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• SENIORS NEED RESOURCES TO PURSUE COMPLAINTS •

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INTRODUCTION

In May 2005, the “Report of the Auditor General on Seniors Care and Programs” (“the Report”) was released.¹ The Auditor General examined services provided to seniors in long-term care facilities, the Seniors Lodge Program and the Alberta Seniors Benefit Program.² In total, the systems of nine Regional Health Authorities (RHAs), 25 long-term care facilities, and 20 lodge operators were examined.

The Auditor General gave the following reasons for conducting the audit:

- seniors represent a vulnerable segment of our population since many of them need to rely on others for their financial and physical support;
- Alberta’s population is aging and the cost of seniors care and programs is likely to increase;
- members of the public, professional organizations and members of the Legislative Assembly encouraged the Auditor General to examine and report on the extent to which the programs and services were meeting seniors needs;

- Albertans, through their taxes, pay a significant amount for seniors and care; and
- service delivery systems are complex.

The Department of Health and Wellness has set Basic Service Standards (Basic Standards) for services provided in long-term care facilities. However, the Department does not require the Regional Health Authorities to inspect facilities and report to the Department on compliance with Basic Standards. Most RHAs do not have any processes in place to monitor whether their facilities comply with all the Basic Standards. The Report concludes that only 69 per cent of the Basic Standards related to care were met by the long-term care facilities. The Auditor General was most concerned about:

- providing medication to residents,
- maintaining medical records, particularly the application and recording of physical and chemical restraints, and
- developing, implementing and monitoring resident care plans.

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Seniors Need Resources to Pursue Complaints
— *Mary A. Marshall* 1

HEALTH LAW IN CANADA

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The Report observed that two facilities appeared to schedule resident care for the convenience of staff. In one case, staff washed and dressed residents as early as 3:00 a.m. even though breakfast was not served until 8:00 a.m. In another facility, 75 per cent of the residents were in bed by 7:00 p.m.

There was considerable variation in practice between facilities in assessing fees for such things as transportation to medically necessary appointments, bed alarms, restraint systems, relocation between rooms in a facility, and use of “hip-saver” pads to cushion residents in case of falls.

The Report noted a number of problems with the use of physical and chemical restraints. There were inconsistencies in policies, procedures, practice, decision-making, evaluation of outcomes, charting methodology and involvement of family members. Some facilities utilized chemical or physical restraints, often without adequate documentation and in a few isolated cases, without apparent authorization.

The Report also identified a number of problems relative to medication administration to residents, including the following practices that pose significant safety risks:

- inconsistent documentation of the effectiveness and adverse effects of medication therapies, particularly relative to pain control and chemical restraint;
- inadequate security and storage;
- pre-pouring of medications;
- inconsistent control over phone orders signed-off by physicians; and
- insufficient or untimely notification of physicians or pharmacists following medication errors.

The Report notes that most facilities collected quality and performance indicator data, such as frequency of falls, incidence of skin breakdowns, infections, unusual incidents and complaints. However, the process for root cause analysis was inadequate, and few facilities consistently analyzed this data to understand trends or patterns which may arise.

The Report makes a number of recommendations. Shortly after the Report was released the Minister of Health and Wellness and the Minister of Seniors and Community Supports released a joint Statement indicating that the Report's recommendations support the work that is already underway in the Departments, and will assist with identifying further actions. For that reason, the Ministers accepted all the

recommendations in the Report.³ They stated that the "...goal is to build a continuing care system that works in partnership with residents and their families, and puts their needs first". This article builds on that goal by suggesting an independent Commissioner to conduct investigations in long-term care facilities. As well, this paper suggests that it is necessary to provide seniors with access to formal advocacy services, and to create a legal clinic that will provide individual and group advocacy, public legal education, community development, and engage in law reform activities.

EXISTING AND PROPOSED MECHANISMS

There are existing mechanisms for inspecting long-term care facilities and investigating complaints. This section examines the limitations of these mechanisms, as well as the proposed expansion of the jurisdiction of the provincial Ombudsman.

HEALTH FACILITIES REVIEW COMMITTEE

The Health Facilities Review Committee (the "Committee") was established in 1973.⁴ The Committee may investigate complaints at facilities including approved hospitals (acute care and auxiliary care), nursing homes, mental health hospitals, and special care centres. The Committee must visit the facilities "...for the purpose of reviewing and inspecting them and the manner in which they are operated". As well, the Minister may request the Committee to conduct a visit, and report to the Minister on any matter specified in the request. Finally, if a complaint is made, the Committee must investigate the care and treatment of the patient and the standards of accommodation of the facility.⁵

However, there are limits on the Committee's role and powers. The Report notes as follows:

- The Committee does not check for compliance with all Basic Standards. Its processes do not

The Committee does not check for compliance with all Basic Standards. Its processes do not contemplate areas covered by Basic Standards, such as provision of minimum care hours, frequency of physician assessments, therapeutic diets, maintenance of health records and care plans, user fees and trust accounts.

contemplate areas covered by Basic Standards, such as provision of minimum care hours, frequency of physician assessments, therapeutic diets, maintenance of health records and care plans, user fees and trust accounts.

- The provisions of the *Health Facilities Review Committee Act* specifically prohibit the review by committee members of medical records without the resident's consent,⁶ and financial records. Their reviews are primarily qualitative-based assessments concerned with the dignity and satisfaction of residents and families.
- Members are not required to have medical training.
- The Committee has no authority to enforce compliance. There are no sanctions specified in the *Health Facilities Review Committee Act* for facilities or regional health authorities that fail to implement recommendations following an investigation by the Committee.

PROTECTION FOR PERSONS IN CARE ACT

The *Protection for Persons in Care Act* is legislation that requires health care providers, employees and members of the public to report incidents of abuse against any adults who receive care in hospitals, seniors' lodges, group homes and nursing homes.⁷ Abuse is defined as intentionally:

- causing bodily harm, by such actions as hitting, kicking, or biting;
- causing emotional harm, by such actions as threatening, humiliating, harassing, or socially isolating a person in care;
- administering or prescribing medication for an inappropriate purpose;
- stealing money or valuables;
- failing to provide the necessities of life, such as food or medical attention; or
- subjecting a person in care to unwanted sexual contact or activity.

The Report notes that the *Protection for Persons in Care Act* (PPIC) provides only limited assurance of compliance with Basic Standards because:

- PPIC responds to abuse complaints only; they do not initiate reviews and are prohibited by

their Act from reviewing residents' medical records without consent, or facility records on financial matters.

- PPIC does not conduct compliance or regulatory reviews in long-term care facilities for the Basic Standards, policies, procedures or legislation. However, if they uncover evidence of a facility's failure to meet the Basic Standards, policies or legislation, they will include appropriate recommendations in their reports.

OMBUDSMAN

Alberta was the first Canadian province to appoint a public sector Ombudsman. The Ombudsman may investigate any act, decision or recommendation made in relation to a matter of administration when done by a government department, agency or government employee acting in a government role.⁸ The Ombudsman may initiate an investigation following a complaint, on his "own motion", or pursuant to a Ministerial request.

The Ombudsman may investigate any act, decision or recommendation made in relation to a matter of administration when done by a government department, agency or government employee acting in a government role.

In 2003, the *Ombudsman Act*⁹ was amended to provide a framework for the extension of the Ombudsman's jurisdiction to include the patient concerns resolution processes of the nine RHAs and the Alberta Cancer Board. In his most recent Annual Report, the Ombudsman notes that the Office of the Ombudsman is continuing to work with the Department of Health and Wellness to get the required regulation passed which will allow the Ombudsman to exercise that jurisdiction. However, progress has been "slower than desired".¹⁰

INTERNATIONAL MODELS

There are patient ombudsmen in a number of different countries including Austria, Finland, Greece, Hungary, Israel, New Zealand, Norway, and the United Kingdom. As well, the United States has established an extensive system of specialized long-term care ombudsmen. Central features of an effective patient ombudsmen system are impartiality,

independence, competence, and a systematic approach.¹¹

As well, ombudsmen generally have the following powers and protections:¹²

- unimpeded access to information;
- protection for the confidentiality of the proceedings in order to facilitate co-operation throughout the investigation;
- protection against the use of their evidence in subsequent proceedings;
- immunity from prosecution for anything done in good faith while exercising their duties; and
- the right to require information or documents, as well as examine any relevant person on oath.

In general, ombudsmen do not have the power to enforce compliance with their recommendations and work through persuasion. As well, they have the power to publicize their concerns if recommendations are not implemented.

The concept of an ombudsman originated in Sweden, and has expanded to many different countries. The broad concept of the public sector ombudsman is widely regarded as successful for the following reasons:

- their independence is unquestioned;
- while following the rules of natural justice, the procedures of the ombudsmen are informal, inquisitorial and non-adversarial;
- legal representation is not necessary; and
- the service provided is free and (unlike the court system) there is no risk to the complainant of having to pay the other party's costs if the complaint is not upheld.

Patient ombudsmen are not "advocates" in the traditional meaning of that term. Advocates resolve patients' complaints according to their instructions. Advocates may also provide support to patients to resolve their own concerns or self-advocate. Systemic advocacy may be used to address issues that have an impact on the quality of care, life and rights of a large number of patients.

In contrast, ombudsmen serve as impartial investigators, although they may become an advocate for the implementation of a recommendation at the conclusion of an investigation.¹³

This section will describe three models of specialized health ombudsmen: the New Zealand Health and Disability Commissioner; the Health Service

Commissioner for England, Scotland and Wales; and the U.S. Long-Term Care Ombudsman.

NEW ZEALAND HEALTH AND DISABILITY COMMISSIONER

The Health and Disability Commissioner was created in 1994 as an independent statutory ombudsman to develop and enforce a Code of Consumers' Rights (the "Code") designed to "...promote and protect the rights of health consumers" and "facilitate the fair, simple, speedy, and efficient resolution of complaints".¹⁴ The Code sets out ten rights that are available to all health and disability services consumers, including the right to be treated with respect, to be free from discrimination or exploitation, to dignity and independence, to effective communication, to be fully informed and to give or withhold consent, to services of an appropriate standard, and to complain. Consumers are broadly defined to cover all users of health or disability services (not just patients in traditional hospital settings). A broad range of providers are subject to the Code from institutional providers, and registered health professionals to alternative providers. The Code recognizes the responsibility of providers to take into account the needs, values and beliefs of Maori, the indigenous people of New Zealand.

The long-term care ombudsman (LTC ombudsman) program began in 1972. LTC ombudsmen investigate complaints from residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities.

The Commissioner is required "[t]o promote, by education and publicity, respect for and observance of the rights of health consumers..." and "[t]o make public statements and publish reports in relation to any matter affecting the rights of health consumers...".¹⁵

The Commissioner's focus is on protecting and promoting consumers' rights through complaint resolution. The Commissioner also engages in systemic advocacy.¹⁶

Rather than resigning itself to being an 'ambulance at the bottom of the cliff', the Commissioner's Office seeks to 'build a fence at the top' by contributing to quality improvement in a number of ways. The Commissioner uses individual investigation reports for educational purposes, and advocates on

behalf of consumers at a systematic level in policy and media debates.

HEALTH SERVICE COMMISSIONER FOR ENGLAND, SCOTLAND AND WALES

The Health Service Commissioner (HSC) carries out independent investigations into complaints about poor treatment or service provided through the National Health Service (NHS). The HSC looks into complaints against NHS services provided by hospitals, health authorities, trusts, and health care practitioners. Also, the HSC can investigate complaints against private health providers if the treatment was funded by the NHS. The HSC is statutorily independent, and has extensive investigative powers, including the power to summon witnesses and to access records. It is supported by a directorate of expert clinical advisors.

The HSC has a number of options at the end of an investigation. If something has gone wrong, the HSC can get the organization or practitioner involved to:

- provide an explanation and acknowledgment of what went wrong; and
- take action to put the matter right, including an apology.

Where there are serious faults, the HSC can also recommend:

- changes are made in the way the organization or practitioner works so that similar things or incidents aren't repeated;
- lessons are learnt from things that have gone wrong; and
- payment should be made for a financial loss or for the inconvenience or worry that has been caused.

The HSC notes on the Web site that "[w]hile we have no formal power to enforce our recommendations they are almost always followed".¹⁷

U.S. LONG-TERM CARE OMBUDSMAN

The long-term care ombudsman (LTC ombudsman) program began in 1972. LTC ombudsmen investigate complaints from residents of nursing homes, board and care homes, assisted living facilities and similar adult care facilities.

The LTC ombudsman program is established in all states under the *Older Americans Act*, which is administered by the Administration on Aging (AoA).

One thousand paid and 14,000 volunteer staff investigate over 260,000 complaints each year.¹⁸ Ombudsman responsibilities outlined in the *Older Americans Act* include:

- identify, investigate and resolve complaints made by or on behalf of residents;
- provide information to residents about long-term care services;
- represent the interests of residents before governmental agencies and seek administrative, legal and other remedies to protect residents;
- analyze, comment on and recommend changes in laws and regulations pertaining to the health, safety, welfare and rights of residents;
- educate and inform consumers and the general public regarding issues and concerns related to long-term care and facilitate public comment on laws, regulations, policies and actions;
- promote the development of citizen organizations to participate in the program;
- provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and
- advocate for changes to improve residents' quality of life and care.

The Ontario Ministry of Health and Long-Term Care is currently engaging in a consultation process relating to "Future Directions for Legislation Governing Long-Term Care Homes". A Seniors' Advocate is one of the suggestions that has been put forward to enhance protection for seniors.

Ombudsmen help residents and their families and friends understand and exercise rights that are guaranteed by law, both at the federal level and in many states. Residents have the right to:

- be treated with respect and dignity;
- be free from chemical and physical restraints;
- manage their own finances;
- voice grievances without fear of retaliation;
- associate and communicate privately with any person of their choice;
- send and receive personal mail;
- have personal and medical records kept confidential;
- apply for state and federal assistance without discrimination;

- be fully informed prior to admission of their rights, services available and all charges; and
- be given advance notice of transfer or discharge.

ONTARIO MODEL

The Ontario Ministry of Health and Long-Term Care is currently engaging in a consultation process relating to "Future Directions for Legislation Governing Long-Term Care Homes". A Seniors' Advocate is one of the suggestions that has been put forward to enhance protection for seniors.¹⁹ The Seniors' Advocate would be empowered to advocate on behalf of residents who could not or need assistance to speak for themselves. The Seniors' Advocate would complement the work already undertaken by the Advocacy Centre for the Elderly (ACE).

ACE was established in 1984, and is one of 70 community legal clinics in Ontario.²⁰ ACE was the first community legal clinic in Canada providing legal services to seniors with a focus on "elder law" issues such as health care consent, substitute decision-making, long-term care, community care, retirement home tenancies, seniors' consumer issues, and elder abuse. ACE currently employs five lawyers and three support staff. All the staff provide direct client services although each has a primary area of responsibility. The lawyers include an Executive Director that, along with the Office Manager, is responsible for the operational management of the clinic. Two of the lawyers are primarily responsible for the client intake service and any litigation undertaken for clients. One lawyer is primarily responsible for the legal research as well as the ACE publications and Web site. One lawyer is an "Institutional Advocate". The institutional advocate is responsible for providing legal services to clients who need advice or assistance with legal issues in long-term care homes, hospitals, psychiatric facilities, and other institutional settings.²¹

ACE provides services in four areas:

- individual and group client advice and representation,
- public legal education,
- community development, and
- law reform activities.

INDIVIDUAL AND GROUP CLIENT ADVICE AND REPRESENTATION

ACE provides advocacy in a wide variety of areas, including those that were of concern in the Auditor General’s report. The following case examples are taken from a recent report:²²

In the past, we have had complaints from numerous residents of long-term care homes who are locked in because they do not want to stay at the home, not because they are at risk of wandering and potential harm. This is not a legal use of these units. However, there is no system in place to challenge placement, and unless they have access to an outside advocate, it may be impossible for these residents to challenge their placement.

Blanket consents to treatment are frequently found in admission contracts. The clauses we have seen state that the resident, or substitute decision-maker if the resident is not mentally capable “pre-consents” or “consents” to anything that the physician or other health care practitioners should order for the resident’s care while the resident is living at that particular long-term care home, unless the resident or substitute decision-maker specifically objects.

PUBLIC LEGAL EDUCATION

ACE provides public legal education to seniors so that they know their rights, are able to self-advocate, and know when to seek legal assistance. ACE also provides legal education to those who provide services to seniors because of their influence in seniors’ lives.

ACE staff deliver numerous community presentations and workshops each year. As well, ACE publishes a number of pamphlets and booklets on seniors legal issues, such as “Long-Term Care Facilities in Ontario: The Advocate’s Manual”.

COMMUNITY DEVELOPMENT

ACE has engaged in various community development activities, including a recent project working with communities throughout Ontario to set up elder abuse community response networks to address elder abuse at the local level.

LAW REFORM ACTIVITIES

ACE has been active in law reform activities affecting the elderly for over 20 years. ACE is well placed to provide input into government initiatives to amend legislation, policies or procedures as a result of ACE’s individual and group client advice and representation.

As an example, ACE was one of the stakeholders that provided advice to the Ontario Ministry of Health and Long-Term Care on revisions to standards that apply to long-term care facilities. The standards relate to the use of restraints, abuse, reporting of “critical incidents”, skin care and wound care management, nutrition and hydration, and continence care. The Ministry plans to review and revise all existing standards and policies relating to long-term care in the near future.

ANALYSIS AND CONCLUSION

The Auditor General’s Report sets out the results of his audit, highlights a number of concerns, and makes helpful recommendations that have been accepted by the Minister of Health and Well-

ness, and the Minister of Seniors and Community Supports. However, the Report also makes it clear that seniors are a vulnerable sector of the population that requires better access to investigative and advocacy services when complaints and concerns occur. The proposed expansion of the Ombudsman’s mandate will provide for jurisdiction over the patient concerns resolution processes of the RHAs. The Alberta Office of the Ombudsman has a great deal of expertise in designing effective complaint systems,²³ and the regulation that will allow him to begin investigating RHAs should be finalized and brought into force as soon as possible.

The complaints process should be well-defined and easy for a complainant to use. In this way, those with legitimate complaints will be encouraged to come forward. However, a specialized Commissioner for Long-Term Care would be able to investigate complaints against a wide variety of providers, including long-term care facilities and seniors’ lodges. The Commissioner would be able to conduct impartial investigations, and make recommendations in appropriate cases. The Commis-

However, the Report also makes it clear that seniors are a vulnerable sector of the population that requires better access to investigative and advocacy services when complaints and concerns occur. The proposed expansion of the Ombudsman’s mandate will provide for jurisdiction over the patient concerns resolution processes of the RHAs.

sioner should be empowered to conduct “own motion” investigations, as well as respond to complaints. This power is critical when dealing with vulnerable populations, such as seniors in long-term care facilities. If the Commissioner observes patterns, such as inappropriate use of restraints, he or she should be able to conduct an investigation without waiting for a specific complainant to come forward. Patients or their families may fear repercussions if they bring a complaint against caregivers, and this fear may deter them from making their concerns known. As well, the Commissioner should have unimpeded access to information. This would avoid some of the limitations currently experienced by those conducting reviews under the *Health Facilities Review Committee Act*, and the *Protection for Persons in Care Act*. Although the Commissioner would have the powers of an ombudsman (*i.e.*, the power to recommend and not order), the Commissioner should also have the discretion to publicize the results of investigations when recommendations are not accepted; or, when the conclusions of a systemic investigation would be helpful information for the public.

In addition, seniors need better access to advocacy services. Alberta has been slow to embrace the community legal clinic model that has been used successfully to provide legal assistance to low-income persons in Ontario and other provinces. As noted by the Canadian Bar Association,²⁴

For people with little money, publicly funded legal representation through legal aid plans allows them to rely upon legal protections and guarantees that are intended for all. Without legal aid, access to justice is a hollow idea - many individuals simply cannot take advantage of these legal entitlements and protections.

The Alberta Legal Aid Society has established Family Law Offices,²⁵ and Youth Criminal Defence Offices²⁶ in Edmonton and Calgary. Both were started as pilot projects, and confirmed as continuing programs after their usefulness was established following a substantial period of time for evaluations. The Advocacy Centre for the Elderly established in Ontario serves as a useful model for a future pilot project in Alberta.

As the Auditor General notes in his Report, the systems are complex. The establishment of a specialized Commissioner for Long-Term Care, along with a dedicated advocacy service, would permit the de-

velopment of the expertise required to assist individuals with their concerns and complaints, and identify systemic problems. Consequently, these issues could be addressed on a timely basis by service providers, and regional health authorities. As well, the Alberta government would receive well-informed comments and submissions on necessary changes to legislation, policies and procedures.

[*Editor's note:* Mary A. Marshall is Principal of the Mary A. Marshall Professional Corporation in Edmonton, Alberta.]

- ¹ *Report of the Auditor General on Seniors Care and Programs*, May 2005, available at: <<http://www.oag.ab.ca/>>.
- ² The Alberta Seniors Benefit Program is the primary provincial program providing financial support to seniors in Alberta, many of whom live in long-term care facilities and lodges.
- ³ Ministers' Statement, *Auditor General's Report on the Government of Alberta's Seniors Core Services and Programs*, May 9, 2005, available at: <<http://www.health.gov.ab.ca/>>, and attached as Appendix A. The Government MLA Task Force on Continuing Care Health Service & Accommodation Standards has issued a Discussion Guide to obtain feedback on health and accommodation services in continuing care available on-line at: <http://www.continuingcare.gov.ab.ca/pdf/Discussion_Guide.pdf>.
- ⁴ *Health Facilities Review Committee Act*, R.S.A. 2000, c. H-3.
- ⁵ *Ibid.*, ss. 7-8.
- ⁶ The Health Facilities Review Committee Annual Report for 2003-2004 indicates that 34 complaints were received between April 1, 2003 and March 31, 2004. However, out of that total number, the Committee was unable to proceed with an investigation of 24 complaints because the *Authorization to Disclose Health Information Form* was not received.
- ⁷ *Protection for Persons in Care Act*, R.S.A. 2000, c. P-29.
- ⁸ The extent to which the provincial Ombudsman has jurisdiction over health care bodies varies from province to province. For example, the government of Nova Scotia has recently expanded the provincial Ombudsman's jurisdiction to include nursing homes, residential care facilities for seniors, and homes for the aged. See “Seniors Services” at: <http://www.gov.ns.ca/ombu/Child_Ombud/senior.asp> and “Young People and Seniors Benefit From Changes to Jurisdiction” May 27, 2005, at: <<http://www.gov.ns.ca/news/details.asp?id=20050527004>>.
- ⁹ *Ombudsman Act*, R.S.A. 2000, c. O-8.
- ¹⁰ The 37th Annual Report of the Office of the Ombudsman covering the period from April 1, 2003 to

- March 31, 2004 is available on-line at: <<http://www.ombudsman.ab.ca/AnnualReport2004.pdf>>.
- ¹¹ See Lars Fallberg, "Patients Ombudsmen – a Different Approach to Improve Quality in Health Services" (2003) 10 *European Journal of Health Law* 339; Lars Fallberg and Stephen Mackenney, "Patient Ombudsmen in Seven European Countries: an Effective Way to Implement Patients' Rights?" (2003) 10 *European Journal of Health Law* 343.
- ¹² See Mary A. Marshall and Linda C. Reif, "The Ombudsman: Maladministration and Alternative Dispute Resolution" (1995) 34 *Alta. Law Rev.* 215.
- ¹³ See Dean M. Gottehrer and Michael Hostina, "Essential Characteristics of a Classical Ombudsman", on-line: United States Ombudsman Association <www.usombudsman.org>.
- ¹⁴ *The Health and Disability Commissioner Act 1994*, 1994 No 88, s. 6.
- ¹⁵ *Ibid.*, ss. 14(1)(c), (d).
- ¹⁶ R. Patterson, Dr. M. Bismark, "Investigating the Quality of Psychiatric Care: The New Zealand Experience" 24 *Health Law in Canada*, No. 3, 60 at 63.
- ¹⁷ See Web site for Parliamentary and Health Service Ombudsman, *Making a Complaint*, located at: <http://www.ombudsman.org.uk/make_a_complaint/health/index.html>.
- ¹⁸ This information is taken from the Administration on Aging Web site at: <http://www.aoa.dhhs.gov/prof/aoapro/elder_rights/LTCombudsman/ltc_ombudsman.asp>.
- ¹⁹ See "Future Directions for Legislation Governing Long-Term Care Homes", 2004 Submission of the Psychiatric Patient Advocate Office, available on the Web site at: <www.ppa.gov.on.ca/pos-ltc.html>. Also see *Commitment to Care: A Plan for Long-Term Care in Ontario, Spring 2004*, at p.16., available on the Web site at: <http://www.health.gov.on.ca/english/public/pub/ministry_reports/ltc_04/mohlrc_report04.pdf>.
- This Report was prepared by Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care as a result of a request by the Minister to undertake a review of long-term care facilities across Ontario. Ms. Smith concludes that there is a "need for a third party to advocate on behalf of seniors in long-term care homes".
- ²⁰ Community legal clinics have been established in Ontario to address the unique legal needs of low-income people and communities. Lawyers and legal workers provide information, legal advice, and represent people. In addition, clinics also can engage in test cases, public legal education, community organizing, and other law reform initiatives. Most community legal clinics are located in specific geographic communities, and each community in Ontario is served by a clinic. As well, there are 17 specialty legal clinics that either deal with a specific area of law (e.g., workers' compensation, workers' health and safety), or represent a specific, non-geographic community (e.g., seniors, the disabled, urban aboriginals).
- ²¹ This information is taken from a December 2004 submission prepared by the Advocacy Centre for the Elderly entitled *Future Directions for Legislation Governing Long-Term Care Homes*, directed to Monique Smith, MPP, Parliamentary Assistant to George Smitherman, MPP, Minister of Health and Long-Term Care.
- ²² *Ibid.*
- ²³ See *Internal Complaint Mechanism*, Alberta Office of the Ombudsman Web site, located at: <<http://www.ombudsman.ab.ca/complaint.html>>.
- ²⁴ Canadian Bar Association, "CBA Launches Test Case to Challenge Constitutional Right to Civil Legal Aid", Media Release, June 2005, available on-line at: <http://www.cba.org/CBA/News/2005_Releases/2005-06-20_backgrounder.aspx>.
- ²⁵ Legal Aid Family Law Offices opened in Edmonton and Calgary in 2001 as a four-year pilot project funded by the Legal Aid Society of Alberta. The status of the project recently changed from pilot to a continuing program. In each office, lawyers, social workers, and specialized support workers streamline access to Legal Aid assistance during divorce, child welfare disputes, custody disputes, and other family law issues.
- ²⁶ The Legal Aid Society of Alberta, the Law Society of Alberta, and the Alberta Justice Department approved the establishment of a three-year pilot project to test-out a staff delivery model of providing legal service to young offenders in Edmonton and Calgary, starting with the opening of offices in both cities in October, 1993. After two-and-a half years of evaluation, the Legal Aid Society of Alberta adopted the recommendation that the Legal Aid Youth Office project be continued on a permanent basis. The Youth Criminal Defence Offices operate under the supervision of a Senior Counsel who is hired by and reports to the Board of Directors of the Legal Aid Society. The Office also employs eight other lawyers in Calgary and seven in Edmonton. Two social workers, four youth workers and four administrative employees support the lawyers.

APPENDIX A – MINISTERS’ STATEMENT

AUDITOR GENERAL’S REPORT ON THE GOVERNMENT OF ALBERTA’S SENIORS CORE SERVICES AND PROGRAMS

The Auditor General, this government and our departments have a common goal: to ensure that Albertans receive quality programs and services for public expenditures. Quality services and programs for seniors are respectful, safe, preserve their dignity and, to the extent possible, support their independence.

The majority of seniors receiving care through publicly funded home care, assisted living and long-term care facilities do receive quality care. However, we do have some concerns.

Our departments have already taken action. Our goal is to build a continuing care system that works in partnership with residents and their families, and puts their needs first.

Working with health authorities, Alberta Health and Wellness has launched several initiatives over the last few months. Those initiatives include:

- Development of new standards for Continuing Care Health Service Standards;
- Implementation of improved resident assessment tools, which will show whether individual care needs, and provincial health goals, are being met;
- Development of standardized elements for contracts between Regional Health Authorities and long-term care operators;
- Development of a training program for health care aides; and
- Increasing the average care hours per resident from 3.1 to 3.4 per day by the end of this fiscal year (2005/2006).

Updating the Continuing Care Health Services Standards has been one of Alberta Health and Wellness’ first priorities. These new standards will focus care practices around the needs of the individual. By focusing how we care for residents around their individual needs, we improve their quality of life, as well as the quality of care. Our proposed new standards will:

- require development of a care plan for each client, and focus measuring and reporting on the effectiveness of care provided to each individual;
- clearly spell out the responsibilities of clients and their families, health care providers, operators, Regional Health Authorities and the department; and
- establish a process for regular reviews and upgrading of standards to meet professional best practices.

Alberta Seniors and Community Supports will build on the Auditor General’s recommendations by continuing work in the following areas:

- re-establish reviews of seniors lodge facilities while lodge standards are being clarified and enhanced;
- review how the Alberta Seniors Benefit Program meets the financial needs of seniors following the July 2004 increase to income thresholds and monthly payments;
- develop accommodations standards for long-term care, supportive living environments and seniors lodges, and ensure appropriate mechanisms are in place to monitor compliance with these standards.

MLA Len Webber, Chair of the Healthy Aging and Continuing Care in Alberta Implementation Advisory Committee, and MLA Ray Prins, Chair of the Seniors’ Advisory Council, will conduct a stakeholder review of the standards beginning immediately and concluding by the end of August this year.

We want to thank the Auditor General for his work, which was thorough and thoughtful.

His recommendations support the work that is underway, and will help us identify further actions. For that reason, we intend to accept all the recommendations in his report.

We will be working together with Regional Health Authorities and health care providers on several further initiatives to improve monitoring for compliance with standards, measures of the cost effectiveness of services, and planning for the future. Alberta Health and Wellness will introduce more frequent, unannounced quality assurance visits to long-term care facilities with quality improvement and monitoring teams composed of clinical and management operations specialists, in addition to the current work of the Health Facilities Review Committee.

We want to emphasize that although 70 per cent of standards were fully met, and that in many cases Regional Health Authorities have moved beyond the current standards for care, we need to do much better. Standards need to be improved, and this is a core piece of what we will do.

In that work, as in all our actions, we will keep our eyes on the target: working with those in care to clearly understand and respond to their individual medical, physical and social needs.

This will mean change and we face challenges. It requires ensuring that a variety of services are available and accessible, emphasizing both quality of life and quality of care, and promoting independence to the extent possible. Working with those who need care, their families, health care providers and Regional Health Authorities, we can meet those challenges.

Honourable Iris Evans, Minister of Health and Wellness

Honourable Yvonne Fritz, Minister of Seniors and Community Supports

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