *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 6.

⁴¹² *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181, s. 3(1).

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According to the professional standards established by the College of Physicians and Surgeons of British Columbia and the College of Registered Nurses of British Columbia, both physicians and nurses are expected to communicate effectively with people in care in order to ensure that they have the information they need to make informed health care decisions.⁴¹³ They must also respect a capable person's right to refuse or withdraw consent to treatment.⁴¹⁴

The Consent Practice Standard for registered nurses requires nurses to obtain informed consent to any treatment they provide, and to verify that consent has been given when aiding in the delivery of treatment by another health professional. The standard emphasizes the need to re-establish consent when a person's care plan changes or when the person is reconsidering a treatment decision. However, when establishing a nursing care plan to be carried out by a team, registered nurses are encouraged to obtain informed consent to the overall plan so that it is easier to carry out the repetitive aspects of care.⁴¹⁵

Determining a person's capacity to give consent and obtaining informed consent to administer medication are required by legal and professional standards. They are also crucial to respecting the autonomy of people in care to make informed decisions about their own health care. Despite this, there is currently no legal requirement to document that a person in care's capacity to give consent has been considered or assessed, or that informed consent has been obtained from a person in care or a substitute decision-maker. The Consent Practice Standard for registered nurses stipulates that nurses should document the "consent process"; however, this standard is not legally binding, and no such standard applies to physicians or other health care providers.⁴¹⁶ Without any clear documentation requirements, it is difficult to ensure that informed consent has been obtained and verified before medication is administered to people in care. In order to protect the rights of people in care, the ministry should establish binding legal requirements to document consent.

To respect the principle of informed consent, consent to health care needs to be re-established on an ongoing basis and health providers must reassess a person's capacity to consent to treatment at regular intervals, as well as reconfirming the person's continued consent. The Regulation under Ontario's *Long-Term Care Homes Act* states that licensees must ensure that any consent to treatment is reviewed at the time when a resident is reassessed or when his or her care plan is reviewed.⁴¹⁷ Orders for the administration of a drug must also be reviewed at these times.⁴¹⁸ No such requirements apply to licensees of residential care facilities in British Columbia.

To better protect the rights and autonomy of people in care, a reasonable time period for consent should be established after which a senior's consent to the administration of medication expires unless it is reconfirmed. The health care provider would reassess the person's capacity to consent and would then need to re-establish

⁴¹³ College of Physicians and Surgeons of British Columbia, Code of Ethics, adopted from the Canadian Medical Association Code of Ethics (updated 2004), ss. 21 and 22; College of Registered Nurses of British Columbia, Code of Ethics, adopted from the Canadian Nurses Association Code of Ethics (2008 Centennial Edition), "Promoting and Respecting Informed Decision-Making," s. 1.

⁴¹⁴ College of Physicians and Surgeons of British Columbia, Code of Ethics, s. 24; College of Registered Nurses of British Columbia, Code of Ethics, "Promoting and Respecting Informed Decision-Making," s. 4.

⁴¹⁵ College of Registered Nurses of British Columbia, Practice Standard, "Consent," Principles 4 and 12 <<https://www.crnbc.ca/Standards/Lists/StandardResources/359ConsentPracStd.pdf>>.

⁴¹⁶ College of Registered Nurses of British Columbia, Practice Standard, "Consent," Principle 14 <<https://www.crnbc.ca/Standards/Lists/StandardResources/359ConsentPracStd.pdf>>.

⁴¹⁷ *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, s. 29.

⁴¹⁸ *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, s. 117(a).

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informed consent. A person in care or substitute decision-maker should also have the option of specifying the duration of his or her consent to the administration of medication. In both cases, the duration of the consent obtained should be documented by the health provider and verified by facility staff before administering medication.

While the focus of this section is on administering medication, the requirements to obtain informed consent apply to all medical treatments, except when provided in an emergency.

The Ombudsperson finds that

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

The Ombudsperson recommends that

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

The Ombudsperson finds that

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.

The Ombudsperson recommends that

R140. The Ministry of Health take the necessary steps to establish legal requirements for operators to:

- ensure that facility staff verify from 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

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Antipsychotic Medications and *Pro re nata* (as needed) Prescriptions

Antipsychotics are a class of psychotropic medications that are primarily used to manage psychosis and have a tranquilizing effect.⁴¹⁹ Some studies indicate that antipsychotics may impair cognitive and emotional functioning, and may cause significant physical side effects.⁴²⁰

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.⁴²¹ PRN means “as needed” or “as the situation arises.” PRN medications are prescribed to be taken as required as opposed to on a regularly scheduled basis.

The decision about when to administer PRN medications is up to registered nurses and licensed practical nurses in a facility. Despite this, neither the *Community Care and Assisted Living Act* nor the *Hospital Act* contains any specific requirements around the prescription and administration of PRN medications in residential care facilities.⁴²² Having procedural safeguards in place is especially important where the PRN medication is an antipsychotic, because of the potential risks associated with the use of these medications.

To ensure patient safety and assist staff in deciding when and how to administer PRN medications, prescriptions should clearly describe the target

Pro re nata Medications

“Pro re nata (PRN) medications are standing orders that allow caregivers in group home, residential, or hospital settings to administer a psychotropic medication for the emergency management of aggression, psychotic agitation, insomnia, and other troublesome symptoms without a physician assessment or specific approval. While the prescribing clinician typically sets parameters for the use of these medications, the decision to medicate is placed in the hands of the milieu staff, typically a nurse. While clearly not the intent, PRN medications may encourage reliance on the use of medications to manage disruptive behaviors rather than psychosocial or behavioral interventions.”

Source: Naylor et al., “Psychotropic Medication Management for Youth in State Care: Consent, Oversight and Policy Considerations,” *Child Welfare* 86 (September/October 2007): 185.

⁴¹⁹ Merriam-Webster Online, “Antipsychotic”

<<http://www.merriam-webster.com/dictionary/antipsychotic?show=0&t=1312906771>>.

⁴²⁰ Juan Francisco Artaloytia et al., “Negative Signs and Symptoms Secondary to Antipsychotics: A Double-Blind, Randomized Trial of a Single Dose of Placebo, Haloperidol, and Risperidone in Healthy Volunteers,” *American Journal of Psychiatry* 2006; 163: 488-493 <<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,” *American Journal of Geriatric Psychiatry* 2006;14: 3 <<http://davidhtaylor.md.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-mpps/medeff/advisories-avis/prof/_2005/atyp-antipsycho_hpc-cps-eng.php>.

⁴²¹ As indicated previously under “Restraints”, the Ministry of Health is conducting a review of the use of antipsychotic medications in residential care facilities.

⁴²² The College of Pharmacists bylaw includes requirements regarding PRN medications that are binding on pharmacists.

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symptoms they are intended to treat, how frequently the dose can be given, the maximum daily dose 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.⁴²³

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

Staffing Levels

When facilities lack adequate staff, the staff who are available not surprisingly face very real challenges in providing safe and appropriate care. Research shows that having adequate and appropriate staffing leads to better outcomes for residents and, more specifically, that the higher the proportion of professional staff, particularly registered nurses, the better the quality of care.⁴²⁴ However, just as staffing levels are a significant factor in the quality of care, they are also a significant factor in facility budgets. Since staffing is the largest component of operating costs and the most flexible (given the subjective nature of current staffing standards), it is an area where adjustments may be made when facing budgetary constraints.

There are two aspects of staffing that 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. Staff hours are calculated by multiplying the number of staff on duty in a given period by the hours they worked. For example, three licensed practical nurses on duty for an 8-hour shift would result in 24 staffing hours. A more precise approach is to measure only the hours that those staff provided direct care, rather than just the hours they were on duty. This approach accounts for the fact that not all staff provide direct care, and that even those who do also have other duties. This is generally the approach taken in British Columbia.

The other aspect of staffing is the mix of staff and the training and qualifications they have. Most of the staff who provide direct care in residential care facilities are care aides, licensed practical nurses or registered nurses. Care aides have the least training and registered nurses have the most.

⁴²³ Ontario Ministry of Children and Youth Services, *Standards of Care for the Administration of Psychotropic Medications to Children and Youth Living in Licensed Residential Settings*, Summary of Recommendations of the Ontario Expert Panel, February 2009, 9.

⁴²⁴ Ministry of Health, "Home and Community Care Provincial Residential Care Facility Staffing Framework," fact sheet, May 2008.

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Legislated Requirements

There are no legislated requirements for the minimum number of staff that 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 per day. Nor are there any specific legislated requirements for the type or mix of staff that must be on duty.

Instead, there are a number of what the ministry describes as “outcome-based” staffing standards, which are contained in either the *Community Care and Assisted Living Act (CCALA)* or the *Residential Care Regulation* that accompanies it. For example, the Regulation requires operators to:

- ensure that, at all times, the employees on duty are sufficient in numbers, training and experience and organized in an appropriate staffing pattern to meet the needs of people in care
- assist people in care with daily living activities, including eating, mobility, dressing, grooming, bathing and personal hygiene in a manner consistent with their health, safety and dignity
- ensure that people who require supervision when outside the facility are appropriately supervised
- ensure that, at all times, there are employees on duty who can communicate effectively with all of the people in care
- ensure that there is an employee on staff at all times who holds valid first aid and CPR certifications, is knowledgeable of each person in care’s medical conditions, and is capable of communicating effectively with emergency personnel⁴²⁵

The Act also requires operators to only employ people of good character who meet the standards for employees specified in the Regulation, which require 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 also 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

While it is obviously necessary to have employees available who can meet these needs, the Regulation does not specify how many should be available or what is an appropriate mix of RNs, LPNs and care aides. For example, some operators choose to have a registered nurse available on-site at all times but the

⁴²⁵ *Residential Care Regulation*, B.C. Reg. 96/2009, ss. 41 and 42.

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Regulation does not require this, and operators could choose not to do this and still be in compliance. The Ministry of Health has also not provided guidelines on what it considers to be an “appropriate staffing pattern.”

Ministry of Health staff told us that the ministry has no plans to establish legislated, quantitative staffing requirements. The ministry has provided the health authorities with a guideline of 3.36 direct care hours per resident per day to assist in developing plans for the use of new funds collected under the revised residential care rate structure. (Further information about the health authorities’ three-year plans can be found under “Residential Care Rate Structure” in this section of the report.) However, while this guideline is specific and measurable, it is not legally binding on the health authorities.

While we understand that outcome-based requirements offer operators flexibility, subjective requirements are difficult to monitor and enforce. In addition, in the absence of specific and measurable legislated standards on staffing and direct care hours, it is difficult to identify if a staffing mix is inadequate until after it is clear needs have not been met. In order to avoid this risk, the ministry would need to specify the mix of registered nurses, licensed practical nurses and care aides that is required to meet the needs of seniors in residential care.

Setting quantifiable and objective standards would assist operators in identifying gaps in coverage and would also provide residents and their families with a basis upon which to express concerns regarding inadequate staffing before harm or injury occurs. Staffing levels could then more easily be monitored on a regular basis to verify compliance through periodic random audits and inspection of facility operator staffing records.

Hospital Act Facilities

Currently, similar staffing requirements apply in extended care hospitals or private hospitals governed by the *Hospital Act*. As with facilities licensed under the *CCALA*.

Staffing Requirements for Child Care Facilities

The non-specific outcome-based approach to staffing requirements in the *Residential Care Regulation* is in stark contrast to the Ministry of Health’s approach to regulating child care facilities, which are also licensed under the *CCALA*. We found this interesting, given that both types of facilities care for people who are vulnerable. Unlike residential care facilities, child care facilities do not provide 24-hour care. Despite this difference, child care facilities are subject to detailed minimum staffing requirements. The following table is taken from the *Child Care Licensing Regulation*, which is made under the *CCALA*.

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Table 37 – Child Care Group Sizes and Employee-to-Children Ratios⁴²⁶

Care program	Maximum group size	Children per group	Ratio of employees to children in each group
Group child care (under 36 months)	12, with a separate area designated for each group	1-4	One infant /toddler educator
		5-8	One infant /toddler educator and one other educator
		9-12	One infant /toddler educator, one other educator and one assistant

The ministry's establishment of such specific, measurable standards for child care facilities demonstrates that it is quite possible to set staff ratios that apply to settings in which vulnerable people receive care if there is the will to do so. In addition to overall staff ratios, the *Child Care Licensing Regulation* specifies how many of each type of staff are required. This is an example of an objectively measurable staffing standard that could also be applied to seniors in residential care.

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 to each person 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 38 – 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.

⁴²⁶ *Child Care Licensing Regulation*, B.C. Reg. 332/2007, Schedule E, s. 1 (extract from full table).

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In the research and consultations we conducted during this investigation, we found that the recommended range of care hours was generally between 3.2 and 4.0 hours per resident per day. As the previous table shows, however, as of 2011, none of the health authorities had achieved this.

Progress

In February 2009, six months after we started our investigation, the Minister of Health Services issued a directive to the health authorities requiring each of them to create a three-year plan to address a number of issues, including details of how they could provide 3.36 direct care hours per resident per day in their plans.⁴²⁷ The health authorities responded to the ministry as follows:

The **Fraser Health Authority** said it would need to invest an additional \$79 million in staffing to achieve the guideline. This amounted to a 24 per cent increase in staffing costs. Fraser Health indicated that it would not be able to meet the guideline without more funding.⁴²⁸

The **Interior Health Authority** estimated that it would cost \$39 million to achieve the guideline. It said that in the absence of additional resources and with limited ability to reallocate existing funds, it would continue to “stay the course.”⁴²⁹

The **Northern Health Authority** said it would require an additional \$11.6 million to meet the guideline. This would increase its staffing costs for registered nurses, licensed practical nurses and residential care attendants by 25 per cent.⁴³⁰

The **Vancouver Coastal Health Authority** said that it would cost approximately \$57 million to achieve the guideline. It indicated that it could reallocate \$6.7 million to help fund this, but would not be able to address the remainder of the gap without additional funding.⁴³¹

BC Care Providers Association

The BC Care Providers Association (BCCPA) includes more than 130 owners of private residential care facilities across B.C. The BCCPA recommended adopting 3.2 hours of care per resident per day as the preferred provincial standard for residential care facilities, and 2.8 hours as the baseline standard.

The BCCPA recommended that all residents be assessed using tools currently used in health authorities to determine the actual direct care hours of each resident and therefore the total required hours in a facility. Using this approach, facilities housing residents with more complex needs would be expected to require correspondingly higher staff-to-resident ratios.

Source: BCCPA, *Residential Care and Safety Guidelines*, 2009.

⁴²⁷ The ministry has since increased this target to 3.37 hours of care per resident per day.

⁴²⁸ FHA submission to the Ministry of Health Services in compliance with Home and Community Care Quality and Performance Management Directives, Directive A, 2.

⁴²⁹ IHA submission to the Ministry of Health Services in compliance with the Home and Community Care Quality and Performance Management Directives, Directive A, 2.

⁴³⁰ NHA submission to the Ministry of Health Services in compliance with the Home and Community Care Quality and Performance Management Directives, Directive A, 2.

⁴³¹ VCHA submission to the Ministry of Health Services in compliance with the Home and Community Care Quality and Performance Management Directives, Directive A, 2.

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The **Vancouver Island Health Authority** stated that it could not fund increased staffing by reallocating its resources and that it would not be able to achieve the guideline without additional resources.⁴³²

Shortly after the ministry directive, additional resources were available as the new residential care rate structure took effect in January 2010. It was projected to generate approximately \$53.7 million in extra revenue every year after its second year of implementation. The ministry informed the health authorities that it expected them to invest the additional revenue back into the delivery of care and to prioritize increasing direct care hours.⁴³³ However, even with the increased revenue, none of the health authorities except Northern Health currently anticipate being able to meet the ministry's guideline of providing 3.36 direct care hours per resident per day by the end of 2012/13.⁴³⁴ The other four health authorities have estimated that they will continue to be between 4 and 17 per cent below the ministry's expectation by that date. In 2011, the direct care hours actually provided in the health authorities were between 5 and 24 per cent below the ministry's guideline. This demonstrates that considerable work still needs to be done to provide 3.36 direct care hours and an ongoing disconnect exists between the ministry staffing level guideline and the resources available to meet those guidelines.

The Ombudsperson finds that

F112. The Ministry of Health has not established clear, measurable and enforceable staffing standards for residential care facilities.

The Ombudsperson recommends that

R142. 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

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.

⁴³² VIHA submission to the Ministry of Health Services in compliance with Home and Community Care Quality and Performance Management Directives, Directive A, 2.

⁴³³ Ministry of Health Services, *Home and Community Care Analyses of Health Authority Investment of Revenues from Revised Residential Care Client Rates*, 30 March 2010, Background, 3.

⁴³⁴ 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).

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Access to Visitors

Having opportunities to visit with friends and family is tremendously important for seniors in residential care facilities who may suffer from loneliness. Many seniors in residential care are not well enough to leave their facilities for social outings, so having visitors allows them to maintain important relationships, which in turn can have an enormous impact on their health and quality of life. Visiting opportunities are also important for friends and family.

Seniors in residential care facilities have a right to receive visitors and to communicate with them in private. In the course of our investigation, we heard from people who felt that facility operators or staff were unnecessarily restricting visitors to avoid dealing with difficult and perhaps disruptive conflicts. Others were concerned that operators or staff had prohibited visitors without first considering less restrictive options. The complaint that Ted brought to us is an example of the types of concerns we heard about visitor access. (The name has been changed to protect confidentiality.)

Ted's Story

Ted contacted our office after he was restricted from entering the residential care facility where he had been visiting his wife for over five years. Ted visited his wife daily to keep her company and to help with her exercise, meals and dressing. He told us that over the years, he had raised valid concerns about his wife's condition that facility staff had not responded to in a serious and timely way. In one instance, it took him nearly a month to convince staff that his wife needed an X-ray when she had in fact broken her hip. Consequently, Ted kept a close eye on the care his wife received at the facility.

Staff reported to the facility's management that Ted's vigilance made them uncomfortable and sometimes interfered with their ability to do their jobs. They reported that his behaviour was sometimes rude and verbally abusive. Over the years, there had been several heated discussions between Ted and various staff members. One day, without notice, Ted was escorted out of the facility and told he could not return. He received a letter from the director confirming that he was no longer permitted to enter the facility, effective immediately.

Ted complained to our office. He thought it was unfair to restrict him from entering the facility without any warning, and he didn't understand how his behaviour warranted taking steps that prevented him from seeing his wife. He missed his wife and was worried that her condition would deteriorate without his care. His worst fear was that she would die without him having a chance to see her again.

We investigated Ted's complaint and concluded that the facility had not followed a fair process when it restricted his access. Ted did not have the opportunity to explain his perspective or concerns before the decision was made, nor was he informed of the potential consequences of his behaviour. In an effort to resolve the complaint, the facility agreed to reinstate Ted's right to visit his wife and apologized to him. The facility also agreed to develop new processes for, and guidelines on, visitor access.

The Right to Receive 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 (CCALA)*, 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 any time and

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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 *Adult Guardianship Act* allows health authorities to apply for a court order restricting a visitor's access to a senior when the health authority has reason to believe the senior is being abused or neglected by that person. Under the *Residential Care Regulation*, it is at the discretion of facility operators to determine when a visitor's conduct undermines "the health, safety and dignity of all persons in care." The ministry has not developed any policy to guide the exercise of this discretion, and in its absence, we've seen examples of residents' rights that were unfairly restricted.

It would be useful for the Ministry of Health and the health authorities to work together to develop a policy that addresses the following points:

- Seniors and their loved ones should be informed of circumstances that may lead to restrictions on visiting rights.
- If an operator is considering a restriction, the affected visitor should be told this before the decision is made and have the opportunity to discuss and address concerns.
- The least restrictive option that is appropriate for the situation should be applied first.
- The person who is subject to the restriction should be told how to request a review or appeal the restriction to an independent authority.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

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Services for Residents with Dementia

Dementia is a term that is used to describe a variety of symptoms that result from diseases that affect the brain. Common symptoms of dementia include impairment of memory, orientation, comprehension, learning capacity, judgment, reasoning and ability to communicate. Other symptoms may include changes in mood and behaviour, which impact a person's ability to complete daily activities. The most common forms of dementia are Alzheimer disease, vascular dementia, dementia with Lewy bodies and frontotemporal dementia. In 2008, Alzheimer disease and vascular dementia accounted for 83 per cent of all dementia cases in Canada.⁴³⁵ The chances of developing dementia increase with age and the prevalence of dementia is higher in females than in males.

Dementia in Canada

In 2008, there were 480,618 Canadians living with dementia (1.5% of Canadians).

In 2008, there were 403,622 seniors in Canada living with dementia (1 in 11 seniors).

It is projected that in 2038, there will be 1,125,184 people in Canada living with dementia (2.8% of Canadians).

Source: Alzheimer Society of Canada, 2009 media release
<<http://www.alzheimer.ca/english/media/putyourmind09-release.htm>>.

Number of People Affected

An estimated 35.6 million people were living with dementia worldwide in 2010. This number is expected to increase to 65.7 million by 2030 and 115.4 million by 2050. In 2010, the estimated worldwide costs of dementia were US\$604 billion.⁴³⁶

In Canada, there were 403,622 seniors living with dementia in 2008. It is projected that by 2038, there will be 1.1 million people living with dementia in Canada (2.8 per cent of the population). In 2008, 55 per cent of those with dementia who were 65 or over 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.⁴³⁷ The Alzheimer Society of Canada estimates that over the next 30 years the demand for long-term care for dementia patients will increase by over 10 times the 2008 demand. It also predicts that because of a shortage of residential care beds, more people living with dementia will have to rely on informal care and home support services.⁴³⁸

"So far, in the context of provincial dementia strategies, only Ontario has attached significant funding in support of strengthening dementia care."

Source: Alzheimer Society of Canada, *Rising Tide: The Impact of Dementia on Canadian Society*, 2010, 42.

⁴³⁵ Alzheimer Society of Canada, *Rising Tide: The Impact of Dementia on Canadian Society*, 2010, 18.

⁴³⁶ Alzheimer's Disease International, *World Alzheimer Report 2010: The Global Economic Impact of Dementia*, 4.

⁴³⁷ 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.

⁴³⁸ Alzheimer Society of Canada, *Rising Tide: The Impact of Dementia on Canadian Society*, 2010, 20.

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More than 70,000 British Columbians were living with Alzheimer disease or another form of dementia in 2010, 60,000 of whom were over the age of 65.⁴³⁹ It is estimated that in 2006, \$1.3 billion was spent in British Columbia on direct dementia-related care. These costs are projected to increase to \$1.97 billion by 2016.

In the course of our investigation, we asked the Ministry of Health and the health authorities about specific services and service delivery approaches for seniors with dementia.

In 2007, the Ministry of Health Services worked with stakeholders to develop the BC Dementia Service Framework.⁴⁴⁰ The goal was to develop a comprehensive set of practice recommendations to guide the provision of all levels of dementia care and to support health authorities and other service providers in planning, prioritizing and implementing service improvements.⁴⁴¹ The participants identified the following barriers to, or gaps in, the provision of optimal dementia care in British Columbia:

- the health care system's limited capacity and ability to address the clinical and support needs of people with dementia and their families and caregivers
- the limited number of health care providers with expertise in elder and dementia care
- the lack of knowledge among health care providers about dementia and best practices in dementia care
- the lack of policies in place to mitigate the impact of dementia on people with the disease and on their families, caregivers and communities
- the failure to recognize the role of families and caregivers as partners on the care team
- the limited capacity and ability of the acute care setting to address the needs of people with dementia
- the lack of formal integration, collaboration and communication across care settings, between health care providers and across health authorities

Best Practice: Pilot Project — Licensed Dementia Housing

Vancouver Island Health Authority

During the course of 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.

⁴³⁹ Alzheimer Society of BC, Disease Statistics <<http://www.alzheimerbc.org/Alzheimer-s-Disease-and-Dementia/Disease-Statistics.aspx>>.

⁴⁴⁰ Stakeholders included the health authorities, the Alzheimer Society of BC, the Centre for Applied Research in Mental Health and Addiction, and Impact BC.

⁴⁴¹ Alzheimer Society of BC, *BC Dementia Service Framework*, September 2007, 12.

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Despite the time and work invested in developing the framework, the ministry has not established standards, policies, services and training that are specific to dementia care.

The health authorities have responded in a variety of ways to the demands of caring for residents with dementia. Some have no specific policies and others provide best practice guidelines, training or other resources. The housing pilot project that the Vancouver Island Health Authority developed with a non-profit partner is particularly notable. It provides a more home-like housing environment for those who can no longer live safely in their homes or assisted living but are able to walk independently and who require additional security features and 24-hour care. In view of the growth in the number of people with dementia that is expected in the coming years, the Ministry of Health and the other health authorities might consider whether VIHA's pilot project can be usefully replicated in other parts of the province.

Dementia affects not only the people with the disease but also their families, friends and communities. Given the number of people affected by dementia in British Columbia, it is critical that there be specific, planned approaches to delivering care and services to people with dementia and to their loved ones.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

End-of-Life Care

End-of-life care is a term used to describe the specialized clinical and support services required by those who are approaching death. The term encompasses both hospice and palliative care. Hospice care is for people who are in the last stages of a terminal illness. Palliative care is treatment provided specifically to alleviate suffering, rather than to cure a disease or condition. Although it is most commonly provided in the context of end-of-life care, it can also be provided to those who are not necessarily nearing death.

"My mother was not dying with dignity at the care facility."

Source: Respondent, Ombudsperson's questionnaire.

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Hospice 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. The type of care provided depends on the needs of each patient, but the focus is on reducing pain and treating the side effects of illness or medication. Hospice services are provided by a team of professionals and volunteers that may include doctors, nurses, therapists, counsellors and other caregivers. Care can be provided in a residential care facility, hospital, hospice centre or a patient's home.

Hospice services generally include the following:

- basic medical care, with a focus on pain and symptom control
- medical supplies and equipment, as needed
- volunteer support for tasks such as meal preparation and errands
- respite care
- guidance on life completion and closure
- counselling and social support to help the patient and his or her family with psychological, emotional and spiritual issues

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, or should be, distinct from that of day-to-day residential care. More privacy and flexibility with daily routines are needed. Counselling services, pain and symptom management and compassionate nursing care need to be planned and coordinated in a way that respects the dignity and choices of seniors who are nearing death.

Every year, approximately 25 per cent of all deaths in the province occur in residential care facilities.⁴⁴² Given how frequently facility operators are required to care for dying residents, we expected residential care facilities to be models of excellence when it comes to planning for and providing end-of-life care. We did not find this to always be the case.

In the course of our investigation, we heard from people who had concerns about the adequacy of the end-of-life care available in residential care facilities. Some people didn't understand what they were entitled to and others were concerned that the level of service for those in residential care seemed to be lower than that available to seniors who are still in the community. Facility operators also told us that they wanted to improve their end-of-life services but were limited by space, and funding issues. For example, one facility operator told us that because of a lack of space they are not able to provide a private room for residents who are dying and their families. Residents in this facility share a room with one to three other people.

One Family's Experience

"They transferred him to the long-term care home as respite for my mother... The long term care home was not prepared to care for a person in isolation, with special diet and needs, who was about to die..."

Source: Respondent, Ombudsperson's questionnaire.

⁴⁴² 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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When we investigated this issue, we found that there are no legislated requirements that facility operators must comply with when 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.

While they don't contain enforceable standards, there are two ministry documents that provide some guidance on end-of-life care. In 1999, the ministry published *Model Standards for Continuing Care and Extended Care Services* to assist health authorities, service organizations and care providers in evaluating care, service delivery and organizational systems.⁴⁴³ Section 5.14 of this document says that staff in residential care facilities should anticipate, recognize, support and respond to residents with palliative care needs by:

- monitoring and controlling symptoms
- adapting routines to accommodate residents' and caregivers' need for privacy and flexibility
- providing emotional support and information to residents and caregivers
- collaborating with community resources to arrange counselling, hospice and chaplain services

More recently, the ministry published *A Provincial Framework for End-of-Life Care* (2006) to guide and coordinate efforts to improve the delivery of end-of-life care in the province. 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 respect to the latter, the framework states that the regular residential care services will need to be supplemented to make it possible for quality end-of-life services to be provided to residents. The framework states that these services should include:

- appropriate advance care planning
- pain and symptom management
- psychosocial support
- specialist support and backup
- access to specialized medications and equipment similar to those available to patients participating in the BC Palliative Care Benefits Program⁴⁴⁴

Ministry Vision for End-of-Life Care

"End-of-life care in British Columbia will be an essential part of the health service system. Patients and families will have choices, including a range of options to support death with dignity and comfort in the setting that best meets the needs of patients and family caregivers...."

Principles for end-of-life care:

- patient- and family-centred
- ethical
- enhancing quality of life and end-of-life
- accessible
- effective
- collaborative
- adequately resourced and cost-effectively delivered"

Source: Ministry of Health, *A Provincial Framework for End-of-Life Care*, May 2006, 4-5.

⁴⁴³ Ministry of Health, *Model Standards for Continuing Care and Extended Care Services*, April 1999.

⁴⁴⁴ Ministry of Health, *A Provincial Framework for End-of-Life Care*, May 2006, 9.

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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.⁴⁴⁵ The program provides required medical supplies and equipment to these patients at no cost, and medications that are covered under the BC Palliative Care Drug Plan. Seniors in residential care are not eligible for this program, but as the ministry's framework states, facility operators are supposed to provide them with similar benefits. There is no evidence of either the ministry or the health authorities monitoring whether services in residential care facilities receive adequate access to end-of-life services including specialized medication and equipment.

How much a senior in residential care has to pay for medications — or whether he or she has to pay at all — varies depending on the type of facility involved. This is one of the areas where the legislation that applies is important. Seniors who are receiving end-of-life care in extended care facilities, which are governed by the *Hospital Act*, generally do not have to pay for medication, as the cost of both prescription and non-prescription drugs is part of facility budgets. Seniors in facilities licensed under the *Community Care and Assisted Living Act (CCALA)* and those who are in private hospitals do have to pay for their own non-prescription drugs, but their prescription costs are typically covered by PharmaCare's Plan B. The coverage provided under Plan B is not as extensive as that provided the BC Palliative Care Drug Plan (Plan P) however. This means that seniors in facilities often have to pay for pain management drugs from their own resources. These seniors may pay more for specialized medications than seniors who receive end-of-life care in extended care hospitals and in their own homes.

Analysis

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 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. The ministry should work with the health authorities to inform the public about the additional end-of-life care benefits that seniors in residential care facilities can expect 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.

⁴⁴⁵ Ministry of Health, *BC Palliative Care Benefits Program*, patient information sheet, December 2009.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

Residential care facilities provide 24-hour care to seniors who need professional nursing care and supervision. Given the nature of this care and 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 consequence of this reality and are an important mechanism for both identifying problems when they occur and resolving them. In this sense, complaints are an integral part of service delivery and quality assurance. Since initiating this investigation, we have heard from many seniors and families who were unsure of how to complain or raise concerns about the care provided in residential care facilities.

Complaining to Facilities

In many cases, raising concerns with or making complaints directly to the facility that is providing the care will be 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

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resolve disputes within the facility.”⁴⁴⁶ The Residents’ Bill of Rights came into force in December 2009 and 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 concerning complaints processes.

There are additional requirements that apply to facilities licensed under the *Community Care and Assisted Living Act (CCALA)* and *Residential Care Regulation*. The Regulation requires operators of these facilities to establish “fair, prompt and effective” processes for resolving complaints and disputes. The Act requires operators to ensure that a person in care is not subject to retaliation as a result of anyone expressing a concern. Operators are also required to record complaints and how they responded to them. In addition, the Regulation requires operators to inform residents and their representatives of their facility’s policies about the complaints process and of how they can complain to the health authority’s medical health officer and patient care quality office.

The requirements of the *CCALA* and Regulation are examples of outcome-based regulation. Operators are allowed to determine what their own complaints processes will be, as long as they meet the test of being “fair, prompt and effective.” While operators may appreciate this degree of flexibility, it results in wide variations in the complaints processes that are in effect in facilities across the province.

During our investigation, we learned that other provinces take a different approach to complaints processes. For example, 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 *CCALA* facilities in British Columbia. The Act requires that, wherever possible, 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. When complaints can’t be resolved within 10 business days, operators must send the person who complained a written acknowledgement of receipt of the complaint and provide a date by which resolution is expected. In these cases, operators are required to follow up “as soon as possible.”⁴⁴⁷

Operators in Ontario are required to record the following information about each verbal or written complaint they receive:

- what it is about
- the date it was received
- the type and date of actions taken to resolve it and any follow-up action required
- every date on which they responded to the complainant and a description of the response
- any response by the complainant
- the final resolution, if any

⁴⁴⁶ 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>.

⁴⁴⁷ *Long-Term Care Homes Act*, S.O. 2007, s. 101(1)2.

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A further requirement, and one which goes far beyond what is required by the *CCALA*, is that operators must immediately forward any written complaints they receive to the director of the Ministry of Health and Long-Term Care.⁴⁴⁸

Operators in Ontario must also review and analyze complaints at least quarterly and take the results into account when determining which improvements to make to their facilities. They must keep a record of their reviews and the improvements they've made in response to complaints.⁴⁴⁹ Operators of *CCALA* facilities in British Columbia are only required to keep a record of complaints received and their responses.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

Complaining to Health Authorities

People who are not satisfied with the way a facility has handled their complaint, or who don't 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. The following sections review the adequacy of the information that health authorities provide about the various complaints processes, as well as the adequacy of the processes themselves.

⁴⁴⁸ *Long-Term Care Homes Act*, S.O. 2007, s. 22.

⁴⁴⁹ *Long-Term Care Homes Regulation*, Ont. Reg. 79/10, s. 101. The documentation requirements don't apply to verbal complaints that the licensee is able to resolve within 24 hours.

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Case Managers

Health authority case managers act as coordinators to help seniors and other clients obtain home and community care services.⁴⁵⁰ Case managers determine a senior's eligibility for services and assess his or her health care needs, as well as the nature, intensity, duration and cost of the services the senior requires. If seniors or their families have concerns about subsidized services that they are not able to resolve with their caregivers, they can contact their case manager. This is an informal process that is available only to seniors receiving subsidized care.

Community Care Licensing Offices

Community care licensing offices are staffed by licensing officers and overseen by medical health officers. Licensing officers are responsible for ensuring that residential care facilities (and child care facilities) licensed under the *CCALA* meet the requirements of that Act and its regulations. 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.

The Act gives medical health officers the authority to examine any part of a facility and to inquire into and inspect all matters concerning its operations, employees or residents. Medical health officers can also require operators to produce records. (This process is discussed more fully in the Monitoring section.) In practice, however, medical health officers delegate the responsibility for conducting these investigations to licensing officers who are employees of the health authorities.

The *CCALA* does not apply to facilities governed by the *Hospital Act*, and licensing officers are not authorized to investigate complaints about those facilities. As a result, seniors in *Hospital Act* facilities have fewer options for pursuing complaints than seniors who live in *CCALA* facilities, even though they have the same care needs.

Public Information

We reviewed the health authorities' 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 the information provided by each health authority is useful, it would increase the accessibility of the community care licensing offices if each health authority provided comprehensive information about making a licensing complaint on its website, including:

- who can complain to the community care licensing office
- which facilities can be complained about
- what types of complaints are accepted by the community care licensing office
- how to complain
- how licensing staff will respond to complaints

⁴⁵⁰ The term "case manager" is no longer used in the ministry's revised *Home and Community Care Policy Manual*. According to the manual, assessments are to be done by a "health professional" (2.D, 1).

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- how the role of the community care licensing office differs from that of the regional patient care quality office
- what to do if dissatisfied with a licensing investigation

This information should also be available in print and provided to all people living in residential care facilities.

Number of Complaints Received

We asked each of the health authorities to tell us how many licensing complaints they received about *CCALA* residential care facilities between 2004/05 and 2010/11.

Table 39 – Licensing Complaints at Facilities Serving Seniors, 2004/05 to 2010/11⁴⁵¹

Health authority*		FHA	IHA	NHA	VCHA ¹	VIHA ²
		Number of licensed facilities and licensing complaints ³				
2004/05	Licensed facilities	65	61	12	41	Not available
	Licensing complaints	46	8	8	Not available	68
2005/06	Licensed facilities	64	59	12	42	Not available
	Licensing complaints	62	13	8	Not available	60
2006/07	Licensed facilities	63	59	12	42	Not available
	Licensing complaints	59	35	0	Not available	84
2007/08	Licensed facilities	65	59	12	42	64
	Licensing complaints	63	25	0	Not available	98
2008/09	Licensed facilities	62	60	12	42	63
	Licensing complaints	75	27	3	Not available	103
2009/10	Licensed facilities	65	69	12	42	66
	Licensing complaints	99	37	3	Not available	103
2010/11	Licensed facilities	63	69	12	42	66
	Licensing complaints	80	91	6	Not available	97

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

¹ Vancouver Coastal Health was unable to provide statistics on complaints received because this information was not tracked in its database. The health authority tracks the number of complaint inspections conducted, but a complaint investigation does not necessarily result in an inspection.

² Vancouver Island Health Authority was unable to provide the number of licensed facilities for years prior to 2007/08.

³ All of the health authorities except for Fraser Health have facilities with both licensed beds and beds governed by the *Hospital Act*. In other tables in this section, these facilities have been counted as 0.5 of a licensed facility. In this table, each of these facilities has been counted as one licensed facility.

⁴⁵¹ The 2009/10 and 2010/11 data include both subsidized and non-subsidized facilities licensed under the *CCALA*. However, previous years' data from Interior Health appears to include only subsidized facilities. Data may include facilities and complaints about facilities that do not provide services for seniors primarily.

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The health authorities have received few licensing complaints relative to the number of licensed facilities and beds. For instance, in 2010/11, there were more than 19,000 licensed long term residential care beds in approximately 250 facilities in British Columbia. In 2010/11, the Fraser, Interior, Northern, and Vancouver Island health authorities received a combined 186 complaints. (Vancouver Coastal Health Authority was not able to provide us with the number of complaints provided).

How Licensing Complaints Are Investigated

The Ministry of Health's policy on investigation of licensing complaints is outlined in its draft document, *A Guide to Community Care Facility Licensing in British Columbia*.⁴⁵² The health authorities have also developed their own policies to guide licensing investigations.

According to the ministry's draft manual, when someone complains that a facility is not complying with the *CCALA* or the *Residential Care Regulation*, licensing officers should respond to and document the complaint in a timely and appropriate fashion and determine whether it falls within their jurisdiction. If the complaint does involve a licensing issue, licensing officers are to complete the appropriate intake documents and contact the agency that funds the facility, if applicable. If the complaint involves a possible criminal matter, the licensing officer is supposed to contact the police.

The next step is for the licensing officer to determine the nature of the complaint and its urgency, including whether anyone in care is at risk and, if so, to what degree. Licensing officers are then supposed to prepare an action plan, notify the facility operator of the allegations, and investigate.

When conducting investigations, licensing officers must decide whether, on the balance of probabilities, an operator has contravened the Act or its Regulation. In order to do so, licensing officers collect and analyze evidence. This may involve conducting a non-routine inspection of the facility in question and interviewing those involved in the allegation. Licensing officers are supposed to document all of these steps. If an officer concludes that a contravention has occurred, he or she must then decide whether to recommend that the regional medical health officer take any steps to adjust the facility's licence. Medical health officers have the authority to attach terms and conditions to a licence, suspend or cancel a licence.

Communicating with Complainants

When reviewing the ministry's draft manual on licensing investigations, we observed that most of the direction it provides to licensing officers about communication pertains to the way they communicate with facility operators. In contrast, there are very few requirements on communicating with the person who actually made the complaint. For example, the manual states that licensing officers should inform facility operators about the progress of their investigations, involve them wherever appropriate and notify them of an investigation's outcome as soon as possible. The manual does not direct officers to inform complainants about the progress of investigations or notify them of the outcome. The draft manual also 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 on providing information to complainants at the conclusion of investigations. In fact, the manual specifies that licensing officers should not provide information to anyone other than the operator, the ministry's director of licensing and the funding body.

⁴⁵² Ministry of Health, *A Guide to Community Care Facility Licensing in British Columbia*, draft policy document, November 2009.

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The ministry's website also states that complainants "will not be provided with follow-up information regarding the outcome of the investigation."⁴⁵³ This is consistent with what we heard from people who contacted our office, several of whom complained to community care licensing offices and were not told the outcome of their complaint.

We asked the health authorities about their practices of providing information to complainants at the end of licensing investigations. 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 requires licensing staff to verbally advise complainants of the outcome of its complaint investigations. However, 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.⁴⁵⁴ 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 our view, the lack of any requirement for licensing officers to update complainants during or at the conclusion of investigations is an unfair aspect of this complaints process. It is reasonable for those who complain to expect that they will be informed about the status and outcome of their complaints. Unless doing so would impede the investigation, licensing officers should be able to provide complainants with updates upon request. Complainants should also be informed when investigations have concluded and what the results of the investigation were.⁴⁵⁵

The transparency of the process would improved if licensing officers provided this information routinely, without complainants having to file a *FOIPPA* request.

Timeliness

The Ministry of Health has not established time frames for completing licensing investigations. We were told this is to account for and reflect the variations in the complexity and time required to complete these investigations. Licensing officers do have the discretion to prioritize work they consider urgent, but they are not required to do so. Fraser Health and VIHA both have a target for licensing officers to complete investigations within 60 days.

⁴⁵³ Ministry of Health, Complaints <<http://www.health.gov.bc.ca/ccf/complaints.html>>.

⁴⁵⁴ These complaints were about the facility that he or 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.

⁴⁵⁵ It may not always be possible to provide the complainant with a copy of the investigation report because it may contain personal information about a third party. That information has to be removed in order to comply with the *Freedom of Information and Protection of Privacy Act*.

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Recourse

The Ministry of Health's Community Care Licensing Branch describes itself as the provincial steward of the community care licensing programs in the regional health authorities. Despite this, there is no formal way for someone who is dissatisfied with a licensing investigation or with the care provided at a licensed facility to complain to the ministry's community care licensing branch. The only other available options for those who wish to register a complaint at this level are informal. People who are dissatisfied with the way a licensing officer has carried out an investigation can complain to the officer's supervisor, who is usually a regional manager at the health authority or the medical health officer.

Stewardship involves careful and responsible management, and requires the collection and use of information. Because one of the important functions of the community care licensing offices is investigating complaints we expected the ministry's community care licensing branch to collect complaint information from the health authorities. However, we found that the ministry's director of licensing is not regularly informed about the licensing complaints that health authorities receive and investigate.

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. (For a general discussion of the role of PCQOs and the process by which they handle care quality complaints, see the Home and Community Care section of this report.) A person who is unhappy with the way a PCQO has handled his or her complaint can ask the regional patient care quality review board (PCQRB) to review it. The review boards are part of and accountable to the Ministry of Health rather than to a health authority. Both of these processes were created when the *Patient Care Quality Review Board Act* took effect in October 2008.

Whose Complaints Can Be Accepted

Each PCQO is limited to accepting complaints from the person receiving care or from a person on his or her 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. This can be limiting if, for example, a resident's legal representative is a child in another province who only rarely sees his or her parent.

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 not acting on a person's behalf are not officially recognized as being included in the legal definition of those who can complain to PCQOs.

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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 PCQOs do this.

While the provincial government's 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.

The patient care quality review boards are doing a better job of providing clear information on the complaints they will deal with. The joint website for the boards includes a clear description of the type of complaints that they will review and how they are handled.

Responding to Complaints: Facilities Licensed under the *Community Care and Assisted Living Act*

When dealing with complaints, PCQO staff have the authority only to consider the information and records that are either available to the health authority or provided by a service provider or complainant. Unlike licensing officers, PCQO staff do not have the authority to inspect a residence or interview staff and care providers. The role of the PCQOs is limited to trying to negotiate resolutions to complaints and recommending that health authorities improve their practices. The PCQOs cannot compel service providers to take actions and do not have the authority to take enforcement action themselves or compel health authorities to do so.

During our investigation we found that when PCQOs receive care quality complaints about a *CCALA* facility, the normal practice is to refer them to the local community care licensing office for investigation. We found that PCQOs follow this practice regardless of whether a community care licensing office has already been involved in the complaint. This means that when people who have already complained to a community care licensing office and have been dissatisfied with the investigation that it conducted take their complaint to their regional PCQO, the complaint gets referred back to the same people who have already investigated it. The PCQOs have not done a good job of letting the public know this. This practice is problematic even when community care licensing offices have not already been involved with a complaint, since complainants should be given basic information about how their complaint will be handled and have the opportunity to consent to the referral. It is worse, however, when a complaint has already been investigated by a medical health officer or licensing officer. People who bring complaints to PCQOs are entitled to expect that their issue will receive a fresh and independent consideration and not just be referred back to the people who already looked at it.

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Responding to Complaints: Facilities Governed by the *Hospital Act*

During our investigations we found two obstacles to the role of the PCQOs when responding to complaints about facilities licensed under the *Hospital Act*. We observed that PCQOs often refer complaints about residential care to licensing. However, licensing does not have a role in facilities under the *Hospital Act* and it is unclear whether a PCQO would conduct its own review or just request the facility's management to investigate and report back to it. PCQOs can only obtain information that is available to the health authority, provided by a contacted agency or provided by a complainant. PCQOs lack clear authority to obtain information about care provided in private hospitals that are not under contract with a health authority.

Timeliness

Under the *Patient Care Quality Review Board Act*, PCQOs are required to complete their complaint reviews within 30 business days. However, according to the ministry's orientation manual, the time allowed for PCQOs to process complaints about facilities licensed under the *CCALA* can be extended. According to the ministry, the rationale for allowing this is that the medical health officers and licensing officers who investigate complaints about *CCALA* facilities are not bound by specific time limits.

Comparison of the Community Care Licensing Office 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 for the following reasons:

- PCQOs can only deal with complaints about “care quality,” as defined in the *Patient Care Quality Review Board Act*. The jurisdiction that community care licensing offices have over *CCALA* facilities is broader. They must investigate every complaint about a community care facility not complying with the Act, its regulations or the terms or conditions of the facility's licence.
- PCQOs can only accept complaints from residents and their representatives or agents. Community care licensing offices can accept complaints from anyone, including complaints submitted anonymously.
- PCQOs do not have the authority to conduct inspections or to interview staff. The *CCALA* gives community care licensing offices broad investigative powers.
- PCQO staff do not usually conduct their own investigations of licensed facilities.
- PCQO staff are not trained or qualified to conduct inspections or in-depth investigations. Community care licensing officers are trained to conduct inspections.
- The role of PCQOs is limited to negotiating resolutions and recommending practice improvements. Under the *CCALA*, community care licensing offices have the authority to take enforcement actions, such as attaching conditions to a licence or varying its terms.

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While the community care licensing offices are generally better positioned to effectively respond to complaints, we found that the PCQO process has the following advantages:

- PCQOs can respond to complaints about residential care facilities that are licensed under the *CCALA* and those that are governed by the *Hospital Act*. Community care licensing offices can only investigate complaints about *CCALA* facilities.
- Under the *Patient Care Quality Review Board Act*, PCQOs must process complaints within 30 business days, though extensions are allowed under certain circumstances. There are no time limits that apply to the investigations conducted by community care licensing offices.
- PCQOs are required to inform complainants of the outcome of their complaint within 10 business days of resolving them. Community care licensing offices are not required to do this.
- People who complain to a PCQO and are not satisfied with the outcome of their complaint can request that their regional patient care quality review board review the matter. People who complain to a community care licensing office have limited rights of appeal of specific decisions made by licensing officers.
- PCQOs must report quarterly to their review board (which is part of the Ministry of Health), as well as directly to the Minister of Health. Community care licensing offices do not report to the ministry.

Conclusion

It is not surprising that people are confused about where to complain, because none of the health authorities provide complete and clear information about the complaints that each agency will and will not respond to or how they will do so. Furthermore, there is a lack of clear information about the differences in process and potential outcomes of each process.

There is no clear rationale for having two overlapping complaints processes for residential care. 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 patient care quality office 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.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

R149. The Ministry of Health establish the community care licensing offices as the single process for responding to all complaints about residential care:

- 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

Monitoring is the ongoing process of observing and checking to determine whether care, safety and service delivery standards are being met. Monitoring of residential care facilities is carried out through inspections, complaint investigations and review of reportable incidents. The current 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."⁴⁵⁶

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.

⁴⁵⁶ Ministry of Health, *Home and Community Care Policy Manual*, April 2011, Performance Management: General Description, 3.A.

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Monitoring Facilities Licensed under the *Community Care and Assisted Living Act*

Role of the Ministry of Health

The Community Care Licensing Branch of the Ministry of Health is responsible for directing the provincial community care licensing program. The branch leads the development of legislation, regulations and policies that govern the health, safety, well-being and dignity of seniors who live in residential care facilities that are licensed under the *CCALA*.

Role of the Director of Licensing

The director of licensing 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 approximately 250 licensed community care facilities serving seniors. The director is a statutory decision-maker appointed by order of the Minister of Health. Section 4 of the *CCALA* states that the director of licensing has the power to:

- require a health authority to provide routine or special reports on the operation of a facility, a licensing program or the results of investigations
- inspect the books, records or premises of a community care facility
- require a health authority to audit the operations of a community care facility
- carry out or order the investigation of a reportable incident, or a matter affecting the health or safety of a person in care
- specify policies and standards of practice for community care facilities
- make other orders he or she considers necessary for the proper operation of a community care facility or for the health and safety of people in care, including an order that is contrary to the decision of a medical health officer

The director also has the authority to enter and inspect a facility that appears to be providing residential care services without the required licence.⁴⁵⁷

We asked the ministry how often and under what circumstances the director of licensing has exercised these powers. The ministry provided us with the following information dating back to April 2004, which is when most of the *CCALA* came into force. The following table summarizes these findings.

⁴⁵⁷ *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75, s. 9(2).

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Table 40 – Monitoring Actions Taken by the Director of Licensing, 2004 to 2011

Actions	2004	2005	2006	2007	2008	2009	2010	2011	Total
Reports required	0	0	0	0	8	0	0	0	8
Inspections and audits conducted	0	0	0	0	2	0	1	1	4
Investigation of reportable incidents ordered	0	0	0	0	0	1	0	0	1
Policies and standards specified	1	0	1	0	1	0	0	1	4
Orders issued	0	0	0	0	0	3	0	0	3
Total	1	0	1	0	11	4	1	2	20

As the table shows, between 2004 and 2011, the director of licensing exercised her authority under the Act a total of 20 times.

Reports

In the past seven years, the director of licensing has required:

- on five occasions, a health authority to report on the operation of a licensed community care facility. Four of these reports were requested in 2008 and all were related to the announced closure of a residential care facility in Duncan owned by the Vancouver Island Health Authority. On the fifth occasion, the director required that the health authority report on a weekly basis any concerns regarding a particular residential care facility that was new.
- on three occasions, all five health authorities to report on their licensing programs. For example, in June 2008, the director asked all health authorities to report the number of residential care complaints their licensing offices receive and the number of licensing investigations they conduct.

Inspections and Audits

In the past eight years, the director of licensing has ordered inspections of four residential care facilities.

Investigation of Reportable Incident

In the past seven years, the director of licensing has, on one occasion, ordered the investigation of a reportable incident or a matter affecting the health and safety of residents. The order was made in 2009 in response to allegations that staffing levels in several facilities operated by the same owner were lower than those reported on schedules and other documentation provided to health authorities. It was also alleged that the same owner was serving food of lesser nutritional value than stated on menu plans.

Policies and Standards

In the past seven years, the director of licensing has, on four occasions, specified policies or standards of practice for community care facilities. In June 2004, the director issued a standard on first-aid certification for residential care staff. In September 2006, the director issued a standard on care planning and advanced

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directives. In June 2008, the director issued a standard on immunizations for seniors in residential care facilities. In September 2011, the director issued a standard to clarify that aggressive behaviour by a resident towards another resident is a reportable incident.

The ministry is currently developing provincial community care licensing policies to guide and support the licensing activities undertaken by the health authorities.

Orders for Proper Operation and Health and Safety

In the past seven years, the director of licensing has, on three occasions, issued orders considered necessary to ensure the health and safety of facility residents. All of these were for facilities in the Interior health region in 2009. For example, in one instance the director was concerned about seniors at a facility who were going outside. The director ordered the operator to: ensure that residents were accompanied by a staff member at all times when outside; accommodate residents' requests to go outside; keep a log of the times each resident went outside; and provide the director with a copy of the log every week.

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 authority and are often directly responsible to the health authority's CEO.⁴⁵⁸ The primary duties of medical health officers are outlined in the *Public Health Act* but they also exercise authority under other acts. The job descriptions for medical health officers indicate they are also responsible to the provincial health officer, for the quality of their work.

Specific responsibilities of medical health officers, under section 15 of the *CCALA*, are to:

- investigate every application for a licence to operate a community care facility
- investigate every complaint about the operation of an unlicensed community care facility
- investigate every complaint about a licensed facility that does not comply with the Act, its regulations or the terms of the facility's licence
- inspect community care facilities

In practice, medical health officers delegate most of these licensing duties to licensing officers, who are employees of the health authority.

Licensing officers are responsible for monitoring health and safety conditions in both child care facilities and residential care facilities for youth and adults. Both types of facilities are licensed under the *CCALA*. The primary duties of licensing officers, when it comes to residential facilities, include:

- providing information on residential care facilities to facility operators, licence applicants, funding partners and the public
- guiding applicants through the licensing process
- assessing licence applications for community care facilities
- investigating complaints about facilities licensed under the *CCALA*
- investigating and following up on reportable incidents

⁴⁵⁸ *Public Health Act*, S.B.C. 2008, c. 28, s. 71.

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- making decisions on requests for exemptions from the requirements of the *CCALA* or its regulations
- monitoring and inspecting licensed residential care facilities to ensure that they are meeting the requirements of the *CCALA* and its regulations
- applying progressive enforcement measures when facility operators have not met legislated requirements

Provincial Training for Licensing Officers

The ministry has not established any standard qualifications for licensing officers. 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 confirmed that no standardized provincial training programs exist for licensing officers and there is no requirement for these individuals to have any training in geriatrics. While training is the responsibility of each health authority, the ministry told us that it is considering developing a provincial training program for licensing officers.

Conclusion

Effective stewardship and oversight of programs require the collection and analysis of relevant and timely information about those programs. The information that the Ministry of Health requires health authorities to report to it monthly includes the number of licensed facilities in the region, the number of new facilities, the number of changes to facility licences and the number of reportable incidents.

However, the ministry does not regularly collect or track information about complaints received, inspections conducted and enforcement action taken against residential care operators. For example, the ministry could not tell us how often in the past eight years the health authorities in the province had suspended or cancelled the licence of residential care facilities.

For the Ministry of Health to effectively oversee the health authorities' residential care licensing programs, it is critical that the director of licensing obtain regular reports from all health authorities on complaints, investigations, inspections, reportable incidents, exemptions, facility closures and disruptions, and on any enforcement actions taken.

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The Ombudsperson finds that

F119. The Ministry of Health has not developed adequate provincial community care licensing policies in a timely manner.

The Ombudsperson recommends that

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.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

R151. The director of licensing require community care licensing offices to report to the Ministry of Health 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.

The Ombudsperson finds that

F121. The Ministry of Health has not developed provincial training standards and minimum education and experience requirements for community care licensing officers.

The Ombudsperson recommends that

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.

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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 *Community Care and Assisted Living Act (CCALA)* and the *Residential Care Regulation*, facility operators may apply for and be granted an exemption under certain conditions.⁴⁵⁹

Under section 4 of the Regulation, an operator can apply to a medical health officer for an exemption. Under section 16 of the *CCALA*, if a medical health officer believes that granting the exemption will result in *any* increased risk to the health and safety of those in care, he or she should not approve it.

When granting an exemption, a medical health officer also has the option of attaching terms and conditions to the exemption. As well, he or she may suspend, cancel or vary an exemption after it has been granted.

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.

Table 41 – Exemptions Granted to Licensed Residential Care Facilities, May 14, 2004, to March 31, 2009

Health authority*	Facilities granted exemptions	Exemptions granted
FHA	23	38
IHA	7	20
NHA	7	13
VCHA	10	19
VIHA	63	203

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

The Ministry of Health's draft guide for licensing officers states that they should consider the following factors when they are assessing whether to grant an exemption:

- any previous exemptions or variances granted to the operator
- the facility's history of compliance or non-compliance with the Act and its regulations
- the facility's history of reportable incidents

⁴⁵⁹ 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)).

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- the number of people in care who will be affected
- the length of time for which the exemption is requested
- any concerns that residents or their families have about the proposed exemption
- the views of residents and their families
- how the exemption and reasons for it address the Act's objectives
- the measures the operator proposes to ensure residents' health and safety
- whether any terms or conditions should be attached to the exemption
- whether the exemption should be posted with the facility licence

We asked each health authority to tell us how many exemptions from the *CCALA* and the *Residential Care Regulation* they had granted to the operators of residential care facilities between May 2004 and March 31, 2009. In total, 293 exemptions were granted.

The most frequently granted exemption (115 times) was from section 8.4(2)(a) of the former *Adult Care Regulations*, which stated that only staff members can administer medication. In most cases these were granted to residents in mental health facilities to allow them to administer their own medications.

While the *CCALA* gives medical health officers the authority to grant exemptions, they often delegate that power to licensing officers.⁴⁶⁰ Practice among the health authorities varies by who is responsible for approving different types of exemptions.

In the **Fraser Health Authority**, exemptions to the regulations are granted by licensing officers or licensing managers, depending on the type of request. Exemptions to the *CCALA* are granted by the medical health officer.⁴⁶¹

Cannot be Exempted

Schedule A of the Residential Care Regulation prohibits certain provisions of the Act and Regulation from being exempted, including:

Community Care and Assisted Living Act

- *prohibition against operating a community care facility without a licence*
- *requirement for a licensee to maintain certain standards, including promoting the health, safety and dignity of persons in care*

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- *character and skill requirements for staff*
- *prohibition against harmful actions, such as abuse and neglect*
- *restrictions on the use of restraints*

[for a full list of the provisions that cannot be exempted see Section A of the *Residential Care Regulation*]

⁴⁶⁰ Schedule A of the Regulation outlines the sections for which exemptions may not be granted. An exemption cannot be granted to any of the following provisions of the *Community Care and Assisted Living Act*: 1, 2, 5, 6, 7(1)(a)(b)(d), 18(2)(3), and 22. An exemption cannot be granted to any of the following provisions of the *Residential Care Regulation*: 1, 2, 12, 37, 38, 46(1), 52, 54(2), 55, 73, 74(2), 76, 77, 89.

⁴⁶¹ Licensing officers make determinations on exemptions relating to areas such as staffing requirements, financial and statistical reports, and physical plant requirements. Licensing managers decide exemptions from regulations, including the health of employees, administration of medication and the keeping of medication records, and investigations and complaints processes.

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In the **Interior Health Authority** exemption decisions are made by licensing officers.

In the **Northern Health Authority**, most exemption decisions are made by the regional licensing manager.

In the **Vancouver Coastal Health Authority**, medical health officers decide on a case-by-case basis whether to delegate an exemption request to an individual licensing officer. Exemption requests that are not delegated to licensing officers are decided by either a licensing supervisor or the medical health officer.

The **Vancouver Island Health Authority** (VIHA) has also created three levels of exemptions: licensing officers may only approve level one exemption requests, while level two requests can be decided by supervisors. Level three requests can only be decided by medical health officers.

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.⁴⁶² 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), we find it 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.

The Ministry of Health does not require health authorities to inform it when exemptions are granted, so it could not provide us with a provincial total. This means that the ministry has no information on either the overall number of exemption requests or the requirements being waived. As the steward of the provincial licensing program, the ministry is responsible for the development of legislation and policy. Having an understanding of the sections of the Act and Regulation from which operators request exemptions would help the ministry in setting policy direction and determining whether a review is required. (Requests for exemptions from notice requirements and appeals of these decisions are discussed later in this section, under “Closing, Downsizing and Renovating Facilities.”)

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

⁴⁶² Section 50 of the Regulation 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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The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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

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 in their region. The Act does not specify, however, the type or frequency of inspections that must be conducted. This means that inspections may be scheduled or may be unannounced.

Inspections that involve assessing a facility's compliance with all areas of the *Residential Care Regulation* are referred to as routine inspections. Routine inspections are comprehensive and can take two to three days to complete. Follow-up inspections are usually related to specific aspects of the Regulation. They may or may not be the result of a previous inspection. Inspections may also be conducted in response to a complaint.

While the Act gives the authority for conducting inspections to medical health officers, these powers are often delegated to licensing officers who are employees of the health authority. Most inspections are conducted by them. Licensing officers have discretion to plan how and when the inspections will occur. Inspection plans can vary based on a number of factors, including health authority policy and practice, the type of facility, the nature of the community, and the facility's risk assessment and history of compliance.

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At the conclusion of an inspection, the licensing officer or medical health officer completes an inspection report and provides a copy to the operator. The inspection report must clearly identify any instances of non-compliance with the applicable provisions of the Act or Regulation. Health authorities have posted inspection reports for CCALA-licensed facilities on their websites since November 2008.⁴⁶³

After an inspection, a licensing officer follows up on instances of non-compliance by conducting a follow-up inspection or requiring a written response from the operator outlining how the facility has or will come into compliance.

Two types of ratings are assigned after the inspection of a licensed residential care facility, a hazard rating and inspections priority level rating.

The *hazard rating* of a facility is based on the results of a particular inspection and the analysis of those results by licensing officers.⁴⁶⁴ In effect, a hazard rating is like a snapshot of a facility's situation at the time of inspection. If an inspection is a scheduled inspection, then the snapshot may be "posed" rather than capturing everyday circumstances.

The *inspection priority level rating* (formerly called the risk rating) is a more comprehensive assessment of a facility based on factors that have accumulated over time.

Hazard Ratings

At the conclusion of an inspection, the inspecting 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.

Steps in a Typical Inspection in the Vancouver Coastal Health Region

Before the inspection, licensing officers review the facility's file, including recent inspection reports, incident reports, investigation reports and complaints.

In the case of an announced inspection, the licensing officer makes an appointment with the facility's manager.

The licensing officer develops a plan for the inspection, including what files and policies are to be reviewed, what parts of the facility are to be inspected and who needs to be interviewed.

The licensing officer then conducts the inspection.

Afterwards, the officer reviews any identified issues with the facility's manager or representative.

The officer writes an inspection report.

The officer provides a copy of the inspection report to the facility's manager.

The officer develops a plan to follow up on any outstanding issues.

Source: Response by VCHA, June 24, 2009, 1.

⁴⁶³ Health authorities do not post inspection reports for facilities governed by the *Hospital Act*. Further discussion follows in this section under "Inspections in Facilities Governed by the *Hospital Act*."

⁴⁶⁴ The Vancouver Coastal Health Authority does not assign hazard ratings and the Vancouver Island Health Authority discontinued assigning hazard ratings in 2010.

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The following table shows the percentage of *CCALA*-licensed residential care facilities in each health authority that had low, medium or high hazard ratings as of March 31, 2010, and March 31, 2011. The Vancouver Coastal Health Authority could not provide us with this information as it does not assign hazard ratings.

Table 42 – Percentage of Facilities with Low, Medium and High Hazard Ratings as of March 31, 2010, and March 31, 2011⁴⁶⁵

Health authority*	Facilities (%) by hazard rating level					
	March 31, 2010			March 31, 2011		
	Low	Medium	High	Low	Medium	High
FHA	95	3	2	91	8	1
IHA ¹	65	31	4	68	29	3
NHA	92	8	0	100	0	0
VCHA ²	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
VIHA ³	73	8	1	Not Applicable	Not Applicable	Not Applicable

* 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 plans to discontinue its use of hazard ratings with an information upgrade in early 2013.

² The VCHA does not use hazard ratings.

³ In VIHA, 18 per cent of facilities had no rating assigned as of March 31, 2010. VIHA reported to us that the assignment of hazard ratings to inspection reports has been discontinued in order to support a consistent approach by health authority licensing programs.

Inspection Priority Levels (Risk Ratings)

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 the following six categories of concern. Some of these categories are given additional weight to reflect their importance:

- inspection hazard ratings, reportable incidents, investigations and any history of abuse
- effectiveness of management
- staff qualifications and supervision practices
- physical plant of the facility
- policies and procedures
- self-monitoring, prevention, quality improvement and staff training

⁴⁶⁵ These hazard ratings are based on the most recent inspection results for facilities as of March 31, 2010, and March 31, 2011.

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These factors assist licensing officers in identifying sources of operational difficulties and predicting the likelihood of problems in the future. Inspection priority levels are typically updated whenever a routine inspection is conducted.

As the following table shows, the health authorities vary in the range of points they have set to indicate a particular inspection priority level. This means that the same compliance and risk factors can result in different inspection priority level ratings depending on which health authority a facility is located in.

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.

Routine Inspection Frequencies

In all health authorities but one (Northern), 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 supposed to be inspected at least once every 12 months. Similar facilities in the Vancouver Island Health Authority need 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 region's 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.

The following table also shows the minimum frequency of routine inspections required by each health authority for facilities at each priority level. The Ministry of Health has not established any policy in this area or set out required frequencies of inspection for facilities at each priority level. As a result, there is no consistency across the province in the approach to the timing of facility inspections.

Table 43 – Points-Determined Inspection Priority Level Ratings and Routine Inspection Frequencies

Health authority*	Risk Level					
	Low risk (points)	Inspection frequency (months)	Medium/moderate risk (points)	Inspection frequency (months)	High risk (points)	Inspection Frequency (months)
FHA	13-29	12	30-39	6	40-65	4
IHA	13-30	12	31-50	6	51-65	3
NHA	Not used	12	Not used	6	Not used	3
VCHA	0-30	12	31-40	6	41-65	4
VIHA	0-30	18	30-40	12	40-65	6

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

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Scheduled Inspections

The Ministry of Health's draft provincial community care licensing policy states the following about unannounced and scheduled inspections:

Unannounced Inspections: It is important that most aspects of a facility operation are assessed at a time when the facility is in its usual routine. This is best carried out through unannounced inspections. Unannounced inspections are standard practice in most regulatory activities such as restaurant and food inspections, liquor licensing, bylaw enforcement and occupational safety.

Scheduled Inspections: It is sometimes appropriate to schedule inspections. For example, an inspection to assess specific aspects of a facility's operation that require the licensee/manager to spend time with licensing officers is usually scheduled to ensure those individuals are available.

Though the ministry's draft policy states that it is important that unannounced inspections are used to assess "most aspects of a facility operation," in practice, most inspections are scheduled. In addition to scheduled inspections, all the health authorities sometimes conduct unannounced inspections.⁴⁶⁶

Given that residential care facilities operate on a 24-hours basis, it is important for licensing officers to conduct inspections during all times that care is provided, including evenings, weekends and overnight. Four of the five authorities conduct nearly all inspections during normal business hours (8:30 a.m. to 5:00 p.m., Monday to Friday). The Northern Health Authority is the only one that regularly conducts inspections outside normal business hours. ("Normal" business hours tend to be those times when the most facility staff are on duty.)

Ombudsperson's Review of Inspection Files

To determine how often inspections of residential care facilities had been carried out, we reviewed a sample of inspection reports for 30 residential care facilities in each health authority. All reports were for the period January 2008 to June 2010, inclusive.

For the four health authorities whose inspection targets were once every 12 months, we determined that Vancouver Coastal met its annual goal for 80 per cent of the 30 sampled facilities and Interior for 67 per cent of its 30 sampled facilities. By comparison, Fraser met its target for only 43 per cent of its 30 sampled facilities, and Northern for only 23 per cent of its sampled facilities.⁴⁶⁷

While the Vancouver Island Health Authority has set less frequent inspection goals — once every 18 months — it met its target for only 40 per cent of the 30 sampled facilities.

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 and inspection priority levels.

⁴⁶⁶ In the Fraser Health Authority, unscheduled inspection is the preferred method.

⁴⁶⁷ Fraser Health Authority 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 consider 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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The Ombudsperson finds that

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.

The Ombudsperson recommends that

R156. The Ministry of Health establish provincial standards for inspection frequencies, hazard ratings, and inspection priority levels for residential care facilities.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

Inspections in Facilities Governed by the *Hospital Act*

In addition to facilities licensed under the *Community Care and Assisted Living Act (CCALA)*, there are 101.5 residential care facilities in the province governed by the *Hospital Act*: 77.5 are extended care hospitals and 24 are private hospitals.⁴⁶⁸ The 9,827 residents in these facilities make up approximately 34 per cent of the total provincial population of residential care facilities.

⁴⁶⁸ Each health authority, except for Fraser Health Authority, has facilities with both *CCALA* beds and *Hospital Act* beds. These facilities were counted as 0.5 of a *CCALA* facility and 0.5 of a *Hospital Act* facility.

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Table 44 – Extended Care Facilities and Private Hospitals, 2010/11

Health authority*	Facility type	
	Extended care hospitals	Private hospitals
FHA	15.0	12
IHA	16.0	1
NHA	11.5	1
VCHA	14.5	9
VIHA	20.5	1
Total	77.5	24

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

Table 45 – Ownership of Facilities Governed by the *Hospital Act*, 2010/11

Health authority*	Facility operated by	
	Health authority owned and operated	Contracted
FHA	15.0	12
IHA	16.0	1
NHA	11.5	1
VCHA	10.5	13
VIHA	15.5	6
Total	68.5	33

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

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 ministry-appointed hospital inspectors or by certain health authority staff. The medical health officers and licensing officers who inspect facilities licensed under the *CCALA* do not have the legal authority to inspect facilities governed by the *Hospital Act*.

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.

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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 we noticed 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 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 any or all of them were actively involved in inspections.

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 the inspections conducted on *CCALA*-licensed facilities, nor are these processes conducted with any regularity.

The Ombudsperson finds that

F126. The Ministry of Health's list of appointed provincial hospital inspectors is outdated.

The Ombudsperson recommends that

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.

Inspection of Private Hospitals

In theory, private hospitals may be inspected in the following three ways:

- by hospital inspectors appointed by the Minister of Health
- by a health authority inspector, if the facility is under contract with the health authority
- by the regional medical health officer, if he or she has concerns about the facility's sanitation or other public health matters

Section 7 of the *Continuing Care Act* states that private hospital operators who have a service agreement with a health authority are required to permit an inspector from that health authority to inspect all records of current and former clients, all financial records and the facility itself. Inspectors must also have access to all clients in the facility. (This is not as extensive as the authority granted to medical health officers under the *CCALA*.)

The Ministry of Health delegated the authority to inspect private hospitals to the health authorities in 1997, and has stated it expects the health authorities to inspect those facilities with which it has a service agreement.

In 2003, the ministry sent a letter to the health authorities reminding them of their authority to inspect those private hospitals they had service agreements with. The ministry confirmed with each health authority that it had such agreements with all the private hospitals in its region.

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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 the government's intention to shift the regulation of private hospitals from the *Hospital Act* to the *CCALA*, but said that, 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 further delayed but was expected to occur later in 2007. He noted that until then, the health authorities should continue to inspect private hospitals. The health authorities, he said, should 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

The health authorities' inspections of extended care and private hospitals were perhaps not as active as the ministry expected. We considered the time period between 2002 and 2011.

The **Fraser Health Authority** did not conduct regular inspections of the 15 extended care hospitals and 12 private hospitals located in its region between 2002 and 2008. The only aspects of the facilities inspected were for food safety (conducted by environmental health officers) and fire (conducted by the fire department) which were conducted regularly in all of the health region's facilities during this period.

In 2008, in anticipation of proclamation of section 12 of the *CCALA*, the Fraser Health Authority began conducting “transitional reviews” of the private hospitals in its region.⁴⁶⁹ The reviews were carried out jointly by one employee with licensing experience and another from the residential care sector. The reviews conducted in 2008 focused on eight areas:

- nutrition and food services
- medication
- hygiene and communicable disease control
- records and reporting
- physical aspects of the facility, including equipment and furnishings
- staffing
- policies and procedures
- care and supervision of residents

The **Interior Health Authority** did not conduct regular inspections of its 16 extended care facilities between 2002 and 2008. In 2008, the Interior Health Authority implemented a “regional quality site review process” for residential care facilities governed by the *Hospital Act*. Since then, the majority of the health region's extended care facilities have been reviewed under this process. These reviews are not akin to the inspections conducted by the Interior Health Authority's licensing officers under the *CCALA*.

There is one private hospital in the region. The health authority did not conduct regular inspections of this facility between 2002 and 2008. However, the facility was reviewed under Interior Health's quality site review process in January 2009.

⁴⁶⁹ In 2010, FHA conducted subsequent reviews of 9 of the 12 private hospitals and reviewed all extended care facilities during the 2010/11 fiscal year.

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The **Northern Health Authority** has not conducted regular inspections of its 11.5 extended care facilities or one private hospital since 2002.

There is one privately operated extended care hospital in the region. Although the Northern Health Authority has a service agreement with this facility, and therefore has the right to inspect it, it has not done so with any regularity. An inspection of this facility was conducted in 2004 in response to complaints the Ministry of Health received about nutrition, cleanliness, nursing care and building maintenance. In 2010/11, Northern Health's licensing staff inspected the newly renovated extended care hospital in order to assess the physical facility. The health authority told us that its approach to monitoring the care delivered in this facility is collaborative and involves meetings with management and site visits.

Before 2007, the **Vancouver Coastal Health Authority** did not conduct inspections of 23.5 residential care facilities governed by the *Hospital Act*. In 2006, the health authority delegated the responsibility for monitoring these facilities to its medical health officer. Since September 2007, however, Vancouver Coastal Health's staff have been regularly inspecting all 9 private and 14.5 extended care hospitals governed by the *Hospital Act*, including those Vancouver Coastal owns and operates itself. Staff base their inspection and monitoring of these facilities on the requirements of the *CCALA* and *Residential Care Regulation*.⁴⁷⁰

Vancouver Coastal Health is the only health authority which has, since September 2007, conducted the same type of inspections of its *Hospital Act* facilities as of its facilities under *CCALA*.

Vancouver Island Health Authority (VIHA) did not conduct regular inspections of the 20.5 extended care hospitals in its region since 2002. It is not clear whether the health authority has conducted inspections of the one private hospital in the health region.

Since 2004, however, the kitchens of VIHA facilities governed by the *Hospital Act* have been regularly inspected by environmental health officers. The kitchens are the only part of these facilities that are recorded as being regularly inspected. VIHA told us that in lieu of doing full inspections, it relies on the following tools as a means of checking standards:

- voluntary incident reporting
- reviews of reports from service providers
- site visits
- contractual obligations
- audits of food service contracts
- cleanliness audits by VIHA's environmental support services

Best Practice — VCHA Inspections of Facilities Governed by the *Hospital Act*

"In anticipation of proclamation of Section 12 of the CCALA, and in consideration of the fact that the same standards for health, safety and quality of care should apply to an extended care facility or a private hospital as to a facility licensed under the CCALA, VCHA has determined that we will proceed with using the CCALA and the Residential Care Regulation as a framework for our inspections."

Source: VCHA, letter to the Office of the Ombudsperson.
18 February 2010, 9

⁴⁷⁰ Private hospitals, however, are not expected to undergo renovation in order to comply with the physical requirements of the Act and Regulations.

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Oversight of Health Authority Inspections by the Ministry of Health

Despite the fact that the ministry sent letters to the health authorities reminding them of their authority to inspect private hospitals that provide residential care services, none of the health authorities conducted regular inspections until 2007 — the year that the Vancouver Coastal Health Authority began doing so. Between 2002 and 2007, extended care hospitals and private hospitals were not inspected with the same rigour and regularity as residential care facilities under *CCALA*. In 2008, both the Interior and Fraser health authorities initiated processes to begin reviewing these facilities. In addition, although hospital inspectors from the Ministry of Health have the authority to inspect residential care facilities governed by the *Hospital Act*, the ministry does not have records of any inspections occurring and could not tell us whether ministry staff had conducted any since 2002.

While the ministry reminded the five health authorities of their authority to inspect private hospitals several times between 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 time frame were required to provide any information to the ministry about their inspection of residential care facilities governed by the *Hospital Act*, not even copies of inspection reports or schedules. In fact, it wasn't until 2009 that the ministry required the health authorities to report to it on inspections conducted.

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 residential care facilities. The directive also indicates that the health authorities are to report to the ministry quarterly on the inspections they conduct, the results of those inspections and any further actions required.

We asked the ministry to update us on the implementation of this directive. We expected to receive copies of the health authority three-year plans and quarterly reports on inspections conducted. However, the information consisted mostly of general monitoring and inspection policies, some of which were several years old.

The information provided by the **Fraser Health Authority** to the ministry included a description of the “transitional assessment review” process it initiated in October 2008 to monitor and inspect the facilities in question. The health authority gave the ministry a list of the private hospitals that it had already reviewed during phase one of the transitional assessment review process, as well as a list of the extended care hospitals it planned to review during phase two. There was no evidence of Fraser Health submitting quarterly reports to the ministry and no evidence that Fraser Health had conducted inspections or additional reviews, including the phase two reviews. The health authority's documentation said that it would require additional resources to continue implementing its current review process.

The information provided by the **Interior Health Authority** to the ministry provided a detailed description of its quality review tool, a self-assessment tool it uses to monitor facilities governed by the *Hospital Act*. Despite the ministry's directive, the information provided by Interior Health did not include a three-year plan for inspecting *Hospital Act* facilities.

The information provided by the **Northern Health Authority** to the ministry included a policy stating that all residential care facilities in the region are expected to commission an external review of their facility provided every two years. Since the policy is not dated, it is not clear whether it was created in

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response to the ministry's directive. The health authority did not provide the ministry with a three-year plan for monitoring and inspecting *Hospital Act* facilities, nor did it provide a quarterly report or any other information about whether it has conducted inspections.

The **Vancouver Coastal Health Authority** provided the ministry with two inspection reports completed in June 2009, but did not include a monitoring and inspection process or a three-year implementation plan.

The **Vancouver Island Health Authority** was the only health authority to provide the ministry with a three-year plan. The plan, however, was brief and did not include any references to actual inspection practices, focusing instead on data collection and reporting. The health authority did not provide the ministry with a quarterly report or any other evidence of inspections conducted.

According to the ministry, the purpose of the directive, which it described as a key component of the ministry's stewardship role, was to outline the specific deliverables that the health authorities had to achieve. Clearly, however, the directive 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 its directive or to itself ensure 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 are.

The Ombudsperson finds that

F127. The Ministry of Health has not taken reasonable steps to ensure that residential care facilities under the *Hospital Act* are being properly inspected.

The Ombudsperson recommends that

R159. The Ministry of Health require the 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.

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The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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 Health, 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 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.⁴⁷¹

This concerns us because the ministry currently has no timeline for implementing section 12 of the *CCALA*, and it is still unclear whether this change will actually take place. At the same time the ministry provided the above response, it directed the five health authorities to develop a three-year plan for monitoring and inspecting facilities governed by the *Hospital Act*. Given that the ministry asked for a three-year plan in February 2009, it seems unlikely that section 12 will be implemented before the expiration of this first three-year plan in February 2012. Perhaps a larger obstacle to posting inspection reports of *Hospital Act* facilities is the fact that, with the exception of Vancouver Coastal Health Authority, these types of inspections are not being done.

⁴⁷¹ Director of Home and Community Care Services, letter to the Office of the Ombudsperson, 23 February 2009, 4.

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The Ombudsperson finds that

F129. The health authorities do not post the results of inspections of residential care facilities governed under the *Hospital Act* on their websites.

The Ombudsperson recommends that

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.

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. Section 77 of the *CCALA* states that a person in care is involved in a “reportable incident” when that person is the subject either of a reportable incident or, in the case of emotional, physical, financial or sexual abuse or neglect, of an alleged or suspected reportable incident. (See complete list in text box.)

When a resident in a *CCALA* facility is involved in a reportable incident, the operator must 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.⁴⁷²

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 type of abuse — emotional, financial, physical and sexual — specifically excludes abusive behaviour perpetrated by another resident, unless the behaviour results in the need for emergency medical treatment or hospitalization.⁴⁷³

For example, the Regulation defines physical abuse as “any physical force that is excessive for, or is inappropriate to, a situation involving a person in care and perpetrated by a person not in care.”⁴⁷⁴ In accordance with the Regulation, physical abuse of one resident by another is only reportable if it results in the need for emergency medical attention or hospitalization. However, a resident’s “aggressive or unusual behaviour” toward another resident has to be reported if that behaviour had not already been documented and addressed in the aggressor’s care plan.

⁴⁷² “Immediately” is not defined in the Act or Regulation.

⁴⁷³ 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.

⁴⁷⁴ *Residential Care Regulation*, B.C. Reg. 96/2009, Schedule D.

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Effective September 1, 2011, the Ministry of Health's director of licensing issued a standard of practice under section 4 of the *CCALA* that clarifies that aggressive behaviour by a person in care towards another person in care is always a reportable incident, regardless of the outcome. Emotional or financial abuse however is still only reportable when it is carried out by an employee, volunteer or someone else who is not a resident.⁴⁷⁵

The rationale for excluding abuse by another resident from the list of reportable incidents in regulation is not clear, as the recent standard of practice highlights. Therefore, the Regulation should be amended to include abuse by other residents in care.

Ombudsperson Review of Reportable Incidents

While the *CCALA* requires operators to notify the health authority's medical officer, in practice, reportable incidents are received and reviewed by licensing officers. Licensing officers are supposed to review each of these reports and determine what further action, if any, is needed.

We received complaints about facility operators failing to report incidents and about the response of licensing officers to incidents that were reported. During our investigation, we reviewed how 15 different *CCALA*-licensed facilities handled reportable incidents in the period 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.

The complaint we received from Susan (see story below) illustrates the need for health authorities to improve their monitoring of incident reporting and to apply meaningful consequences when facility operators do not comply with requirements. (Names have been changed to protect confidentiality.)

Susan's Story

Susan's father, William, was living in a residential care facility licensed under the Community Care and Assisted Living Act (CCALA). Susan had complained to her health authority's community care licensing office several times because she didn't think the facility operator was complying with all the relevant legal requirements, including the ones on reportable incidents. Susan wasn't satisfied with how the licensing office responded to her concerns, so she complained to our office and we investigated.

Reportable Incidents under the Residential Care Regulation

- *aggressive or unusual behaviour*
- *attempted suicide*
- *choking*
- *death*
- *disease outbreak*
- *use of 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*

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

⁴⁷⁵ *Residential Care Regulation*, B.C. Reg. 96/2009, Schedule D.

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Susan didn't think the health authority's licensing officers had done enough to ensure that the facility was properly caring for residents and meeting the legal requirements related to reportable incidents. In particular, Susan was concerned about how the facility responded on two occasions when her father was injured. Although both injuries met the criteria for a "reportable incident," as outlined in the *CCALA* and the Residential Care Regulation, facility staff did not report either incident to the health authority. They only did so after Susan brought her concerns to the attention of the health authority's licensing officers.

Licensing officers investigated Susan's complaints and determined that the facility operator had not met the requirement to report both incidents. They also noted other concerns during their investigation. However, the only action they took was to require that "All reportable incidents ... be promptly reported by licensee to Licensing." Susan didn't think the health authority's investigation resulted in meaningful corrective action or consequences.

In Susan's case, the facility failed on at least two occasions to comply with its legal obligation to notify the health authority of reportable incidents. Licensing officers investigated and confirmed this, but their response was simply to reiterate an already existing legal requirement.

This complaint is only one of several we received about similar issues — that is, the failure by facility operators to report incidents and of health authority licensing officers to apply meaningful consequences in response. This concerned us, since the requirements on reportable incidents are one of the main tools that health authorities have to monitor the health and safety of seniors in residential care.

In such circumstances, licensing officers need to consider imposing more meaningful consequences on operators. For instance, facilities that display a pattern of failing to comply with the reportable incidents requirements can be given a written warning the first time, and advised that future incidents of non-compliance will result in stricter measures, such as attaching conditions to their licence.

Hospital Act Facilities

One of the key differences between facilities licensed under the *CCALA* and those governed by the *Hospital Act* is that for the latter there is no requirement to report "reportable incidents." This is a serious shortcoming in the oversight of those facilities. Only one health authority, Vancouver Coastal, 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 has established this reporting process, this is a policy in a single health authority and does not have the force of regulation or law.

The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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*.

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The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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*.

The Ombudsperson finds that

F132. The health authorities have not taken adequate steps to ensure that all operators of residential care facilities report reportable incidents promptly and consistently.

The Ombudsperson recommends that

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

Options Available under the *Community Care and Assisted Living Act*

Inspection and monitoring systems are effective only 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 provided is of 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 cancel a licence to operate permanently.

In British Columbia, the *Community Care and Assisted Living Act (CCALA)* provides enforcement options that can be applied to operators of facilities licensed under the 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, has broken other relevant provincial or federal laws, or has contravened a term or condition of the facility's licence, the officer can do any of the following:

- suspend or cancel the licence
- attach terms or conditions to the licence
- vary the existing terms and conditions of the licence

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A delegated licensing officer can take any of these steps, if he or she has reasonable grounds to believe that a resident's health and safety is at immediate risk. Attaching terms and conditions to a licence can then be effective in ensuring an operator's compliance, because those terms and conditions can be enforced like any other provision in the Act or Regulation.

Under section 23 of the *CCALA*, if the Minister of Health has reasonable grounds to believe that a resident's health or safety is at risk, he or she can appoint an administrator to operate a facility for a set period. Appointing an administrator for a facility has an effect similar to putting a company in receivership. The facility continues to operate under the direction of the administrator, who is responsible for approving all significant operational and financial decisions, including the hiring of staff and collecting of fees from residents.⁴⁷⁶

A decision of a medical health officer to take action on a licence and a decision to appoint an administrator can be appealed to the Community Care and Assisted Living Appeal Board.

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.⁴⁷⁷ 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 the *CCALA* was brought into force in 2004, no charges have been laid against operators of residential care facilities under the *CCALA*.

In the residential care context, licensing officers are supposed to use progressive enforcement (that is, steadily increasing the severity of consequences for non-compliance) to ensure the provisions of the *CCALA* and the *Residential Care Regulation* are met. For a minor breach, education may be the most appropriate choice. This may be the case when licensing officers believe that all that is needed is reinforcement of an operator's understanding of the requirements. Verbal and written warnings are the next step. In cases where there have been repeated failures to comply with requirements, stronger sanctions may be appropriate, such as taking action on licences.

The health authorities told us that facility operators are expected to address all the gaps or problems that licensing officers identify during inspections, and that licensing officers are supposed to follow up with operators until all such issues are resolved. The Ministry of Health told us that licensing officers consider each case of non-compliance individually and that there are no pre-determined penalties that they must apply in particular situations.

We wanted to know how often enforcement options more severe than a written warning available under the *CCALA* are actually used. The table below shows the number of times that health authorities took formal enforcement action between 2002/03 and 2009/10.⁴⁷⁸

⁴⁷⁶ The administrator is paid a fee from the facility revenue, which is approved by the minister. If there is a shortfall in revenue, the difference in the administrator's fee will be paid by the minister. The operator is entitled to net revenue after all other expenses have been paid.

⁴⁷⁷ Section 5 prohibits operating a community care facility without a licence. Section 6 requires the manager of a licensed facility to be an adult. Section 18(2) prohibits licensees from encouraging persons under 19 to enter British Columbia to become a person in care without certain approvals. Section 18(3) prohibits licensees from taking certain actions such as persuading a person in care to alter a will, and acting as a power of attorney for a person in care. Section 26(1) prohibits operating an assisted living residence that is not registered. For more detail, see the *Community Care and Assisted Living Act*.

⁴⁷⁸ When we refer to formal enforcement actions, we mean any actions taken against a licence.

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Table 46 – Enforcement Actions Taken on Residential Care Facility Licences, 2002/03 to 2009/2010⁴⁷⁹

Health authority*	FHA	IHA	NHA	VCHA	VIHA	Total
Number of CCALA-licensed facilities (2009/10 figures)	65	69	12	42	66	254
Capacity of CCALA-licensed facilities (2009/10 figures)	5,936	4,242	794	4,364	4,187	19,523
Type of enforcement action						
Conditions attached to licence	14 ¹	19 ²	0	1 ³	1 ⁴	35
Conditions on licence varied	Not available ⁵	0	0	0	0	0
Suspension of licence	0	0	1 ⁶	0	0	1
Cancellation of licence	1	0	1	0	0	2
Administrator appointed	1	0	1	0	1	3

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

¹ The FHA reported that these 14 conditions were ones that were agreed to by licensees.

² In the Interior health region, 19 facilities have had conditions attached to a licence. Two of those facilities have each had two conditions attached.

³ In the Vancouver Coastal health region, three conditions were attached to one facility's licence.

⁴ Administrator later appointed in 2007/08.

⁵ The FHA could not provide data for 2002/03-2008/09. In 2009/10, the FHA did not vary conditions to a licence.

⁶ Initially the licence was suspended. After reconsideration, it was cancelled, as shown in cell below.

As the previous table shows, in the period from 2002/2003 to 2009/2010, the health authorities took formal enforcement action on residential care facilities a combined total of 41 times.⁴⁸⁰ While we understand the necessity to be fair when taking any formal enforcement action, it is clear that the health authorities, with the exception of the Interior Health Authority and the Fraser Health Authority, have rarely used enforcement beyond verbal or written warnings.

Of the 35 times the health authorities have attached conditions to residential care facility licences, 19 are in the Interior health region. The types of conditions attached to licences in those cases 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.

Based on the information we received, none of the health authorities has varied the conditions of a licence. Only two — the Northern Health Authority and the Fraser Health Authority — have suspended or cancelled a licence.

⁴⁷⁹ Includes actions taken on all CCALA-licensed long-term care facilities, whether those facilities are subsidized by a health authority or not.

⁴⁸⁰ This does not include the eight licences not granted by the Fraser Health Authority.

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Appointment of an Administrator

The Ministry of Health has delegated its authority to appoint an administrator to the boards of the health authorities. A health authority's board has appointed an administrator to a residential care facility in British Columbia on three occasions since the *Community Care and Assisted Living Act (CCALA)* came into force: once in the Northern Health Authority (2006), once in the Fraser Health Authority (2006) and once in the Vancouver Island Health Authority (VIHA; 2007).

In 2007 the VIHA board appointed an administrator to run a facility located in Victoria. An administrator was appointed after several complaints made to VIHA's community care licensing office generated significant public concern. We asked VIHA to provide us with its records on licensing complaints and investigations for this facility. What follows is a summary of the events that led to the appointment of the administrator.

Overview of the Situation

The following example shows that even though VIHA monitored the facility in accordance with statutory, regulatory and policy requirements and followed principles of administrative fairness, problems persisted at the facility. VIHA had a process of monitoring and enforcement, but this example indicates the real challenges involved in enforcing minimum standards. Licensing officers need to conduct thorough investigations and provide operators with an opportunity to respond. They also need to consider that while a facility is not meeting the minimum standards set out in the legislation, seniors continue to live in these conditions. These seniors may not be in a position to complain or leave an unsafe situation. Consequently, timeliness in applying progressive enforcement is critical.

The 80-bed residential care facility, has been operated by a private company since 1992. It is licensed under the *CCALA*, so its residents received a higher degree of statutory protection than those in similar facilities regulated under the *Hospital Act*.

Between 1997 and 2003, VIHA licensing officers conducted seven investigations in response to complaints that facility staff were neglecting residents, emotionally and physically abusing them, and failing to follow a resident's dietary requirements. In December 2002, VIHA's community care licensing office substantiated a complaint that two staff had abused a resident by pouring water on her to prompt her to remove her clothing. No changes to the facility's licence were made as a result of these investigations.

Eleven complaints about the facility were made to VIHA's community care licensing office in 2004. Although all the complaints related to serious contraventions of the *CCALA*'s requirements, licensing officers took no action against the facility's licence, as they were satisfied by facility management that the issues would be addressed.

In March 2005, VIHA's licensing office received a complaint about several incidents: neglect, poor documentation of medication, poor communication, inadequate staffing, hygiene concerns and poor nutrition. After investigating, licensing officers attached a set of conditions to the facility's licence, including suspending admissions for four months. Facility management gave further assurances that concerns would be addressed and necessary measures taken to reinstate confidence in their services.

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More complaints were made to VIHA's licensing office beginning in July 2007. These were in response to a change in the contracted service provider hired by the operator to provide care at the facility. After reviewing these new allegations and past incident reports, the VIHA board appointed an administrator to operate this facility for six months beginning in October 2007.

Findings of the Investigation by VIHA's Licensing Staff

2004

Between May and August 2004, VIHA's licensing office received several complaints about neglect, falls, foul odours throughout the facility, unsatisfactory storage of medications, and poor communication. The most alarming was an allegation that a resident left restrained and unsupervised in a wheelchair had later died. Another complaint alleged that a staff member slept on the night shift and disabled the call bell system so that residents' calls for assistance went unanswered.

VIHA's licensing officers met with the operator to determine whether these allegations could be substantiated and, if so, how to address them. After investigating, licensing officers confirmed that there was enough evidence to support claims of neglect and poor maintenance. They also confirmed that practices for documentation, medication storage and communication were poor, and that this put the health and safety of persons in care at risk. Licensing officers also found that most care plans were outdated, inconsistent and lacking in necessary information.

Although they confirmed several contraventions of the *CCALA* and the *Adult Care Regulations* (the precursor to the *Residential Care Regulation*), licensing officers ultimately decided not to take any formal action against the facility operator's licence. The operator assured licensing officers that the contraventions would be addressed, in part by splitting the role held by the manager of care, who had previously acted as both facility manager and supervisor of care. Licensing officers accepted the operator's commitment to meeting its legislated responsibilities and planned to continue monitoring compliance.

2005

In March 2005, VIHA's licensing office received another complaint, which it investigated in April.

The investigation substantiated that incidents of neglect had taken place, including delay of treatment, failure to follow a treatment protocol, an unsafe lift and transfer, inadequate implementation of pain treatment and poor documentation of medical treatment. The investigation also concluded that facility staff had failed to properly administer medication, resulting in one resident not receiving required medication for approximately six months. As well, licensing officers substantiated concerns about delays in reviewing nutrition care plans and failure to monitor residents' weight and nutrition intake.

Another of the key concerns that arose from this investigation was the failure of facility staff to inform VIHA of reportable incidents. Licensing officers examined the facility's internal incident reports from January to March 2005 and identified 26 reportable incidents that had not been reported to VIHA. Incidents that were not reported included cases of resident neglect, falls, unexpected illnesses, wandering, and aggressive or unusual behaviour, as well as general service delivery problems.

Licensing officers also had serious concerns about poor documentation practices and poor communication between facility staff and physicians, pharmacists, dietitians, the facility manager and the director of care.

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Licensing officers concluded that the operator, the facility manager and the supervisor of care were either unwilling or unable to meet legal requirements, as demonstrated by their continued failure to report reportable incidents or comply with minimum health and safety standards. The investigation report noted that licensing officers had found the same risks to health and safety and incidents of non-compliance as had been found in 2004. Despite the operator's past assurances, the continued evidence of unacceptable practices demonstrated an inability to ensure that facility staff were providing appropriate care.

As a result of this investigation, VIHA's medical health officer decided to attach a set of conditions to the facility's licence at the end of April 2005. The conditions required the facility to:

- ensure that the manager responsible for daily operations, the supervisor of care and a registered dietician-nutritionist all worked on site for a minimum of 35 hours per week, with the dietician-nutritionist to work on site for a year following the date of the medical health officer's decision
- within one month, develop a plan to ensure delivery of appropriate care that was acceptable to the medical health officer, including processes to ensure appropriate documentation, communication and staff training
- suspend admissions for four months
- submit progress reports on the issues identified in the report in 3, 6 and 12 months

The facility did not request a reconsideration and did not appeal this decision.

2007

In April 2007, the medical health officer wrote to the facility stating he was satisfied with its compliance with the conditions attached to the licence, based on the high level of compliance with the regulations during the most recent routine inspection and the lack of recent complaints.

In May 2007, the operator notified the facility that there would be a change in its contracted care provider, effective July 2007. As a result of the change, several facility employees received lay-off notices that same month. Shortly after that, VIHA licensing officers received complaints about substandard care, including poor housekeeping, insufficient staffing and decreased bathing hours. Although the operator hired a new general manager and a new director of care, family members and staff continued to have concerns and the licensing office received 10 complaints between August and September 2007. Licensing and other VIHA staff conducted several site tours and audits during this time and a Quality of Care Review Team was appointed in the fall to look in more detail at ongoing care issues.

In response to this round of complaints, licensing officers conducted another investigation which showed that the operator was again contravening the *CCALA* and *Adult Care Regulations*. Examples of non-compliance included:

- a bath log that showed that residents were often going without baths for two weeks and sometimes three
- three further instances of neglect
- poor incident reporting
- insufficient staffing

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- failure to ensure that staff had the required immunisation and TB records, valid first-aid certificates and medical authorizations before starting employment
- significant concerns about the nutrition needs of 20 residents
- the inability of care aides to identify puréed foods that they were feeding to residents
- insufficient blood glucose monitoring
- failure to administer prescribed medication
- medication being administered as much as four months past their expiration date
- extremely poor documentation practices relating to the administration of medication, care plans and nutrition
- cases of lost and wandering residents

Following the 2007 review, licensing officers concluded they had lost confidence in the operator's ability to run the facility safely in accordance with legislative requirements. Given the risks to residents that resulted from the deficiencies, licensing officers recommended that an administrator be appointed for a minimum of six months beginning in October 2007.

Conclusion

A review of the events that led to the appointment of an administrator for this facility shows that there were problems at the facility from 2002 onwards. It was clear after licensing officers conducted their second formal investigation in 2005 that the operator had failed to address the substantiated concerns raised in the first formal investigation. Between March 2004 and September 2007, VIHA staff inspected the facility 66 times, 31 of which resulted in a high hazard rating. Still, another 29 months passed before an administrator was appointed to take over the operation of the facility.

Despite the regular presence of licensing officers at this facility, major issues with safety and service quality persisted over a prolonged period. When 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.

It is unacceptable for seniors, who may not be in a position to complain or to leave an unsafe situation, to have to live in a facility that does not meet the minimum standards set out in legislation. And it is unfair for those seniors, who are dependant for their basic needs on care providers, to have to contend with delays in addressing quality of care concerns. 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.

Drawing a Comparison: Enforcement in Child Care Facilities

We were surprised to learn of the low number of formal enforcement actions that health authorities had taken against operators of residential care facilities. To find out how this pattern compared with that for other types of facilities that community care licensing offices oversee and regulate in British Columbia, we looked at child care facilities in the province.

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We asked each health authority to tell us how many licensed child care facilities it had in its region, and how many times it had taken action against a child care facility licence each year since 2002. While the capacity of licensed child care facilities is approximately seven times that of residential care facilities, we believe they offer a useful basis for comparison, since often the same licensing officers oversee and inspect both kinds of facilities. In addition, both types of facilities provide service to vulnerable populations that may have difficulty raising concerns.

A quick review of the figures we received from the health authorities (see the following table) shows a marked difference in how active they have been in enforcing standards for the care provided to children as compared with seniors, even after taking the increased number of children per facility into account.

Between 2002/03 and 2009/10, the health authorities took formal enforcement action against licensed child care facilities approximately 159 times. Forty-four of those actions involved the suspension or cancellation of a licence.⁴⁸¹ We noted, for example, that while the Vancouver Coastal Health Authority has yet to take formal action against the licence of an adult facility licensed under the *Community Care and Assisted Living Act (CCALA)*, it took action against child care facility licences 17 times in the period of review.

Table 47 – Actions Taken on Child Care Facility Licences, 2002/03 to 2009/10

Health authority*	FHA	IHA	NHA	VCHA	VIHA	Total
Number of CCALA-licensed facilities (2009/10 figures)	1,651	822	662	1,357	1,572	6,064
Capacity of CCALA-licensed facilities (2009/10 figures)	29,034	14,001	6,989	23,952	44,244	118,220
Type of enforcement action	FHA ¹	IHA ²	NHA	VCHA ³	VIHA	Total
Conditions attached to licence	6	92	0	7	5	110
Conditions on licence varied	0	1	0	4	0	5
Suspension of licence	4	2	0	1	2	9
Cancellation of licence	14	11	3	5	2	35
Administrator appointed	Not available	0	0	0	0	0

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

¹ The FHA reported that its information system did not capture the details we requested. The information provided to us was therefore based on the recollection of licensing officers. The health authority said that because taking action on a licence is not a common occurrence, it was fairly confident the information was accurate.

² The IHA could not provide data for 2002/03.

³ The VCHA reported that this information is not tracked in its information system, and was instead gathered anecdotally from discussions with licensing officers.

⁴⁸¹ The FHA also informed us of the number of times it has refused to issue a licence. These eight instances are not included in the table.

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Clearly, health authorities are more active in taking formal enforcement against the operators of child care facilities to ensure they are meeting the minimum legislated requirements.

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.⁴⁸² Some jurisdictions use administrative penalties to enforce compliance with the law. For example, 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. Additional federal enforcement remedies can also include the imposition of fines, based on the department's recommendations.⁴⁸³

While the *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.

As outlined above, the offence provisions in the Act are limited and, at least since 2002, no operator of a residential care facility has been charged.

While not the approach taken for violations of the *CCALA*, there are many 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 on a party who fails to comply with the water monitoring requirements in the *Drinking Water Protection Act*
- a police officer, motor vehicle inspector, park ranger, park warden, constable appointed under section 255 of the *Railway Act*, or police constable appointed under section 22 of the *Canada Ports Corporation Act* can impose a fine on a person for riding a bicycle on the sidewalk, which contravenes the *Motor Vehicle Act*
- 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*

The contraventions listed above are, arguably, less serious than failing to ensure minimum standards of care and safety in residential care facilities that serve a vulnerable population.

⁴⁸² Ontario Department of Health, *Report on Long-Term Care Homes — Frequently Asked Questions* <http://www.health.gov.on.ca/english/public/program/ltc/27_pr_faq.html>.

⁴⁸³ California Department of Public Health <<http://hfcis.cdph.ca.gov/AboutUs.aspx>>. The amount of the fine imposed depends on the “significance and severity of the substantiated violations.” The California State Department of Justice also has a Facilities Enforcement Team that “investigates and prosecutes corporate entities ... for adopting policies or promoting practices that lead to neglect and/or poor quality of care.” In 2009/10, the team was responsible for 46 convictions, which resulted in \$429,870 in criminal restitution paid and \$510,000 in civil monetary recoveries. For more information, see <<http://ag.ca.gov/bmfea/elder.php>>.

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Research by British Columbia's Attorney General's office has outlined the benefits of including administrative penalties as part of a regulatory framework.⁴⁸⁴ 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.

Allowing licensing officers to impose administrative penalties could offer several key benefits:

- It would create a middle option in the present system of enforcement. Currently the health authorities can seek only voluntary compliance through education and warnings or take formal action on a licence.
- It provides the health authority another enforcement option when considering whether to attach conditions to the licence of a facility the health authority operates.

In particular, the option of issuing tickets with attached fines would give the health authorities more flexibility in their efforts to achieve compliance. A ticketing system might provide an economic incentive to follow the rules. Using a ticketing system in the residential care context also means that penalties can be imposed for activities that create a risk of harm. As research by the Attorney General's office suggests, imposing such penalties might encourage regulatory compliance so that actual harm occurs more rarely.⁴⁸⁵

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.

The Ombudsperson finds that

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*.

The Ombudsperson recommends that

R165. The Ministry of Health develop a policy to guide community care licensing officers on how and when to apply progressive enforcement measures.

⁴⁸⁴ BC Ministry of Attorney General, Administrative Justice Office, "Administrative Monetary Penalties: A Framework for Earlier and More Effective Regulatory Compliance — A Discussion Paper," 2008.

⁴⁸⁵ BC Ministry of Attorney General, "Administrative Monetary Penalties," 2008, 9.

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The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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.

Enforcement Options Available under the *Hospital Act*

The *Hospital Act* establishes very limited enforcement options, particularly against operators of extended care hospitals. Upon the minister of health's recommendation, the lieutenant governor in council can appoint an administrator to manage an extended care hospital's affairs, similar to the appointment power under the *Community Care and Assisted Living Act (CCALA)*.⁴⁸⁶

In addition, if the minister of health is unsatisfied with the way an extended care hospital is administered, or if an extended care hospital fails to comply with the Act, the lieutenant governor in council can withhold an amount payable to the hospital.⁴⁸⁷

For private hospitals, the minister of health can also revoke an operator's licence if they fail to take corrective measures to address issues such as: providing inadequate patient care; addressing problems with equipment or the premises in a timely manner; or operating the facility in contravention of a condition of the licence.⁴⁸⁸

⁴⁸⁶ *Hospital Act*, R.S.B.C. 1996, c. 200, s. 52. The Minister also has the authority to appoint one or more people to the hospital board, but this is an indirect way of responding to problems in a facility and would not readily address individual circumstances.

⁴⁸⁷ *Hospital Act*, R.S.B.C. 1996, c. 200, s. 47.

⁴⁸⁸ *Hospital Act*, R.S.B.C. 1996, c. 200, s. 14.

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The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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*.

Closing, Downsizing and Renovating Facilities

We discuss in other sections of this report how 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.

Given how unsettling the transition to residential care can be, it is not surprising that seniors and their families have many concerns when operators propose to close their facilities or make other significant operational changes, such as renovating or downsizing, or to transfer a senior for a reason not related to health and well-being.

Residential care facilities are home to the seniors who live in them. Elderly people often find the adjustments required as a result of a move difficult to make. This is particularly true if the change results in a new set of caregivers unfamiliar with an individual's routines, preferences and needs.

During our investigation, we received complaints about how operators and health authorities handle situations in which facilities are closed, downsized, renovated or affected by mass staff replacement.

Some matters people complained about were:

- learning of a planned closure through media reports or a notice on a bulletin board
- family councils not being involved in decisions about closures or downsizing
- vague or inconsistent reasons given for closures
- medical officers not being given adequate notice of closures or downsizing plans
- the potential for moves to undermine residents' health and well-being
- the potential for the quality of care to decline as a result of a move
- lack of opportunity to provide any input into decision making

Residential Care

Ministry Policy on Resident Moves

2009 Provincial Guidelines for Closures of Residential Care Facilities

In 2009, while our investigation was underway, the ministry created new provincial guidelines on the closure of residential care facilities.⁴⁸⁹ The guidelines apply to all residential care facilities that are owned or funded by health authorities, regardless of the legislation that applies.

The guidelines state that the health authorities must develop their own policies and procedures on facility closures and downsizing that include the following:

- a process to provide opportunities for a care conference with health authority and facility staff, and to develop an individual placement plan
- timely communication with the client and an opportunity for follow-up discussion
- a reasonable time frame for the client to plan for the relocation
- a process to assess the client's needs and evaluate the suitability of his or her facility preferences
- a process to communicate the client's current clinical and special clinical needs to staff in the receiving facility

The guidelines indicate that the health authorities are to establish an appeal process that can be used when seniors or their families object to placement decisions that health authorities make in the process of closing facilities. It is important that health authorities ensure this team informs seniors and their families are aware of how they can appeal a placement decision.

The provincial guidelines also state that at least one month before a facility closure is announced, the health authority involved must: create a communication plan to ensure that residents, families, staff and other stakeholders will be properly informed of the closure decision; and publish a notice of the closure in the local newspaper.

As well, the guidelines require health authorities to create a facility closure team. The province's Residential Care Standing Committee is responsible for establishing a cross-authority facility closure committee to ensure that closure processes are consistent across the health authorities.

2011 Home and Community Care Policy Manual

The Ministry of Health has a policy that applies to all situations in which subsidized residents must move because their existing care facility is being renovated or closed.⁴⁹⁰ The policy, which went into effect on April 1, 2011, applies whether the facility in question is licensed under the *CCALA* or governed by the *Hospital Act*.

According to the policy, health authorities must do the following when planning and managing residential moves:

⁴⁸⁹ Ministry of Health Services, Home and Community Care, *Provincial Guidelines for Closure of Residential Care Facilities*, 11 June 2009.

⁴⁹⁰ 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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- maintain the quality and safety of care
- ensure that residents will not have to move more than once unless they request to do so
- provide information on appropriate facilities in the area
- offer opportunities to meet with health authority and facility staff in order to identify key concerns and develop individual placement plans
- ensure that a resident is not moved until a care conference has taken place and an individual placement plan developed
- offer placement options that account for the distance, time and terrain that caregivers will need to travel in order to visit the resident
- ensure that couples who currently live together and wish to stay together are relocated together, even if their care needs differ
- facilitate a move to another health region if requested⁴⁹¹

Both Ministry of Health policies apply to facility closures and the 2011 Home and Community Care policy manual also applies to situations where residents are required to move because a facility is being renovated. During our investigation we received complaints from residents who had to move because a health authority has decided to reduce its funding of beds at a facility. Such a move can be as disruptive to residents as a move made for any other reason. Despite this neither ministry policy specifically covers situations where a senior has to move because of the funding decision.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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.

⁴⁹¹ 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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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. The Regulation does not require notification of residents and their families under any of these circumstances.

The provincial guidelines require operators to develop a communications plan one month before the public announcement of a closure, but that announcement may therefore occur long after the decision to close is made and steps are taken that make it more difficult for seniors and their families to challenge a particular decision.

Section 16 of the *CCALA* authorizes medical health officers to exempt an operator from 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 so 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 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. 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.

The complaints our office received about the closure, disruption or renovation of *CCALA*-licensed facilities raised many complex issues. These issues became an important focus of our investigation. Two cases we investigated in depth — Cowichan Lodge and Newton Regency Care Home — are summarized below.⁴⁹²

Community Care and Assisted Living Appeal Board (CCALAB)

The CCALAB hears appeals from 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.

On appeal, 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>>.

⁴⁹² Greater detail of both investigations is available on our office's website: <www.bcombudsperson.ca>.

Residential Care

Facility Closure Investigation

Cowichan Lodge was built in Duncan on Vancouver Island in 1981. It was first used as an intermediate care facility but was switched to a complex care facility in 2002.

In 2007, the Vancouver Island Health Authority (VIHA) conducted a review of its residential care facilities. It concluded that Cowichan Lodge did not meet current standards and would be too expensive to renovate to bring it up to those standards. Important to note is that while Cowichan Lodge did not meet some of the physical requirements of the *Adult Care Regulations* that were in effect at the time, it was not required to do so because it had been licensed before August 1, 2000, and was exempted from the requirements. A number of facilities across the province continue to operate under such exemptions.

Although VIHA had worked out an initial plan for its 2008/2009 budget it learned in February 2008 that its budget allocation increase for the 2008/09 fiscal year was less than originally anticipated. This resulted in cost pressures. VIHA senior management then had to revise its budget. In April and May 2008, VIHA presented its proposed 2008/2009 operating budget and service plan to its board for consideration. The plan included a description of the region's residential care capacity, and planned closure of Cowichan Lodge.

The board approved the revised 2008/2009 operating budget on May 28, 2008, which meant the planned closure of Cowichan Lodge was approved.

At that time, section 14(1) of the *Adult Care Regulations* required VIHA, as the operator of this licensed facility, to provide the regional medical health officer with a year's notice of the closure decision. If it wished to close a licensed facility with less than a year's notice, VIHA could request an exemption from the notice period. In May 2008 when VIHA presented the plan to close Cowichan Lodge in August, no mention was made of the requirement to seek an exemption. VIHA had not consulted facility staff, residents or their families during this process.

VIHA decided to tell Cowichan Lodge staff, residents and families about the closure on Friday, June 20, 2008, more than three weeks after the board's decision. VIHA management met with union executives on June 18 to discuss the closure, believing the information would remain confidential until it was publicly announced. However, information about the pending closure became public as early as June 18, and many residents and family members heard of the closure from sources other than VIHA, including the media.

On June 20, VIHA met with Cowichan Lodge staff to inform them of the closure. A letter from the facility's manager to residents and families was also posted at the lodge. The letter said that Cowichan Lodge did not meet standards and could not be renovated to do so; and that a new facility, Sunridge Place, was opening nearby where VIHA would start relocating residents in August. All moves were to be finished by mid-September, when VIHA intended to close Cowichan Lodge. The letter did not mention VIHA's plan to hold a meeting about the closure at Cowichan Lodge on June 24 or the legal requirement to notify the medical health officer one year in advance of the planned closure and seek an exemption to allow an earlier closing date.

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The plan to close Cowichan Lodge was a surprise to the community. There had been no prior public discussion of this possibility. In fact, in the year before the announcement, VIHA had spent roughly \$600,000 upgrading the facility. When VIHA announced the closure, all 94 beds at Cowichan Lodge were occupied, including all 72 permanent complex care beds. Some residents had lived at Cowichan Lodge for as long as 11 years, and most for at least two years.

When VIHA told Cowichan Lodge staff about the closure, it did not also tell them that Sunridge Place was still hiring. A number of people who contacted the Office of the Ombudsperson after being informed of the decision on June 20, 2008, had heard that June 18, 2008 was the deadline to apply to Sunridge Place, which was scheduled to open June 25.

Throughout the weekend of June 21, VIHA made efforts to call families about its June 24 meeting on the closure. However, we heard from some family members listed as residents' next of kin that they had not been called. Unfortunately, VIHA's notes about calls made during this period were discarded around July 8, leaving no record of who had been contacted and when.

At the June 24 meeting, residents were told that Cowichan Lodge was being closed because of safety concerns and that residents would have priority access to their preferred facility. VIHA did not mention that it needed to get an exemption from the 12-month notice requirement in order to proceed with its plan to close the lodge by mid-September.

Also on June 24, the executive director of Sunridge Place wrote to Cowichan Lodge's manager to say that Sunridge Place was continuing to accept job applications in all areas, and asked that this information be communicated to staff. The letter was posted on the staff information board at Cowichan Lodge and shared at staff meetings.

VIHA's community care licensing office is responsible for ensuring that residential care facilities licensed under the *CCALA* meet the requirements of the Act and its regulation. When VIHA's regional manager of licensing, who works directly with VIHA's medical health officer and has delegated authority from that officer, heard of the plan to close Cowichan Lodge on June 24, she contacted VIHA's residential services section to ask for more information. She followed up with VIHA's residential care section on June 25 and 26, passing on information about the notice requirement and the exemption request process. She also explained that if the medical health officer granted an exemption, that decision could be appealed to the Community Care and Assisted Living Appeal Board (CCALAB).

On Friday, June 27, VIHA's chief medical health officer received a letter from VIHA's chief operating officer requesting an exemption to the 12-month notice period for closure of Cowichan Lodge. The letter provided little specific detail. The chief medical health officer conducted an online review of medical literature on relocation of fragile seniors and reviewed the inspection history of Cowichan Lodge over the weekend.

On Wednesday, July 2, VIHA's CEO wrote to the chief medical health officer with a more detailed request, asking for an exemption and approval of a reduced notice period of 60 days. This letter did not address any issues associated with relocating individual Cowichan Lodge residents within a greatly reduced notice period. It did include information about a general transition plan for the relocation of residents and it referred to a literature review by VIHA and to best practices for relocation. It also referenced VIHA's previous experience relocating residents to three new facilities. The CEO wrote that the opening of Sunridge Place offered a one-time opportunity to relocate residents and that a delay might result in residents being transferred to communities as far away as Port Alberni and Victoria.

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Section 16 of the *CCALA* authorizes a medical health officer to grant an exemption if he or she is satisfied that doing so will not result in any increased risk to residents' health or safety. On July 2, the same day the CEO's letter was received, VIHA's regional manager of licensing considered the exemption request and recommended to VIHA's chief medical health officer that it be granted. The chief medical health officer granted the exemption later that same day, reducing the required notice period from one year to 60 days. In his decision he stated that he was satisfied that the reduced notice period would not result in an increased risk to the health and safety of residents, but he did not set out how he had reached this conclusion. Residents and families were not consulted at any point during this consideration process.

A number of families first learned of the notice requirements and exemption request process at a meeting of families and VIHA representatives on July 8. However, VIHA did not inform families of their right to appeal the chief medical health officer's decision to the CCALAB within 30 days. Several people we spoke to raised concerns about the process. They noted that the medical health officer reports directly to the CEO. An organization chart posted on VIHA's website in June 2008 confirmed this direct reporting relationship.

VIHA's public announcement that the transfer of Cowichan Lodge residents would be complete by mid-September 2008 came a week before the medical health officer had even received a written request for an exemption to the notice requirements. The timing of the two events and the fact that VIHA seemed certain of its schedule before having submitted an exemption request added to concerns about the exemption process.

Residents and families learned of their right to appeal the chief medical health officer's decision to the CCALAB from sources other than VIHA, including this office. On July 18, the first appeals of the chief medical health officer's decision were filed with the CCALAB by, or on behalf of, 24 Cowichan Lodge residents. Appellants requested that the board stay the exemption decision, pending the outcome of the appeal.

On July 25, a letter from VIHA's CEO was posted at Cowichan Lodge and on the VIHA website. It provided information about the appeals to the CCALAB and the requests to stay the chief medical health officer's decision until the board decided the appeal.

The same day, the CCALAB did just that, ordering that the exemption granted by VIHA's chief medical health officer be stayed until August 31, with an expedited hearing of the appeal to be scheduled during the week of August 25. The board concluded that issuing a stay would not risk residents' health or safety.

On August 19, VIHA's CEO asked its chief medical health officer to rescind the exemption it had requested and he had granted. The CEO cited a decision issued by the CCALAB on July 21 regarding a different health authority, in which the CCALAB had decided that the medical health officer in that health authority had failed to consider the views of residents and families before granting an exemption. In that decision, the board allowed the appeals and set aside the exemption.

VIHA's chief medical health officer rescinded the exemption.

On August 20, VIHA's CEO and the lawyer for the chief medical health officer both wrote the CCALAB to request that it cancel the scheduled hearing and dismiss the appeals of the decision to grant the exemption because the exemption had already been rescinded. Appellants opposed this request, as they believed there were still outstanding issues to be heard and decided by the CCALAB.

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On August 22, the CCALAB issued its decision on the request to dismiss the appeals.⁴⁹³ In its decision, it stated:

The Board is of the view that the Licensee's surrender to the setting aside of the Exemption in favour of the required 12-month notice period ends the necessity and appropriateness of hearing the merits of the numerous grounds of appeal. It also has the effect of discharging, or making academic, what would otherwise be the appellants' burden under s. 29(11) of the *CCALA* to prove that the Exemption was not justified.⁴⁹⁴

On August 21, 2009, the last resident of Cowichan Lodge was transferred. Cowichan Lodge ceased operation as a residential care facility the following day, more than 13 months after the request to grant an exemption to the 12-month notice period had been requested.

We received complaints from 10 family members of Cowichan Lodge residents in June and July 2008. We investigated these complaints and found that:

- Information provided by VIHA about the closure of Cowichan Lodge was inadequate and confusing.
- VIHA delayed notifying Cowichan Lodge staff of the pending closure for more than three weeks after its board's decision.
- Risks to residents' health and safety were not adequately addressed in the exemption process.
- VIHA acted improperly when it announced that Cowichan Lodge would close by mid-September 2008, before VIHA had received an exemption to the notice period.
- the option of delegating the decision on the request for exemption to someone not affiliated with VIHA, which would have enhanced confidence in the process, was not exercised.
- VIHA failed to inform residents and families in a timely manner that they could appeal the chief medical health officer's exemption decision to the CCALAB.

Our Recommendations

Our office recommended that, to address these issues, VIHA:

Develop a publicly available policy about the process to follow when closing a facility that includes:

- providing timely information to those affected by a closure, including reasons for the decision, available options to challenge the decision and available remedies
- keeping records about contacts made regarding the decision
- posting meeting information beforehand and recording minutes at meetings.

Ensure, when planning a schedule to announce a facility's closure, that consideration be given to employment opportunities and recruitment needs at other facilities to which affected residents might transfer.

⁴⁹³ Community Care and Assisted Living Appeal Board, *Twenty-four residents of Cowichan Lodge v. Vancouver Island Health Authority and Cowichan Lodge*, 2008 BCCCALAB 7 at para. 8.

⁴⁹⁴ Community Care and Assisted Living Appeal Board, *Twenty-four residents of Cowichan Lodge v. Vancouver Island Health Authority and Cowichan Lodge*, 2008 BCCCALAB 7 at para. 8.

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Develop a publicly available policy specifying the relevant information and criteria that operators (including VIHA) must include in applications for exemption from the 12-month notice of closure. This information is to help the decision-maker determine whether there is no increased risk to residents' health and safety if a reduced notice period is approved.

Provide a year's notice of a facility closure or seek an exemption to regulatory notice periods; and explain, in policies about facility closure, the need to meet regulatory requirements or apply for exemptions in a timely way.

Ensure that those people affected know that an earlier closure date is conditional on an exemption being granted and explain the process by which those people can provide their views when planning to close a facility without a year's notice.

Establish procedures in consultation with appropriate provincial level authorities to ensure an alternative decision-maker who is not directly affiliated with VIHA consider VIHA's requests for exemptions to the 12-month notice requirement.

Ensure that requests for and decisions about exemptions are posted prominently at affected facilities, along with information about how to appeal the decisions.

Inform those affected promptly about requests for exemptions, exemption decisions and the right to appeal an exemption decision.

VIHA accepted all the recommendations except that it establish procedures to ensure that a decision-maker not directly affiliated with VIHA considers VIHA's requests for exemption to the 12-month notice period, as it does not have the statutory authority to do so.

Resident Move Investigation

The Office of the Ombudsperson also received several complaints about the process followed by the Fraser Health Authority when it decided to cease funding a number of beds at Newton Regency Care Home in Surrey. These complaints raised a number of issues related to bed closures and moves.

In 2004, the Fraser Health Authority started purchasing temporarily funded residential care beds in various facilities, including Newton Regency, pending the construction of new permanently funded beds scheduled to be completed over the following few years.

Many residents who were placed in these beds were not told by the health authority that their beds were only temporarily funded, nor were they given the opportunity to decline placement, even though such a placement could result in the need to move again in the future.

In May 2008, Fraser Health wrote to 77 residents at Newton Regency who were in temporarily funded beds to inform them that the health authority would continue to fund their beds while they wished to remain there. The health authority said that it believed that closing the temporarily funded beds by attrition would be the least disruptive approach. The then-Minister of Health read excerpts from that letter in the Legislature and explained that while residents who wished to do so could transfer to another facility, they would not be obliged to move. Some of the 77 residents in the temporarily funded beds did choose to transfer.

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After a financial review in June 2009, the Fraser Health Authority decided it could no longer afford to keep the temporarily funded beds open despite the commitment it made in May 2008. Then, on August 12, the 37 residents who still remained in the temporarily funded beds received a letter from Fraser Health informing them that they must relocate before the end of September.

The health authority gave residents the option to transfer to one of three newly built facilities nearby on a priority basis. Alternatively, residents could choose a different facility and be placed there on a priority basis, as long as a bed at their selected facility became available before the end of September. Otherwise, they would have to move to one of the three new facilities and wait there for another transfer to their preferred facility. If the residents chose to stay, said the health authority, they would have to pay the full, non-subsidized costs of their bed.

The health authority's plan to transfer residents from these temporarily funded beds prompted great concern and opposition from residents' families. Three family members complained to our office. A summary of the findings to our investigation follows.

1. Given its earlier written assurance that these temporarily funded beds would be closed by attrition, was the Fraser Health Authority's decision to move residents fair and reasonable?

By providing a written commitment to residents that their beds would be closed by attrition, the Fraser Health Authority created a reasonable expectation that residents would be able to stay until they either chose to leave or pass away as long as the facility continued to be financially viable and able to provide safe, quality care.

If the Fraser Health Authority was faced with an unexpected and significant change in its financial situation, it should have carefully evaluated all reasonable and available options that would allow it to respect its written commitment. If, after analyzing the circumstances, the health authority concluded that honouring its written commitment was impossible, it should have consulted in an open and reasonable manner with the people involved, in order to minimize the adverse effects on them and to provide a process to dispute the decision. In this situation, however, Fraser Health failed to explore any other option, including closing temporarily funded beds at other facilities where no commitment had been made.

We concluded that by deciding to close these temporarily funded beds without giving adequate weight to its prior written commitment to close the beds by attrition, the Fraser Health Authority acted unfairly.

We recommended that the Fraser Health Authority: apologize to the residents and families who were affected by its decision; explain to them the process it followed when deciding to close the beds; and set out the steps it will follow in future — namely, to take its commitments seriously, to consider all reasonable options related to meeting those commitments and, if meeting them is not possible, to follow procedures that safeguard individuals affected by its actions.

We also recommended that the Fraser Health Authority develop a clear and transparent administrative policy to guide its decision making and so ensure that it reviews its commitments (not including those made under contract) and considers how to meet them. If the health authority decides that it is not possible to keep a commitment, it should consult with the people affected and ensure they can dispute the decision.

2. Did the Fraser Health Authority give enough notice to residents and their families of the bed closure and the need to either relocate or pay the full cost of a private bed?

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Although the decision to discontinue funding these temporarily funded beds was made in early July 2009, the Fraser Health Authority did not inform residents and families until August 12. The health authority then offered residents and families an opportunity to meet with a transition team the following week. Residents were encouraged to make their decisions as quickly as possible and told they would have to move by the end of September 2009. This gave them a maximum of 49 days' notice. Those who had not moved by then would have to pay the full, unsubsidized cost of their bed.

When considering what would constitute reasonable notice in this situation, we noted that regular tenants are entitled to two months' written notice when a landlord ends a tenancy. Also, under the *Community Care and Assisted Living Act (CCALA)*, operators must give written notice to the medical health officer at least 120 days before reducing, expanding or substantially changing the nature of the accommodation or services they provide. We therefore concluded that, in order to adequately protect resident and still accommodate the health authority's need for flexibility, 60 days is the minimum notice that should have been provided to these seniors. By this measure, Fraser Health did not provide adequate or reasonable notice of the bed closure to the residents.

We recommended that when the Fraser Health Authority decides to cease funding beds for reasons other than the health and safety of the residents, resulting in individuals having to move to another facility, the health authority provide at least 60 days notice to residents and families; and make it clear that there is flexibility on final move dates, to minimize moves and facilitate resident transfers to a facility of choice.

During our investigation, we learned of many more seniors in the Fraser Health Authority's facilities being in temporarily funded beds — more than 300 in total. We also learned that many of these residents were unaware of the temporary nature of their placements. We therefore concluded that the Fraser Health Authority had not properly informed people they were placing in these beds about their temporary status, which deprived those people of the information they needed to make an informed decision about their placement.

We recommended that the Fraser Health Authority inform people, upon offering them a place in a residential care facility, about whether that place is temporary or permanent and what that means.

We also recommended that the health authority develop a policy on offering temporary placements. The policy would specify that if a temporary placement is declined because an individual or family member has concerns that the temporary funding status may result in greater potential for the resident to face additional moves, then Fraser Health would consider the placement inappropriate. The policy proposed would also specify that declining an offer in these circumstances would not change a person's position on the waiting list for a residential care placement.

3. Did the Fraser Health Authority adequately consider the risks to the health and safety of the residents it required to move?

During our investigation, staff in our office reviewed the case management files of the 39 residents who had received the letter of commitment from the Fraser Health Authority in May 2008 and still remained in temporarily funded beds at the beginning of July 2009. We considered whether there was evidence that the plan to decommission the temporarily funded beds was flexible enough to accommodate the needs of these residents and their families.

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The health authority told residents and their families that the residents were guaranteed beds in one of three new facilities. If they wanted to move to some other facility, they could do so as long as a bed was available by the end of September 2009. If not, they would have to transfer into one of the three new facilities until a bed in their preferred facility became available. Aside from paying the full cost of a non-subsidized bed, these were the only options Fraser Health gave the residents in question. Many residents and families were upset and strongly opposed the move. However, given the financial consequences, they felt they had no other choice but to cooperate.

It was evident from our file review that the case managers assigned to the transition team were as accommodating as they could be, but felt bound to operate within the confines of the health authority's plan. We concluded that Fraser Health's transition process was not flexible enough to allow for adequate consideration of individual circumstances.

We recommended that the Fraser Health Authority's transition planning processes for moving residents to new facilities include enough flexibility to allow individual circumstances to be taken into account and to minimize adverse effects from the transition.

4. Were the Fraser Health Authority's planning processes adequate?

The Fraser Health Authority told us that Newton Regency was the last facility it factored into its budget mitigation strategy. However, the documentation we reviewed showed that even though Fraser Health closed the temporarily funded beds there and did not fulfill its commitment to the remaining 37 residents, it continued to allow temporarily funded beds at other facilities to close by attrition. We concluded that the Fraser Health Authority had not given adequate consideration to the commitment it had made.

In addition, we asked Fraser Health to show us documents that demonstrated it had calculated the costs of allowing the temporarily funded beds at Newton Regency to close by attrition before it made that commitment in May 2008 to residents. While the health authority did provide us with a cost breakdown, it could not show that it had done these calculations before making the commitment. We therefore concluded that the Fraser Health Authority had not planned adequately before making its May 2008 commitment.

We recommended that the Fraser Health Authority always plan, at the time it makes a commitment, for the resources required; and that the health authority, before it makes a commitment, ensure it has those resources required to follow through.

5. Did the Fraser Health Authority require Newton Regency and other facilities to comply with the provision of the *Residential Care Regulation* that states operators must provide notice of a decision to suspend the operation of a community care facility?

The Fraser Health Authority is responsible for monitoring and enforcing the *CCALA* and *Residential Care Regulation*. During our investigation, we became concerned that the health authority was not requiring facility operators to comply with notice requirements on facility closures. The documentation we reviewed indicated that Fraser Health was not planning to require Newton Regency to comply with the notice requirements if it closed, nor had Fraser Health required other facilities to comply with these requirements.

We asked Fraser Health to provide us with information about all licensed residential care facilities that were closed in its region between 2004 and 2010. Although seven facilities were closed during this time period, we received complete information for only five. In each of those, the facility was closed with significantly

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less than the required one year's notice to the medical health officer. As well, each of the five facilities closed less than one year after the medical health officer was notified and without having requested or received an exemption to the notice requirement.

In one of the facilities we reviewed, the licensee provided notice of its intention to close in less than three months, and the Fraser Health Authority recommended to the operator that it not request an exemption from the notice requirement. The health authority appeared to be concerned that a decision by the medical health officer could be appealed to the Community Care and Assisted Living Appeal Board (CCALAB), which would delay closing the facility. Fraser Health explained that it believed any delay — such as that which could result from an appeal to the board — in closing the facility “increased risk for the site to be able to continue to care for the residents and maintain staff at the site.”

Based on the documentation provided, it appears to us that Fraser Health intended to take the same approach in this situation. In the end, however, Newton Regency decided to continue to operate.

In both cases, as required by legislation, the Fraser Health Authority should have either ensured compliance with the one-year notice requirement or ensured that the operator requested an exemption from the requirement.

We concluded that the Fraser Health Authority failed to ensure compliance with the legal notice requirements; and that it improperly recommended that an operator not apply for an exemption to the requirements. A medical health officer's decision to issue an exemption can be appealed to the CCALAB. So, by recommending that an operator *not* apply for an exemption, the health authority effectively took away the legal right of a person affected by the decision to appeal it to the board.

We recommended that the Fraser Health Authority:

- ensure that operators of licensed residential care facilities are informed of their obligations to provide notice to the medical health officer of a decision to cease operating or to substantially change the nature of the operations of a residential care facility
- take any and all actions available to it under the *CCALA* and contract to enforce compliance with the notice requirements in the *Residential Care Regulation*
- ensure that residents and families are informed of requests for exemptions to the notice requirements
- ensure that residents and families are informed of exemption decisions, including by verifying that a copy of the decision is posted in a prominent place in the facility, is provided to residents and families, and contains information the decision can be appealed.

The Fraser Health Authority has accepted all the recommendations.

Notifying the Medical Health Officer

Section 9 of the *Residential Care Regulation* requires facility operators to notify their regional medical health officer when they are planning to make changes to the operation of a residential care facility. The length of the required notice period varies depending on whether an operator is planning to close a facility or to make less intrusive changes to its operations.

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Section 9(1) states that an operator must not suspend, temporarily or permanently, the 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 not all health authorities had procedures in place to ensure compliance with the notice requirements.

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 and neither the Ministry of Health nor the health authorities have a specific policy outlining the circumstances when notice must be provided under section 9 of the Regulation. This creates the potential for uncertainty among operators about when notice is required, and leads to inconsistent compliance with the 120-day notice requirement.

During our investigation, we heard concerns about facility operators replacing many staff within a short period. In the absence of ministry or health authority policy, it is unclear whether a mass replacement of staff constitutes a substantial change in the nature of the services at a facility though logically it would seem that would be the case.

Mass replacement of staff can occur when facility operators switch from contracting with one private service provider to another. Such turnovers can disrupt the lives of seniors in residential care, especially those residents whose care needs are complex. Over time, long-term staff acquire specialized knowledge of these needs, so the simultaneous replacement of many employees can make it difficult for the seniors because continuity of care is disrupted. This is particularly the case for residents with dementia. It can also be stressful to families since they often need to provide extra support to their relatives during such transitions.

The impact of mass staff turnovers on seniors in residential care is currently not recognized in the *Residential Care Regulation* or by ministry policy. There is no requirement for facility operators to notify residents when they plan these changes, or for operators and health authorities to mitigate the impact of these changes.

Given that mass staff turnovers have been a regular occurrence in recent years, it is important that safeguards be put in place to ensure that quality of care is not adversely affected. An important step would be requiring that any planned mass staff turnover at a facility receive medical health officer notification and approval.

This protection should apply to residents of all residential care facilities — those governed by the *Hospital Act* as well as to those licensed under the *CCALA*.

Staff Replacement

“Staff do not want to work in a facility that has this kind of job uncertainty. ... This impacts seniors in terms of the lack of continuity of their care. ... There are many examples of significant problems for residents created in circumstances where new staff have no personal connection to the residents, or where new staff are unfamiliar with the needs of residents. ... The point is that these problems do not exist in facilities that do not engage in contract flipping.”

Source: Respondent, Ombudsperson questionnaire.

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The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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 client 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 the resident’s relocation.⁴⁹⁵ However, neither the ministry policy nor health authority policies define what that means.

Before the development of the new policy, residents and families at a *Community Care and Assisted Living Act* facility complained to our office about the short notice they were given when the announcements were made about the closure of beds. In that case, residents were given only six weeks’ notice that they had to move due to funding changes. That type of decision does not require notifying the medical health officer. In our view, it is unreasonable that residents who must move as a result of a health authority’s funding decision do not receive the same protection as residents who must move as a result of a facility closure.

⁴⁹⁵ 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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Although the Regulation does not currently require notification of residents, it is both reasonable and fair that all parties — residents and families, the regional medical health officer, and employees and contracted staff — be notified of any planned closure or significant changes as soon as possible after an operator makes such a decision. This way, all those affected by bed or facility closures would have the maximum amount of time to weigh their options and make plans. In our view, it is unreasonable that residents who must move as a result of a health authority's funding decision do not receive the same protection as residents who must move as a result of a facility closure.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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

Exemptions to Notice Requirements

Under section 4 of the *Residential Care Regulation*, a facility operator can apply to a medical health officer for an exemption from the notice requirements in section 9. Section 16 of the *Community Care and Assisted Living Act (CCALA)* gives medical health officers the authority to grant an exemption from a requirement of the Act or the Regulation, if they are satisfied that doing so will not result in any increased risk to residents' health and safety.

When granting an exemption, medical health officers can attach terms and conditions. They can also suspend, cancel or vary exemptions already granted.

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

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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.

Giving Notice of Exemption Decisions

Section 16 of the *CCALA* allows exemption decisions by medical health officers to be appealed to the Community Care and Assisted Living Appeal Board.

Section 29(3) of the *CCALA* allows these decisions to be appealed within 30 days of the decision by a person in care, or that person's agent, representative, spouse, relative or friend. However, to exercise this 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. They should also be told that the medical health officer's decision can be appealed and within what time limits. Being made aware of a medical health officer's decision on exemption becomes even more important when people have not had the opportunity to provide input to the medical health officer before the decision is made.

The only type of decision that a resident — or someone acting on behalf of a resident — can appeal under the *CCALA* is that of a medical health officer to grant an exemption from the Act or its associated *Residential Care Regulation*. For this right of appeal to be meaningful and relevant, information on how to exercise it must be available to those affected by these decisions.

The Ombudsperson finds that

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

The Ombudsperson recommends that

R172. The health authorities ensure that seniors and their families are:

- informed when an operator of 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

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Consulting Residents about Exemption Requests

Section 16 of the *CCALA* 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 results 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.

The Community Care and Assisted Living Appeal Board has affirmed the importance of seeking input from affected residents and families.⁴⁹⁶ In *BG and FS v. Fraser Health Authority and Valleyhaven Guest Home*, the board decided that even though the medical health officer had sought input from the fire inspector and program staff, the officer erred by failing to consider information from residents and their families before issuing an exemption. The board stated:

Another significant error was that, while the MHO [medical health officer] required Valleyhaven to bring forward information or approval from others and she herself sought out opinions of the fire inspector and the Geriatric Residential Supported Living Services branch of the Fraser Health Authority (a so-called stakeholder in the Exemption), she failed to take into consideration information from residents or their families. By not requiring Valleyhaven to notify residents and families, or the resident council at the least, about the application for the Exemption, Valleyhaven was relieved of providing any information (letters of support or concerns about increase risk to the health and safety of person [*sic*] in care) from that constituency. Given that the nature and scale of the Exemption made is specific and significant in its effect on each person in care, with the exception of the four private pay residents who would remain in their existing bedroom accommodations, the residents' perspective on increased risk to their health or safety — as formulated by them or their family or family council representatives — was a relevant consideration that the MHO should have required Valleyhaven to bring to the table in connection with its application.⁴⁹⁷

The board concluded that residents' and families' perspectives on the risks to health and safety were a relevant consideration that the medical health officer failed to consider.

In June 2009, 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.⁴⁹⁸

⁴⁹⁶ While useful or persuasive, these decisions are not binding precedent.

⁴⁹⁷ Community Care and Assisted Living Appeal Board, *BG and FS v. Fraser Health Authority and Valleyhaven Guest Home*, 2008, BCCCALAB 5 at para. 30.

⁴⁹⁸ Ministry of Health, Home and Community Care, *Provincial Guidelines for Closure of Residential Care Facilities*, 11 June 2009.

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While this is a useful step, residents and families should not be restricted to funnelling input through a facility operator, especially since it is the operator who wishes to close the facility in a relatively short time frame. Rather, in addition to being consulted by the operator, residents and families should be able to provide these views directly to the regional medical health officer. The medical health officer would benefit from hearing their views directly because this would put him or her in a better position to make an informed decision about health and safety risks.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

Independence of Medical Health Officers

Many health authorities own and operate residential care facilities. If a health authority decides to close one of their facilities or otherwise change its operations, 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 officers, and particularly chief medical health officers, are often either a member of the 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 officer 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.

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Currently, there are not guidelines to assist medical health officers in dealing with the challenges of deciding exemption requests submitted by their 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 this role.

The Ombudsperson finds that

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.

The Ombudsperson recommends that

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.

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.

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.

In the **Fraser Health Authority**, any changes in the operation of *Hospital Act* facilities are negotiated between the health authority and the facilities operator

In the **Interior Health Authority**, although the authority is not legally required to do so, it expects all facilities in its jurisdiction (including the ones it owns and operates) to follow the process used for facilities licensed under the *Community Care and Assisted Living Act (CCALA)*.

The **Northern Health Authority** indicated that it would follow the same process for facility and bed closures with *Hospital Act* facilities as it does with facilities licensed under the *CCALA*.

The **Vancouver Coastal Health Authority** expects *Hospital Act* facilities to conform to the *CCALA* requirements, but acknowledges that, legally, these facilities do not have to apply for exemptions to the *CCALA*'s notice requirements.

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The **Vancouver Island Health Authority** (VIHA) decided that 365 days would be the health authority’s standard notice period for all facilities, including facilities it operates under the *Hospital Act*.

Despite the fact that some health authorities have voluntarily adopted practices that seek to align the operations of *Hospital Act* facilities with *CCALA* requirements, no legally binding notice requirements apply to closures or substantial changes to the operation of *Hospital Act* facilities. This would change if section 12 of the *CCALA* were brought into force.

The Ombudsperson finds that

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*.

The Ombudsperson recommends that

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*.

Aging in Place — Campus of Care Settings

A “campus of care” is a group of residences or building in which more than one level of housing and care is provided — often a combination of supportive housing or assisted living and residential care.

The campus of care concept is meant to allow seniors to stay in one place even as their care needs change, a benefit the provincial government has often emphasized when announcing new facilities built on this model.⁴⁹⁹ Moving seniors from home and between facilities can be extremely stressful, and increases health risks, especially among the frail elderly. Providing care through the campus model is one way to reduce that stress. It can also promote the development of social networks, a sense of place, and security. As well, it can allow couples to continue to live close together, even if they require different levels of care.

The total number of facilities that exist within a campus of care in British Columbia is unknown because they are not formally designated and health authorities do not track this information.

The provincial government began to encourage the campus of care model after assisted living was introduced as an intermediate care option in 2002.

⁴⁹⁹ This has been emphasized by the former Minister of Health Services in statements promoting new facilities, such as “Selkirk Place offers a campus of care that allows seniors to remain in their homes and community as their care needs change” and “Surrey seniors will be able to age in place at Elim Village as their care needs change.”

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The extent to which the benefits of the campus of care model are realised, however, depends on ensuring that once placed in such a site, individuals can continue to stay there as their care needs change. In the course of our investigation we heard from people living in a campus of care site who told us that it had been easy for them to transfer to the on-site residential care facility when their needs increased. We also heard from others who had the opposite experience. We visited campus of care facilities where staff told us that they could guarantee their subsidized assisted living residents would be offered placement in a subsidized bed in the on-site residential care facility, but in other similar facilities we visited, no such guarantee was made.

When we asked the Ministry of Health about this, we were told that no health authority can guarantee the availability of a bed in a specific site. Health authorities have policies to ensure that clients whose preferences for a specific facility cannot be met on admission can ask to be put on the waiting list for transfer to their preferred facility or community. However, we found the health authority policies and practices with respect to access to campus of care placements to be inconsistent.



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.	National Pensioners and Seniors Citizens Federation
Association of Advocates for Care Reform	North West Regional Hospital District, Terrace
BC Association of Community Response Networks	New Horizons Family Council (Campbell River)
BC Care Providers Association	Old Age Pensioners Organization – Sooke Branch
B.C. Government and Service Employees' Union	Pederson Elder Health
BC Health Coalition	Qmunity
BC Psychogeriatric Association	Ridge Meadows Seniors Society
BC Seniors Advocacy Network	Saanich Peninsula Hospital Family Council
Beacon Community Services	South Island Health Coalition
British Columbia Nurses Union	Terraceview Family Council
Burquitlam Care Society	UBC Centre for Health Services Policy and Research
Canadian Centre for Policy Alternatives	UBC Centre for Research on Personhood with Dementia
Central Care Home Family Council	UBC Division of Palliative Care
Concerned Friends, Ontario	UBC Geriatric Psychiatry Program
Council of Seniors Citizens Organizations	UVic Centre on Aging
Cowichan Lodge Auxilliary	Vancouver Coastal Administrators Council
Denominational Health Association	Vancouver Cross Cultural Seniors Network Society
Diamond Geriatrics	Vancouver Island Association of Family Councils
Elder College	
Gerontology Research Centre, Simon Fraser University	
Hospital Employees' Union	
Nanaimo Seniors Village Family Council	

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.

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.

Findings and Recommendations

- 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.

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.

Findings and Recommendations

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

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.

Findings and Recommendations

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
- 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.

Findings and Recommendations

- 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
- 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.

Findings and Recommendations

- 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.
- 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.

Findings and Recommendations

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
- 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.

Findings and Recommendations

- 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.
- 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

Findings and Recommendations

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.

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.

Findings and Recommendations

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.
- 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.

Findings and Recommendations

- 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.
- 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.

Findings and Recommendations

- 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.
- 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.

Findings and Recommendations

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.
- 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.

Findings and Recommendations

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.

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.

Findings and Recommendations

- 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.

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

Findings and Recommendations

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.

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

Findings and Recommendations

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

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

Findings and Recommendations

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.

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.
- 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.

Findings and Recommendations

- 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*.
- 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*.

Findings and Recommendations

- 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*.

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.

Findings and Recommendations

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

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

Findings and Recommendations

- 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.
- 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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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* (CRRRA), 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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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
Ombudsperson
Province of British Columbia
947 Fort Street
PO Box 9039 Stn Prov Govt
Victoria, BC V8W 9A5

via email

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:

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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 <i>The health authorities ensure that the MRR system is fully operational in their regions by May 31, 2012.</i>	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 <i>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.</i>	FHA, IHA, NHA, VCHA	Recommendation Accepted. Fraser Health Authority will adjust its website information to reflect this recommendation.
F129 – R161 <i>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.</i>	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 Str. 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 will 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

Page 2

- *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

Page 4

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.

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
<p>F4-R5</p> <p>The health authorities ensure that the MRR system is fully operational in their regions by May 31 2012</p>	<p>All Health Authorities</p>	<p>Recommendation Accepted.</p> <p>In fact, VCH is now compliant with the Ministry requirements for MRR</p>
<p>F7-R8</p> <p>The IHA and the VCHA track the length of time seniors wait to be assessed for home and community care services</p>	<p>VCHA and IHA</p>	<p>Recommendation not accepted as the finding is incorrect.</p> <p>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.)</p>
<p>F57-R71</p> <p>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.</p>	<p>FHA, IHA, NHA and VCHA</p>	<p>Recommendation not accepted as the finding is incorrect.</p> <p>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.</p>

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.

Authority Responses

Schedule C-1 – Appendix A

Home Support Performance Management Framework		VANCOUVER ISLAND health authority											
		YEAR 1						YEAR 2					
Data Entry Template		Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/	Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/	Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/
		Jun	/ Sep	Dec	Mar	Jun	/ Sep	Dec	Mar	Jun	/ Sep	Dec	Mar
		Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter
		1	2	3	4	1	2	3	4	1	2	3	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

Home Support Performance Management Framework		VANCOUVER ISLAND health authority											
		YEAR 1				YEAR 2							
Data Entry Template		Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar	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	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		VANCOUVER ISLAND health authority											
		YEAR 1				YEAR 2							
Data Entry Template		Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/	Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/	Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/
		Jun	/ Sep	Dec	Mar	Jun	/ Sep	Dec	Mar	Jun	/ Sep	Dec	Mar
		Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter
		1	2	3	4	1	2	3	4	1	2	3	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		VANCOUVER ISLAND health authority											
		YEAR 1				YEAR 2							
Data Entry Template		Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/	Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/	Apr/May/	July/Aug	Oct/Nov/	Jan/Feb/
		Jun	/ Sep	Dec	Mar	Jun	/ Sep	Dec	Mar	Jun	/ Sep	Dec	Mar
		Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter	Quarter
		1	2	3	4	1	2	3	4	1	2	3	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							
k-1	CHW's Training Hours (# of attendees x # of hours of session)	Apr/May/ Jun	July/Aug / Sep	Oct/Nov/ Dec	Jan/Feb/ Mar	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	Quarter 1	Quarter 2	Quarter 3	Quarter 4

Authority Responses

DEC 12 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.

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Authority Responses

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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.

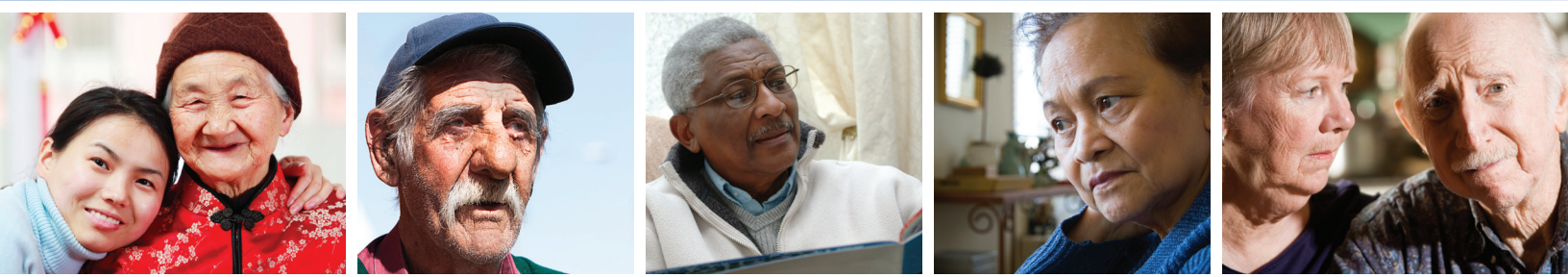
In 2010, the provincial government decided that the responsibility for Assisted Living tenancies should rest with the Ministry of Health, since health conditions prompt someone to move from independent living to an Assisted Living residence. The province intends to repeal the provisions of the *Tenancy 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



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