

# Legal Issues in Residential Care

An Advocate's Manual

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# Introduction

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## Introduction and Forward

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### Introduction



Each year, approximately 38,000 adults in British Columbia will live in a residential care facility. For most it will become their home for the last months or years of their lives.

The residents living in British Columbia's care facilities today are generally older, more disabled and closer to the end of life than residents were a decade ago (1). Many will be frail and the vast majority will be aged 85 and over. It is estimated that about eighty percent of the people living in British Columbia's residential care facilities have dementia, although the degree of impairment can vary considerably from person to person.

Residents in British Columbia's care facilities are often treated as if they are all the same. From one narrow perspective they may be - they have experienced major changes in their health and social circumstances where their needs typically can no longer be met in the community with the support of their spouse or partner, family, friends or neighbours, through formal services, or in other types of housing settings. However, they are also a very diverse group of individuals. Each person remains very much an individual, each with very different lived experiences. Each resident has their own preferences, values, beliefs, and interests.

A residential care facility is the person's home, as well as where others work. It is a collective setting, in which the rights of individuals must be balanced against the rights of other residents living there, as well as the rights and responsibilities of the staff and administration.

Residential care is a complex area. Many laws shape and affect the residents' lives in this collective setting. There can be regional differences in policy, as well as differences in the way the law has been interpreted and applied in various parts of British Columbia. Providers may operate facilities in a number of other jurisdictions in Canada or United States, and that may affect their expectations, contracts, and way of working.

This is also an area of constant change, as the area responds to new emerging issues, often with legal implications for the residents, friends, family and the staff who work in the care facilities. This manual describes some of the laws that set out the responsibilities of providers and rights of residents, helping to clarify some common misunderstandings along the way. As an introductory text, it largely focuses on how systems work in the context of the Community Care and Assisted Living Act(2) and the Residential Care Regulations (3).

This e-book describes the key legal issues related to residential care in British Columbia, along with the appropriate processes and available legal or administrative remedies. It is written in the midst of change, recognizing that a number of important changes to residential care are currently under development.

The focus of the book is specifically on all the licensed residential care facilities, extended care facilities and private hospitals in British Columbia. It does not cover legal issues related to assisted living or home support, although we

recognize the importance of those areas.

## Target Audience

This advocate's manual is intended as a primary resource for legal staff at the BC Centre for Elder Advocacy and Support (BCCEAS) in serving individual clients. It will also be useful to advocates and professionals in the legal and health care systems who also want to support residents in the best manner possible. The-book will be updated on an ongoing basis.

The e-book will be available on the BCCEAS website, with live links to sources of non-legal information (e.g., health authorities and other government resources) and to resources such as residential care family councils, senior-serving community organizations, and professional associations.

## Scope

The focus of this e-book is on:

- a) licensed residential care for adults—including the for profit and not for profit care facilities, private hospitals, and extended care hospital beds.
- b) legal issues in these facilities-which includes policies, procedures, regulations, laws, any administrative review or appeal processes.It is not intended to be a comprehensive statement of the law, but a useful foundation.

The e-book begins with an overview of the statutory framework for residential care facilities and residents' rights declarations. The subsequent chapters focus on five key areas of law in residential care:

- **Legal issues related to admission and transfer** - such as the admission process, and transfer from hospital or other settings, consent to move into a residential care facility (particularly where the prospective resident has diminished capacity), use of the Mental Health Act as a transfer mechanism; the care plan and the contract, and responsibility for fees.
- **Legal issues arising while living in residential care** - which includes for example, residents' rights, standards of care, professional care, informed consent, inappropriate use of physical and chemical (medication) restraints, resident safety (including preventing harm from other residents), abuse and neglect, control over residents, control over access to residents (visitors).
- **Rights, remedies and problem resolutions** - how to resolve problems: civil and administrative remedies, enforcement, mandatory reporting, complaints, and criminal law.
- **Capacity & consent** - treatment and personal care decisions, use and misuse of advance care planning, consent in the context of physical and chemical restraints in care facilities, and improving understanding about the requirements of consent.
- **Substitute decision-making** - including the use of power of attorney, advance directives, and representation agreements in residential care.

## **Language and Perspective**

The manual takes a client-centred, advocacy perspective to describe and understand the common legal matters affecting people who live in residential care facilities, as well as those who care about and support them.

In this area, statutes may refer to people as “persons in care”, “patients”, “clients”, or “residents”. Throughout this manual we use the term “resident” and “person” interchangeably.

Occasionally the term “older adult” or “senior” will be used unless the context otherwise warrants. We use the generic term “operator” to cover the wide range of public, private, for profit and not for profit care facility licensees, owners and operators who provide care and support to older adults in residential care facilities, including private hospitals and extended care hospitals.

## **Viewing Residential Care in the Context of Elder Law**

Some of the laws and regulations identified in the manual such as the Community Care and Assisted Living Regulation regulate care facilities for persons with chronic or progressive conditions, primarily due to the ageing process. The same laws also apply to and regulate facilities for also a wider group of people receiving care. This includes facilities providing hospice (palliative) care, homes for people with developmental disabilities or acquired brain injury and facilities for people with substance abuse or mental disorders. The focus in this manual, however, will largely be on seniors who make up the vast proportion of the resident population in the care facilities.

Throughout the text we focus on specific aspects of law. Some sections will describe a range of legal issues related to documents such as power of attorney, but in the specific context of life and issues in residential care facilities. These sections are not intended to be comprehensive statements of law on those documents.

## **Disclaimer**

This material contains information and guidance for practice. We have taken considerable effort to reflect the law, policy and practice as accurately as possible in this complex area. However, there can be minor differences in interpretation, plus law, policy and practice in this area are constantly changing. We also recognize that some important sources such as the Ministry of Health’s Home and Community Care Policy Manual are currently under review.

The information is not legal advice. All material provided is current as of May 31, 2014. Any changes to the law or policy after May 31, 2014 are not reflected in these materials.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# Acknowledgements

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In developing this e-manual we have drawn on the knowledge and experience of key stakeholders in health care and law, government agencies, community groups, family councils and in some cases residents themselves. These people have allowed us to identify key issues, content, and resources.

This e-manual is based on an approach first used by the Advocacy Centre for the Elderly (ACE) in Toronto, Ontario where their manual became a practical information tool useful to many stakeholders. We would like to thank ACE for the initial idea of creating the e-book as well as their support. We have drawn on their quarter century experience in legally advocating on behalf of older adults in long term care settings.

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# 1-Statutory Framework

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## Overview of Legal Issues in Residential Care

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This chapter introduces residential care in British Columbia. It provides an overview of the laws that commonly come into play for residential care facility providers, the staff and the residents who live there. The chapter is divided into two parts. The first is an overview of residential care system and the people who work in this system; the second describes key laws that govern the area and the lives of many residents.

### What is Residential Care?

“Residential Care” is the formal term used by the British Columbia Ministry of Health for what the public commonly calls nursing homes, care homes, care centres, long term care homes, extended care, or geriatric care facilities. The Ministry of Health notes:

*“Residential Care is for adults with complex health care needs requiring 24-hour professional care due to physical disability or mental or behavioral conditions, including brain injuries or dementia.”*

The term “residential care” refers to places where a person can receive health care services, accommodation and support on a regular basis. Residential care is typically viewed as providing a higher level of care and support than other types of facilities in the community such as assisted living. Since 2002 under provincial health care policy, publicly funded (subsidized) residential care facilities are available only to people who need “complex care”(4).

While acute care hospitals are places of temporary stay for health care, residential care facilities are very importantly the person’s home in which health care, assistance and other support will be provided on a regular, ongoing basis. It is where the people live their lives and continue to have relationships. Residential care facilities are also collective settings, meaning that the rights of residents must sometimes be balanced against the individual and collective rights of other residents to safety, privacy, etc.

### When is it Residential Care?

Residential care facilities are required to provide a number of core services. These include:

- Accommodation
- 24-hour care
- Meals, housekeeping, laundry, recreational activity programs, emergency response (5)
- Personal care assistance
- Other services such as physical therapy, social work and nutritional support
- A secure environment.

British Columbia’s residential care facilities differ from other types of accommodation, services and support such as assisted living facilities in the types of health care services and support (“prescribed services”) that can be provided there, as well as the numbers, and intensity of services and support. Residential care facilities must provide three or more “prescribed services”(6) These services include:



- (a) Regular assistance to the person with activities of daily living, including eating, mobility, dressing, grooming, bathing or personal hygiene;
- (b) Medication administration or monitoring as the person takes the medication; storing and distributing medication;
- (c) Maintaining or managing the resident's cash resources or other property;
- (d) Monitoring the resident's food intake or whether the person is adhering to a therapeutic diet;
- (e) Providing structured behaviour management and intervention;
- (f) Providing psychosocial rehabilitative therapy or intensive physical rehabilitative therapy.(7)

Any care facility that provides these "prescribed services" to three or more persons who are not related to each other by blood or marriage must be licensed as a residential care facility.(8)

It is not always easy to identify whether a facility provides independent living, residential care or an assisted living simply by its business name. The area is further confused by the fact that some businesses or organizations offer a "campus of care" in which different kinds or levels of health care services, accommodation and support are being offered in the building or location (for example, independent living, assisted living, residential care, and specialized dementia care). The situation is further complicated by the fact that some residential care may be provided in "extended care" (an extended care wing of an acute care hospital, or in an extended care building, which may be physically near the hospital).

Practically speaking, what makes residential care facilities in British Columbia distinctive are the characteristics of the people who live there. In contrast to assisted living facilities where residents must be able to make decisions on their own in order to live there (9), a sizeable proportion of people who live in British Columbia's residential care facilities today may have difficulty making some types of decisions without support.

## What is Complex Care?

The term "complex care" as used by the Ministry of Health refers to care and support for people who:

- are moderately or severely cognitively impaired;
- are physically dependent (their medical needs require professional nursing care, and they need a planned program to retain or improve their functional ability);
- have multiple disabilities and/or complex medical conditions that require professional nursing care, monitoring and/or specialized skilled care ("clinically complex"); or
- have severe behavioural problems on a continuous basis. (10)



**Quick Facts on Residential Care in British Columbia (2009)**

- In 2009, there were 348 residential care facilities in the province.(11)
- Together these facilities had 28,992 residential care “beds”. (12)
  - Two thirds (19,165) of the beds came under the Community Care and Assisted Living Act.
  - One third (9,827) of the beds came under the Hospital Act (13) (7,099 extended care beds, and 2,728 private hospital beds).
- Private hospitals are primarily located in Vancouver Coastal Health Authority and Fraser Health Authority.
- 91% of residential care beds were publicly subsidized (26,491 beds).
- Many BC residential care facilities have a high turnover of residents and staff
  - Over 38,411 adults received residential care services in 2009. (14)
  - Approximately 45-50% of the residents are new each year.
  - There is an annual staff turnover of 50 per cent.
- Approximately 43% of the care aides in the province work on a casual basis (that means they have no guarantee of hours per week and may have multiple employers).

Each Health Authority’s website carries basic information on the residential care facilities within their jurisdiction. See Table 1 for the websites. That may include for example, the facility’s location, the costs, the number of beds and how many (if any) are subsidized. It may also include information on whether the facility has been nationally accredited, any special security features, if there are policies on pets, scooters, or smoking. Some health authority lists of residential care facilities will also direct the public to the provider’s website with more information.

**Table 1 Residential Care Facilities Listed by Health Authority**

<b>Health Authority</b>	<b>Listing</b>
<b>Fraser Health</b>	<a href="http://www.fraserhealth.ca/your_care/residential_care/residences/">www.fraserhealth.ca/your_care/residential_care/residences/</a> <sup>[1]</sup>
<b>Interior Health</b>	<a href="http://www.interiorhealth.ca/FindUs/_layouts/FindUs/By.aspx?type=Location">www.interiorhealth.ca/FindUs/_layouts/FindUs/By.aspx?type=Location</a> <sup>[2]</sup>
<b>Northern Health</b>	<a href="http://www.northernhealth.ca/YourHealth/HomeandCommunityCare/HomeandCommunityCareServices/ResidentialCare/ResidentialCareFacilities.aspx">www.northernhealth.ca/YourHealth/HomeandCommunityCare/HomeandCommunityCareServices/ResidentialCare/ResidentialCareFacilities.aspx</a> <sup>[3]</sup>
<b>Island Health</b>	<a href="http://www.interiorhealth.ca/FindUs/_layouts/FindUs/By.aspx?type=Location">www.interiorhealth.ca/FindUs/_layouts/FindUs/By.aspx?type=Location</a> <sup>[2]</sup>
<b>Vancouver Coastal Health *</b>	<a href="http://www.vch.ca/your_health/health_topics/residential_care/">www.vch.ca/your_health/health_topics/residential_care/</a> <sup>[4]</sup>
<b>*Click on the address to find more information</b>	

**NOTE:** Information on a particular residential care facility’s company website will not always be up to date or accurate. In some case, it may represent the law or process of another jurisdiction.

## **Funding: Three Types of Facilities**

The public is often very confused about care facilities, who runs it, who is responsible, and who pays. There is good reason for that confusion:

- a) A care facility may be directly operated by a regional health authority. These are partially subsidized by public funds.
- b) Most facilities are operated by providers that have a contract with a regional health authority. These are financially supported, but not directly operated, by the regional health authority. Most of these rooms are partially subsidized by public funds, but some providers also offer private pay rooms in the same facility.
- c) The third type of facility is not connected with the regional health authority. These facilities only have private pay rooms.(15) For private pay rooms, all costs are covered by the resident. (16)

Funding for subsidized residential care comes from two main sources: the provincial government (public funds) and monthly payments from residents (or their families on their behalf).(17)

People living in subsidized residential care pay up to 80 per cent of their after-tax income as a residential care fee, provided that they have at least \$325 remaining from their income each month. The fee, referred to as a “co-payment,” ranges from \$1005.80 to \$3,198.50 per month (2016 figures). (18)

From those remaining funds, the resident may be required to pay additional charges for “optional services “ (called “chargeable extras”), including specialized wheelchairs, private accommodation, “preferred care products”, haircut, cable, outings and telephone services (19). Since January 1, 2016 "basic personal wheelchair for exclusive use" and their basic maintenance is included in the general client rate. The cost of prescription and non prescription drugs are not covered in the residential care fee, except in extended care units.

The maximum client rate is adjusted annually based on changes to the Consumer Price Index. There is a mechanism for obtaining a “temporary rate reduction” if the amount would cause the person or their family serious financial hardship. (20)The Ombudsperson Report notes that this information on the availability of a reduced rate often was not being provided to people. The Ministry of Health has begun including the information in letters to clients and now posts it on the Home and Community Care website.(21)

## **What are the Differences Between Licensed Residential Care Facilities and Extended Care or Private Hospitals?**

There are several important differences between residential care facilities that fall under the Community Care and Assisted Living Act and the care facilities that fall under the Hospital Act. These relate to whether the facility will have legislated care standards, physical environment standards or restrictions on double occupancy;(22) whether the facility is subject to routine inspections; whether there are reporting requirements for abuse, neglect or other incidents; and whether they are required to have a medical practitioner or registered nurse on site. Some of these differences are summarized in Table 2.

**Although there are funding and other differences, all three types of facilities are licensed by the health authority.**

**Table 2 Comparisons of Licensed Residential Care Facilities & Licensed Private Hospitals & Extended Care Units**

	<b>CCALA (Residential Care Facilities)</b>	<b>Hospital Act (Private Hospitals &amp; Extended Care Hospitals)</b>
How people are described <i>in law</i>	Persons in care (residents)	Patients
Legislated care standards (23)	Yes (24)	No
Residents' bill of rights statement	Yes (25)	Yes (26)
Criminal record checks required by law for staff	Yes	Yes
Remedies under Patient Quality of Care Review (PCQO/PCQRB)	Yes	Yes
Detailed physical standards (27)	Yes	No
Licensed	Yes (28)	Yes for private hospital (29)
Restrictions on double occupancy room	Yes	No
Responsibility to report incidents to key parties (30)	Yes	Yes
"Routine" inspections	Yes	No (31)
Inspection reports posted (32)	Yes	No legal requirement/In practice, yes but varies among health authorities
Legally required to report abuse or neglect of residents	Yes	No – not under Hospital Act
Legal protections for people reporting concerns	Yes for abuse and neglect (33)	No - not under Hospital Act (but come under general Adult Guardianship Act protections)
Medical practitioner or registered nurse required to be on site	No (34)	Yes
Prescription and non prescription drugs covered	No (35)	Yes for extended care facilities; No for private hospitals

## Knowing the Specific Parties

*“Residential Care facilities provide 24-hour professional care and supervision to adults in a supportive, secure environment.” (36)*

It is important to recognize that the identified “24 hour professional care” does not mean nursing care (care by registered nurses). The professional care is delivered by a mix of direct care staff (typically residential care aides or health care assistants) under the supervision of a licensed practical nurse, or possibly a registered nurse. 937) The term “Health Care Assistant” (HCA) is becoming a preferred term for care aides in British Columbia.

In many residential care facilities, the registered nurse will be the Director of Care, who may or may not be on site for that facility. In addition, the residential care facility may employ other professional staff to help support the resident’s care and well-being, including for example, a nutritionist, social worker, occupational therapist, a part time physician, physical therapist or recreational therapist.

### **Residential Care Aides (RCAs)**

Residential Care Aides provide basic resident care, offering residents assistance with the activities of daily living - such as bathing, dressing, grooming - and often serve meal trays and feed residents. They are also known as care attendants or care assistants. When directed by nursing staff (an LPN or RN), the care aides take basic measurements, such as the person's blood pressure, temperature and pulse. They are also the frontline workers who are called upon to collect urine, feces or sputum specimens. (38) At present RCAs are not involved in the overall planning of care for residents, although there have been efforts to make this possible as they often have the most direct contact with the resident.(39) Depending on the facility, they may provide input for care conferences to review the resident's care.

RCAs are unregulated health care providers. A broad range of private and public colleges or institutes offer "Resident Care Attendant" certificates. In 2008, the Health Care Assistant (HCA) Program Provincial Curriculum was established.(40) While it is not compulsory at present for the various teaching colleges to use it, there is a special program recognition process for those colleges that do.(41) After June 30, 2014, all students who have completed their program in British Columbia will be required to show that they have graduated from one of the recognized British Columbia Health Care assistant programs listed on the Registry website in order to become registered care assistants.(42)

There is no regulatory organization (like the College of Licensed Practical Nurses of BC) to ensure program graduates have the ongoing skills necessary for licensing. The residential care aide program is a relatively short program. It has attracted many qualified people who had a health care career (such as nursing) before immigrating, but who do not qualify to be certified, registered or licensed in their previous occupation in Canada.

### **Licensed Practical Nurses (LPNs)**

Licensed Practical Nurses in residential care provide routine bedside care, including the distribution of medication to patients and performing personal treatment. They also help evaluate residents' needs, develop care plans, and supervise RCAs. To work as a LPN in British Columbia, the person must have completed a Practical Nursing program or other approved programs and must be licensed with the College of Licensed Practical Nurses of BC.

About 28% of LPNs in the province work for multiple employers and are casual workers often working multiple jobs and many hours in a row.

### **Registered Nurses (RNs)**

Registered nurses hold a four-year baccalaureate degree in nursing from a Canadian university or its international equivalent. These nurses may specialize in a variety of areas such as surgery, geriatrics, psychiatrics, pediatrics, community health, occupational health, emergency, rehabilitation or oncology. In the few residential care facilities that have registered nurses, they may be the Director of Care. There are very few geriatric nurse specialists working residential care facilities in British Columbia.

## **“Providers” - Owners, Operators, Managers, Licensees**

The Licensees (Owners, Operators) of residential care facilities in British Columbia come from a very wide variety of backgrounds. The Licensee may be a not-for-profit society, a for-profit business (including a federal pension group), and in some cases, the local health authority. Managers in many cases have a background in hospitality or management; some may have a background in health care.

## **Health Authorities**

While the overall responsibility for residential care facilities, extended care facilities and private hospitals lies with the Ministry of Health, each of British Columbia’s five regional health authorities is responsible for most of the oversight in this area. Community Care Licensing Offices in each health region are responsible for licensing and inspecting the residential care facilities, extended care facilities and private hospitals. There are often regional differences among the health authorities in how those responsibilities are carried out. Complaint mechanisms such as the Patient Care Quality Offices are provincially legislated but are operated by each health authority.

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5. These are sometimes referred to as “hospitality services”.
6. CCALA, s. 2.
7. Community Care and Assisted Living Regulation. B.C. Reg. 217/2004 [O.C. 476/2004]. s. 2 [Subsequent reference will be “CCALA Regulation”]. Online: [http://www.bclaws.ca/EPLibraries/bclaws\\_new/document/ID/freeside/217\\_2004](http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/217_2004). (Last accessed January 9, 2016).
8. CCALA Regulation. Also, CCALA, s. 1 See definition of “Community care facility”. Online: [http://www.bclaws.ca/Recon/document/ID/freeside/00\\_02075\\_01](http://www.bclaws.ca/Recon/document/ID/freeside/00_02075_01). (Last accessed January 9, 2016).
9. There is an exception in the law when the spouse is living with the person.
10. Ministry of Health Home and Community Care Policy Manual, Chapter: 6 Residential Care Services, Section 6.D : Access to Services (October, 15, 2012) [Subsequent reference will be “H&CC Policy Manual”]
11. More recent information from the Ministry of Health identifies that there are 361 residential care facilities in the Province. See: <http://www.bccare.ca/bccpa-hosts-fire-safety-meeting/>
12. Ombuds, Best of Care, pg. 204.
13. Hospital Act [RSBC 1996] c. 200. Online: [http://www.bclaws.ca/civix/document/id/complete/statreg/96200\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/96200_01) (Last accessed January 9, 2016).
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19. H&CC Policy Manual. Chapter 6. Residential care Services. Section F Benefits and allowable charges. Online: [http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6\\_hcc\\_policy\\_manual\\_chapter-6.pdf](http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter-6.pdf) (Last accessed January 9, 2016). Section F.1 "Basic wheelchairs" highlights an important HCC policy change effective January 1,2016. Each residential care facility is required to provide "basic wheelchairs" with for "exclusive personal use" of residents assessed to need them; this is included in the general client cost paid by residents. Modified and specialized wheelchairs, plus other fees are still allowable charges.
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21. BC Office of the Ombudsperson. Update on Status of Recommendations. The Best of Care: Getting It Right for Seniors in British Columbia (Part 2) Public Report No. 47. Recommendation 47.
22. However even where there are restrictions, some health authority operated care facilities may exceed the double occupancy restrictions.
23. The standards are on hygiene, recreation opportunities, emergency preparedness, nutrition and the administration of medication, for example.
24. RCR, Division 2 to 5.
25. CCALA, s. 7 (1)(c.1)(ii).
26. As identified in s.4 (3) (a) of the Hospital Act [RSBC 1996] c. 200.
27. E.g. for bedrooms, bathrooms, temperature and lighting
28. CCALA, Part 2.
29. Under Hospital Act, Part 2, s.6.
30. To their local licensing office and their funding body, as well as to the affected resident's family and the resident's family doctor.
31. The Ombuds, Best of Care, pg.208 notes that the Vancouver Coastal Health Authority is the only exception. It has been inspecting private hospital facilities under the Hospital Act regularly since September 2007.
32. Inspection information can now be found on the specific Health Authority website. A particular health authority may provide summary, limited or no information on the care facilities and private hospitals. Interior Health provides inspection information for both types in a table form, but only identifying if there has been a critical or non critical infraction and with no other information. However, Interior Health has developed a useful summary of "substantiated complaints" based on inspections which can be accessed online: <https://www.interiorhealth.ca/YourEnvironment/ResidentialCareFacilities/Documents/Substantiated-Complaints-in-Seniors-Care-Facilities.pdf>. In contrast, Fraser Health provides summary inspection reports on residential care facilities and private hospitals (online: [http://www.healthspace.ca/Clients/FHA/FHA\\_Website.nsf/CCFL-Adult-Frameset-Facilities](http://www.healthspace.ca/Clients/FHA/FHA_Website.nsf/CCFL-Adult-Frameset-Facilities)). Type "hospital" to quickly find private hospitals. It identifies routine inspections and those in response to a complaint. Island Health identifies whether there has been a routine or non routine visit, and if any conditions have been placed on the residential care facility or private hospital. Northern Health also provides very limited information and most of the hospitals have not received an inspection in over 3 years. Vancouver Coastal in comparison provides much more comprehensive and

transparent information. As of February 2015 it has a beta website with inspection reports for residential care facilities and private hospitals, with links to the report. It identifies outstanding infractions and outstanding Bill of Rights infraction. Online: <https://inspections.vcha.ca/>. Vancouver Coastal also has a Legacy Inspection Report website online with older inspection reports: <http://vchlegacyinspections.ca/>.

33. CCALA, s.22.
34. CCALA facilities are required only to ensure that either a medical or nurse practitioner can be contacted in an emergency. However the funding agreement with the health authority may require a registered nurse to be on site.
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**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

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# Legal Frameworks of Residential Care

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## The Statutory Framework for Care Staff



Most of the staff members who provide direct care in residential care facilities are care aides/ health care attendants, licensed practical nurses or registered nurses. They gain their experience through formal training and work experience. Care aides have the least formal training in the health care system and registered nurses have the most.(1)

Almost all direct care is delivered by the residential care aides, who may be supervised by a licensed practical nurse.

RCAs employed in any residential care facility that directly or indirectly receives public funds are required to register with the BC Care Aide & Community Health Worker Registry.(2) The RCAs working at facilities in the private and not-for-profit sectors are encouraged to register as well, especially for those planning to work in the public sector in the future. The Ministry of Health is looking to expand the Registry to cover private care facilities in the future.(3) Employers register to access the registry information on care aides.

The Registry system is described in more detail in Chapter Four “Legal Issues When Living in Care Facilities” and Chapter Five “Rights, Remedies and Problem Resolution”. Registered care aides can be “de-registered” and lose their right to work in any public health care setting in British Columbia if they are found to have abused or neglected residents.(4) The definitions of abuse relied on are those in the Adult Guardianship Act, Part 3. Currently there is no provision for addressing issues that relate to the overall competency of the worker (for example, poor quality care or “fitness to practice”). At present, the registry system itself does not come under any specific law. However, investigations of abuse are subject to principles of natural justice.

Licensed Practical Nurses and Registered Nurses both come under the Health Professions Act(5). Their respective regulatory bodies or associations provide oversight and discipline where required. Registered nurses for example, must be registered with the College of Registered Nurses of British Columbia.(6)

Existing and prospective staff, as well as volunteers and students working residential care facilities are required to undergo initial and follow up criminal records checks as required by the Criminal Records Review Act.(7)

## The General Statutory Framework in Residential Care

British Columbia has two different legal frameworks to govern the care of residents and the responsibilities of care facility operators. The first of these relates to “residential care facilities” and the second covers private hospitals and extended care units of hospitals.

In 2011, the BC Ombudsperson determined that the two separate legislative frameworks for residential care resulted in unfair differences in the care and services that seniors receive, as well as the fees they pay. The Ombudsperson recommended that the Ministry of Health harmonize the residential care regulatory framework.(8) In the alternative, the Ombudsperson recommended that if the government chose to continue to maintain the two regulatory regimes, it should ensure that residents in the Hospital Act facilities are protected by the same standards afforded under the Residential Care Regulation, and that the Hospital Act facilities are subject to the same active oversight and inspection requirements.(9) That has not happened yet.

## Residential Care Facilities come under the Community Care Facilities Act



- **Community Care and Assisted Living Act (10)** This Act and its related Residential Care Regulation (11) govern approximately 70 per cent of residential care facility beds in British Columbia. Together they 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.(12)
- **Residential Care Regulation [RCR]** many of the details of the RCR will be set out in the following chapters. Under this regulation, the people who live in the residential care facilities are referred to as “persons in care”. In everyday practice, they are referred to as

“residents”.

In general, this set of regulations establishes the minimum standards of the care facility, the requirements for staffing(13), admissions,(14) care (15) and care plans (16), nutrition,(17) medication,(18) the use of restraints,(19) and “reportable incidents”.(20) It requires the operator to have written policies and procedures in place in relation to care and supervision of persons in care,(21) including falls prevention.(22)

The regulations cover communication, access to telephone, and privacy.(23) These regulations also set out the physical requirements for bedrooms, bathrooms, common areas and work areas(24), as well as more detailed specifics such as the temperature of water,(25) and signalling devices. The RCR also sets out records management requirements.(26)

The regulations outline a broad principle intended to guide all residential care. It states the residents’ dignity will be considered when determining care standards.(27) Specific examples are offered in the regulation: operators are required to consider the dignity of the individual when assessing the adequacy of privacy, furniture and equipment in bedrooms and bathrooms.(28) Staffing must also be sufficient for individuals to receive care in a manner consistent with their dignity.(29)However, as the BC Ombudsperson report notes, terms like “dignity” are difficult to measure and how the dignity standard is respected has not been specified.

Under RCR, the Licensees must provide residents, their representatives and family members an opportunity to establish a resident and family council.(30) Under the regulations, employees are required to undergo a criminal record check,(31) and provide character references.(32) The employers are required to check the prospective employee’s work history and proof of relevant training prior to being hired.(33) Facility operators are required to regularly review the performance of staff and ensure that employees do not carry out duties which they are not competent to perform.(34)

The RCR identifies the circumstances in which specific types of “incidents” and health concerns must be recorded in the facility’s internal documentation and when it will need to be reported to external authorities.(35) For example, under the RCR, all medication errors must be recorded.(36) As of December, 2013 incidents of “aggression between persons in care” that cause injury must be recorded by the care facility.(37) There are reporting measures that apply to the use of restraints and occurrences of communicable diseases.(38)

The RCR requires operators take certain safety and identification measures for any cognitively impaired resident who is considered to be at risk of leaving the premises without alerting staff, and of not being able to identify themselves. That might involve placing a bracelet or other secure means of identification on the person. The bracelet must give the name of the person and the community care facility as well as the emergency contact information.(39)

## **Private Hospitals and Extended Care Facilities come under the Hospital Act**

Approximately thirty per cent of British Columbia's residential care facility beds are in private hospitals and extended care facilities licensed under the Hospital Act. This Act regulates private hospitals and extended care hospitals that provide residential care. At a given point in time approximately 9800 residents needing long term care will live in these settings. These facilities currently have different regulatory standards, fees, monitoring and enforcement processes than the licensed care facilities that come under the Community Care and Assisted Living Act. Private hospitals that provide residential care services are regulated by part 2 of the Hospital Act.(40)

Private hospitals must be licensed in accordance with the Hospital Act. Residential care can also be provided as "extended care" in a hospital setting. In this case, these units or facilities are also subject to the Hospital Act. The definition of hospital in the Hospital Act includes, "a non-profit institution that has been designated as a hospital by the Minister of Health Services and is operated primarily for the reception and treatment of persons requiring extended care at a higher level than that generally provided in a private hospital licensed under Part 2."(41) Extended care units or hospitals are often either part of a general hospital or near a general hospital.

Unlike the RCR, the Hospital Act does not set out mandatory standards for operators who provide residential care. However that does not mean there are no standards of care or practice to which the staff and administration of private hospitals or extended care units are accountable.

The law requires that the private hospital (or "house" as it is identified in law) has been approved by the provincial chief inspector of hospitals as suitable for the purpose indicated when the operator applied for a license. (42) The Hospital Act also states that a licensed private hospital may be inspected "at any time" by a hospital inspector who is employed by a regional health authority.

It has been recognized that there would be significant advantages to having the three types of facilities (residential care, extended care units and private hospitals) come under a common set of standards, inspection and monitoring structure. However, a number of implications related to funding, property tax, capitalization, and user fees would arise. (43)

As mentioned, the Ombudsperson 's report has stated that 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.(44)

## **Differences between the two frameworks**

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.(45) The general public, older adults and their families typically do not know under which legislation a particular facility falls. (46) The Act that governs the facility makes a significant difference to the rules, standards and oversight mechanisms which govern the care provided.

### **Hospital Act**

The principal focus of the Hospital Act has been the regulation of public hospitals that provide acute, extended and rehabilitation care. However, the Act has also regulated private hospitals over the past 50 years. According to the definition set out in the Hospital Insurance Act Regulations,(47) the prime function of extended care hospitals is to provide "skilled nursing care and continuing medical supervision."

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14. RCR, Part 5, Division 1, s. 46-50.
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22. RCR, s.81 (3)(e).
23. RCR, s. 18.
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26. RCR, s.69(1).
27. For example: RCR s. 7, 21, 25, 26, 29, 30, 42, 47, 53, 57, 73, 78, 93.
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29. RCR, s. 42(1).
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31. RCR, s. 37(1).
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34. RCR, s.40 (1).
35. RCR, s. 77(1).
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This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

## Other Key Laws and Regulations

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### Beyond the Big Four - the Supporting Cast

Together the four statutory and regulatory components of the law provide the general framework for the operators of the facilities, setting out their general responsibilities, and the licensing framework, and minimum standards for operation.

There are several other important pieces of legislation relevant to the rights of seniors in residential care facilities, and the responsibilities of others for the care of seniors. For example, the Mental Health Act can have important implications for prospective residents who are viewed as mentally incapable.(1)

### Care

The primary statutory requirements for care in care facilities come under the Residential Care Regulations. However, other laws are important to residential care issues, especially in the context of mental capacity issues.

#### Adult Guardianship Act

This Act sets out the presumption that adults of any age are capable of making decisions about their own personal care, health care and financial affairs.(2) Part 3 of the Act covers support and assistance to vulnerable adults who may be experiencing abuse and neglect in almost any setting. (3)

#### Health Care (Consent) and Care Facility (Admission) Act (4)

This Act sets out the general rules for consent to treatment, the presumption of capability to consent, and what is meant by “health care” in this context. It identifies who can be a statutory (temporary) substitute decision maker for health care when a person becomes mentally incapable. It describes the scope of representation agreements in health care settings. It identifies the scope and requirements for advance directives, as well as how and when advance directives apply.

#### Mental Health Act (5)

The Mental Health Act is protective legislation designed to ensure the safety and well-being of people with mental illnesses. It establishes the mechanism by which a “person with a mental disorder” can be involuntarily detained and admitted to a “mental health facility”. The Act has been used to involuntarily admit people who are considered “mentally incapable” of consenting (or refusing to consent) to move into a residential care facility by transferring

them from hospitals to care facilities on “extended leave”.(6) This process is described in Chapter Two on Admissions & Transfers. It is generally considered as inappropriate to use the law in this manner.

It has been used primarily because Part 3 of the Health Care (Consent) and Care Facility (Admission) Act has not come into force. Part 3 creates a process allowing a substitute decision-maker to consent to the admission of an adult who is not capable of making an informed decision to a care facility. The Mental Health Act sets out a process by which the involuntary detentions can be reviewed by the Mental Health Review Board.

#### Occupational Health and Safety Regulations

These concern the employer’s obligations regarding a violence prevention program (risk assessment, procedures/policies, instruction of workers) in a workplace, and an employee’s right to refuse unsafe work.

## **Financial and Related Matters**

#### Power of Attorney Act (7)

This Act enables individuals to draft a power of attorney or an enduring power of attorney so that others may make financial decisions or deal with financial and related legal matters on a person’s behalf. It identifies that mechanism and process of making a power of attorney (including the presumption of capability), and sets out the duties and responsibilities of the person granted the power. The power of attorney is one of the most commonly misunderstood documents in residential care.

#### Public Guardian and Trustee Act (8)

This Act authorizes the Public Guardian and Trustee to investigate and audit the affairs, dealings and accounts of an adult who has a guardian, an adult who is apparently abused or neglected, as defined in the Adult Guardianship Act, or an attorney under a power of attorney or an enduring power of attorney for failing to follow his or her duties properly.(9)

In addition, the Public Guardian and Trustee may investigate the personal care and health care decisions made by a representative or guardian, if the Public Guardian and Trustee has reason to believe the representative or guardian has failed to comply with his or her duties.

## **Substitute Decision-Making**

#### Representation Agreement Act (10)

This Act allows adults to arrange in advance how, when and by whom, decisions about their health care or personal care, the routine management of their financial affairs, or other matters will be made if they become incapable of making decisions independently. It is also intended to avoid the need for courts to appoint someone to help an adult make decisions, or someone to make decisions for adults, when they are incapable of making decisions independently.

#### Patient Property Act (11)

This Act authorizes people to be certified as mentally incapable in British Columbia. It has been in place since 1979.(12) Once a certificate has been issued, it gives the Public Guardian and Trustee the authority to manage the person’s estate. The Act provides statutory mechanisms under which a public or private committee (a government agency or private person) may exercise what is essentially guardianship. It also provides for a court ordered committee. The committee has authority over the incapable adult’s financial and legal decisions about their money and property (referred to as a “committee of the estate”) or the incapable adult’s health and personal care decisions (a “committee of the person”).

## Privacy Matters

In British Columbia the Personal Information Protection Act (13) covers the collection, use and disclosure of personal information by non public bodies. The Freedom of Information and Protection of Privacy Act (14) covers the collection, use and disclosure of personal information by public bodies. People may want or need to share personal information about a prospective or current resident. For example at admission, the operator may ask the health authority for personal information about a prospective resident to determine whether a prospective resident has shown violent tendencies or behaviour in the past. In other instances, other parties may want information about residents from the Operator.

[See Chapter Three “Legal Issues in Admission & Transfer” and Chapter Four “Legal Issues When Living in Residential Care”.]

The issue of what and when to disclose information may also arise if the facility administration wants to properly accommodate the person and his or her needs. This can help avoid discrimination based on a protected ground under the Human Rights Code, e.g. sexual orientation, ethnicity, disability. This will be discussed further in Chapter Five “Rights, Remedies, and Problem Resolution”.

## Special Populations

There can be laws and policies that apply to special groups of people seeking residential care, such as veterans,(15) or older sponsored immigrants. (16)Some residential care facilities have contract beds designated for priority access for eligible Veterans. The financial, familial and legal implications of who pays for care and access to care can become especially problematic for sponsored immigrants and their sponsors.(17)

## Rights, Remedies and Oversight

Most issues or concerns about residential care will be addressed internally using the care facility’s complaint procedures. There are also a number of external administrative and legal mechanisms for raising concerns about residential care that may offer methods of redress or remedies (described in detail in Chapter 6, Rights, Remedies and Problem Resolution).These include:

- **Community Care Licensing Offices** - Community Care Licensing is responsible for the developing and implementing legislation, policy, and guidelines to protect the health and safety of people being cared for in licensed facilities.(18) Community Care Licensing falls under the Home, Community and Integrated Care Branch (Health Authorities Division). A Medical Health Officer appointed under the Public Health Act (19)is responsible for issuing care facility licences, inspecting licensed facilities and investigating complaints that an unlicensed facility is being operated.(20) Inspections of facilities are carried out on a risk assessment basis.(21) Licensing deals with health and safety complaints, as opposed to quality of care matters.
- British Columbia now has a province-wide process for receiving and responding to complaints about the quality of health care services (a “patient care quality complaint”).(22) The Patient Care Quality Office is the central complaints office within each health authority. It is required to receive, investigate and respond to complaints regarding the quality of care that a person receives. It covers both the delivery of the services and the quality of the services. The Office derives its authority from the Patient Care Quality Review Board Act(S.B.C. 2008, c.35).(23)



- Patient Care Quality Officers review complaints received, investigate and are required to provide responses back to the complainant within 30 business days, giving information about what was learned during the investigation. The Act also requires each regional health authority to establish a Patient Care Quality Review Board to review complaints that remain unanswered within 30 days or not answered to the person's satisfaction.
- **Human Rights Code** (24)- The Code protects people from discrimination in many areas including "accommodations, services or facilities customarily available to the public".(25) In order to be "discrimination", the action must be without bona fide and reasonable justification. (26) The Code also protects from harassment (a form of discrimination)(27). Unlike the Charter which only covers [public] government action, the Human Rights Code covers the actions of both public and private bodies. The areas protected for accommodation, services or facilities relate to a person's or group's age, physical or mental disability, race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, or sexual orientation.(28) Cases are heard by the Human Rights Tribunal,
- **Ombudsperson Act**(29) - The Office of the Ombudsperson is responsible for assuring that specified provincial government ministries or public agencies treat the public fairly and reasonably. The Office is responsible to impartially investigate the complaints to determine whether fair treatment has occurred, and whether the actions and decisions of provincial government ministries or public agencies were consistent with relevant legislation, policies and procedures.
- **Canadian Charter of Rights and Freedoms** (30)- The Charter guarantees certain civil rights to people in Canada from the policies and actions of all level of government. It covers fundamental freedoms, equality rights, legal rights, democratic rights, mobility rights, and language rights, many of which are particularly relevant to the treatment of people in residential care.
- **Criminal Code** (31) - As in any other setting, some actions that occur in residential care facilities such as theft, assault, gross neglect leading to death (32)or homicide may come within the scope of criminal law. The actions of staff, volunteers, visitors as well as residents can come under the force of the Criminal Code of Canada. Very recently, s. 215 of the Criminal Code ("failure to provide the necessities of life") was used in a precedent setting way to lay a charge against staff in an institutional (non care) setting.(33)
- A resident may have been experienced problems with family, neighbours or others in the community that follow the resident into the facility. New problems or conflicts may also develop there. In some of these cases, advocates and providers may need to be familiar with peace bonds ("810 recognizances") and "no contact orders" issued by criminal court judges; "release conditions". As well they may need to be familiar with "family law protection orders" under the Family Law Act.(34)
- **Consumer Protection** - Some services provided to residents in care facilities may be direct performance contracts. The Business Practices and Consumer Protection Act (35) prohibits unfair practices, sets out the requirements for certain consumer contracts and provides licensing requirements for regulated businesses. The Act consolidated several consumer statutes. It protects consumers by standardizing contract terms, clarifying cancellation rights and ensuring that penalties for infractions are applied consistently across industries. The Ministry of Health is currently drafting standardized contract template for admission agreements.
- **Coroners Act** (36) - Among other things, this Act places a responsibility on everyone in British Columbia to report the death of anyone who they believe has died as a result of violence, accident, negligence, misconduct or malpractice, (37)or suicide to a coroner or peace officer.(38)That includes the death of a person living in a residential care facility or who is transferred to a hospital or other setting from a residential care facility. Accidental, negligent or violent deaths in residential care may involve a wide variety of circumstances, including a missing person who is cognitively impaired, a mechanical equipment malfunction, scalding during bathing, or assaults between residents.



- In recent years, the BC Coroner has investigated incidents of residents' death caused by another resident. (41) In theory, a Coroner's investigation may result in a coroner's inquest, a death review panel, or a coroner's report to the institutions that were responsible for the care of the residents involved. The Coroner can also investigate any sudden and unexpected death when the person was apparently in good health and not under the care of a medical practitioner,(39) as well as deaths from disease, sickness or unknown cause, for which the person was not treated by a medical practitioner.(40)

## Legislation Related to Funding

- **Canada Health Act** (42) - Hospitals and doctors are covered by the Canada Health Act; residential care facilities are not. The Canada Health Act establishes the criteria and conditions that the provinces and territories must meet to be eligible for available federal government health care funding.
- The extended care services provided in residential care facilities are not included in the funding criteria and national standards contained in the Act. However, for the purpose of this legal manual, the Canada Health Act remains important as it relates to what hospital administration can do or can charge patients in the transition from hospital care to residential care. This is described further in Chapter Three Legal Issues in Admissions & Transfers.
- **Continuing Care Act and Regulations** -Continuing care is defined as one or more health care services to persons with a frailty or with an acute or chronic illness or disability that does not require hospital care. This Act (43) allows the Minister of Health to enter into payment Agreements with operators for the services given to clients so they can receive continuing care from the operator. The Act also sets out applicable standards, guidelines or directives issued by the minister.
- **Continuing Care Fee Regulations** (44)- The regulations authorize the Minister to charge residents a prescribed monthly fee.
- **Hospital Insurance Act Regulations.** (45) Section 8.4 of this Act sets out a monthly charge for extended care hospital residents.

**IMPORTANT NOTE:** The Continuing Care Fee Regulations, (s. 6) and the Hospital Insurance Act Regulations (s. 8.6) authorize the Minister to reduce some or all the charges that the resident might otherwise be required to pay in residential care facilities and extended care hospitals. These are the legal basis for the "hardship waivers" for which residents or their legal representatives can apply.

## Professional Responsibility Laws

- **Health Professions Act:** This act governs the regulation of a number of health professions. The Act also sets the expected response to certain harms perpetrated on people in care by health professionals. The Act requires identified "designated health professionals" to report certain harms to their registrar, including, (a) sexual misconduct (by someone in that profession) and (b) behaviour by someone in that profession that is dangerous to the public. (46) Reporting sexual misconduct requires the client's consent (or consent by his or her legal representative if the person is not capable). A list of Health Professions covered by this Act most relevant to this setting is listed in Appendix B.

## Miscellaneous

### Cremation, Interment and Funeral Services Act (47)

This Act identifies who can authorize the picking up human remains from a care facility. There is current disagreement about who can give authorization and whether funeral instructions in an admission agreement are valid (the right to give instructions re: funeral does not vest until after death).

### Labour Relations Code (48)

Governs the conduct of both parties in the event of a breakdown in labour negotiations. Also the Code calls for the development of an essential service plan for residents in the event of labour disruption.

## References

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3. AGA, s. 44 states "The purpose of this Part is to provide for support and assistance for adults who are abused or neglected and who are unable to seek support and assistance because of
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  2. (b) a physical handicap that limits their ability to seek help, or
  3. (c) an illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect."
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**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# Chapter One Resources and Appendix

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## Appendix A: Care Requirements Summary

(138) In 2009 BC Care Providers Association developed a summary classification of residents for their organization. This table is a modified version of that classification, with more focus on the “typical “ residents. Most residents in care facilities fall into Groups 1, 2 and 3. A small minority may come within Groups 4 or 5, some of whom may be living in specialized units.

### Prospective complex care residents may be categorized into five groups

#### GROUP 1

Physically dependent and cognitively intact with medical needs requiring professional nursing for monitoring or medical intervention. Requires a planned care program. Unable to use wheelchair independently. Requires paraprofessional interventions.

#### GROUP 2

Clinically complex requiring professional nursing, monitoring and skilled intervention. May be re-ambulation, hospice/palliative, medical sub acute (high needs).

#### GROUP 3

Cognitively impaired, socially appropriate. Unable to communicate needs, requires directional assistance and/ or requires total care with ADLs. Requires a secure environment for safety. May or may not be independently mobile.

#### GROUP 4

Cognitive impaired, socially inappropriate, anti-social behaviours. Unable to communicate needs, requires total care with ADLs. Requires a secure environment for self protection.

#### GROUP 5

Residents with severe behavioural problems, destructive, aggressive, violent. May or may not be independently mobile.

## Appendix B

### List of Regulatory Colleges Specifically Relevant to Residential Care

College of Dietitians of BC

[www.collegeofdietitiansbc.org](http://www.collegeofdietitiansbc.org)

College of Licensed Practical Nurses of BC

[www.clpnbc.org](http://www.clpnbc.org)

College of Occupational Therapists of BC

[www.cotbc.org](http://www.cotbc.org) <sup>[1]</sup>

College of Pharmacists of BC

[www.bcpharmacists.org](http://www.bcpharmacists.org) <sup>[2]</sup>

College of Physical Therapists of BC

[www.cptbc.org](http://www.cptbc.org) <sup>[3]</sup>

College of Physicians and Surgeons of BC

[www.cpsbc.ca](http://www.cpsbc.ca) <sup>[4]</sup>

College of Registered Nurses of BCP

[www.crnbc.ca](http://www.crnbc.ca) <sup>[5]</sup>

College of Registered Psychiatric Nurses of BC

[www.crpnb.ca](http://www.crpnb.ca) <sup>[6]</sup>

BC College of Social Workers

[www.bccollegeofsocialworkers.ca](http://www.bccollegeofsocialworkers.ca) <sup>[7]</sup>

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## References

[1] <http://www.cotbc.org>

[2] <http://www.bcpharmacists.org>

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[4] <http://www.cpsbc.ca>

[5] <http://www.crnbc.ca>

[6] <http://www.crpnb.ca>

[7] <http://www.bccollegeofsocialworkers.ca>

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## 2-Resident's Bill of Rights

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### Understanding the Bill of Rights and Residential Care

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This chapter briefly introduces the Residents' Bill of Rights <sup>[1]</sup>.

*Residents retain all their rights and entitlements as adults.*

In December 2009 a Residents' Bill of Rights was added to the Community Care and Assisted Living Act and Residential Care Regulations, as well as the Hospital Act for residents in private hospital and extended care facilities.

These Bills of Rights can be an important legal mechanism to interpret and understand the required approach to care and quality of life for residents. While these are expressed as the resident's rights, to actually give the rights effect often requires the support of other people (including "family" or "representative") important to the resident. The Bill of Rights recognizes and supports their active involvement.

The Residents' Bill of Rights set out some of the rights that residents living in care facilities can expect to have respected. This statutory list of Rights operates in addition to residents' common law rights, their other rights under municipal, provincial or federal laws, the Canadian Charter of Rights and Freedoms in respect of government actions, as well as rights from other sources.

British Columbia's Bill of Rights for residential care facilities is a combination of human rights, individual freedoms, consumer rights, care and representation rights, as well as policy expectations. The rights are to be read and contextualized in light of what is reasonably practical given the resident's physical, mental and emotional circumstances. Where necessary, a resident's rights may need to be balanced with the need to protect and promote this resident's health or safety, or the rights, health and safety of other residents.

The Residents' Bill of Rights is a distillation of a number of standards of care that have been identified over the years in the former Adult Care Regulations and newer Residential Care Regulations.(1) The rights in this Bill offer a commitment to care. They also set out the residents' rights to health, safety and dignity; rights to participation and freedom of expression; as well as rights to transparency and accountability. The general scope and any general limitations on these rights are also identified. This list of rights is required to be posted in the facility.

While the Ministry of Health has described this as a "comprehensive list of rights", (2) it is important to note these are a codification of certain rights. They are not the only rights that residents have in residential care facilities. These identified rights are sometimes identified as largely educational. (3) That kind of statement may inadvertently appear to diminish the importance of these responsibilities for operators. These are rights, not simply wishes or good intentions.

The legal scope of the Bill is discussed in Chapter Five on "Rights, Remedies and Problem Resolution". Unlike some Canadian jurisdictions, British Columbia's Residents' Bill of Rights has not been specifically identified in law as a deemed part of the residential care contract and does not give a separate right of action. However, that does not mean they are not enforceable.

## Understanding the Bill of Rights

The Bill of Rights in the Residential Care Regulations is not a comprehensive statement of rights. However it covers four important domains or themes:

- (a) commitment to care;
- (b) rights to health, safety and dignity;
- (c) rights to participation and freedom of expression; and
- (d) rights to transparency and accountability.

## References

1. Health Statutes (Residents' Bill of Rights) Amendment Act. S.B.C. 2009, s.8. Bill 17 (2009). In force by Order in Council 708 December 8, 2009). Online: [http://www.bclaws.ca/civix/document/id/complete/statreg/08035\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/08035_01) (Last accessed January 9, 2016).
2. Ministry of Health. Policy and Standards. Residents Bill of Rights. Online: <http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/accountability/policy-and-standards> (Last accessed January 9, 2016).
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**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## References

- [1] [http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/pdf/adultcare\\_bill\\_of\\_rights.pdf](http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/pdf/adultcare_bill_of_rights.pdf)



# Key Bill of Rights Provisions for Residential Care

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## Commitment to Care

1. An adult person in care has the right to a care plan developed
  - (a) specifically for him or her, and
  - (b) on the basis of his or her unique abilities, physical, social and emotional needs, and cultural and spiritual preferences.

Section 1 emphasizes a commitment to using an individualized approach to whatever care and support will be provided to the resident, and how it will be provided. The approach to care is expected to be shaped by the resident's unique abilities (who they are and have been, what they are able to do, where they are able to make their own decisions, and where they may need some support). The approach to care is expected to focus on more than just the person's physical needs, but also their emotional and social needs as a person. The resident's cultural and spiritual preferences are also important.

Social needs might include, for example who they prefer to sit with at the dining room, who they want to associate with within the facility, their continued connection with friends or the community, or who they do not like to visit. In some cases, requirements in the residential care regulations can affect the opportunities that an operator and staff have to provide more individualized care and support.<sup>(1)</sup>

Cultural and spiritual preferences include opportunities to participate in the facility or outside in activities or rituals meaningful to that resident. Cultural preferences may also include matters such as food preferences, alternative or complementary therapies, their preferred method of information sharing, and preferred approach to end of life care.

## Rights to Health, Safety and Dignity

2. An adult person in care has the right to the protection and promotion of his or her health, safety and dignity, including a right to all of the following:
  - (a) to be treated in a manner, and to live in an environment, that promotes his or her health, safety and dignity;
  - (b) to be protected from abuse and neglect;
  - (c) to have his or her lifestyle and choices respected and supported, and to pursue social, cultural, religious, spiritual and other interests;
  - (d) to have his or her personal privacy respected, including in relation to his or her records, bedroom, belongings and storage spaces;
  - (e) to receive visitors and to communicate with visitors in private
  - (f) to keep and display personal possessions, pictures and furnishings in his or her bedroom.

Section 2 identifies how the resident is to be treated. The key aim of the section focuses on the care facility's role to promote each resident's dignity, health, and safety, as well as safeguard residents if these rights or freedoms are being infringed. These three (dignity, health, and safety) are inter-related concepts that often work together. Several types of specific rights are identified in this part including: autonomy rights and non-discrimination; self expression and recognition of personhood and life history; rights to communication and association; freedom from abuse or neglect, as well as protection from these harms.

There are many areas of care where dignity is involved. One is continence care (assistance going to the bathroom). The British Columbia Ombudsperson noted:

*“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.” (2)*

A second area key to promoting dignity in residential care is the use of physical, chemical or environmental restraints. As the British Columbia Ombudsperson has noted:

*“Regardless of the circumstances or the method used, restraining someone reduces that person’s individual liberty and affects his or her dignity.”(3)*

## **Privacy**

Section 2 acknowledges and protects personal privacy in several contexts (privacy when receiving care, privacy in communication, privacy in physical space and environment, and privacy of personal information and records). “Privacy” in residential care has several related meanings, including the right to be treated in a dignified manner when receiving care, irrespective of whether a person seems to be mentally aware, and the right to control over certain aspects of one’s life (e.g. meals, visitors, mail, information, records). In other contexts, privacy can mean the right to be left alone (e.g. to choose to not participate).

In section 2, safety is viewed as one important consideration but it is not the only consideration. Personal privacy needs to be respected in all aspects of the residents’ lives. Common examples of respecting privacy in residential care include when staff and others:

- provide personal or health care (e.g., putting in dentures) in private, not in public areas of the facility
- knock before entering the resident’s room, and waiting for the resident to answer
- ask permission before cleaning a resident’s room or anything else that belongs to the resident, or touch a resident’s personal belongings.

Respecting privacy in residential care is often shown by what people do not do. That includes, for example, when staff:

- do not use the resident’s possessions (e.g. wheelchair or walker) for someone else without their permission,
- do not share personal and confidential information about the resident without consent, or
- do not talk with each other unnecessarily about residents’ lives.

Issues about limits on personal privacy issues can come when care facilities ban smoking or alcohol consumption by residents. Sometimes an operator may try to enforce the policy by having the staff search a resident’s room under pretext of “cleaning”, and seize “contraband” possessions without permission. In some cases, family members’ possessions might be searched. Whether these are reasonable limits will depend on the particular circumstances, the actions taken and the specific risks involved.

Physical privacy is often an issue for residents in the private hospitals which tend to have double and quadruple occupancy rooms for residents. Privacy is becoming an increasingly important issue in residential care because of developing technologies that allow for continuous monitoring of a person, falls detection, as well as video surveillance by family or the operator.

## Rights to Participation and Freedom of Expression

3. An adult person in care has the right to participate in his or her own care and to freely express his or her views, including a right to all of the following:

- (a) to participate in the development and implementation of his or her care plan;
- (b) to establish and participate in a resident or family council to represent the interests of persons in care;
- (c) to have his or her family or representative participate on a resident or family council on their own behalf;
- (d) to have access to a fair and effective process to express concerns, make complaints or resolve disputes within the facility;
- (e) to be informed as to how to make a complaint to an authority outside the facility;
- (f) To have his or her family or representative exercise the rights under this clause on his or her behalf.



Section 3 focuses on the resident's personal involvement and family involvement in the resident's individual care and the broader systemic issues affecting this resident and others in the facility. It recognizes autonomy, and joint decision making in care. Each resident has the right to participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters.

Section 3 stresses the importance of residents being able to freely express views, plus participate in the development and implementation of any plans for their care. It includes personal and supported involvement, where the resident and family shape the care by working with the staff and have a right to accept, revise or turn down what is being proposed. The term "family" here means whomever the resident wants to include. Section 3 of the Bill of Rights also recognizes resident and family councils as important mechanisms to help improve individual and collective care within the facility.

Section 3 also stresses the importance of residents, family or representatives having effective opportunities and avenues for raising concerns if and when problems arise, as well as having these addressed at that point. In many cases, that right can only be exercised by first knowing about the internal and external complaint mechanisms. However the mechanisms must also be appropriate to the circumstances of residents and others advocating on their behalf.

## Rights to Transparency

### Rights to transparency and accountability

4. An adult person in care has the right to transparency and accountability, including a right to all of the following:
- (a) to have ready access to copies of all laws, rules and policies affecting a service provided to him or her;
  - (b) to have ready access to a copy of the most recent routine inspection record made under the Act;
  - (c) to be informed in advance of all charges, fees and other amounts that he or she must pay for accommodation and services received through the facility;
  - (d) if any part of the cost of accommodation or services is prepaid, to receive at the time of prepayment a written statement setting out the terms and conditions under which a refund may be made;
  - (e) To have his or her family or representative informed of the matters described in this clause.

Section 4 of the Bill of Rights focuses on information that is expected to be readily available for the resident and family. The terms “transparency and accountability” in the title is somewhat unorthodox, in that the term is more commonly used in the context of government actions.

Information expected to be available from the operator would include fees, charges, and rules, internal and external policies. The information expected to be available from health authorities and Ministry of Health would include specific information on the facility (inspection record), laws affecting residential care, plus any health authority, or Ministry of Health or other Ministry rules and policies that apply in this area. In theory, access to this information aids self advocacy or advocacy on behalf of the resident.

One of the positive features of this “right to access” is that it may reduce problems in interpretation. People can see both the wording and rationale behind the policy, which may help in understanding whether a different (e.g. less restrictive, more supportive) approach could be used with a particular resident or residents generally.

Some parts of Section 4 are consumer rights (e.g. s. 4 (c) and (d)); these may look out of place in a Bill of Rights. However, this explicit statement is intended to address a common problem raised by the BC Ombudsperson Office of when residents moved into a care facility without knowing the costs, or what services were included. Residents and families are often unaware of Residential Care Rate Structure, or Rate Reductions and Waivers.(4)

## Scope of Rights

This section sets out the scope of the rights, describing what limitations, if any, there are on the listed rights.

5. The rights set out in clauses 2, 3 and 4 are subject to:

- (a) what is reasonably practical **given the physical**, mental and emotional circumstances of the person in care,
- (b) the need to **protect** and **promote** the health or safety of the person in care or another person in care, and
- (c) *The rights of other persons in care.*

The Scope of Rights section is very notable in that there are only two identified “limits” on the residents’ rights. The first is the person’s capabilities (for example, which might make it difficult to actively participate). The second justifiable limit under the Bill of Rights is *where it can be demonstrated* that an action to respect one resident’s right would negatively affect the health and safety of another resident or the rights of others residents. The needs or interests of staff or the provider are not relevant in this context and are not a legitimate limit on these rights. Mere possibility or conjecture that it might affect other residents’ health or safety would not be acceptable limits.

## References

1. See RCR, s. 64 (1) Food Service Schedule.
2. Ombuds, Best of Care.
3. Ombuds, Best of Care.
4. Ombuds Best of Care.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# Protecting and Enforcing Rights in Residential Care

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## **Complaints that rights have been violated**

If a resident believes that his or her rights have been violated, the resident (or a person acting on his or her behalf) may submit a complaint under the Patient Care Quality Review Board Act.(1) These will be treated as care quality complaints.(2)

## **Protection for persons in care**

The Residents' Bill of Rights prohibits an Operator from retaliating against the resident because of a complaint made under the CCALA and Regulations, or made under the Patient Care Quality Review Board Act. They cannot "evict, discharge, intimidate, coerce, impose any pecuniary or other penalty on, suspend a service to, deny a right or benefit to or otherwise discriminate against a [resident] because of a complaint made in relation to the [resident].(3)

## **No right to sue**

As previously noted, there is no independent right of action or right of compensation based only on a violation of a resident's rights under the Bill. (4) However, it remains important evidence of legal duties owed by the operator, staff and health authorities to the resident or residents.

## **References**

1. Residents' Bill of Rights, s. 2(1).
2. Residents' Bill of Rights, s.2 (2).
3. Residents' Bill of Rights, s. 3.
4. Residents' Bill of Rights, s. 4.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

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# 3-Legal Issues in Admission and Transfer

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## Introduction to Legal Issues in Admission and Transfer

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This chapter describes legal issues associated with the process of a person transferring from home, hospital or other setting such as an assisted living facility to residential care. It briefly describes the assessment process; consenting to admission; care plan development; and contracts signed at the time of admission. The admission process is largely shaped by the Ministry of Health's Home and Community Care Policy, residents' rights and the common law (contracts and consent).

### Introduction

Although the number of older adults in British Columbia needing care and support has increased significantly in the past decades, the number of higher level "care beds" to meet those needs has only increased marginally, leaving a gap in care and support. In many cases, people move into residential care facilities because their needs have expanded beyond what other systems such as assisted living and community or family support can offer.

Licensed residential care facilities have three essential features that set them apart from other supportive living environments, such as assisted living. Each is an important consideration when applying and interpreting the law in this area.

- a) A person cannot be admitted to a subsidized residential care facility or extended care facility without having specific care needs. The person must have a level of care need that cannot be appropriately met in the community. (1)Today, that means the person requires what is referred to in the British Columbia health system as "complex care".
- b) All licensed residential care facilities (including private pay hospitals and extended care facilities) have a responsibility for monitoring on-going care needs, identifying significant changes and meeting the current and changing care needs of the residents.
- c) The primary reason for discharging a resident from a residential care facility is that the resident no longer requires the care offered by the facility, or the resident requires a higher level of care that can only be provided elsewhere.

### Basic Issues in Eligibility for Residential Care

British Columbia has a provincial home and community care assessment and placement system, but operated and managed within each regional health authority. This system determines people's eligibility for admission to care facilities, decides who has priority, and manages the waiting list for admission to publicly funded "beds" in residential care facilities. In theory, no one can be admitted to a facility unless the health authority has found the applicant eligible and authorizes their placement in a particular facility, and the applicant (or appropriate substitute decision maker) consents to that placement.

To be eligible for residential care, the person must:

- Have a health care need that requires 24-hour nursing and personal care (2)
- Be a citizen of Canada or have permanent resident status \*
- Be 19 years of age or older
- Have lived in B.C. for ninety (90) days or longer\*\* (can be waived in certain circumstances)
- Agree to the assessment process \*\*\* (unless involuntarily admitted or transferred to the facility under the Mental Health Act).

**Special note : Financial Eligibility for Subsidized Rate**

In order to be eligible for residential care at a subsidized rate, the person must also agree to the release of financial information to the health authority in order to determine financial eligibility. If they do not agree to that financial disclosure, or they are not capable of consenting, they are assessed at the highest rate.

Some health authorities state in their public information that the individual must also exhaust all other home care community options. (3)Nothing in the Ministry of Health eligibility criteria requires this. The primary issue for most residential care admissions is that the person meets the high threshold of needing 24 hour care. For subsidized residential care, the person must also meet the financial eligibility requirements for the public subsidy.

The most common reason for people to need residential care these days is a blend of physical health and cognitive factors for the prospective resident, as well as environmental factors such as risky living circumstances and caregiver burnout. The prospective residential care facility applicant is often a person with multiple and complicated chronic health conditions, with or without dementia that has progressed to the moderate to advanced stages.

In British Columbia, people who can no longer be cared for in their own homes or in an assisted living residence will be candidates for residential care services if:

- they are physically dependent, with medical needs that require professional nursing care, and require a planned program to retain or improve functional ability;
- their conditions are clinically complex (meaning they have multiple disabilities or complex medical conditions that require professional nursing care, monitoring or specialized skilled care);
- they are moderately to severely cognitively impaired; or
- they have severe behavioural problems on a continuous basis.(4)

To determine the prospective resident's health care needs in the community the Ministry of Health uses a standardized tool called the Resident Assessment Instrument (or RAI). That assessment tool helps to identify needs and degree of urgency for placement. A specific version of the standardized assessment tool Resident Assessment Instrument Minimum Data Set (RAI MDS 2.0) is used in residential care facilities for the assessment and care planning.

**Special Note: An Exception is Always Possible**

For any type of health authority decision made about prospective or current residents, an exception is always possible. It may be rare, but it is possible.

*“Health authorities may authorize exceptions to policy in client specific circumstances, based on assessed need. Health authorities must maintain a record of waivers and any exceptions to provincial policy and report these, with the relevant background information such as rationale and timeframe for the exception, to the ministry.”(5)*

## Moving to Residential Care



A prospective resident (or applicant) may come from a variety of places while waiting to move to a residential care facility. This includes living at home, in an assisted living residence, in a hospital, an alternate level of care (transition care facility) (6), in a non-subsidized residential care bed, or in a subsidized residential care bed that is not in their preferred facility or community.(7)

Placement in residential care is based on a system of “priority access”. According to Ministry of Health policy, clients on the waiting list are prioritized based on the urgency of their care needs. That priority is established by the assessment process administered by health authorities and is commonly referred to as the “first available bed” or “first appropriate bed” process. (The Ministry of Health now prefers the term “first appropriate bed.”)(8) In recent years, the health authorities in British Columbia have given priority for residential care placement to people transferring from hospital over those at home or in another facility.(9) The health authorities, not the private care facility operators, manage the waitlists for all funded beds in the residential care facilities.

**Important Note: If the resident or substitute decision maker decides to pay privately, the resident will be placed further down the waitlist for a publicly funded bed because the person’s situation is no longer considered as urgent by the health authority.**

In the best of worlds an older adult’s admission (or transfer) to a residential care facility would be a carefully considered and planned matter. Today for many people this decision and process often occurs in a rushed manner, with few options and without needed information. This can leave the prospective resident, family and others struggling to know:

- what choice in facilities they have, if any,
- what information they should be receiving,
- what their rights and responsibilities are,
- what the financial implications of their decisions are,
- what the Operators’ responsibilities are, and
- any avenues of recourse they may have if issues arise.

Part of the challenge that people face are systemic issues and pressures in the acute care hospital for the prospective resident to be “anywhere but here in the hospital.”

## Transfers

People 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. (10)In practice, transfers from other residential care facilities are becoming far less common, in part because of the complex care needs. Today the average length of residence for people from the time of their admittance to the care facility to the end of life is only six to eighteen months. Families find that the waiting time to transfer commonly exceeds that, (11)and one health authority states it does not permit transfers within the first two months.(12)



## Costs

### **Cost of a (subsidized) residential care facility**

The cost of publicly funded residential care services is shared between the Ministry of Health and the person receiving services. The Continuing Care Fees Regulation sets out the fees payable for subsidized residential care, identifying a maximum and minimum rate. This is referred to as a “client rate”.(13)

The Ministry of Health and the health authorities pay for the cost of care in publicly funded residential care services. The resident pays the “accommodation costs” in what is sometimes referred by the Ministry as a “co-payment”.

Accommodation in some older residential care facilities may consist of 3 or more beds to a room. Most new residential care facilities have semi-private rooms (2 beds in a room), or a private room has a single bed in a room. Multi bed rooms are considered “basic accommodation,” with private rooms commanding a higher rate.

The Resident Bill of Rights for Residential Care Facilities, private hospitals, and extended care units in hospitals identify a responsibility on the Operator to “advise persons who are being admitted of all fees, charges, and policies”, and “provide an avenue to file concerns or complaints.” (14) This requirement is reinforced by s. 48 (1) (a) of the Residential Care Regulations.(15)

People in subsidized residential care will pay up to 80 per cent of their after-tax income to cover the cost of housing and hospitality services including meals, routine laundry and housekeeping (“the accommodation costs”), subject to a minimum and maximum monthly rate. The actual amount paid must leave the individual with at least \$325 (effective February 1, 2012) remaining from their income each month. For many British Columbia residents, this remaining amount often may be all that is available to cover all their “optional costs” (for examples, telephone, own wheelchair, “preferred” incontinence or grooming supplies, recreational activities). There is considerable variation among Operators in what is included in the accommodation cost, and what can be charged extra, and how much can be charged. (16)

The resident “co-payment” ranges from \$1005.80 per month to \$3,198.50 per month (January, 2016). The minimum rate is adjusted annually based on changes to the Old Age Security/Guaranteed Income Supplement rate as of July 1 of the previous year. The maximum client rate is adjusted annually based on changes to the Consumer Price Index.

### **Applying for subsidized residential care.**

The cost of subsidized residential care is typically borne by and paid by the individual resident. It is based on income not assets. To apply for subsidized residential care, residents first must consent to disclosure of the income tax information they provided to Revenue Canada. This consent to disclose is required annually. If there is a spouse, the spouse must consent as well. If either person does not consent or cannot consent, the resident will be assessed at the highest residential rate. (17) After calculations, the health authority informs the Operator of the appropriate client rate and is not permitted to share any income information. (18)

There are many reasons why it may be difficult to obtain this consent and as a result the default position to assess the resident at the highest residential rate can cause considerable hardship for the individual and a spouse, partner, or family. According to the Home and Community Care policy, a spouse or other person can only give consent to provide the income tax and other financial information for the purposes of determining financial eligibility if they can show they have legal authority to do so (that is through a power of attorney, section 7 Representation Agreement, or as a Committee of the Estate).(19) Documentation of that legal authority is required.

## **Hardship Waiver (“Temporary Rate Reductions”)**

As previously noted, the statutory authority for client rates is covered by the Continuing Care Fees Regulation. The person may have low income, or may have higher income but his or her spouse is still living at home. If paying the full client rate would cause serious financial hardship for the resident (or the resident's spouse), the resident or his or her substitute may apply for a temporary reduction of the rate. This rate reduction can last for up to one year, and the person can reapply if the situation continues.

This is referred to as a “hardship waiver” in the regulations. The Ministry of Health and health authorities use the term “temporary rate reductions”. These waivers or reductions are also available for other costs such as wheelchair fees.

Residents and families are often unaware these waivers exist. They may not know how to apply, or realize the need to re-apply annually. For others, the fact these are referred to as hardship waivers is itself embarrassing and stigmatizing,(20) especially given the fact that many older people and their families do not want to be thought of as “charity cases”.

Some reports suggest that residents' are often turn downed when applying for these waivers. (21) It is also unclear how or whether residents can seek a review of those health authority decisions to decline the waiver request.

## **Cost of private pay (unsubsidized) residential care facility**

In a private hospital or any unsubsidized care bed in a private pay facility, the individuals directly access the residential care services from the Operator.(22) The facility staff conducts an assessment to decide whether or not the facility can provide the services that are being requested. In private pay facilities, the services and accommodation received are part of a private business arrangement between the Operator and the person in care and are defined through the contract.

All aspects of service provision are agreed to by the individual and the Operator in the contract. Government does not provide any financial assistance to individuals or Operators for the service.(23)

## **References**

1. There are no specific admission criteria for private hospitals or the private pay beds in residential care facilities, other than the ability to pay. However, most of the people using the resource will have similar care needs to those in a subsidized residential care facility or extended care facility. As the Ombudsperson report *The Best of Care* (2012) notes all three types of facilities now provide complex care. [page 210]. That report will be referred to as the “Ombuds, Best of Care” throughout this manual.
2. This is determined by the health care tool, the Resident Assessment Instrument (RAI).
3. See for example, Interior Health, which states that the person must also “Have tried all of the avenues available for receiving care at home.” Online: <http://www.interiorhealth.ca/YourCare/HousingHealth/ResidentialCare/Pages/Eligibility.aspx> (Last accessed January 1, 2016).
4. British Columbia. Health Services. Health and Safety. Long-Term Residential Care. Online: <http://www2.gov.bc.ca/gov/topic.page?id=4FEC0F570BC04692810548267D09577E> (Last accessed January 1, 2016).
5. Ministry of Health Home and Community Care Policy Manual, Chapter 1, Overview.
6. Alternate Level of Care refers to the transition period between acute (hospital) and post-acute ( non hospital) settings. People in this transition period are referred to as alternate level of care (ALC) patients. Even though they no longer require the intensity or specialized medical care provided by acute hospitals, they are not able to be discharged to the community ( to a residential care facility or “back home”) because the available resources are unable to meet their needs. They may be delayed from being discharged to a post-acute Provider, typically because of lack of appropriate, available space. See: Canadian Institutes for Health Information. November 2012. Seniors and alternate level of care:

- building on our knowledge. Online: [https://secure.cihi.ca/free\\_products/ALC\\_AIB\\_EN.pdf](https://secure.cihi.ca/free_products/ALC_AIB_EN.pdf) (Last accessed January 1, 2016).
7. Adapted from Best of Care. [pg.34].
  8. Ombuds, Best of Care. [pg. 225].
  9. Ombuds, Best of Care. [pg. 34]. Also for a good discussion of surrounding the law and ethics of discharge from hospitals to nursing homes and other settings in the Ontario context, see J. E. Meadus & J. 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 Online: <http://www.ancelaw.ca/appimages/file/ACE%20-%20Ethical%20Issues%20&%20First%20Available%20Bed%20Policies%20-%202008.pdf> (Last accessed January 1, 2016).
  10. Ombuds, Best of Care. [pg. 34].
  11. Ombuds, Best of Care. [pg. 33].
  12. See for example, Vancouver Island Health Authority Residential Care Guide, pg. 6 ["VIHA"].
  13. Home and Community Care. Online: <http://www2.gov.bc.ca/gov/theme.page?id=A8F32056E4192102A51A3F0FF373223C>
  14. Resident Bill of Rights. Online: [http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/pdf/adultcare\\_bill\\_of\\_rights.pdf](http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/pdf/adultcare_bill_of_rights.pdf) (Last accessed January 9, 2016).
  15. Residential Care Regulations. B.C. Reg. 96/2009, as amended. Online. [http://www.bclaws.ca/Recon/document/ID/freeside/96\\_2009#section48](http://www.bclaws.ca/Recon/document/ID/freeside/96_2009#section48) (Last accessed January 9, 2016).
  16. The Ministry of Health is currently reviewing "Chargeable extras".
  17. HCC Policy Manual. Chapter 7. Client Rates, BC Ministry of Health. Home and Community Care. ("HCC, c. 7") Online: [http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/7\\_hcc\\_policy\\_manual\\_chapter-7.pdf](http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/7_hcc_policy_manual_chapter-7.pdf) (Last accessed January 9, 2016).
  18. HCC, c. 7.
  19. HCC, c. 7.
  20. Farrell, J. (July 15, 2013). Why wheelchair fees are not fair and what they say about the state of seniors care in BC. Centre for Policy Alternatives. Online: <https://www.policyalternatives.ca/publications/commentary/why-wheelchair-fees-are-not-fair-and-what-they-say-about-state-seniors-care#sthash.y4TGTDck.dpuf> (Last accessed January 9, 2016).
  21. M.Mckinney. (2010. Standards of respect:The human cost of residential care fee increases in British Columbia. Hospital Employees Union. Online: [http://www.heu.org/sites/default/files/uploads/2010\\_Newsletters/StandardsOfRespect\\_7dec10.pdf](http://www.heu.org/sites/default/files/uploads/2010_Newsletters/StandardsOfRespect_7dec10.pdf) (Last accessed May 10, 2016).
  22. Ministry of Health. Who pays. Publicly subsidized or private pay services. Online : <http://www2.gov.bc.ca/gov/topic.page?id=D2A2D928853B489DBC280E9F451187F1&title=Publicly%20Subsidized%20or%20Private%20Pay%20Services> ["Who pays"](Last accessed January 9, 2016). Fraser Health for example notes under "How do I access private pay facilities? that "an assessment by Fraser Health staff is not needed for admission to a private pay residence." Online: [http://www.fraserhealth.ca/your\\_care/residential\\_care/options\\_for\\_residential\\_care/](http://www.fraserhealth.ca/your_care/residential_care/options_for_residential_care/)(Last accessed January 9, 2016).
  23. Ibid. Who pays.

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# Admission to the Residential Care Facility

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*“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.”*

*Best of Care, pg. 243*

Mentally capable adults have the right to decide where they will live, and those who are not mentally capable should still have their needs and wishes considered. Prospective residents have the right to decide whether or not they want to live in any residential care facility, as well as a particular care facility. Neither the Community Care and Assisted Living Act nor the Hospital Act contains any specific provisions on the admissions process or how to obtain consent for admission to a residential care facility.(1)

In many cases, prospective residents have made the decision to move to a residential care facility on their own because they realize they are no longer able to live at home with supports safely. For them consenting to the admission is a simple matter.

Other mentally capable adults will prefer to continue to “live at risk”, even if it means the strong possibility of deteriorating health, being injured (e.g. falls) in their home or dying there. However, some mentally capable adults will find that family or others may try to act in what they consider the person’s “best interests” and “try to plan around them.”

In other instances, individuals may not have insight into their conditions, or the effects that their decisions and risk taking have on others. Still others have come to rely on promises that family or friends made them in the past to “not make them go to a nursing home” (family or friends may simply no longer be able to keep that promise, or may not have ever intended to try). In many of these cases, silence, avoidance, subterfuge done “in their best interest” and “little lies” (“Mom, it is just for a short stay until you are stronger”) or even blatant misrepresentation has been used by family or others in the health care system to have the person admitted to a care facility.

## Agreeing to the Admission

In the past, Ministry of Health policy simply required that health authorities authorize the admission of clients to residential care facilities and that clients agree to admission. (2)At present, the ministry policy requires health authorities 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.”(3) These provisions were developed in anticipation of the enactment of the Part 3 sections of the Health Care Consent and Care Facilities (Admission) Act dealing with admissions to the facility, which to date are not in force.(4)

This policy raises a number of interrelated issues – the capacity for giving or refusing one’s consent to admission; giving informed consent to admission; evidence of consent; the responsibility to provide residents and families with appropriate information in order to exercise informed consent; and having the capacity to consent to the contractual agreement.

**Note: If a person has been given authority to receive administer the resident’s Old Age Security or Canada Pension Plan cheques as a Private Trustee, this is *not considered* as sufficient legal authority to consent to admission or sign the admission agreement.(5)**

## Demonstrating Consent

Consenting to admission can be done verbally or in writing. A person may indirectly communicate informed consent to the Operator by nodding the head, cooperating with the questions asked, etc. Verbal consent has occasionally created problems for Operators when the resident no longer remembers or later denies having given consent. Today, Ministry of Health policy focuses on have a signed document showing consent. Arguably, that does not mean the resident or substitute must sign. However, it can be important for the Operator to document in some manner that the person has consented to admission, even if it was done verbally.

## Assessing Capability to Consent?



As noted above, health authorities are required to assure “that a client’s capacity to provide informed consent to facility admission has been assessed. “Assess” may be interpreted in two ways in this policy context:

- a) colloquially (“determine if the person appears to be mentally capable of providing informed consent: consider the way they communicate, signs and behaviours...”, “Does it seem as if they are consenting and are mentally capable of making this decision (recognizing that acquiescence is not the same as consent)?”) or
- b) undertake a formal assessment of mental capability.

The British Columbia Office of the Ombudsperson Best of Care Report suggests that the term “assess” here may mean a formal assessment of capacity. If a formal assessment is the intended meaning of the HCC policy, it would undermine the legal presumption of mental capability of many prospective residents. It would likely be considered a discriminatory policy violating British Columbia’s Human Rights Code, by placing a burden on people seeking residential care that other adults do not ordinarily experience. (6)It would also involve a significant use of formal resources to undertake an assessment of all prospective residents, especially given the high turnover in residential care beds. That would seem to violate the Ministry of Health’s policy on effective use of resources.(7)

If the person was formally assessed and was discovered to be mentally incapable of making the admission decision, this still does not “fix the real problem”. Unless the person has a committee for the person, or has appointed a representative with authority for personal care decisions under the Representation Agreement Act, there may be no legally recognized substitute who can consent to the admission on behalf of the mentally incapable person. People holding an enduring power of attorney may have the authority to make financial decisions on the resident’s behalf, but not “personal care decisions”, which include where the person will live. (8)A power of attorney drafted and signed in another jurisdiction may or may not be legal in British Columbia. The issue is further complicated by the fact the Mental Health Act is currently being used at times to admit the person when there is no one to give proper consent for a prospective resident. That is an inappropriate use of the Act.

The issues of consent in various legal contexts are described in greater detail in the chapters on “Consent & Capacity” and “Substitute Decision-Making”.

## **What Kind of Decision is Admission to a Residential Care Facility and Who Makes It?**

For mentally capable adults, the decision whether to move to and be admitted to residential care rests with them. In all other cases, it will rest with someone else. (9)

Historically in British Columbia as in other jurisdictions, we have made a distinction between health care, personal care and financial or legal decisions. "Where I will live?" is considered a personal care decision. (10) Making the decision about admission to a care facility is a hybrid decision that has personal care, health and financial aspects. This leads to some confusion and debate about who (other than capable adults deciding on their own) can agree to admission to a residential care facility. A closely related question is "Who can sign an admission agreement and bind the parties?"

In health care practice, legal documents such as enduring powers of attorney have been accepted by Operators as evidence of a family member or others' authority to act on the mentally incapacitated older adult's behalf. As discussed in Chapter Seven, a power of attorney can give authority over financial and certain legal decisions and sorting out payment of the care facility costs will be part of the admission process. Operators have a legitimate need in clearly identifying what the payment process will be.

However, strictly speaking, representation agreements are the only planning document that gives chosen people the legal authority to make personal care decisions on another person's behalf. (11) In practice, they are not yet a commonly used planning tool in British Columbia. The power of attorney is often an "add on" legal document to a representation agreement to help cover a range of financial decision-making issues when people become mentally incapable of making and exercising those decisions on their own.

It is sometimes suggested that admission a residential care facility is a part of or a step to a health care decision that could fall under the Health Care Consent and Care Facility Admission Act. This interpretation suggests that (absent Section 2, of the Act coming into force), hospital administration, discharge planners and care facility Operators could simply rely on the statutory list of temporary substitute decision makers for health to get consent for admission. While this might be a convenient solution for admitting mentally incapable adults, "health care" is narrowly defined under that Act and would not support that interpretation. (12)

Currently, admission agreements may have clauses specific to the attorney's (financial and legal) functions and other clauses that fall within the representative's (personal care) scope. It may be possible to sever the clauses into different agreements as the substitute decision maker's authority may not cover both types of decisions. Creating two separate documents may or may not improve the situation.

## **References**

1. Ombuds, Best of Care. [page, 243].
2. Ombuds, Best of Care. [page, 243].
3. HCC Policy Manual. Chapter: 6 Residential Care Services Number: 6.A Section: A General Description and Definitions. Effective: January 1, 2013.
4. Ombuds, Best of Care. [page 234]
5. For general information on private trustees for Old Age Security or Canada Pension Plan, see: <http://www.servicecanada.gc.ca/cgi-bin/search/eforms/index.cgi?app=prfl&frm=isp3506cpp&ln=eng> (Last accessed January 9, 2016).
6. Human Rights Code [RSBC 1996] c. 210.
7. HCC Policy Manual. Chapter: 1 Overview Number: 1.A Section: At Home And Community Care Services Page: 2 Of 4 Subsection: Effective: January 1, 2013.

8. For a legal discussion of problems with “personal care decisions” that come up in residential care facilities in Ontario, see : R. Chrolavicius. ( November 26, 2013) Misuse of powers of attorney for personal care. Advocacy Centre for the Elderly. Online: <http://www.advocacycentreelderly.org/appimages/file/Misuse%20of%20Powers%20of%20Attorney%20for%20Personal%20Care-LR%203.pdf> (Last accessed January 9, 2016).
9. The Mental Health Act, again is often used to admit individuals who do not have anyone to consent on their behalf.
10. See:
  1. Representation Agreement Act , [RSBC 1996] c. 405, s. 1 Definitions “Personal care”.
  2. Power of Attorney Act [RSBC 1996]c. 370. Part 2 Enduring Power of Attorney, s. 10 (Definitions, “personal care”).
  3. Also see Nidus. “ Personal Care”. Online : [http://www.nidus.ca/?page\\_id=275](http://www.nidus.ca/?page_id=275) (Last accessed January 9, 2016).
11. See Representation Agreement Act.
12. s. 1 Definitions. “ health care” mean anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes
  1. (a) a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem,
  2. (b) a plan for minor health care that
    1. (i) is developed by one or more health care providers,
    2. (ii) deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and
    3. (iii) expires no later than 12 months from the date consent for the plan was given, and
  3. (c) participation in a medical research program approved by an ethics committee designated by regulation.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# Terms in Admission Agreements and Contracts

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Applicants faced with an admission contract should not sign it if they do not understand it. Retaining a lawyer or trained advocate may be appropriate in these circumstances. An admission agreement must not contain clauses that are illegal. The clauses will not be enforceable. People cannot contract out of their human rights and Operators cannot contract out of the legal responsibilities under the Community Care and Assisted Living Act, or other law.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## Common Legal Matters in Contracts

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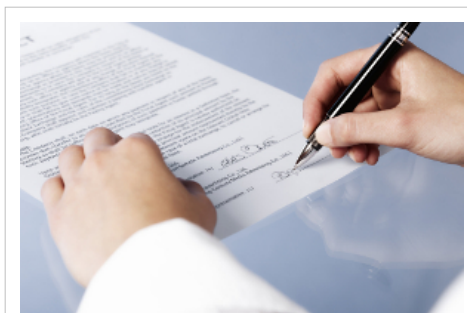
There are several legal matters that applicants and people who are helping them should be especially aware of in regards to contract clauses in admission agreements and contracts.

### Payment Default and Guarantees

Some operators make efforts to require someone else (e.g., a family member, attorney, representative, substitute decisionmaker) to pay, if the resident defaults in payment or if the resident's income falls short of the minimum accommodation rate. If the resident's income is insufficient to pay for basic accommodation in a subsidized facility, the resident may apply for a rate reduction. While the Operator does not have access to the resident's income information, the Operator should assist the resident (or whomever the resident has chosen to help, including substitute decision-maker) to know how to apply or re-apply for a subsidy.

No one else should be required to make up the difference between the resident's income and the accommodation rate. Residents are not required by law to provide a guarantor or designate a representative. Even if the resident supplies the name of a family member or friend as a contact person, that person will not be legally obligated to make payments from their own funds unless that person has signed the admission contract under conditions where it is clear they are assuming that legal responsibility.(1)

### Signing as a Substitute Decision-Maker (SDM)



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If the resident is not mentally capable of signing an admission agreement, then a substitute decision-maker may sign on behalf of the resident. The Ministry of Health policy requires the agreement to be in writing.(2) However the law does not require a substitute to sign the written agreement in these circumstances. In some instances, the substitute decision-maker may not want to if there are specific clauses in the agreement that cause concern.

If substitute decision-makers choose to sign they are not personally liable for payments- again, as long as they make it clear that they are only signing as a substitute. For example, they are liable if they have identified



that they are signing as a representative for finances under a representation agreement, as an attorney under an enduring Power of Attorney or as a court-appointed committee. In these circumstances, the SDM will be liable to make payments from the resident's own funds where the resident cannot look after his or her finances. However, the SDM is not obligated to pay from the SDM's own funds.

This is a common legal issue in residential care in British Columbia and other Canadian jurisdictions. The Advocacy Centre for the Elderly, for example, notes:

*"A facility has no legal basis whatever for refusing admission to an applicant who does not provide a guarantor or co-signer to sign an admission contract. While it may be useful to a facility to obtain the signature of a guarantor, it is of no particular use to the applicant and the applicant cannot in any way be penalized for failure to provide one."*(3)

## Other Areas

There are a number of other provisions that frequently come up in the written agreements that need careful attention. Prospective residents may be asked on admission if they have care planning documents in place that the Operator should be aware of (such as an advance directive, power of attorney, representation agreement). This information can be helpful for the Operator to know and document. However, operators cannot require or give people the impression that they must have planning documents as a term of admission or as a term of the contract. (4) A substitute decision-maker also cannot give "blanket consent" to future health care decisions, including medications or restraints.(5) See Chapter Six ("Capacity & Consent") and Chapter Seven ("Substitute Decision-Making").

One worrisome trend is to tell prospective residents who do not already have a Representation Agreement or other appropriate legal document at the time of admission that they need to "nominate (choose) someone to act on your behalf in case you are unable to make decisions for yourself".(6) These "nominations" are wrong for many reasons. The instructions make it sound as if the resident must do it, and do it at the time of admission. The nominations would have no legal basis unless they met the statutory requirements for the actual legal documents of representation agreement, enduring power of attorney, etc. Plus, they can give Operators a false sense of security, believing that they can legally turn to someone else if the resident becomes unable to make decisions for him or herself.

Recent Ministry of Health Home and Community policy focuses on having written agreements so that the costs, terms, expectations and responsibilities are clear. That is very valuable information for the applicant and family or substitutes. However the issues of informed consent, having a written contract and signing the agreement are substantially different legal matters.

Problems can arise even when some form of written consent exists. For example, an Operator may erroneously try to rely on forms from another facility as proof of a person's consent to admission to this facility. An Operator may erroneously try to rely on a term in an admissions agreement as proof that a person had authorized future medical treatment.(7)

The Ministry of Health has been working to develop a template for a standard agreement form which will be recommended for Operators to use. However, if a standard agreement or template document comes into practice, any advocate should look at the agreement very carefully. Some of the clauses in the standard agreement may be problematic and may not be legal.

## References

1. Advocacy Centre for Elderly. Long-Term Care Facilities in Ontario: The Advocate's Manual. Chapter 3. Entering a long-term care facility ["ACE LTC Manual"]
2. HCC Policy Manual. Chapter: 6 Residential Care Services Number: 6.A Section: A General Description and Definitions. Effective: January 1, 2013. ["HCC, c. 6"]
3. ACE LTC Manual. Chapter 3. Entering a long-term care facility 3.29.
4. Representation Agreement Act, s. 3.1; Health Care Consent and Care Facility Admission Act [RSBC 1996] c. 181 s. 19.91
5. Romano, L & Meadus. J. (August 5, 2009). Congregate living and the law as it affects older adults . Research Paper for the Law Commission of Ontario: Advocacy Centre for the Elderly. [Page 23]. Online: [http://www.advocacycentreelderly.org/appimages/file/ACE-LCO-Congregate\\_Living\\_and\\_the\\_Law\\_as\\_it\\_Affects\\_%20Older\\_Adults.pdf](http://www.advocacycentreelderly.org/appimages/file/ACE-LCO-Congregate_Living_and_the_Law_as_it_Affects_%20Older_Adults.pdf) (Last accessed January 9, 2016).
6. This is language being used by some Operators. This is not the same as nominating a committee.
7. Ombuds, Best of Care. [pg. 242].

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## Contractual Protections in Admission and Transfer

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In a 2013 Guidebook, the provincial government suggested that the admission agreements or contracts are future performance agreements and are regulated under British Columbia's Business Practices and Consumer Protection Act (1) and the Consumer Contracts Regulation. (2) This may give the public the impression they have certain legal protections in respect of residential care agreements.

In a strict legal sense, the admission agreements or contracts are future performance agreements: the service or final payment is not provided at the time of signing, but will be provided in the near future. However, these agreements have substantive differences from the typical future performance contracts in that the cluster of health and personal "services" and "goods" provided in residential care are provided on an ongoing basis, may change as the person's needs change, and can be essential to the person's wellbeing. Some of the services are funded through government, others are not.

The agreements appear to share some characteristics with continuing services contract (a type of future performance contract), but at present they are not actually covered as such under the consumer protection law or regulations. There may be some consumer protection for the "optional services" in the contract. However, most concerns about care are expected to be brought to the attention of the Operator, and if that does not succeed to be taken to the local Patient Care Quality Office for resolution. There are important questions about the capacity of the Patient Care Quality Offices to resolve these types of matters that blend law and care. See Chapter 5 on Rights, Remedies and Problem Resolution.

No matter how the agreements are characterized, it is essential that people know in advance what they are contracting for in terms of services funded by the government or the Operator, and any costs for which they are personally

responsible to the Operator. In its public information, the government has identified that:

*“contracts for residential care services must include a description of the range of services available at the facility. Care services (e.g., bathing and dressing) are provided to residents based on their individual care plans. Hospitality services (e.g., housekeeping, meals, recreational programming) are provided to all residents. The cost of services is based on a percentage of income for subsidized facilities, or an agreed upon amount in private pay facilities. All consumers are entitled to know, in advance, what they will be charged per month and must understand that they may refuse additional services if they do not wish to receive them.”*(3)

## References

1. Business Practices and Consumer Protection Act [SBC 2004] c. 2. Online: [http://www.bclaws.ca/Recon/document/ID/freeside/04002\\_00](http://www.bclaws.ca/Recon/document/ID/freeside/04002_00) (Last accessed January 9, 2016)
2. BC Government. (2013). Planning for Your Care Needs. Online : <http://www.health.gov.bc.ca/library/publications/year/2013/planning-for-your-care-needs.pdf> [“Planning Needs”] (Last accessed January 9, 2016 ).
3. Ibid. Planning Needs.

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## Consenting to Admission to a Care Facility

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Legally, adults are presumed to be capable of making decisions unless there is evidence to the contrary. The individuals 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, the individual's capacity to make that particular decision should be assessed. This is not necessarily a global assessment of mental incapacity, as the person's mental capacity is dependent on the particular type of decision to be made.

Many older adults are capable of consenting (or refusing consent) to admission to a care facility. Age or disability alone does not take away that capacity.

The consent must be free (of misstatements, misrepresentation and undue influence), plus it must be informed. That means they should have appropriate information on all material matters, which should include:

- where they are going (admission to a care facility and not returning home);
- what care they can expect there (general care plan);
- what they will be paying, what is included as basics and what are extras.

Arguably, the capacity to consent to admission may be an easier threshold for many prospective residents to meet than having the capacity to contract.

## Screening

Care facility operators have a responsibility prior to admission to determine if a prospective resident's needs can be met at that particular facility. This involves considering:

- the needs of the person
- the number of employees plus the their training and experience
- patterns of employee coverage
- the design of the community care facility and its physical resources
- the health, safety and dignity of other persons in care
- any criteria set by, or advice or information from, a funding program (1)

## Assessing Capacity for Admission

The person (or if substitute decision-maker) must give informed consent to admission. There are two aspects – having the capacity to consent and having the relevant information on which make the decision about admission generally or to a particular facility.

## Consent

Unlike some jurisdictions, British Columbia does not describe a specific legal process for consenting to admission. However common law elements of consent are relevant for consent to admission to a residential care facility:

1. The consent must relate to the admission.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud.

A person is presumed to be capable with respect to admission to a care facility unless “reasonable grounds” to suspect incapacity exists. Incapacity may be suspected on the basis of direct observation of the person or from information obtained from family or other caregivers.

<b>Part 3 - Health Care (Consent) and Care Facility (Admission) Act - The process that is currently not there</b>
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Part 3 of this Act created a process for appointing a substitute decision-maker when a person had been assessed by a health care provider as incapable of consenting to admission to a care facility and a substitute decision-maker was not already in place.
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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.
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If and when it is in place, Part 3 will require health care facilities, at the time of admission, to provide patients with a proposal that clearly outline the care to be provided. Patients or their substitute decision-makers would be able to accept or reject this care proposal.
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A mechanism for bringing Part 3 of the original Health Care Consent law or something akin to it into force is being explored by the government.
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## Use of the Mental Health Act to Admit Older Adults to Residential Care

The Mental Health Act (2) is also sometimes used to admit cognitively impaired (and sometimes non-impaired older adults) into residential care facilities if they cannot consent or will not consent to go. In some instances these involuntary detention cases come about as a result of a person having an unaddressed health problem, an alcohol or other substance use problem, or the person is living in perceived unsafe conditions, including suspected abuse or neglect by others. In a typical situation, family expresses concern, and they then contact Mental Health or police to bring the person to the hospital. In other situations, the person may be living alone with few community supports. She or he has not selected anyone as substitute decisionmaker (that is, has not done advance planning) and refuses to go to a facility.

The older adult is first taken to a “designated mental health facility” under s.22 of the Mental Health Act . The term “designated mental health facility” in practical terms refers to most public hospitals. The person can be held there involuntarily for 48 hours on a medical certificate signed by one doctor which declares that the individual is a “person with a mental disorder” and in need of protection. This becomes the basis of the older adult’s involuntary detention. Within 48 hours, a second certificate continuing the involuntary detention must be signed or the person must be released.

<p><b>Mental Health Act, [RSBC 1996] c.288 s.1</b></p> <p><b>"person with a mental disorder" means a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability</b></p> <p>(a) to react appropriately to the person's environment, or</p> <p>(b) to associate with others</p> <p><b>"treatment" means safe and effective psychiatric treatment and includes any procedure necessarily related to the provision of psychiatric treatment.</b></p>
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The person may then be involuntarily transferred to a residential care facility using section 37 of the Mental Health Act [“put on extended leave”]. A person who is put on extended leave and transferred to a residential care facility continues to receive psychiatric “treatment” (medications) for the mental disorder, but in a residential care facility instead of in a mental health facility. The involuntary detention remains in place. The person may have treatment imposed and is not at liberty to leave a facility.

The Ombudsperson has noted that this is an inappropriate use of the Mental Health Act:

*“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.”*

A person can challenge the involuntary placement (detention) through a Mental Health Review Board hearing (s. 25). In the alternative, they can apply directly to the Supreme Court to challenge their involuntary detention (s.33). Both remedies are rarely used for older adults, and these remedies exist more in theory than in practice. The Best of Care report questioned the fairness of involuntarily detaining people under the Mental Health Act, and then charging them residential care facility fees for the “privilege” of being involuntarily detained.

The more pressing legal issue, however, may be whether or not the Mental Health Act is an appropriate mechanism when someone has a concern about an older adult’s living situation. In case law, the Mental Health Act has not been considered a violation of the person’s Charter (section 7 and 9) rights, largely because of the two physician certification process. (3) However if the certificates are signed based on limited if any information and the person is effectively “forced” into care, there is an arguable legal case that the involuntary detention violates the person’s Charter rights.

The British Columbia Ombudsperson specifically found that 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 was

being done without clear provincial policy to ensure that the Mental Health Act is used as a last resort. This omission meant the Ministry was not acting in a way that assured older adults were not unnecessarily deprived of their civil liberties. (4) Advocacy groups have noted that the involuntary detention provisions of the Mental Health Act endure long past the admission process, and have long lasting repercussions for the individual in residential care. For example, it effectively strips individuals of the health care rights that they would otherwise enjoy. (5)

**Special Note: Rights Information is required on 2nd Certificate of protection**

At the point when the second certificate of protection is signed, the detained older person is supposed to receive “rights information”, including being shown the information by which they were admitted in the first place. Staff is expected to facilitate the rights advice, identifying options, and repeat the information as necessary, again identifying reasons for detention.

## References

1. RCR, s. 47 (2)
2. Mental Health Act [RSBC 1996] c. 288. Online: [http://www.bclaws.ca/civix/document/id/complete/statreg/96288\\_01](http://www.bclaws.ca/civix/document/id/complete/statreg/96288_01) [Last accessed January 9, 2016]
3. See for example : *McCorkell v. Director of Riverview Hospital Review Panel* (1993), 104 D.L.R. (4th) 391 (B.C.S.C.).
4. Ombuds, Best of Care, Finding 101.
5. See for example, BC. Civil Liberties Association. “Suggested changes to BC’s Mental Health System regarding involuntary admission and treatment in non-criminal cases” Adopted by the BCCLA, 2011,

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# First Appropriate Bed Policy

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Health authorities sometimes give the prospective residents and families the impression that they must accept the first bed in a care facility that becomes available. This is not quite accurate. It does not reflect the letter or spirit of the law, the Model Standards (1) nor Home and Community Care Policy. The Model Standards state:

Prospective residents, families and caregivers are [to be] provided with sufficient information to make a decision about the suitability of the facility.(2)

The Home and Community Care Policy states that health authorities must:

- ensure that residential care services are delivered in compliance with the Residential Care Regulation;
- establish local service delivery models that will provide clients with access to residential care services within their community or within accessible distance to their community.(3)

## What is “Appropriate”?

The term “appropriate” is not defined by the Ministry of Health or the health authorities. As a result it is subject to different interpretations. Administratively, a placement may appear medically appropriate if it meets a minimum standard of care, but from a person centred (resident’s) perspective looking at their total wellbeing, it may not. The British Columbia Office of the Ombudsperson stresses “Without a consistent and clear understanding of how the appropriateness of a placement is determined, seniors’ preferences may not be given sufficient weight.” (4)

It is important to recognize that some older adults may have fears about residential care placement generally, as well as legitimate concerns about whether a particular care facility is appropriate to their needs. As legal advocates have pointed out there are many reasons affecting whether or not an applicant or the substitute decides a particular facility is appropriate. These reasons may have nothing to do with how attractive the facility is or its reputation for providing good care. The applicant may decide that a care facility is too far away from a spouse, or partner, family or friends who will want to visit. Cultural or religious preferences may also play an important part in deciding. (5)

The Model Standards identify a number of important considerations which the residents and families should know about the facility prior to admission, including its philosophy of care and pertinent policies on alcohol, smoking, visiting, and use of restraints.(6)

An appropriate location can be one that allows the resident to remain socially engaged, commonly by remaining near the community or area. “Appropriate” should also take into consideration the perspective of those who will be the key contacts for the resident (accessible distance). Location is not necessarily the determining factor, but it can be a prominent one for many older adults, their spouse or partner and their families. It can be particularly important in residential care: the resident who does not have regular contact with family or friends is more likely to be isolated. Isolated residents can be more susceptible to harms, and if these situations occur, the problems can easily go unidentified for a long period of time.

The facility must also have the resources to appropriately support this prospective resident, along with others. (7) For example if the prospective resident has dementia, “appropriateness” means having staff who are well trained in dementia care and understand the needs and behaviours of people with dementia, especially if there has been evidence that the person has “responsive behaviours”.

“Appropriate” can depend on a prospective resident’s abilities. A resident may have lost the ability to communicate verbally due to dementia, or may have never had the ability to communicate in English. Appropriate may mean the availability of staff who can communicate in that person’s current language in order to provide good personal care, health care and support emotional wellbeing. The importance of appropriate “communication” services in patients accessing publicly funded health care has been recognized by the Supreme Court of Canada. (8) The responsibility to accommodate different prospective and current residents’ needs is described in greater detail in the Chapter Five “Rights, Remedies and Problem Resolution” (Human Rights).



Appropriate placement for an lesbian, gay, bisexual or transsexual (LBGT) senior would be a facility that is “gay friendly”, that feels “safe“ to the resident and the persons that are important to them, that recognizes their relationships, and facilitates inclusive activities- ones in which the LBGT resident feels she or he can participate (“Family Days” become “Family and Friends Days”). (9)

## **The Effect of Declining an Offered Placement**

Turning down a facility has implications, and so does accepting it.

It is increasingly common place for families of hospitalized older adults who need residential care to be told that “You must accept the facility selected. You can apply to transfer to another facility”. They are told if they do not accept, their parent or relative will lose their urgent status, and will be temporarily or permanently removed from the region’s residential care waiting list. (10) As previously noted in some health authorities, people are also informed they must wait at least two months before applying for a transfer. (11) These types of statements and pressures undermine any semblance of people giving “informed consent” to the admission to a facility.

The statements also do not accord with Ministry of Health’s Home and Community Care Policy, which emphasizes among other things, that

*“Health authorities must facilitate access to long-term residential care services consistent with the following requirements*

- manage access to residential care services and transfers of clients between residential care facilities, based on the preference of the client and the available resources in the community;
- ensure that a client has the opportunity to identify a preferred facility or location;
- manage, in an equitable manner, a client’s transfer to a preferred facility where a client’s request for a preferred facility cannot be met on admission...” (12)

This last requirement is particularly important. Health Authorities note that priority for placement is always given to those “with the highest need” and “at the greatest risk”. (13)

In some cases, older adults in crisis require residential care now. People may decide to try private pay facilities as a short term measure, only to learn that:

- if they “choose” to be admitted to private pay facility privately on a temporary basis, they actually lose their position on the waiting list because from the health authority perspective, they are housed and their needs are being met.
- if they “choose” to pay privately on a temporary basis that does not guarantee the person will be transferred to a subsidized bed in the same building. (14)



The BC Ombudsperson has formally identified these practices as administratively unfair. Health authorities also were not informing residents and families whether the beds in a particular facility in that health region were temporarily funded (subsidized) beds or not, meaning that residents could end up paying unsubsidized rates for the same bed. (15) The BC Ombudsperson recommended that older adults and families be given better information.

Arguably, simply informing a prospective resident about the effects of the decision in advance does not make it any fairer or accord with key aspects of residential care policy. It is illusory to call this informed choice. The information may be there, the choice is not.

## **The Operator's Authority to Decline Certain People**

Residential care operators note that they sometimes feel under pressure from the Health Authorities to accept any prospective resident being offered by the health authority for admission to the facility. (16) As will be discussed further in Chapter 4 on "Legal Issues When Living in Residential Care ", accepting residents who may be unsafe to live there can sometimes cause safety issues that significantly affect the residents and staff. At the same time, there are responsibilities on public and private operators to reasonably accommodate the needs of prospective and current residents.

The Community Care and Assisted Living Act specifies that as part of the standards to be maintained, the Operator must operate the community care facility in a manner that will promote the health, safety and dignity of persons in care (s. 7(1)(b)). Part of this includes an adequate and fair screening process. See below.

## **Residential Care Regulations state**

46 (1) A licensee may accommodate only those persons who will receive both safe and adequate care in the community care facility.

### **Admission screening**

47 (1) Before admitting a person to a community care facility, a licensee must screen the person to ensure the person will receive both safe and adequate care if admitted to the community care facility.

(2) A licensee must consider, as part of the screening process under subsection (1), all of the following:

- (a) the training and experience of employees, the number of employees and patterns of employee coverage;
- (b) the design of the community care facility, its construction, and the facilities and equipment within the community care facility;
- (c) the needs of the person, including any needs that should be identified specifically in a care plan;
- (d) the health, safety and dignity of other persons in care;
- (e) any criteria set by, or advice or information from, a funding program.

## References

1. British Columbia Ministry of Health and Ministry Responsible for Seniors. (April 1999). Model Standards for Continuing Care and Extended Care Services. Online: <http://www.health.gov.bc.ca/library/publications/year/1999/modelstandardsofcare.pdf> ("Model Standards") (Last accessed January 9, 2016).
2. Model Standards . Residential Services. Pre-Admission. Standard 1.
3. Home and Community Care Policy Manual. Chapter: 6 Residential Care Services Number: 6.A. Section: A General Description and Definitions . Subsection: Effective: January 1, 2013
4. Ombuds, Best of Care, p. 227.
5. Adapted from ACE, LTC Manual, Chapter 2 (2.17).
6. Other matters that can affect the degree a facility is appropriate are the care and specific services; the facility's organizational structure; types and qualifications of staff; access to community resources (e.g. advocacy groups, counsellors and volunteer services); physical environment and resident's personal space and furnishings; programs, services, supports; and, pertinent policies related to care planning, food services, medications, smoking, alcohol use, visiting, restraints, pets, per diem cost, personal charges (e.g. dental), and personal belongings.
7. There are legal responsibilities to accommodate to the needs of residents.
8. See: *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624.
9. See for example, Sussman, T. Churchill, M., Brotman, S. Chamberland, L..et al. (2012) "Identifying barriers, developing solutions: addressing the health and social needs of gay, lesbian, bisexual and transgender older adults who reside in long term care. " Montreal, Quebec. Or Qmunity Generations. Aging Out Project Policy Dialogue. (November 19, 2013. Burnaby. BC),
10. See for example, the Vancouver Island Health Authority Residential Care Guide at page 6 states "If the first bed offered is not accepted, the client is no longer considered eligible or accepted for residential care. Clients in hospital who do not accept the first appropriate bed will be discharged."
11. See VIHA, *ibid.* pg. 6.
12. Chapter: 6 Residential Care Services Number: 6.D Section: D Access To Services.
13. See: Interior Health."Accessing Residential Care. " Online : <http://www.interiorhealth.ca/YourCare/HousingHealth/ResidentialCare/Pages/AccessingRC.aspx> (Last accessed January 9, 2016).
14. See:
  1. Interior Health: <http://www.interiorhealth.ca/YourCare/HousingHealth/ResidentialCare/Pages/AccessingRC.aspx>
  2. Fraser Health : [http://www.fraserhealth.ca/media/Residential\\_Care\\_in\\_FraserHealthweb.pdf](http://www.fraserhealth.ca/media/Residential_Care_in_FraserHealthweb.pdf) (Last accessed January 9, 2016).
15. Ombuds, Best of Care. Finding 80 and Recommendation 104.
16. BC Care Provider Association. Residential Care Health and Safety Guidelines. A Guidebook. Online : [http://www.bccare.ca/wp-content/uploads/bccare\\_safety\\_grid\\_v11.pdf](http://www.bccare.ca/wp-content/uploads/bccare_safety_grid_v11.pdf) Last accessed January 9, 2016).

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# Advance Care Planning

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Legal issues regarding advance care planning in residential care are described in greater detail in Chapter 6 “Capacity and Consent” and Chapter 7 “Substitute Decision-Making”. As previously noted, advance care planning issues can come up during the admission process.

Some operators have misinterpreted certain aspects of accreditation focusing on residents’ rights, and may try to require prospective residents to sign advance care documents as a condition of admission. This is not legal. The Licensing “Standard of Practice” for residential care notes:

“A resident (or someone with the legal authority to make health care decisions on the resident’s behalf) must not be required, either as a condition of admission (or as an ongoing requirement to reside in a community care facility) to sign advance directives or levels of intervention documents.” (1)

To require a resident to sign documents of this nature is in contravention of section 7(1) (b) of the Community Care and Assisted Living Act which requires the Operator to operate a care facility in a manner that will promote the health, safety and dignity of persons in care.

## References

1. Director of Licensing. Standard of Practice. “Advance Directives and Care Plans”. Number: 01/08/2006 Effective Date: September 2006. Online : [https://www.vch.ca/media/2008\\_08\\_09FamilyChildCare\\_regulation.pdf](https://www.vch.ca/media/2008_08_09FamilyChildCare_regulation.pdf) (Last accessed January 9, 2016). [“Advance Directives”]

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# Care Plans and Legal Issues in Admission and Transfer

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Prospective residents often only have 48 hours in which to decide to accept the admission to the particular facility and to move there. At the time of the new resident's admission, the Operator may have only limited or out of date information on the new resident. The Residential Assessment Instrument carried out in the community and used to assess needs may have taken place recently, several months or even years ago.

As good standard practice, the Operator is expected to review the resident's pre-admission and admission documents; the physician's assessment and orders, and other pertinent health assessments. The Operator is also expected to conduct and document an initial assessment of the resident within 24 hours of admission which identifies immediate care needs (e.g. diet and medication); risk factors (e.g. allergies, dysphagia, falls, behaviour); personal preferences; and a contact person.(1)

The Operator must develop and complete an individualized care plan for each resident within thirty days of his or her admission to a care facility. "Care plan" means an individualized plan for the provision of services and support to a person in care that takes into consideration the person's abilities and physical, social and emotional needs as well as their cultural and spiritual preferences. As part of the development of a comprehensive care plan, issues related to end of life planning and advance directives may be discussed with a resident and his or her family or support persons, and documented. (2) Legal issues related to care plans and case conferences are discussed in the next chapter (Chapter Four "Legal Issues When Living in Residential Care") and Chapter Six "Capacity & Consent".

## References

1. Model Standard, 3. Standard: 3. Residents' individual health needs and psychosocial status are assessed by the interdisciplinary team.
2. RCR, s. 81. Note the Vancouver Coastal Health Director of Licensing. "Advance Directives" document states six weeks.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# **Residential Care Admission Process for Special Individuals or Circumstances**

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## **Admission of Veterans**

If a veteran is eligible for residential care services, the local health authority is required to contact Veterans Affairs Canada to assess if the veteran is eligible for federal benefits that may help defray costs. Veterans Affairs Canada will also arrange placement on the veterans' priority access bed waitlist in facilities with veterans' priority access beds. (1)

## **Admission of Aboriginal Residents**

Home and Community Care Policy states:

“Aboriginal Affairs and Northern Development Canada is financially responsible for status or non-status Aboriginal clients who were residing on a reserve prior to entering an assisted living residence or residential care facility, provided the client is admitted to a residence or facility where Aboriginal Affairs and Northern Development Canada is authorized to pay for the care.”(2)

## **Admission of Spouses with Different Care Needs**

Health authorities are not required to admit individuals into publicly subsidized residential care facilities who do not meet the criteria for residential care services. In the past this lack of flexibility created significant distress for couples who have been together for a half century or longer, and who have been forced to live apart because of different care needs. (3) Home and Community Care Policy has recognized this and now tries to address the problem. (4)

Health authorities are required to explore reasonable arrangements with the couple and their family “in a collaborative approach” to that would enable spouses to maintain and support their relationship. There are a number of possibilities, including arranging transportation for non driving spouse and, on rare occasions, co-locating the spouse in the facility.(5)

## Admission of Sponsored Immigrants Needing Care



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Sponsorship is a legal agreement between a sponsor, a sponsored family member (typically a parent or grandparent) and the Government of Canada that allows the family member to permanently reside in Canada and receive needed financial support from the sponsor.

The sponsor has signed an undertaking and committed to provide the sponsored person with the basic requirements for daily living for ten years (this has recently increased to twenty years for new sponsorships). During that period, the sponsored person cannot apply for government benefits such as Old Age Security, Guaranteed Income, or social assistance.

The sponsor is responsible for meeting the person's basic requirements which includes: food, clothing, a place to live, fuel, utilities, household supplies, personal requirements, and health care not provided by public health. The sponsor is also responsible for costs such as the co-payment fees for a residential care facility as well as all medical expenses not covered by the provincial health plan.

### References

1. For more information on Veterans and Residential Care matters such as client rates, see: HCC Policy Manual. (Effective: April 1, 2013). Chapter 6 Residential Care Services. Section D. Access to services. Veterans' Priority Access Bed Waitlist. Online: [http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6\\_hcc\\_policy\\_manual\\_chapter-6.pdf](http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter-6.pdf) (Last accessed January 9, 2016). Also: HCC Policy Manual Chapter 7 Client Rates, Section B Income-Based Client Rates (Subsection: 4 Alternate Payers). Online: [http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/7\\_hcc\\_policy\\_manual\\_chapter-7.pdf](http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/7_hcc_policy_manual_chapter-7.pdf) (Last accessed January 1, 2016).
2. Ibid.
3. See HCC Policy Chapter 6.C. Residential Care Services, Service Needs Determination.
4. HCC Policy Manual. Chapter: 6 Residential Care Services Number: 6.D.1 Section: D Access To Services Page: 3 of 3 Subsection: 1 Supporting spouses with differing care needs.
5. HCC Policy Manual. Ibid.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# Chapter Three Resources and Appendix

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## Chapter Resources

### Table 2.1 Health Authorities' Guidebooks for Residential Care

#### Fraser Health

Residential Care in Fraser Health. Online : [www.fraserhealth.ca/media/Residential\\_Care\\_in\\_FraserHealthweb.pdf](http://www.fraserhealth.ca/media/Residential_Care_in_FraserHealthweb.pdf) <sup>[1]</sup>  
[Last accessed January 9, 2016]

#### Vancouver Island Health

Vancouver Island Health Residential Care Guide. Online :  
[www.viha.ca/NR/rdonlyres/4CFF2480-72D7-4B1A-B489-D0A68B4BBC4F/0/viha\\_residential\\_care\\_guide.pdf](http://www.viha.ca/NR/rdonlyres/4CFF2480-72D7-4B1A-B489-D0A68B4BBC4F/0/viha_residential_care_guide.pdf) <sup>[2]</sup> [Last  
accessed January 9, 2016]

#### BC Care Provider Association

Residential Care Health and Safety Guidelines: A guidebook. Online:  
[www.bccare.ca/wp-content/uploads/bccare\\_safety\\_grid\\_v11.pdf](http://www.bccare.ca/wp-content/uploads/bccare_safety_grid_v11.pdf) <sup>[3]</sup> [Last accessed January 9, 2016]

### Table 2.2 Ministry of Health Home and Community Care Policy Manual (Sections Relevant to Admission)

#### CHAPTER: 2 CLIENT ACCESS

2.B Eligibility

2.D Assessment

#### CHAPTER: 6 RESIDENTIAL CARE SERVICES

6.D Access to Services

6.D.1 Supporting Spouses with Differing Care Needs

6.E Assessment

6.F Benefits and Allowable Charges

#### CHAPTER: 7 CLIENT RATES

7.B Income-Based Client Rates

7.B.1 Assessment of Client Rates

7.B.2 Client Rates for Specific Services

7.B.3 Changes in Client Rates

7.B.4 Alternate Payers

7.D Temporary Reduction of Client Rates

**Table 2.3 Summary of Findings and Recommendations Relevant to Admission Process from the BC Ombudsperson “Best of Care” Report**

Finding	Recommendation
<p>Eligibility for Subsidized</p> <p>F76: The Ministry of Health has two unreasonable conditions of eligibility for a subsidized bed in a residential care facility:</p> <ul style="list-style-type: none"> <li>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</li> <li>that seniors have to agree to pay the applicable room rates and other permissible facility charges before knowing the amount of those costs</li> </ul>	<p>R100: The Ministry of Health remove the two unreasonable conditions of eligibility for a subsidized bed in a residential care facility.</p>
<p>Assessment</p> <p>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.</p>	<p>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.</p>
<p>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:</p> <ul style="list-style-type: none"> <li>they will be considered lower priority for transfer to their preferred facility once they have accepted the first appropriate bed</li> <li>how long it is likely to take to transfer to their preferred facility</li> </ul>	<p>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.</p>
<p>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.</p>	<p>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.</p>
<p>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.</p>	<p>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.</p>

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## References

- [1] [http://www.fraserhealth.ca/media/Residential\\_Care\\_in\\_FraserHealthweb.pdf](http://www.fraserhealth.ca/media/Residential_Care_in_FraserHealthweb.pdf)
- [2] [http://www.viha.ca/NR/rdonlyres/4CF2480-72D7-4B1A-B489-D0A68B4BBC4F/0/viha\\_residential\\_care\\_guide.pdf](http://www.viha.ca/NR/rdonlyres/4CF2480-72D7-4B1A-B489-D0A68B4BBC4F/0/viha_residential_care_guide.pdf)
- [3] [http://www.bccare.ca/wp-content/uploads/bccare\\_safety\\_grid\\_v11.pdf](http://www.bccare.ca/wp-content/uploads/bccare_safety_grid_v11.pdf)



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# 4-Legal Issues when Living in Residential Care

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## Common Care Issues

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This chapter examines the wide array of legal matters that arise in the course of living in the care facility. The chapter is divided into two parts; the first deals with common care issues. The second part deals with six increasingly pressing legal issues – medications, control over visitors, abuse and neglect, resident harms, reporting responsibilities, and restraints.

### An Important Starting Point

Although unlike some jurisdictions, British Columbia does not have explicit statement in its laws to this effect, a care facility is the resident's home. It is a home where a person lives along side others in order to receive care and services for their complex needs. The fact this is their home has important implications for how people should look at and respond to issues that arise within the facility.

### Care Plans

A care plan is a blueprint to the personal, health and social wellbeing of the resident's care while at that facility. It sets out in part what needs to be provided, why and how. Its importance is recognized in the Residents' Bill of Rights which emphasizes the responsibility of the Operator to develop a care plan:

- (a) Specifically for the resident, and
- (b) On the basis of his or her unique abilities, physical, social and emotional needs, and cultural and spiritual preferences.(1)

The residential care regulations set out several areas that are expected to be part of the resident's care plan. These include separate plans to address: any medication needs; any behavioural intervention; oral health care; nutrition (including therapeutic diets); recreation and leisure; fall prevention, if prone to falls; elopement risk (a plan to prevent the person in care from leaving, and plan to locate the person if missing), plus any written agreement on the use of restraints.(2)Very importantly, the care and supervision provided for the resident is also required to be consistent with the terms and conditions of the care plan.

For people who are "involuntary patients" and have moved to residential care facility on "extended leave " under the Mental Health Act ("MHA") , the care plan also needs to address any condition or requirement under the MHA associated with the person's admission to the care facility.(3)

The residential care regulations clearly emphasize the importance of the resident and representative participating with the facility staff in the care plan, not only at the first instance, but also as it is reviewed and modified.(4) These care plans are required to be regularly monitored to ensure they are being properly implemented.(5)

The formal care plan must be reviewed whenever there is a substantial change in the resident's circumstances. At a minimum, the plan must be formally reviewed at least once a year.(6) Some handbooks for residents and families may mention the "once a year review", but may gloss over the ongoing responsibility of the care facility staff to monitor and review care plans with the resident and family.

“Substantial change in circumstances” can include a variety of matters, such as unexpected change in physical health, behaviour, or cognition; when care operators are considering adding or changing medications, especially psychoactive medications; when there will be a new roommate (if the person is in a double room) etc. This ongoing planning is to ensure the resident’s needs and preferences are met, plus that the plan is compatible with resident’s abilities and wishes.

Many aspects of care plans involve health care. Consequently these require informed consent by the resident; the resident’s legally appointed substitute decisionmaker, or a temporary substitute decision-maker under the Health Care Consent and Care Facility (Admission) Act, if applicable. That means the people need to have the appropriate information about options, risks, and benefits on which to make the needed decisions about how the care plan will be carried out. The existence of a care plan does not remove the responsibility of the Operator and staff to continue to communicate with the resident and others about the person’s physical, emotional and social health to better support the resident.

### **Who is a “Representative”?**

The regulations talk about the resident and the representative participating in the care planning. The term “representative” under the regulations specifically means a person who is a committee (under the Patients Property Act)(7), a representative for personal or health care under the Representation Agreement Act(8), or the person who would be the resident’s temporary substitute decisionmaker under the Health Care (Consent) and Care Facility Admission Act.(9)

Does that mean that others such as a close friend are excluded from care planning? No, both in law and good health care practice, it is recognized this narrow interpretation would defeat the purpose of developing a care plan for some residents. A mentally capable person always has the right to choose who would be part of his or her support network. That could include anyone that the resident wants to have involved. The threshold for mental capacity for decision-making in this context (“who do I want to help me” or “who I don’t want involved”) is likely very easy to meet.

Many residents today cannot effectively “participate” in their care planning in the facility without the additional support of others who know and understand this person well, to help express their values, wishes and preferences, as well as to help staff understand their behaviours and responses. Committees, representatives, and temporary substitute decisionmakers are simply three groups of people with specific legal authority to make health care and personal decisions with or on behalf of the older adult.

## Communication

Proper and timely communication with residents and family or other representatives is a legal responsibility on all care facility operators. The Patient Care Quality Offices in British Columbia indicate that poor communication is a common problem across the health care system, including residential care.(10) In a care facility, family and friends can become frustrated when they do not know who to talk to in the facility, are simply told “it’s the policy “, or where they feel that problems or concerns are not being effectively addressed (or in a timely manner as required by law).(11) Poor communication ranges from simple time pressures and inadvertent oversights to blatant efforts to conceal information, particularly about the circumstances of a resident’s injury or death.(12)



### Noteworthy: Written Policies

The Residential Care Regulations require the operator to have written policies to guide staff in all matters relating to the care and supervision of persons in care (13)and to make these available to the resident, or the resident’s representative, upon request. (14)Whenever, staff or administration talk with a resident, family member or other support person about a policy, they should always be able to show the resident or representative what the written policy says. At a minimum, that can help identify people if it applies to the matter in question and what it says in the circumstances. **That will not automatically mean the policy adheres to the law or is fair, but it can give all parties a starting point for discussions on matters such as caring and supervision.**

Poor communication may indicate an environment in which respect for residents’ rights is not being given sufficient priority. (15)Residential care operators often become familiar with abuse or neglect issues because the regulations focus on these matters. Residents and families find that rights violations, in contrast often receive less concern and a lesser sense of urgency.(16)

Family may experience considerable frustration when they have been dealing with a long-standing problem, then hear an operator or representative from the local health authority state that “this is the first we have heard of the problem. “Lack of time, inadequate problem solving skills, poor internal communication lines, lack of appropriately trained staff and inadequate dispute resolution processes can exacerbate common communication gaps in residential care. This eventually leads some family or friends to feel any effort is futile. In other cases, they begin responding in a negative manner, with situations becoming increasingly confrontational and adversarial. If situations deteriorate, even the skills commonly promoted as good advocacy (e.g. good note taking about the “who, what, when and where” of concerns, tape recordings can become perceived by the operator or authority as a sign this family member or representative is “trouble”).

The regulations specifically require that there is always a “charge person” designated if the Manager is temporarily absent. (17) The regulations also require the Operator to keep a record of complaints made and concerns expressed, keeping these records for at least two years. (18)This section does not limit it to written complaints; verbal complaints

should be noted. The Operator is also required to produce the record to Licensing on demand. (19)

Poor communication issues may not be limited to matters being raised internally in the care facility. Family members and others raising concerns frequently learn they have been given incorrect information by bodies such as a Patient Care Quality Office (for example, being told they must bring the issue to a particular health profession first).

## Care Conferences

At the time of admission, an initial nursing and medical assessment is completed, and a basic plan of care is formulated with preliminary input from the resident, and family or representative. (20)The operator is required by regulations to have a more detailed care plan for any resident who will live there longer than 30 days.(21)

<b>Care Plans are Mandatory</b>
Residential Care Regulations, s. 81 (1): If a person in care is admitted to the community care facility for a period of more than 30 days, a licensee must ensure that a care plan for the person in care is made in accordance with this section within 30 days of admission.

An initial care conference is held once the resident has been living in the facility about 6-8 weeks. The care conference is integral to the resident's care plan. The goals of the initial care conference are:

- for key staff to get to know the resident and family better (and for them to do the same with staff)
- to gather information about the resident's lifestyle, likes, and dislikes that can be incorporated into the care planning process,
- to ensure staff and administration understand resident's needs appropriately plus
- to answer any questions or concerns.

Family or any other key contact person is normally sent a letter in advance to inform them about the date and time of the conference. It is unclear whether they have any input on the timing. Subsequent care conferences help to review and modify the plan, as needed.

Some facility staff as well as facility information books may leave family or residents with the impression after the initial care conference that the operator's only responsibility to the resident and family is to hold an annual care conference. This is not accurate. A care conference is required whenever there is a change in the resident's condition, and if there is no change, at least once a year. (22) The year review is simply a statutory minimum for all residents and all residents care facilities.

Residents and families report that some care conference are carried out in a way that does not facilitate open communication or planning. Even new guidelines for operators on holding care conferences can leave the impression this is largely one way communication- "what we plan to do". (23) As a result, residents and other people can feel they have little input into the actual "planning" process. It is not appropriate to say that residents or their representatives have accepted or consented to a care plan, if they do not feel there are reasonable options and they are expected to simply accept what has been presented.

## Continuing accommodation of needs

Section 50 of the Residential Care Regulations sets out the requirement of “continuing accommodation.” This involves the staff regularly monitoring the individual resident’s health. As the resident’s health condition or other needs change, the staff and Operator are expected to make ongoing adjustments to the care being offered and provided.

The regulations also state the operator cannot send the resident to hospital unless there is an emergency, or directed by person’s medical practitioner or nurse practitioner. (24)The operator cannot transfer the resident to another community care facility without the consent of the person in care or that person’s representative. (25)Basically the resident cannot be “dumped” somewhere else, simply because the resident’s health care needs change.

## Staffing

One of the common concerns expressed by family relate to the staffing level within the facility and in some cases, the training of the staff to deliver complex care. Many care facilities in British Columbia have a large proportion of part-time and casual staff. (26)Moreover, some operators contract out their care support and other services to other companies. The result is that residents may not have the same staff to regularly provide care.



### What is the legal requirement?

Several years ago, Ministry of Health set a guideline of 3.36 hours of direct care for each resident. However, this guideline has not been met by the health authorities.(27)

In law, there is no minimum staffing level or specific staffing mix required within the provincial legislation for residential care facilities. However, the regulations mandate the operator to have sufficient employees on duty at all times to (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. (28)

This has typically given the Operator considerable discretion in the staffing. In general, the level of staffing has tended to be higher in not-for-profit facilities compared to for-profit facilities.(29) The regulations place the emphasis not just on numbers of people on duty, but sufficient “in numbers, training and experience, and organized in an appropriate staffing pattern”.(30) The law also places a duty on the Operator to also ensure that the available must be able to communicate effectively with all of the persons in care.(31)

Without adequate and appropriate staff, it becomes easier for residents’ needs to be overlooked or neglected, for staff to rush residents at meals increasing choking risk, (32)or for health conditions such as pressure ulcers (bed sores) to go undetected or inadequately addressed. If a resident wanders from the facility or experiences a personal injury, a pattern of inadequate staffing may be indicative of negligence on the part of the Operator and administration.

Providing good care can become further complicated when an operator decides to contract out or change employment agencies, typically to reduce wage and benefit costs. This can cause a large displacement of staff in the facility, and in some parts of the province, the practice occurs on a fairly common basis.

Under the care regulations, the Medical Health Officer (Licensing) must be informed by the operator of any substantial changes in operation. (33) However at present, there is no specific requirement to inform Licensing of these fundamental staffing changes. The Ombudsperson’s Best of Care report specifically recommended that these types of large scale staff

changes be part of the definition of "substantial changes in operation". (34) To date, there has not been a response from the Ministry on this recommendation.

## Quality of Care

Residential care raises many questions for people about the quality of care being given to residents. Media's attention primarily on care quality or other problems that may arise in residential care facilities tends to reinforce the concern many older people and families have about living in a residential care facility.

Many people would probably define quality care as receiving the best care possible for one's condition at this particular point in life. Quality of care covers the entire experience of receiving care and support in the facility, including respectful treatment and delivery of care by operators. It can range from attitude and tone of voice, to the technical aspects of care, to avoiding errors or mistakes, to receiving clear answers to questions and much more.

For the individual, quality of care may be shown in a wide range of efforts to

- prevent health care or other problems from arising (such as pressure ulcers (bedsores), resident to resident conflict),
- recognize the condition or situation if it does develop, and
- promptly and appropriately treat the condition or respond to the situation if it arises.

## Continence Care

The term "continence care" refers to helping individuals with their bladder or bowel functions, either to maintain independence or deal with incontinence. Older adults living in residential care facilities often have balance or mobility problems, which means that they may need help to safely move to the bathroom, or to transfer from a wheelchair to a toilet and back. Continence care may include helping to improve or maintain the person's mobility generally. It generally means assessing the person's current abilities in self care and planning how to improve that if possible. It may include care plans to help the person to the bathroom, if needed, good hydration and efforts to keep the bladder healthy so the person does not develop urinary tract infection (which in many cases can lead to delirium), as well as proper incontinence care and skin care if the person becomes incontinent.

Residents and families often identify several common problems around continence care:

- residents who were continent before admission to the facility lose the ability because there are not enough direct care staff available to help them to the bathroom;
- non response to call buttons, resulting in residents trying to access the washroom on their own, risking falls and injury;
- residents left waiting long periods of time to be helped from the toilet;
- the misuse of continence products (limiting number of pads or briefs, limiting when the resident can be "changed" ["the 75% rule"], or doubling the pads to reduce number of changes);(35)
- restricting fluids for a resident to reduce the use of continence products;
- financial aspects, such as being charged fees for catheters and continence products (these are actually an included benefit in the assessed client rate for residential care. (36)

## Is there a legal “right to good continence care”?

Good continence care is part of the broader responsibility of the Operator to provide good care and meet the individual resident’s care needs. Legal analysis on continence issues in residential care has underscored a number of policies and practices that clearly violate the concepts of individualized care and personal dignity. For example, it is not appropriate for an operator to allow only a certain numbers of continence briefs per resident, per shift, or per staff, (37) nor is it appropriate to put front line staff in the position where they are, in effect, told to ration these supplies and care necessities.

In British Columbia, individual health authority practices vary when it comes to continence care. Interior Health, for example, 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 do not have specific policies on providing bathroom assistance.(38)

Interestingly, sometimes information from health authorities can add to the public confusion on continence care issues. For example, guidebooks may ask people to check if the facility has additional charges for incontinence pads.(39) This leaves the public with the impression that residents can legitimately be charged for these, when they are actually part of the basic cost.

## Risk Taking

One commonly asked legal issue in residential care is: “Which personal risks are residents ‘permitted’ to take?” The issue revolves not only about the perceived risks for the individual (or sometimes other residents), but also is about the efforts taken to mitigate risks and who has the final say in the various “risk” decisions.

### An example from falls prevention

Falls are a common concern in residential care facilities, and happen with considerable frequency, as a result of many interrelated factors including frailty, medications, staffing and environmental factors,(40) as well as cognitive impairment. In some cases, family will ask (“strongly request”) staff to take stronger efforts to help reduce the risk of a resident falling. They may erroneously believe that if staff restricts the resident’s movement (“make her stay in bed”) or if they use physical restraints, this will prevent falls.

Research clearly and consistently indicates that physical restraints do not increase safety.(41) In some types of cases, physical restraint use actually leads to a higher risk of falls.(42) Even the litigious American system has recognized that a facility is much more likely to be held liable in a lawsuit for an injurious fall where proper falls risk assessment and proper falls management were not done, than if the facility was not using physical restraints. (43)From a legal perspective, restraints do not reduce liability.

By law, the operator is required to undertake a falls risk assessment for each resident and develop a falls management plan for those at risk,



record it and regularly review it. However, operators have an overall responsibility to provide good information for people who are making decisions with or on behalf of the resident. As part of this responsibility, operators may need to help families and others

- develop a better understanding of the issues (e.g. the resident's risk to take certain risks, the harms from the restriction), as well as
- the best practices in the area (e.g. ways that the facility works to reduce risks of falls through environmental means, through rehabilitation and mobility preservation).

### **Leaving the facility**

In some residential care facilities, competent residents may be denied the right to leave the facility to visit a nearby coffee shop, or the operator may require that the person only leave with a staff person, family or a companion. If those people are not available, the resident is effectively restricted to the facility. The facility may adopt the policy from a risk management perspective including out of concern for the safety of residents, taking into consideration local traffic, vision or hearing impairment, fall risks, and environmental hazards. Nevertheless it can be a violation of a competent adult's autonomy.<sup>(44)</sup> At law, it may be considered forcible confinement, and may be a criminal offence.<sup>(45)</sup>

When the resident has been transferred to the facility under the extended leave provisions of the Mental Health Act, the issue of leaving the facility also becomes problematic. The person may be mentally capable of making that kind of decisions, but may be restricted from leaving because the Mental Health Act takes away all the person's decision-making rights.

### **Private Communication**

Because care facilities are relatively "closed systems", separated from the broader community, the opportunity for residents to remain in contact with family, friends and other people on the outside is very important. The Regulations require the Operator to have at least one conveniently located private line telephone, for use only by residents. The phone must have "adaptations, as necessary, to meet the needs of persons in care", and be accessible to residents at all times."<sup>(46)</sup>

### **Paid Companions in Residential Care**

Family members or friends may wish to hire a paid companion to supplement time spent with the resident. Companions may be hired under the direction of family or friends or a home care agency to provide companionship for individual residents. This is a private arrangement between the family/resident and the companion. In some care facilities, families feel pressured to hire from an agency with whom the Operator is doing business.

Companion services are primarily social in nature and may include: conversation, reading, card/letter writing, music, recording life stories, shopping, games, and attending appointments. Typically the care facility operator does not assume liability or responsibility for these arrangements. They may request the companion to sign a waiver "to provide clarity regarding the services provided".



## Renovations and Closure of Facilities

Throughout the 2000s, a number of care facilities in British Columbia were closed or renovated. In many circumstances, this process happened in a way that left residents and families with little if any notice, distressed and feeling very uncertain about the residents' future. The Residential Care Regulations require the Medical Health Officer to be informed about closures, but is silent as to residents or families to this information.(47) The Ombudsperson's Best of Care report recommended that health authorities promptly inform residents and families decisions about closure decisions.(48)

The Ministry of Health (Home and Community Care) Policy now has a special section on expectations of Operators and the health authorities when Operators or others are planning to close the facility.(49) At least one health authority has identified that care facilities under a certain size (125 beds) are not economically viable, and consequently should be closed. (50)This will be a very important consideration for current and future residents.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

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## Six Pressing Issues when Living in Residential Care

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### Medications

Families often express concerns that antipsychotic drugs (1) and sedatives are being prescribed to residents with dementia without the knowledge and consent of the substitute decision-maker. Some residents may come into residential care facilities from hospital where they have been prescribed the antipsychotics. In some cases, the apprehension is over the use of these drugs (particularly the "atypical anti-psychotics"), because of health warnings from the manufacturers and Health Canada. (2) These powerful medications come with significant risks, such as falls, bedsores, blood clots and potentially fatal reactions to the drugs. Many residents are on the anti-psychotic drugs without a doctor's diagnosis of psychosis.



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The issue is not only use of the drug, but how it interacts with the many other medications that the resident has been prescribed. About 53 percent of seniors in long term care facilities take five or more different drugs on average for their various health conditions. (3)

In many cases, the family or substitute decisionmaker's concern is the fact that there has been little if any consultation with them about potential risks versus potential benefits. They only learn about medication when they begin to see notable changes in the person's behaviour (e.g. falls, increased sedation, confusion). Typically there has been no effort to obtain informed consent from the resident (or acquiescence is treated as consent), or from their substitute decision-maker prior to commencing treatment.

In some cases families are effectively told they must consent to the use of the particular medication. If they do not, the resident can no longer stay there, and will be discharged back to family's care or to another facility. This approach violates basic principles of health care consent. It violates the prohibition of non- retaliation, and it is illegal.

Medication administration is health care treatment and requires informed consent from the resident, or the resident's substitute decision-maker if incapable. The primary issues are:

- a) matters of fact - Is the particular medication appropriate for this individual? and
- b) rights or process related matters - Has informed consent been properly obtained in advance of the administration of the medication?

Health care consent is described in Chapter 7 (Consent & Capacity) and Chapter 8 (Substitute Decision-Making).

The pharmacological and geriatric literature is very clear that anti-psychotic medications are often inappropriate for older people, as these medications can have serious side effects and sometimes lead to premature death. If an anti-psychotic medication used to manage behaviours results in restraining or restricting a resident's movements, it is a restraint. That means its use must be consistent with the Residential Care Regulations and other provincial legislation on the use of restraints.(4)

In 2011, the Ministry of Health carried out a review and found that in a ten year period, anti-psychotic drug use had increased significantly in British Columbia's residential care facilities. In 2000/1, about one in three residents was being prescribed an anti-psychotic drug; by 2010/11 over one half of all the residents were. Provincial data from 2014/15 suggests that one in three residents are prescribed anti-psychotic medications.(5) The use of anti-psychotic medications in long term care has also been recognized as high and problematic in other Canadian jurisdictions.

In June 2013, the BC Patient Safety and Quality Care Council began the CLeAR initiative. The goal is to reduce the number of seniors in residential care on anti-psychotic medications by 50% across British Columbia by December 31, 2014). It is a province-wide, voluntary initiative. (6)

In 2012, the Ministry of Health developed best practice guidelines to help health care providers respond more appropriately to the behaviours commonly seen in residential care. The guidelines require the staff to:

- focus on a good assessment with this particular resident to determine, for example, what might be causing the behaviour,
- look at risks compared to the benefits of various options,
- try out different kinds of potentially more effective approaches, and less risky interventions, plus
- focus on informed consent prior to treatment. (7)

The guidelines are beginning to be used by some care facilities, but the legal issue of respecting informed consent for medications generally and anti-psychotic medications in particular may continue to be elusive for some time.

In the area of medication use in residential care, it is equally important to have a clear understanding of the multiple purposes for which medications are prescribed and appropriately used for residents with complex and chronic health conditions. The Office of the Seniors Advocate has noted that a large proportion of residents are being prescribed antidepressants without necessarily having a diagnosis of depression. (8) Antidepressants are often used for pain control for people experiencing chronic pain and are internationally recognized as a mainstay in the treatment of many chronic pain conditions — even when depression is not a factor. (9)

<b>Health Care Consent: A Quick Overview</b>
<ol style="list-style-type: none"><li>1. Before providing any healthcare treatment, which includes prescribing medication, all health care Operators (physicians, nurses, therapists, dentists, etc.) are required by law to seek and receive valid and voluntary consent from their patient (if the patient is capable).</li><li>2. If the patient is not capable, consent must be obtained from their authorized decision maker before providing treatment.</li><li>3. Consent must be specific to the treatment being proposed.</li><li>4. Legislation also requires health care Operators to fully inform patients (or their authorized decision maker) of the risks and benefits of the treatment they seek.</li><li>5. Voluntary, informed, consent from a capable adult must be sought except in particular circumstances.</li></ol> <p style="text-align: center;">- A Review of the Use of Antipsychotic Drugs in British Columbia Residential Care Facilities, p. 11.</p>

## **Control Over Visiting**

Control over visiting is a legal issue in some residential care facilities that arises in a wide variety of circumstances and situations. In some cases, a person with an enduring power of attorney or representation agreement may try to control access to the resident by others, and will ask the staff to bar or restrict the person or persons from visiting.

The issue of control over visiting also arises when there are disputes or concerns being raised by the family or others about the care being provided in the facility. Families report that after raising concerns, they have encountered situations where they are barred from visiting, temporarily (for a few days or permanently), or their access is controlled (the visit is being “supervised”).

### **The law and visiting**

The care facility is the resident’s home. Arguably, the resident and the Operator may both be considered “occupiers” with rights to control access to the place under the Trespass Act. (10) The resident has a right to control access to his or her room (much like a tenant) and the operator or staff has a broad right to control access to premises.

The resident’s right to visitors is also very clearly identified within the Residential Care Regulations and Section 2(e) of the Bill of Rights (“Rights to health, safety and dignity) which states “An adult person in care has the right to the protection and promotion of his or her health, safety and dignity, including a right to ... to receive visitors and to communicate with visitors in private.” Sections 57 (1) and (2) of the RCR also underscore the importance of access to the resident, stressing that the Operator

- “must ensure that a parent or representative has reasonable access to a person in care for whom he or she is responsible.” (11)
- “must, to the greatest extent possible while maintaining the health, safety and dignity of all persons in care, ensure that a person in care receives visitors of the person in care's choice at any time.” (12)

The resident’s representative is also expressly recognized under the Act to be given reasonable access to the resident. This right to receive visitors of their preference is well recognized as fundamental to the wellbeing of residents. The risk of social isolation, poorer health outcomes as well as undetected mistreatment greatly increases among residents who have few or no social contacts with people they like having around them.

The capability to demonstrate choice in preference for visitors is usually an easy threshold for many residents to make, whether that is deciding to have the person visit that day, or not at all.

### **What does the right to visitors involve?**

At a minimum, the operator’s responsibility to respect the resident’s right to visitors and to privacy includes having a place where the resident can meet people without others around. When the resident does not share a room, that may be easier to achieve.

### **Control of access by family**

As will be noted later in the Chapter on Substitute Decision-Making, sometimes family may try to control access to a resident by asking staff to bar certain individuals. In some cases there can be good safety and security reasons to do so, such as where has been a history of violence or financial exploitation in the community, and there is a realistic risk it may continue.

However it should be noted that a person granted an enduring power of attorney has no authority to make personal care decisions such as who may visit the resident; neither does a person who is a temporary substitute decision-maker for

health care decisions.(13) Even a person holding a representation agreement that covers personal care decisions is expected to consult with the resident, follow their values, beliefs, wishes and act in their best interests. They cannot misrepresent information or try to unduly influence the resident about whether certain people should visit the resident. While in many cases, staff can simply ask the resident if the person wants that visitor on this occasion, the best approach becomes more complex for cognitively impaired residents who may or may not recognize the family member or close contact.

### **Whose right is it?**

One of the questions for visiting is whose right is it? – the residents' right to receive visitors or the family's and others' right to visit the resident? The visits are the resident's right, but visiting can serve an important purpose for both parties. It helps the resident maintain connection to family, friends and the community, continuing an important part of the person's life history and sense of self. It also helps family.

### **The facility's control of access**

Can the facility ever deny access to people? Yes. The facility staff can deny access temporarily if there is a threat by that person visiting to the safety and well being of the resident, other residents or the staff or administration. However, this response has to be proportional to the actual circumstances, and recognizing that some conflict may be expected, especially when long standing issues have not being adequately addressed in the facility.

A 2012 Ministry of Health policy communiqué stresses the need for a balanced response, and sets out the needed steps to achieve that. (14) Specifically the Communiqué notes:

"It is recognized that family members and other visitors may be under considerable stress for a variety of reasons, and that a supportive and compassionate approach will be helpful in reducing anxiety." (15)

The BC Ombudsperson has found that 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, and that people were being unfairly restricted. The BC Ombudsperson made recommendations to make the process fairer and more accountable.(16)

Efforts to restrict a visitor obviously will affect that individual, but in many cases, it can also be considered a form of retaliation against the resident. Retaliation against the resident when people are raising complaints or concerns is prohibited under the Regulations. (17)

### **Mechanisms to restrict some visitors**

The Adult Guardianship Act allows health authorities to apply for an interim court order restricting a visitor's access for up to 90 days. (18) However this can only occur when the health authority has reason to believe that the adult is being abused or neglected by that person, the situation has been investigated by the designated agency (health authority), and the designated agency has successfully applied to court to put the restriction in place. (19)

The residential care regulations authorize the facility operator to control access to visitors in other specific narrow circumstances. For example, care facility staff can control access to residents for some infectious diseases. Also the operator must restrict or prohibit a person from accessing the resident "as necessary" in order to comply with a court order, e.g. a peace order/ restraining order, or an injunction. (20) Having said that, an operator or the health authority may not use an injunction that a court issued to bar one visitor in one specific situation as implicit or explicit authority to bar other people in other circumstances.

Under the residential care regulations, the Operator is required to record the identity of any individual who the operator has reason to believe may pose a risk to the health, safety or dignity of the person in care.(21) However, there must be a reasonable basis for identifying a person as a risk to the resident. Operators also cannot bar individuals from visiting the resident simply because the Operator or staff members consider them as complainers or “trouble”.

### **Removal and release of residents**

Operators sometimes point out they have a legal responsibility to ensure the resident is not released or removed from the care facility to anyone except the resident’s representative or a person authorized by the representative. (22) They also point out that a care plan or “other pre-existing arrangement” can set out who the resident can be released to, or who can remove the resident from the care facility. (23) Both statements are legally accurate, but they can only apply to situations where the resident is not mentally capable of making that decision for herself or himself. A care plan that purported to make those restrictions without the express consent of a mentally capable adult would not be valid.

### **Can the facility control “visiting hours”?**

In some cases care facility administration or staff may try to limit access to certain hours, such as a hospital might. The regulations clearly permit visiting “at any time”. This reflects the fact that residents can have different preferences or “good times of the day”, and that family’s ability to visit may be circumscribed by their employment and other responsibilities. In some instances, staff may try to restrict visiting to daytime when there is more staff. In other instances, staff or administration may try to restrict visiting to certain times, because the facility locks its doors at night as safety matter. However, the facility is expected to take an individualized approach to residents’ rights and care planning. Failure to do so may be discriminatory and violate the regulations.

### **Can the facility control people from visiting others than “your resident”?**

Staff or administration in some facilities may try to prevent family from talking with other residents or other people, on the basis they are simply respecting the residents’ privacy. Adults are usually able to identify whether or not they want someone around. Unless there has been a specific complaint raised such as the visitor going into another person’s room without permission, the facility should not interfere with socialization or family members talking with others. Indeed the right and opportunity for families to work together to form a family council or other group for the benefit of residents would be effectively undermined under the guise of respecting privacy.

## **Abuse and Neglect**

The Residential Care Regulation requires an operator (licensee) to immediately report to the medical health officer (Community Licensing) if there is an allegation of abuse or neglect of a resident. However, it is very likely that incidents are internally filtered and will be under reported. According to 2014/15 data provided by the health authorities to Office of the Seniors Advocate, there were only 121 abuse or neglect incidents reported to licensing for the over 27,000 residents in care throughout the province. (24)

### **What Do We Mean?**

In everyday language, the terms such as “abuse” and “neglect “ or “mistreatment” loosely refer to a wide range of negative behaviours, actions or inactions in residential care by staff, administration or others that can undermine the residents’ dignity, or cause them physical, emotional or financial harm. “Neglect of a resident” as the public often thinks of the term may also refer to substandard care, including poor housekeeping, hygiene concerns, delay of treatment, ignoring or slow response to call bells, lack of help with to the washroom, being forced to use incontinence products, inadequate pain

treatment, insufficient staffing, poor nutrition, and residents going without a bath for weeks. It can sometimes take extreme forms as well, e.g., a resident lying in urine and feces for extended periods of time, a resident who is malnourished or who develops pressure ulcers due to lack of appropriate care.

Emotional abuse can show up as the usual forms seen in the community, such as yelling and threatening the person. However, there are special forms of inappropriate treatment or mistreatment that show up in residential care. These are either intended to personalize, humiliate or degrade the person, or use power and control over the resident. These forms of emotional abuse include, for example if a staff member, operator or other person working in the facility

- belittles the resident when the person’s clothing or incontinence brief is wet or soiled;
- makes fun of the resident’s mental or physical disability;
- makes racial, cultural or sexual orientation slurs;
- threatens to kick out (“discharge”) the resident if she or he does not “cooperate.”

Within the residential care regulations, the terms “abuse” and “neglect” have very specific meanings. These focus exclusively on harms to “persons in care “ (residents) by people who are “not persons in care“ (staff, administration, volunteers, family, strangers).

The abuse definitions specifically exclude harms by residents to other residents. These resident to resident harms are also considered important care issues and they are “reportable” to Licensing. They are simply recognized as having different causes and needing different responses than do the abuse or neglect situations. (25)

“Abuse” and “neglect “in residential care generally means a deliberate intention to harm a resident, or a high degree of recklessness or indifference to the resident. Any other harms resulting from lack of understanding, poor procedures or documentation, inadequate training, or inadequate staffing are more commonly characterized as “quality of care” concerns or issues related to “non-compliance with standards”. However, the line between neglect and poor quality of care is not always clear in residential care.

The terms “abuse “ and “neglect “ as used in the Residential Care Regulations are also somewhat different than those used by the Adult Guardianship Act, where the definitions are statutory thresholds for action and focus on deliberate harms causing significant loss. See Figure 1. The Residential Care Regulations (s. 52 (2))also prohibit the use of food or fluids as a reward; they are considered a type of mistreatment.

**Figure 1**

Abuse and Neglect Definitions Under the Residential Care Regulations	Abuse and Neglect Definitions under the Adult Guardianship Act
<p><b>"emotional abuse"</b> means any act, or lack of action, which may diminish the sense of dignity of a person in care, perpetrated by a person not in care, such as verbal harassment, yelling or confinement;</p>	<p><b>"abuse"</b> means the deliberate mistreatment of an adult that causes the adult</p> <ul style="list-style-type: none"> <li>(a) physical, mental or emotional harm, or</li> <li>(b) damage or loss in respect of the adult's financial affairs, and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors;</li> </ul>
<p><b>"financial abuse"</b> means</p> <ul style="list-style-type: none"> <li>(a) the misuse of the funds and assets of a person in care by a person not in care, or</li> <li>(b) the obtaining of the property and funds of a person in care by a person not in care without the knowledge and full consent of the person in care or his or her parent or representative;</li> </ul>	

<p><b>"neglect"</b> means the failure of a care Operator to meet the needs of a person in care, including food, shelter, care or supervision;</p>	<p><b>"neglect"</b> means any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage or loss in respect of the adult's financial affairs, and includes self neglect;</p>
<p><b>"physical abuse"</b> means 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;</p>	
<p><b>"sexual abuse"</b> means any sexual behaviour directed towards a person in care and includes</p> <p>(a) any sexual exploitation, whether consensual or not, by an employee of the licensee, or any other person in a position of trust, power or authority, ...,but does not include consenting sexual behaviour between adult persons in care;</p>	

### Addressing abuse or neglect when it happens

Residential care facilities are expected to have written policies in place to address and respond to abuse and neglect of residents. When a resident in a residential care facility is involved in a reportable incident, the operator must immediately notify

- that person's representative or contact person,
- 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.(26)

The response to the abuse or neglect situation will depend on the type of harm and who was involved. The operator has a responsibility to investigate the allegation or the known situation. Staff if involved may be suspended, with or without pay during the investigation and in some cases may be fired, although if unionized, they may grieve the response. If a matter is a crime, facility operators are expected to call the police.

Abuse or neglect situations involving care aides that the care facility operators find are supported by the evidence, are expected to be reported to the BC Care Aide & Community Health Worker Registry to be further investigated (Note : While operators cannot be compelled to report to the Registry, a duty to report is part of the contractual responsibilities of publicly funded operators to the Ministry of Health or health authority, see: [http:// www. cachwr. bc. ca/ About-the-Registry/Employer-FAQ.aspx](http://www.cachwr.bc.ca/About-the-Registry/Employer-FAQ.aspx)). That report to the Registry is to be made with seven days of the suspected staff member being suspended or terminated, pending investigation. (For more information on the process see Chapter Three "Rights, Remedies and Problem Resolution").

If the incident is considered well founded, the care aide worker may be de-registered, which will prevent him or her from working in publicly funded care facilities in the province. Care aides cannot be de-registered for general competence issues.

## **Video-surveillance and abuse or neglect**

Family members sometimes suspect that abuse or neglect of a resident may be happening in the facility. The resident may show possible indicators such as

- repeated falls,
- unexplained or poorly explained bruises,
- a change in behaviour (such as withdrawing in the presence of certain staff).

However, there can other causes.

In some cases, family members have tried to determine whether resident abuse or neglect is occurring by placing a hidden video camera in the resident's room. This is rarely a first response; it typically occurs when the possible indicators are present and

- the resident has cognitive impairment or communication difficulties making it difficult to determine the facts,
- family feel their questions or concerns about specific situations have not been adequately addressed, or
- situations have not been adequately investigated internally by the operator or externally by oversight bodies.

There is no provision in the residential care regulations, the privacy, consent or substitute decision laws that specifically permits or prohibits this covert surveillance. There are distinctions in law between video surveillance in the workplace by the employer and video surveillance in the person's home by those with the authority to consent, as well as video surveillance to detect crime. (27) There are also distinctions made between overt and covert surveillance. If an operator tried to prohibit these efforts by family or others, it would most likely lead to greater concern ("What are they trying to hide?").

The use of this type of video surveillance raises a wide variety of legal issues related to the:

- ways of promoting resident's safety
- intrusion on the resident's privacy,
- consent (obtaining consent, including who can consent to the recording and what type of consent is needed)
- the rights of third parties (staff who are not suspected of harm who may also be recorded),
- use of the information - how the recorded information is subsequently used or displayed (e.g. uTube) by the person who made the recording, as well as
- interpretation and evidentiary matters for the health authority and law enforcement ("what does the tape actually show?").

The overarching issue is:

- What is the objective?
- What is the means used? and
- Is there a more effective and less intrusive way of meeting these concerns?

Use of video surveillance in the privacy of a resident's room may or may not lead to greater resident freedom from abuse or neglect. The issue of whether videotaped surveillance put in place by family can be used as legal evidence is beginning to come before the criminal courts and administrative bodies. (28)



## Resident to Resident Harms

Care facility operators have a general responsibility to promote the health and safety of all residents, and to protect them from harm. This includes harms from other residents. Resident to resident conflict or aggression can have a significant effect on the emotional and physical well-being of the residents and others in the facility.

It has been estimated that 11 per cent of the care facility residents are “aggressive” at some point. (29) Drawing on available data, the Office of the Seniors Advocate concluded there were between 425 and 550 reports throughout the province of resident to resident aggression causing harm in 2014/15. (30) In some instances this can lead to serious injury, even death. The geriatric literature now uses the term “responsive behaviour” to recognize the fact that “aggressive” residents are often responding (inappropriately) to situations that are frightening to them or causing confusion. Residents may be responsive for many reasons, often it is because of confusion caused by dementia, inadequately addressed pain or an underlying medical condition that is not under control. The resident to resident harms can occur in general residential care facilities as well as those with special dementia units.

The Residential Care Regulation requires care facility operators to report “aggressive or unusual behaviour”. This 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.”(31)

Resident to resident harms typically occur because of three types of factors intersect. There are individual resident factors, facility factors and factors from the broader care system. (32) The resident factors for aggression generally include:

- where the residents are cognitively impaired (particularly if they have frontal lobe dementia which impairs inhibitions and their ability to control their behaviour),
- certain medical conditions and psychiatric illness (e.g. under-addressed pain and depression).

It is very common for residents who seem to be aggressive to also show signs of depression and delirium. (33) Other factors can include their personality and their life experience (presence of trauma history, contact sports, the way they have resolved conflicts throughout life).

If there has been a good assessment of the resident prior to coming to the facility (including communication with family or key contacts about whether the person showed aggression in the community), it should be evident whether or not these factors are present.

Resident assessment, however, is an ongoing process and is always required as the person’s health and conditions change. Worksafe BC has indicated that sometimes community service providers are reluctant to share information about a prospective resident’s tendency to respond aggressively, out of concern that the disclosure might breach provincial privacy law. However that it not the case; information about a prospective or current resident’s violence risk can be properly disclosed on a “need to know basis.” (34)

The geriatric literature also shows a significant amount of resident aggression can also be reduced with staff trained in dementia care and particularly with training on “responsive behaviours”, such as “P.I.E.C.E.S.” , U – First, Montessori, or similar programs, as well as staff trained with “Code White” protocols. (35) In 2012, the Ministry of Health developed best practice guideline for accommodating and managing behavioural and psychological symptoms of dementia. (36) In these guidelines, medications to control behaviours are only used after other less restrictive (but hopefully more effective) methods have been tried and ruled out.

Several facility factors are also important in heightening or reducing the level of resident aggression in that facility. These include its size; whether the environment is over stimulating or under-stimulating; and the facility’s culture (whether it is institution focussed or uses a person centred care approach). Equally important are the staff factors - the staff members' style of approach to residents and work, the numbers and mix of staff, their training and available support,

workplace wellness, and leadership factors.

Broad system factors such as the residential care process also have an important role. For example, if policy requires residents to be admitted to the first available facility without also having a good assessment of whether the person is appropriate for that facility, or under what circumstances, this may create special risks for that person, other residents and staff. If the broader societal view of residential care treats the needs of residents to safe and appropriate environments as a low priority, or simply views residents as physically frail, and therefore unlikely to cause harm, resident aggression is more likely to occur and recur.

It may not be possible to eliminate all resident to resident aggression. However, there are a variety recommended policy responses to help reduce it. These include to:

- increase the staff levels in the facility;
- have specific staff in-house in every care facility with behaviour care expertise;
- have more designated behaviour units to care for residents with severe aggressive behaviours; and,
- have regular and recurring behaviour-related training for all care staff.

Resident to resident harm has begun to raise a wide array of complex legal and health care planning issues. For example,

- what is the best way to approach situations when a person with cognitive impairment in the community and residential care settings has caused injury or death?
- should all situations require a police response? If so, what is the nature of the most appropriate justice and health system response?

This becomes particularly relevant when cognitively impaired resident does not appear to have the requisite *mens rea* for assault, the mental capacity to instruct counsel, or fitness to stand trial. Unlike younger adults who have become aggressive as a result of a mental condition, the difficulty for many residents is that dementia does not get better. Having a safe and appropriate place for them to live the last months or years of their lives, without leaving other residents at risk of harm becomes pressing.

## Reporting Responsibilities

The Residential Care Regulations set out a number of mandatory situations (referred to as “reportable incidents”) where the operator (and consequently the staff) must notify certain authorities or key people outside of the facility. In some cases these incidents are reported to the Ministry of Health (generally to Community Care Licensing), but in other instances they are also made to the resident’s representative, or contact person. (37) These incidents include:

- “abuse”, including emotional, financial, physical, and sexual abuse
- “aggression between persons in care”
- "aggressive or unusual behaviour"
- "attempted suicide"
- "choking"
- "death of a person in care”;
- "disease outbreak or occurrence"
- "emergency restraint"
- "fall”
- "food poisoning"
- "medication error"
- "missing or wandering person"
- "motor vehicle injury”

- "neglect"
- "other injury"
- "poisoning"
- "service delivery problem"
- "unexpected illness"

Each term included in incident reporting has a very specific regulatory definition and meaning in residential care. See the Appendix for definitions.

The primary concern expressed by families is that although incident reporting is required by law, it may not occur. Alternatively, if family is called about an incident as required by law, the seriousness of the situation may be downplayed or the incident is mischaracterized (e.g. a sudden death is attributed to a heart attack, not a choking incident).(38) As a result serious problems may remain undetected for a longer period of time.

The formal Incident Reporting process is intended to serve several purposes in residential care:

- to ensure a timely response by the facility to the incident,
- to give Community Care Facilities Licensing staff the opportunity to review the facility's response in a timely manner,
- to help prevent the recurrence of the incident and promote a high standard of care, safety, health and dignity of the persons in care,
- for data collection and analysis of health authority-wide. (39)

### **Reporting is mandatory**

Care staff and the operator are required to report if they have reasonable grounds to believe the actions or behaviours they have observed meet the definitions of "reportable incident" in the legislation. Sometimes operators, care staff or volunteers are led to believe they have discretion in reporting.

This frequently comes up for abuse or neglect cases. Staff may or may not decide to report depending on relative severity of the situation or if they feel ethically uncomfortable with the situation. Abuse and neglect reporting must take place whether it is considered minor mistreatment or major. The follow-up response of the operator and Community Care Licensing to the incident will depend on the circumstances. People cannot opt out of reporting required by law, because they do not feel comfortable or the resident "didn't want me to report". The statements reflect a misunderstanding about discretion that does not exist in the law. As the Advocacy Centre for the Elderly has noted:

"... Mandatory reporting [in residential care] is just that – mandatory." (40)

The operator also must also maintain a written log of:

- Minor accidents and illnesses involving persons in care, that do not require medical attention and are not reportable incidents; and
- Unexpected events involving residents.(41)

<b>Special note : Harm to the resident discovered outside the care facility</b>
Social workers or other health care providers at hospitals may have a concern about a resident who is temporarily in hospital for treatment. British Columbia's law is different than some jurisdictions, in that it does not place a responsibility on "everyone" to report suspected harms to a resident. However, if there is a suspicion that abuse or neglect is occurring, health care providers can still rely on the Part 3 of Adult Guardianship Act and report the concern to a "designated agency". Almost every resident in a care facility who is experiencing suspected abuse or neglect would be considered a vulnerable adult falling within the scope of the Act. Part 3 of the Act (the abuse and neglect section of the Act) applies no matter where the person lives, except for a correctional facility.(42)

## Restraints

A "restraint" is anything that limits the movement of a resident and over which the resident has no control. Restraints may be physical (e.g., lap belt, "posey" jacket, mittens, bed side rails, "geri- chairs"), environmental (barriers which confine a resident to a specific space such as locked units) or chemical (e.g., drugs used to inhibit or control disruptive behaviour). It is also a restraint when an assistive device such as wheelchair is left beyond a resident's reach, or is modified so that the person cannot use it to move around (removing a wheelchair's foot rests).

Today there is a wide variety of technology that "restrains" residents' freedom and these are used for a wide variety of legitimate (and sometimes not so justifiable) reasons. Some residents may be prone to wandering and may need protection from exiting the facility unaccompanied. These residents may be provided with electronic "tags" that will deactivate elevators and alarm the main front exit.

However, depending on the circumstances, the use of physical or chemical restraints for the involuntary immobilization of the resident may not only be an infringement of the resident's rights, but can also result in patient harm, including soft tissue injury, fractures, delirium, and even death. Harms to residents from restraints can arise for many reasons.

Staff may not recognize the practice actually is a form of restraint. Staff may not be adequately trained to identify and address the underlying cause of the problem (why the resident wanders or why the resident is showing this responsive behaviour).(43) As a result, the staff may rely on restraints as the "only tool in their care toolbox". Also:

- staff may not recognize the risks associated with the restraint (e.g. recognize that the person will likely try to leave the bed, escape the restraint, or become more agitated) and
- Staff may be untrained in the proper use of restraints.

In many cases in residential care, restraints efforts intended to be a "last resort" become the "first resort". The Alzheimer Society of Canada notes the special risks for people with Alzheimer's disease or other dementias. For people with Alzheimer's disease, the restraints are a restriction of freedom, can decrease a person's physical activity level and ability to function independently, and can cause injuries.(44)

### The law on restraints

Under the Residential Care Regulations, a "restraint" is defined 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."(45)

Division 5 of the Regulations describes situations in which restraints may be used and the minimum standards for their use. Section 74 (2) specifically stresses that the operator must ensure that a person in care is not restrained:

- (a) for the purpose of punishment or discipline, or
- (b) for the convenience of employees.

## **Circumstances in which restraints can be used**

Restraints may be used in two circumstances:

- (a) in an emergency, or (46)
- (b) if there is a prior written agreement to the use of the restraint. (47)

The term “emergency” is not defined in the regulations. The term “emergency” in everyday language usually refers to events that are out of the ordinary that cause or are very likely to cause serious immediate harm to the person or others. Schedule D of the Regulations describes certain reportable incidents and defines an "emergency restraint" as “any use of a restraint that is not agreed to under section 74 (a prior written agreement). If a resident is in care facility where issues are not recognized and appropriately addressed fairly early on, situations involving staff or other residents can easily deteriorate, turning into “emergencies”. This is not the intention of these sections of the regulation. The proper focus is on prevention and early intervention to avoid the emergency.

## **Restrictions**

Section 73 (1) of the Residential Care Regulations identifies restrictions on the use of restraints, noting “A licensee must ensure that a restraint is not used unless:

- (a) the restraint is necessary to protect the person in care or others from serious physical harm,
- (b) the restraint is as minimal as possible, taking into consideration both the nature of the restraint and the duration for which it is used, and
- (c) the safety and physical and emotional dignity of the person in care is monitored throughout the use of the restraint, and assessed after the use of the restraint.

All three conditions are required – protect from serious physical harm, minimal as possible, and monitor resident’s safety, as well as physical and emotional dignity.

Section 73 of the Residential Care Regulations sets out a number of preconditions, before the use of restraints can be in place and what needs to subsequently happen. It states:

- (a) all alternatives to the use of the restraint must have been considered and either implemented or rejected;
- (b) the employees administering the restraint must
  - (i) have received training in alternatives to the use of restraints and determining when alternatives are most appropriate, and the use and monitoring of restraints, and
  - (ii) follow any instructions in the care plan of the person in care respecting the use of restraints;
- (c) the use of the restraint, its type and the duration for which it is used must be documented in the care plan of the person in care.

## Written agreement to the use of restraints

The Residential Care Regulations identify that restraints may also be used if there is agreement to the use of a restraint by both:

- (i) the person in care... (or in the case of a mentally incapable resident, their representative of the person in care or the relative who is closest to and actively involved in the life of the person in care), and
- (ii) the medical practitioner or nurse practitioner responsible for the health of the person in care.

This agreement, however, must be in writing. All the regular rules on considering alternatives, staff training, following instructions and documentation still apply. The parties can agree when the need for the restraints will be reassessed in the care plan.

## Post emergency restraint requirements

If restraints have been used in an emergency situation, after that emergency the Operator is required to talk with and provide “information and advice” to the resident who was restrained, anyone who witnessed the restraint’s use, as well as any employee involved in the restraint.(48) This “information and advice” is to be documented in the resident’s care plan.(49)

The regulations also set out a stringent process of reassessment of the need for the restraints. If restraints are used longer than 24 hours or continuously, the Operator must:

- have agreement in writing from the resident or their representative, if applicable and
- the medical practitioner or nurse practitioner responsible for the resident’s health care. (50)

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10. Trespass Act, [RSBC 1996] c. 462, s. 1 (a) and (b) apply to resident; and section s.1 applies to the operator. “occupier”, in relation to premises, means
  1. (a) if the premises are land...or are property described in paragraph (a) of the definition of "premises", a person entitled to maintain an action of trespass in respect of those premises,...and [occupier] includes a person who (d) has responsibility for and control over the condition of the premises or the activities there carried on, or (e) has control over persons allowed to enter the premises; "premises" means land, ... and anything on the land including... (a) a building or other permanent structure,
    1. NOTE: An action for trespass can be maintained by the owner or anyone else who has a lawful right to occupy the property.
11. Residential Care Regulations, B.C. Reg. 96/2009, s. 57 (1). (“RCR”)
12. RCR, s. 57 (2).
13. Even if visiting was characterized as an issue affecting the resident’s health in some way, the TSDM is required to consult with the resident, and act on accordance with the person’s beliefs, values, wishes, and if not known , to act in best interests.
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18. AGA, s. 51 (e) (iii).
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20. RCR, s. 78.1(e)(i).
21. RCR s. 78.1 (e) (ii) “Records for each person in care”. The regulation refers to recording the “identification”, which would include identity \* who”), but possibly might include other things to help staff identify the person, such as vehicle type and license number.
22. RCR, s. 58 (1).
23. RCR, s. 58 (2).
24. Schedule D of the Residential Care Regulation lists and defines 20 events, behaviours and actions that constitute a reportable incident. Section 77 of the RCR also 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. or current data on reported abuse or neglect incidents, see Office of Seniors Advocate, "Monitoring Seniors' Services", p. 15.
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46. RCR, s. 74 (1).
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48. RCR, s. 73 (3) (a).
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This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

## Chapter Four Resources and Appendix

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### Chapter Resources

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### Appendix

#### Health Care Consent: A Quick Overview

A consent complies with the Act if the consent:

- relates to the health care that is proposed;
- is given voluntarily;
- is not obtained by fraud or misrepresentation;
- the adult is capable of giving or refusing consent;
- the health care Operator gives the adult the information a reasonable person would require to understand the proposed health care and make a decision about it, including information about:
  - the condition for which the health care is proposed;
  - the nature of the proposed health care;
  - the risks and benefits of the health care that a reasonable person would expect to be told about, and any alternative courses of health care, including the option of having no health care at all; and
- the adult has the opportunity to ask questions and receive answers about the proposed health care.

## **Schedule D**

[am. B.C. Reg. 205/2013, Sch. 2, ss. 1 and 2.]

(Section 77 [reportable incidents])

### **Reportable incidents**

1 For the purpose of this regulation, any of the following is a reportable incident:

"aggression between persons in care"

means aggressive behaviour by a person in care towards another person in care that causes an injury that requires:

- (a) first aid,
- (b) emergency care by a medical practitioner or nurse practitioner, or
- (c) transfer to a hospital;

"aggressive or unusual behaviour"

means aggressive or unusual behaviour by a person in care towards another person, including another person in care, that

- (a) has not been appropriately assessed in the care plan of the person in care, and
- (b) is not aggression between persons in care within the meaning of this Schedule;

"attempted suicide"

means an attempt by a person in care to take his or her own life;

"choking"

means a choking incident involving a person in care that requires

- (a) first aid,
- (b) emergency care by a medical practitioner or nurse practitioner, or
- (c) transfer to a hospital;

"death"

means any death of a person in care;

"disease outbreak or occurrence"

means an outbreak or the occurrence of a disease above the incident level that is normally expected;

"emergency restraint"

means any use of a restraint that is not agreed to under section 74 [when restraints may be used];

"emotional abuse"

means any act, or lack of action, which may diminish the sense of dignity of a person in care, perpetrated by a person not in care, such as verbal harassment, yelling or confinement;

"fall"

means a fall of such seriousness, experienced by a person in care, as to require emergency care by a medical practitioner or nurse practitioner, or transfer to a hospital;

"financial abuse"

means

- (a) the misuse of the funds and assets of a person in care by a person not in care, or

(b) the obtaining of the property and funds of a person in care by a person not in care without the knowledge and full consent of the person in care or his or her parent or representative;

"food poisoning"

means a food borne illness involving a person in care that requires emergency care by a medical practitioner or nurse practitioner, or transfer to a hospital;

"medication error"

means an error in the administration of a medication which adversely affects a person in care or requires emergency intervention or transfer to a hospital;

"missing or wandering person"

means a person in care who is missing;

"motor vehicle injury"

means an injury to a person in care that occurs during transit by motor vehicle while the person in care is under the care and supervision of the licensee;

"neglect"

means the failure of a care Operator to meet the needs of a person in care, including food, shelter, care or supervision;

"other injury"

means an injury to a person in care requiring emergency care by a medical practitioner or nurse practitioner or transfer to a hospital;

"physical abuse"

means 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;

"poisoning"

means the ingestion of a poison or toxic substance by a person in care;

"service delivery problem"

means any condition or event which could reasonably be expected to impair the ability of the licensee or his or her employees to provide care, or which affects the health, safety or dignity of persons in care;

"sexual abuse"

means any sexual behaviour directed towards a person in care and includes

(a) any sexual exploitation, whether consensual or not, by an employee of the licensee, or any other person in a position of trust, power or authority, and

(b) sexual activity between children or youths,

but does not include consenting sexual behaviour between adult persons in care;

"unexpected illness"

means any unexpected illness of such seriousness that it requires a person in care to receive emergency care by a medical practitioner or nurse practitioner or transfer to a hospital.

[Provisions relevant to the enactment of this regulation: Community Care and Assisted Living Act, S.B.C. 2002, c. 75, section 34]

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

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# 5-Rights, Remedies and Problem Resolution

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## The Need for Effective Remedies and Problem Resolution in Residential Care

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*Even in the best homes, there are bound to be complaints. If residents or their loved ones know how to complain and have their issues resolved, they are more likely to be happy with the care at the home than if they have difficulties in resolving the problem.*

- Jane Meadus, Institutional lawyer, ACE(1)

This chapter identifies some of the legally recognized mechanisms available to address concerns or complaints in residential care facilities. These include residents' rights statements, resident or family councils, the internal dispute resolution mechanisms for care facilities, as well as the tier of external processes within health systems and law to resolve problems. It highlights the scope of and barriers within the mechanisms, as well as existing protections or safeguards for the resident and others when reporting concerns.

The chapter briefly describes how these various legal complaint mechanisms function, as well as the adequacy of the information that health authorities provide about them. (2)It explores residents' rights in care facilities as a method for raising concerns and for interpreting issues. It also touches upon some administrative remedies (such as professional colleges and the care aide/ abuse registry), as well as civil and criminal law remedies. To a large extent, these will be general descriptions of the processes, as there can be important differences in the ways that specific health authorities approach these resources.

When looking at resources and recourses for issues or problems that arise in residential care facilities, it will be important to be aware of:

- **Who can make use of the problem resolution resource or remedy?**
  - Who can complain?
  - Is there a mechanism for situations involving incapacitated persons?
- **What is the process?**
  - What is the focus of the process?
  - What is its scope?
- **What can the resource achieve or do? (make a recommendation, compel action).**
- **How timely is the resource? (in its response, in getting to an answer, in getting to some needed change).**
- **Can it achieve systemic change?**

## The Need for Effective Remedies and Problem Resolution

As a group, the people who live in British Columbia's long term care facilities today are advanced in age, very frail, physically and mentally vulnerable. They are often socially isolated and will be dependent on others for their basic care. (3) For today's resident perhaps more than almost any other group, timeliness and responsiveness are very important issues when it comes to addressing problems that may arise in a care facility.

An increasingly high proportion of the residents will have cognitive impairments, but the degree of the impairment varies among residents. People who might be mentally incapable of making certain decisions, may still be quite capable of making others. These can be important considerations in terms of

- a) how we approach the problems that may arise in care facilities and
- b) how we represent or advocate on behalf of the person or persons.

It is generally recognized that people with dementia can be a high risk group in the community and in residential care. (4) Some who experience harm while in care may be unable to recognize problems or identify the staff person, volunteer, family member or other resident causing the harm. Residents who have cognitive impairments may have difficulty explaining a concern. If they do complain, they may not be believed because of their impairment. Resident to resident harms may also occur in care facilities, sometimes because of the physical environment, unaddressed conditions or as a result of behaviours associated with delirium or dementia. (5)

When older adults move into residential care, they are commonly widowed and their social networks are often very small or non-existent. Without an advocate to help address problems early on, the residents' vulnerability to mistreatment or poor quality care is considered to be high. Long term care residents also have little or no choice about where they live. Today if a resident experiences a problem, transferring from one long term care facility to another is seldom an option as a result of the overall lack of beds in the long term care system.

As a group, residents in long term care institutions often fear negative repercussions if they speak up. This can range from losing the remaining freedoms and small privileges they have, to delays in care or not receiving needed care, to being threatened that they will be discharged ("evicted") from the facility. As a result, residents may not necessarily raise concerns about issues that can significantly affect their lives.

Even when residents or their representatives raise a concern and want to make use of a legal or administrative mechanism to address a problem or concern, there are often significant barriers in being able to do so. Left unaddressed, these problems can undermine the quality of life and quality of care for people residing in care facilities.

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**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## The Basic Recourse Process under CCALA

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### “Complaint”

*“Is an expression of dissatisfaction when an expectation is not met. Although it may appear trivial from a health organization’s perspective, it is a very real problem to the complainant and should be taken seriously. Complaining is a patient/resident/ client/customer’s right and the health care organization has the responsibility to inform its customers how to complain”.*

- Health Association of B.C.

As part of the overall responsibility to assure and support the well-being of residents (“a person in care”), the operators of facilities licensed under the Community Care and Assisted Living Act (CCALA or “the Act”) and Residential Care Regulation are required to establish “fair, prompt and effective” processes for resolving complaints and disputes. (1) The Act also requires operators to ensure that the resident is not subject to retaliation as a result of anyone expressing a concern (“making a report”). (2) Other Acts such as the Human Rights Code offer similar non-retaliation or protection safeguards. (3)

<b>Residential care regulations</b>
<b>Dispute resolution</b>
60 A licensee must:
(a) establish a fair, prompt and effective process for persons in care and their parents or representatives, family members and contact persons to express a concern, make a complaint or resolve a dispute,
(b) ensure that there is no retaliation against a person in care as a result of anyone expressing a concern or making a complaint, and
(c) ensure that all complaints, concerns and disputes are responded to promptly.

The Regulations require operators to inform residents and their representatives on admission about facility's complaints process and how they can complain to the local health authority's Medical Health Officer (Licensing) and the Patient Care Quality Office. (4) Operators are also required to record any complaints they receive, plus document how they responded to them. (5)

Operators may identify the complaint process in the admission agreement and may specify how the person is expected to raise concerns. Some operators may have an "internal ombudsperson" so that concerns can be directed to one person who will be responsible for follow-up. It is important to note the law does not require the resident or other person to use a step by step ("start internally and escalate if necessary") process. Although this might commonly be advisable, there may be good reasons why a resident or other person might not do that. For example, the operator or people responsible for the internal complaint mechanism may be part of the problem, previous efforts may have gone unaddressed, or the effort has otherwise been shown to be futile.

Under Community Care and Assisted Living Act and the Regulations, 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." (6) While this offers flexibility, this can result in wide variations in the complaints processes among the facilities across the province. As a result, the BC Ombudsperson recommended the Ministry of Health take a more standardized ("specific, legalized") approach with timeframes and records. (7) While on its face a laudable goal, there may be numerous challenges with a standardized approach. (8)

## **Concerns About Raising Concerns**

Identifying issues and concerns in a care facility and having them addressed in an appropriate, timely, and effective manner is essential to the respecting the rights and dignity of residents, as well as assuring their wellbeing. It can help prevent crises, or recurrence of issues. However, it is very commonplace for residents, as well as family, friends, or others including staff to be very cautious about bringing facility related concerns to the attention of persons who may be able to resolve the issues.

### **Why the apprehension?**

Residential care can be a relatively socially isolated environment. Residents often have small social networks before coming into residential care and may lose their remaining ties with family, friends and rest of the community. This happens for many reasons, including having to leave their friends and community because of "first appropriate bed" policies. Many residents recognize that they are very dependent on staff and others for care, and are often cautious about expressing anything that might be viewed as "rocking the boat". Other residents may not have the physical capacity or mental capacity to identify problems or report their concerns.

Family members and friends are often concerned about the potential for adverse consequences for the resident when they are not there, as well as for themselves (such as restrictions on visiting). (9) Volunteers are there at the largesse of administration. Staff may be concerned about risking their job, including ending up with reduced hours or less favourable shifts, especially if they are casual and part-time workers. Sometimes people's reactions simply reflect fear of the unknown. In other instances, these are reasonable responses to previous situations that may not have been handled well in this care facility or others.



## Reporting Protections

### Who is protected and when?

The CCALA and its accompanying Regulations recognize these realities and offer some protections. In addition to requiring the operator have a fair, prompt and effective process for expressing and addressing concerns, the Regulations specifically note that, the operator must ensure that there is no retaliation against a resident (“person in care”) as a result of any person expressing a concern or making a complaint. (10) All complaints, concerns and disputes are expected to be responded to promptly. (11) That places a positive duty on the Operator to address problems and concerns promptly. Both CCALA and the Adult Guardianship Act offer reporting protections to the resident, staff and others, but to different degrees. See Figure 1 for a summary.



The CCALA, for example, offers residents specific protection against retaliation and adverse consequences. The Operator must not alter, interrupt or discontinue, or threaten to alter, interrupt or discontinue, service to a resident, where a person has made a report or has expressed an intention to do so. (12)The Operator or any other person cannot act in a way that negatively affects service to resident as a result of an abuse report or intention to make the report. (13)Staff and other people also have certain protections if “abuse” reports are made in good faith.

#### Special Note: Who’s protected and when?

It can be challenging at times to understand the scope of existing reporting protections, leading to the question, “So who is protected and when?” The Residential Care Regulations definitions are specifically framed in the context of “reportable incidents”. This leaves the possibility that residents, families and staff may not be protected from adverse consequences when raising concerns that do not fall in this narrow framework.

The abuse reporting protections of the Adult Guardianship Act(AGA) apply to all settings including residential care, although the AGA has not traditionally been used in this setting. (14)The AGA safeguards protect the identity of all good faith reporters. Section 46 (4) of the AGA offers certain employment and professional protections for people who report in suspected abuse or neglect of vulnerable adults made in good faith to a “designated agency” (generally health units in the community).(15) Residents and other people are protected against intimidation and coercion when an abuse report has been made in these circumstances. See Figure 1.

### Figure 1 Reporting Protections

	<b>Residential Care regulations</b>	<b>Community Care and Assisted Living Act</b>	<b>Adult Guardianship Act</b>
<b>Residents are protected against</b>	Retaliation (16)(irrespective of who raises the concern). Non specific	Retaliation – licensee or other person cannot negatively affect service to a resident, as a result of an abuse report, or intention to make a report (17)	<ul style="list-style-type: none"> <li>• Having identity disclosed (as a reporter)(18)</li> <li>• Threats, (19) intimidation, coercion (20)</li> <li>• Being penalized (pecuniary or otherwise) (21)</li> </ul>
<b>Staff are protected against</b>	(see CCALA)	<ul style="list-style-type: none"> <li>• No action or other proceeding if a report is made in good faith. (22)</li> <li>• Licensee must not take action against employee or agent for reporting (23)</li> </ul>	<ul style="list-style-type: none"> <li>• Having identity disclosed (as a reporter) (24)</li> <li>• Employment or professional repercussions (25)</li> <li>• Being penalized (pecuniary or otherwise) (26)</li> </ul>
<b>Others are protected against</b>	(see CCALA)	No action or other proceeding the report is made in good faith (27)	<ul style="list-style-type: none"> <li>• Having identity disclosed (as a reporter) (28)</li> <li>• Intimidation, coercion (29)</li> <li>• Being penalized (pecuniary or otherwise) (30)</li> </ul>

### Are these protections limited to abuse reports?

On its face, these protections appear to only cover “abuse” reports. However, the definitions for abuse and neglect, especially the definition of “neglect” in Schedule D of the Residential Care Regulations, are fairly broad to reasonably include reports being made about many quality of care matters affecting residents.

**Figure 2**

<b>Types of Harm</b>	<b>Residential Care (Definition used for “Reportable incidents”)</b>	<b>Adult Guardianship</b>
<b>Abuse</b>	Abuse is not specifically defined, see details for the various types	General defn: "abuse" means the deliberate mistreatment of an adult that causes the adult <ul style="list-style-type: none"> <li>• (a) physical, mental or emotional harm, or</li> <li>• (b) damage or loss in respect of the adult's financial affairs,</li> </ul> and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors
<b>Neglect</b>	"neglect" means the failure of a care provider to meet the needs of a person in care, including food, shelter, care or supervision	
<b>Physical Abuse</b>	"physical abuse" means 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	

<b>Sexual abuse</b>	"sexual abuse" means any sexual behaviour directed towards a person in care and includes any sexual exploitation, whether consensual or not, by an employee of the licensee, or any other person in a position of trust, power or authority, ... but does not include consenting sexual behaviour between adult persons in care	
<b>Emotional abuse</b>	"emotional abuse" means any act, or lack of action, which may diminish the sense of dignity of a person in care, perpetrated by a person not in care, such as verbal harassment, yelling or confinement	
<b>Financial abuse</b>	"financial abuse" means <ul style="list-style-type: none"> <li>• (a) the misuse of the funds and assets of a person in care by a person not in care, or</li> <li>• (b) the obtaining of the property and funds of a person in care by a person not in care without the knowledge and full consent of the person in care or his or her parent or representative.</li> </ul>	

## Threats of Being Sued

Identifying and addressing problems in care facilities is a socially important matter that needs to be dealt with fairly and in a responsive manner. On rare occasion, a British Columbia operator has initiated a defamation lawsuit against a third party who has publicly identified problems in a residential care facility, on the basis that the comments damaged the business's reputation. When this occurred in another Canadian jurisdiction the operator's lawsuit was not successful; the court considered it in the public interest to raise these issues. (31)

In some instances, a lawsuit may have been initiated to purposefully create a chilling effect so that people will not complain about the quality of care that residents receive. At common law, there are important defences for operators, staff, family and residents to be aware of in this area, including the truth ("justification"), "qualified privilege", "fair comment", and "responsible communication on matters of public interest". (32)

The last of these, responsible communication on matters of public interest, is a new defense identified by the Supreme Court of Canada in 2009. (33) It requires two things: first the published comments must be on a matter of public interest (comments about quality of care in a facility, abuse, or neglect would be good examples). Second, the defendant must show that publisher was responsibly diligent in trying to verify the allegation(s), having regard to all the relevant circumstances.

## References

1. RCR Regulations, s. 60.
2. CCALA. s. 22 (3) and Regulations,
3. Human Rights Code [RSBC 1996] c. 210, s.43.
4. RCR Regulations, s. 48 (b).
5. RCR Regulations, s. 89.
6. BC Ombudsperson (February 2012). Best of Care Getting It Right For Seniors In British Columbia (Part 2), Public Report 47., F. 117 ("Ombuds, Best of Care").
7. Ombuds, Best of Care, Recommendation 148.
8. It can make it harder for the operator to prioritize the concerns in the facility. Some operators may simply leave matters to the last and yet legally be "in time"; other may respond "in time" but in an unsatisfactory manner.
9. For more information on control of visiting, see Chapter 4 on Legal Issues When Living in Residential Care.

10. RCR Regulations, s. 60 (b).
11. RCR Regulations, S. 60 (c).
12. CCALA, s. 22.
13. CCALA , s. 22 (3) - must not alter, interrupt or discontinue, or threaten to alter, interrupt or discontinue, service
14. The AGA was raised in the residential care case of Bentley v. Maplewood Seniors Care Society, 2014 BCSC 165 to prevent family from removing Margot Bentley from the facility when the family disagreed with the staff about spoon feeding her at this stage of dementia, apparently against her pre-expressed wishes. ["Bentley v. Maplewood"]
15. AGA, s. 46 (4) These include, for example protections from being threatened with dismissal, refusing to employ or to continue to employ a person, or discriminating against a person with respect to employment or a term or condition of employment or membership in a profession or trade union.
16. RCR, s. 60 (b).
17. CCALA, s. 22 (3)- must not alter, interrupt, or discontinue service
18. AGA, s. 46 (1).
19. AGA, s. 46(4)(b).
20. AGA, s. 46 (4).
21. AGA, s. 46 (4)(d).
22. CCALA, s. 22 (1).
23. CCALA, s. 22 (2)
24. AGA, s. 46 (1).
25. AGA, s. 46 (a), (c) and (d).
26. AGA, s. 46 (4)(d).
27. CCALA, s. 22 (1).
28. AGA, s. 46 (1).
29. AGA, s. 46 (4).
30. AGA, s. 46 (4)(d).
31. Leisureworld (Ontario). The use of defamation is considered a SLAPP lawsuit (Strategic Lawsuits Against Public Participation,) basically brought to prevent complaints being raised.
32. Canadian Bar Association, BC Branch. Defamation: Libel and Slander , Script 24. Online: <http://cbabc.org/For-the-Public/Dial-A-Law/Scripts/Your-Rights/240> (Last accessed January 9, 2016)
33. Grant v. Torstar Corp., 2009 SCC 61, [2009] 3 S.C.R. 640

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# Starting Points for Problem Resolution

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## Residents Rights

Chapter 2 introduced the Residents' Bill of Rights which can be found in the Schedule to the Residential Care Regulations. The Bill of Rights is typically seen as an important statement of rights that can be used to help inform residents, family and friends, as well as administration, staff and volunteers. It reinforces the fact that people receiving care, as well as their family and friends are not expected to (and do not) "leave their rights at the front door."

## Context of the Bill of Rights

The rationale of the Bill of Rights was to

- clarify and help promote the rights of residents (1)
- "reduce misunderstandings and miscommunications and facilitate consistency of expectations and service delivery"
- assist in the early recognition and resolution of complaints.

The Bill of Rights flows out of Section 7 of the CCALA. This section is a general provision that identifies the standards for the licensee or manager is required to maintain. This includes

- **(i) operating the community care facility in a manner that will promote**
  - the health, safety and dignity of persons in care, and
  - the rights of adults persons in care, plus
- **(ii) employing "only persons of good character who meet the standards for employees specified in the regulations".**

As previously noted, the Bill of Rights is educative (2) and provides context. It can help residents and others know their rights, as well as how to raise concerns and complaints better. It also has considerable potential for helping people approach the diverse issues that may arise in care appropriately, focusing first on the resident ("person-centred"). The Bill of Rights places responsibilities on the facility staff, the operator, and the health authorities to respect and promote the rights. However, while all these identified rights in the Bill of Rights are important, there is a risk that by focusing on these rights, operators, staff, residents, family, advocates or even people providing redress are left with the mistaken impression that other rights which the people have are absent or less important in residential care. (3)

As previously noted in Chapter 2, in British Columbia, the Bill of Rights does not give rise to a separate basis of legal action (that is a person cannot sue for breach of contract or negligence, based solely on a violation of the rights). However, it is an important legal mechanism to interpret and understand the required approach to care and quality of life for residents. It can also provide supporting evidence if an issue needs to go through administrative or other legal channels, including civil lawsuits. (4)

### **Special Note**

The Residents' Bill of Rights does not give rise to a separate basis for legal action. However, it is an important legal mechanism to interpret and understand the required approach to care and quality of life for residents. It can be evidence of Operators' and Health Authorities' duties to residents.

### **Its Scope**

The Bill of Rights in the Residential Care Regulations is a combination of human rights, individual freedoms, consumer rights, care and representation rights, as well as policy expectations. The document covers four domains or themes:

- (a) commitment to care;
- (b) rights to health, safety and dignity;
- (c) rights to participation and freedom of expression; and
- (d) rights to transparency and accountability.

The Bill of Rights identifies that these rights are not passive; they are to be respected, actively protected and promoted by the operator, staff and health authorities. Operators have a responsibility to prominently display the Bill of Rights in a prominent place in the facility so that residents, staff and other people are aware of the rights. (5) The operators also have a responsibility to make the residents' rights "known, orally and in writing, to persons in care and their families and representatives."

The term "family" is not defined in this context. The Bill of Rights, however, is expected to be interpreted in a wide and purposive manner. The term can reasonably be taken to include any person that the resident formally or informally identifies as supportive and acting on their behalf, which may include relatives, extended family, close friends or neighbours. The Residential Care Regulations defines "representative" as those with authority to make health or personal care decision on behalf of the adult under specific pieces of legislation. (6) That may include legally authorized representatives (committee, person appointed under a representation agreement or power of attorney, statutory representatives- temporary substitute decision-maker).

The scope of the rights is set out in the last clause. The listed rights are placed in the context of

- the rights of other residents;
- what is reasonably practical given the resident's physical, mental and emotional circumstances; and
- the need to protect and promote the resident's health or safety or that of another resident.

However whenever there is an effort to justify a limiting a particular right, these will need good evidence from the operator to justify that limit or restriction. Bills of Rights are expected to be given broad interpretation that will match their underlying purposes.

The Bill of Rights is not a new idea to long term care. To a large extent, it is a codification and simplified statement of operators' and staff's legal responsibilities set out in the residential care regulations, which have been in place for over two decades. While the Ministry of Health has described these rights as "comprehensive", (7) these are at best a brief statement of only some of the rights held by residents in care facilities.

Residents (along with their families and friends) retain all their rights and entitlements as adults. This includes, for example, common law rights, rights under provincial or federal laws, the Canadian Charter of Rights and Freedoms in respect of government actions, as well as rights from other sources (e.g., duties that are described in medical codes of ethics).

## Compliance

Compliance with the Bill of Rights is monitored in two ways. Patient Care Quality Offices of each health authority (described below) are required to track complaints about non-compliance with the Residents' Bill of Rights and report this information to the Ministry of Health on a quarterly basis. The community care facilities licensing programs (also described below) within each health authority are required to monitor the facility's compliance with the rights, typically as part of routine or unscheduled inspection by licensing.(8)



## Information rights (The right to know)

The specific provisions of the Bill of Rights are described in detail in Chapter 2. Section 4 of the Bill (rights to transparency and accountability) is particularly germane to remedies and problem resolution. It sets out that residents have a right to ready access to:

- (a) copies of all laws, rules and policies affecting a service provided; (9)
- (b) a copy of the most recent routine inspection record made under the Act. (10)

Section 4 of the Bill of Rights also sets out the consumer rights of residents to know in advance what they will be charged for accommodation and services, and any refund options. (11) It also sets out that residents have a right to have their family or representative informed of all these requirements in order to have greater transparency and better accountability (12) so that people can help residents properly exercise the rights.

The Bill of Rights does not set out how this information is to be provided. It does however mean that residents, their family or representative have the right to expect their requests for information (for example about what has happened, why particular actions are being taken) will be answered in a timely manner by the staff, administration, or the health authority, according to the situation.

## Family and Resident Councils

The Bill of Rights and the Residential Care Regulations specifically acknowledge the importance of residents and others having direct means to raise concerns and have these addressed in the care facilities. One of the vehicles for this is resident or family councils.

### What is a Family or Resident Council?



The Ministry of Health uses the following definition for the councils:

“A resident/family council is a group consisting of persons in care and/or their representatives, family members and contact persons who work together with staff to maintain and enhance the quality of life of residents and to provide a voice in decisions within the facility that affect them.” (13)

The membership thus is wider than just those with legal authority to speak for an individual resident. A resident council is a group of persons who live in a residential care facility. A family council is a group of persons who are the contact persons, representative or relatives of care facility residents. Both types of councils meet regularly for a common purpose related to discussing and working to promote residents’ wellbeing, as well as address issues or concerns within the care facility.

Both family councils and resident councils are intended to be self-led, self-determining and democratic. (14) According to the government resources “Councils exist to engage the resident community in collaborative activities which will advance the quality of life for residents.” A staff liaison from the residential care facility may be appointed to support and facilitate the council.

One of the key roles that a family council or a resident council can play is to promote improved communication and collaboration between family members and the facility staff or management. This may involve working collaboratively on projects that enrich the lives of persons in care, making recommendations to decision makers, communicating common concerns and ideas for improvements.

### Role, mandate

Resident and family councils provide an opportunity to provide support to staff and management in efforts to provide quality care. If members of the resident family council have concerns or complaints they are expected to work with the “facility representative” to seek a collaborative response to the concern. If the concern or complaint is not resolved by this, the council is expected to follow the steps and processes of the facility including contacting the Facility Operator.

The Ministry of Health appears to suggest that Councils can take a matter of concern to the Patient Care Quality Office (“PCQO”, described below), and if needed to the Patient Care Quality Review Board. This, however, does not represent the reality of the PCQO process.



## **Strengths and Limitations**

Family and Resident Councils face a number of challenges to becoming an effective recourse for addressing concerns within a residential care facility or among facilities. First, few residents or family are there long enough to be involved in a council. A high percentage of the residents may be experiencing some degree of cognitive impairment, making participation in residents councils far less likely or less intensive and responsive.

At the same time, there continues to be significant barriers in British Columbia to creating and maintaining family councils. There is a lack of knowledge among families and other supporters of how the health care, residential care and related systems work (“institutional knowledge”). It can take a lengthy period of time (months, even years) for people to understand how their particular facility functions and the potential positive role and function of the councils. It has been noted by council members that just as people begin to gain an understanding of this, “their resident” dies and in most cases, the family member loses contact with people at the facility. The lack of continuity of institutional knowledge can be further weakened where care facility operators try to require that council members who no longer have a resident living there anymore resign and no longer participate. (15)

## **What is the legal requirement for Family/ Resident Council?**

The requirements and support for Family/ Resident Council are not as strong in British Columbia as some other provinces. (16) However, the Residential Care Regulations sets out a number of minimum standards:

1. The operator must provide an opportunity at least once a year to establish a council or similar organization to represent the interests of the persons in care, or their parents or representatives, family members and contact persons, or both.
2. The operator must also meet with the council or group at least once a year to
  - (i) promote the collective and individual interests of the persons in care, and
  - (ii) involve the persons in care in decision making on matters that affect their day to day living.

Unfortunately some operators may treat these minimum requirements as all they have to do. Others become obstructionist, attempting to impose rules (such as having the Director of Care attend the council meetings) which may make it very difficult for family council members to have open discussions of concerns or to plan how they might like to have these matters addressed.

British Columbia’s law is silent on the specific powers of Family and Resident Councils. However, these examples from other jurisdictions can be useful. Effective Councils can

- Provide assistance, information and advice to families and friends when new residents are admitted to the care facility
- Provide information and advice to families and friends about their rights and obligations under the Act
- Provide information and advice regarding the rights and obligations of the care facility
- Help to resolve disputes between the Care Facility and residents
- Sponsor and plan activities for residents
- Collaborate with community groups and volunteers concerning activities for residents.

### **Common issues affecting Family and Resident Councils**

- **Can the Director of Care require that the Director or a staff member attend the Family or Resident Councils meeting?** No, the meetings are for the benefit of the residents and those concerned about them. That means people need a place to air concerns openly, safely and in private among themselves. Problems or misconceptions can often be addressed at that level.
- **What does the Facility have to do to support a Family Council?** The regulations only refer to giving the opportunity to establish a council. This provision must be interpreted in light of its purpose and the Resident's Bill of Rights. At a minimum, that would mean to have an onsite space to meet in private, regular notices to family and others that the council exists and when it meets, and that it is open to all. This may be part of admission information package, but also needs additional reinforcement and encouragement.
- **Who is Family?** Can people other than family organize or support a council or similar group? People have widely differing ideas about who or what is family. The term should be interpreted widely. The regulations do recognize the possibility of other groups organizing for the benefit of the resident.
- **Timeliness of Response:** Even where a Council is able to identify and raise issues with the Operator, there is nothing to require the operator to respond to concerns in a timely manner.

### **References**

1. Office of the Ombudsperson Best of Care Part 1 , pg 28-29.
2. Report on Assisted Living in BC. BCLI Report no. 72, CCEL Report no. 7 September 2013, pg. ["Assisted Living }
3. Assisted Living
4. See Bentley v. Maplewood.
5. CCALA, s. 7 (1) (c) and (c.1) (i) and (ii).
6. Specifically the Health Care (Consent) and Care Facility Admission Act, the Patients Property Act, and the Representation Agreement Act.
7. Ministry of Health. Community Care Facilities . "Residents Bill of Rights". Online: [http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/pdf/adultcare\\_bill\\_of\\_rights.pdf](http://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/pdf/adultcare_bill_of_rights.pdf) ["Bill of Rights"] (Last accessed January 9,2016)
8. Bill of Rights.
9. RCR, s. 4 (a).
10. Bill of Rights , s. 4 (b). Note : A summary of the care facility's inspection record is also available online.
11. Residents' Bill of Rights, s. 4 (c ) and (d).
12. Residents' Bill of Rights, s. 4 (e).
13. Guidelines, p.2
14. Ministry of Health. Home and Community Care. Accountability: Family and Resident Councils. Online <http://www2.gov.bc.ca/gov/topic.page?id=96139325762343BB9F289A0C0F73D868> (Last accessed January 9, 2016)
15. Ostensibly the reason for not including people whose family are no longer residents at the facility is a fear of "political advocacy".
16. For example Ontario's Long-Term Care Homes Act, 2007, S.O. 2007, c. 8, s. 59-60 identifies the responsibility of the licensee to promote the establishment of the Family Council and respond to Council concerns in a specific timeframe. It sets out specific powers of the Council including rights to see the Licensee's funding agreement information.

This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

## Operator Responsibilities in Residential Care

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Operators have a general responsibility under the Residential Care Regulations to perform a criminal record check and obtain character references before hiring any employee. (1) Operators also have an ongoing responsibility to monitor their employees' performance. (2)

The following are the general criminal record check requirements:

- Newly hired staff must complete the criminal record check process immediately.
- Employers must make sure employees get a criminal record re-check every 5 years.
- Regulated Health professionals identified under the Criminal Records Review Act (3) are not required to resubmit a new criminal record check application.
- Employers are responsible to verify that criminal record checks have been completed.

All new criminal record checks are now conducted by the Criminal Records Review Program (CRRP) under the Ministry of Public Safety and Solicitor General. This eliminates the option of going to the local police detachment.

### References

1. Residential Care Regulation, s. 38. ("RCR")
2. RCR, s. 40 (1).
3. Criminal Records Review Act [RSBC 1996] c. 86

This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

# Directing Concerns to Health Authorities

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People who are not satisfied with the way that a facility Operator or staff has handled their concern, or who do not want to take the matter directly to a facility, can take the matter to the regional health authority. Their options depend on whether the facility in question is licensed under the Community Care and Assisted Living Act or governed by the Hospital Act. Another factor that makes a difference is whether the cost of care is subsidized or not.

## Patient Care Quality Office

Every health region in B.C. has a Patient Care Quality Office. If a person feels that a care concern regarding a facility has not been addressed internally, and the person wants to make a formal care quality complaint, they can contact the Patient Care Quality Office in that health region.

### Role, mandate

The purpose of a PCQO is to receive and address complaints from “patients” about the quality of health care they have received (1)(or in some cases, the health care which the person should have received but did not). Residential care facilities licensed or funded by health authorities are covered by the Patient Care Quality Review Board Act.(2) The Office can receive a wide variety of care quality concerns. Most by definition relate to care – for example, deficiencies in care, misdiagnosis, or medication-related concerns. The second most common type of matters dealt with by the PCQO relate to the health care provider’s attitude and conduct, followed by accessibility (which includes issues such as eligibility to be admitted to a care facility, wait-times for treatment, test results and the availability of services), lack of communication (such as explanation about medical conditions or procedures), and “environmental issues” (which includes matters such as food services, and housekeeping).

### Scope

A local PCQO can only accept and deal with complaints that relate to that particular region (health authority). Complaints that relate to a different region or health authority may be referred to the PCQO in that region. In some instances, jurisdiction can be difficult to determine - for example if a matter affects a couple who want to live together in residential care, one of whom is currently in one health authority and the other who is another, which health authority’s PCQO has the jurisdiction?

There are certain matters with which a PCQO cannot deal. These are referred to as “external complaints”, and the PCQO is expected to help identify that appropriate body to which the concern should be addressed.

### Process

Complaints to the PCQO can be made verbally, in person, by phone or in writing.

The Office is expected to deal with the complaint promptly and fairly and has specific timeframes in which to work. The PCQO must acknowledge receipt of complaints in two (2) business days and complete the investigation within 30 business days.

The complaint process is not supposed compromise access or service. Once the complaint is formally registered, the Office works with the complainant to resolve the issue. The Office is required to respond within 40 business days (8 weeks) to explain any actions taken and decisions made. (3) If the Office cannot help with the complaint, they may refer to an agency or body who can (“external complaints”).

The PCQOs in each health authority must report the outcomes of their investigations to the person who made the complaint, and let them know they have a right to a further review by the local patient care quality review board if they remain dissatisfied.

### **Available remedies from PCQO?**

The way that the problem may be resolved by the PCQO will depend on the specific issue at hand, and the willingness of the parties. It is difficult to determine what remedies are available to the PCQO and what authority it actually has. In most cases, people bringing concerns to the PCQO are interested in resolving the matter for their situation, plus preventing its occurrence for others. (4)

### **Review of Complaint or Concern**

If the person is dissatisfied with the response or “resolution” of the complaints brought to the PCQO, the matter can be brought to the attention of the Patient Care Quality Review Board discussed below. The Patient Care Quality Review Board can also reviews complaints if the Office has not responded to the complainants within 40 business days.

### **Use**

Only about seven percent of all the 4558 complaints made to the Patient Care Quality Offices (PCQO) throughout the province in 2012 related to residential care. However, the Seniors Advocate noted that the PCQO received 621 complaints related to residential care in 2014/15 (nearly double the 2012 figures).(5) A 2012 review of the PCQO and PCRB systems noted that the PCQ program is largely geared to addressing concerns in acute care and there are systemic challenges in being able to effectively serve people in residential care or residents of small communities. Personal relationships and fear of retribution were seen as significant barriers to any complaint process. (6)

The legislation generally requires PCQO complaints to be handled on a first-come, first-served basis; this does not facilitate triaging according to case severity. (7) The PCQ program predominantly serves English-speaking Caucasians. (8) It has also been pointed out that the intended focus of the PCQ program is unclear— is it expected to be providing a process for managing complaints, resolving complaints or identifying opportunities for improvement? (9)

### **Patient Care Quality Review Board**

If a concern or complaint is not satisfactorily resolved by the local Patient Care Quality Office, the person can have it independently assessed by the Patient Care Quality Review Board. The Review Board is a separate organization that reports to the Minister of Health. The first boards were appointed in October 2008.

These Review Boards are governed by the Patient Care Quality Review Board Act and External Complaint Regulation in how they review complaints as well as what can and cannot be reviewed. The boards may review any “care quality complaint” regarding services funded or provided by a health authority, either directly or through a contracted agency. (10) The boards may also review complaints regarding services expected, but not delivered, by a health authority (for example, a complaint regarding a cancelled surgery). The term “care quality complaints” also refers to the specifics of the health care services as well as the quality of the health care or “services related to health care”.

**Important: The boards may only review complaints that have first been addressed by a health authority’s Patient Care Quality Office.**

"health care" means anything that is provided to an individual for a therapeutic, preventive, palliative, diagnostic or other health related purpose, and includes

- (a) a course of health care, and

- (b) other prescribed services relating to individuals' health or well-being

## The Process

The individual will be asked to provide basic contact information, details about the complaint, the Patient Care Quality Office's response, other steps taken to resolve the issue and the outcome, or remedied desired, all of which the review board needs in order to process the request.

## Who Can Complain

Under the Act, two types of people can lodge a complaint to the PCQO and PCRB:

- (a) the individual “to whom the health care or service was delivered or not delivered” (the “patient”) and (11)
- (b) a person “authorized under the common law or an enactment to make health care decisions in respect of that individual, the person having that authority”. (12)

### Note: Third Party Consent Form

If the person is making the review request on behalf of another individual, the review board must obtain the consent of that person before proceeding with a review (Third Party Consent Form). By law, the review board cannot collect, use, retain or disclose a person's personal health information without his/her consent. This is a significant problem, as most people in care would not be able to consent and do not have people who can legally act on their behalf.



## Scope

### Are the rights listed in the Bill of Rights, “health care services” and therefore do they come under the scope of the Patient Care Quality Review Board?

Yes. The Patient Care Quality Review Board website specifically notes the existence of the Bill of Rights and points out that people can make formal complaints to the PCQO on these matters. (13)

### What can a Patient Care Quality Review Board review?

The boards can review:

- complaints about the quality of any health care service under the jurisdiction of the health authorities (these complaints must first have been addressed by a health authority's local Patient Care Quality Office),
- complaints about services that were expected, but were not delivered by the health authority,
- complaints that have not been addressed by the Patient Care Quality Office within 40 business days, and
- matters directed by the Minister of Health. (14)

There are a number of legal matters related to care quality that the Review Board *will not review*. For residential care, these include complaints about:

- involuntary admissions under the Mental Health Act (that would include involuntary transfers from the hospital to a residential care facility, or vice versa)
- a decision by a Medical Health Officer or Licensing officer under the Community Care and Assisted Living Act
- a decision of the Community Care and Assisted Living Act Appeal Board. (15)

It is unclear whether "unreviewable Licensing decisions" might include Licensing not responding to (or deciding to not investigate) a complaint.

The Review Board also cannot hear certain matters related to:

- health professionals providing services in private practice,
- health care or related services paid for entirely by the "patient, or by the patient and a private insurer (e.g. dental care, alternative therapies, fully private pay services)
- health care or services provided in privately funded facilities, unless these are provided under contract with a health authority.

## **Residential Care Issues**

Examples of residential care issues brought to the Review Board to date include: infection outbreaks; a resident's loss of a subsidized residential care facility bed after being discharged from acute care facility; concerns about assisted bathing and toileting at a residential care facility. (16) Although the PCQRB states that only three of two hundred requests for review received in 2012/13 dealt with residential care, it is clear that some concerns seen in acute care such as falls from beds would also come within scope in residential care.

## **Recourse**

The review board can make a broad range of recommendations. For example, they may recommend that the health authority's Patient Care Quality Office reconsider the complaint, or may recommend specific changes in policies, procedures and practices to improve patient care quality. (17) The review board may ask the Minister of Health to consider directing the Health Authorities as a whole to take certain steps. The Boards may comment on the appropriateness of fees charged by a health authority, but will not make recommendations regarding reimbursement.

A health authority might be asked to review a current protocol (such as a delirium protocol or a falls prevention protocol), with specific suggestions on how to implement it better. Administration of the facility might be asked to meet with the resident's family to review a care plan. Nonetheless, the people expressing the concern about the quality of care may not feel the actual situation in the facility has been resolved. For example, in one Patient Care Quality Office case about perceived negligent care, the recommended "care plan review" led to the resident being discharged from the care facility to the family. (18) That approach does not address the underlying issue of the quality of care in the facility.

The review boards are required to submit an annual report to the minister. In addition each PCQRB can also submit recommendations for improving patient care to the minister or to the health authority.

## Volume

The PCQO received about 5000 care quality complaints in 2011/12, over 4500 in 2012/13 and over 7100 in 2014/15. Less than 2% of the complaints (90 cases in 2012/13 and 100 in 2014/15) received by the PCQO were reviewed by the Patient Care Quality Review Board.

## 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 licensed under the CCALA meet the requirements of that Act and its regulations. Licensing officers carry out the routine inspections for care facilities.

Anyone who is concerned that a facility is not meeting the CCALA requirements can complain to the licensing office for that area. By law 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. (19) In practice, however, the responsibility for conducting these investigations is delegated to licensing officers who are employees of the health authorities. The duty of the licensing office for the inspections is owed to the public, as opposed to individuals. (20)



It is often unclear whether complaints should be brought to the PCQO or to Licensing. Licensing tends to focus complaints that can be tied to specific Residential Care Regulations, and inspections/paper trails. Licensing also has considerable regional variation in how or whether they respond to complaints. Some health authorities, as Vancouver Coastal will note in their inspection reports whether there are any Bill of Rights complaints/ infractions, but other health authorities do not.

### Advocacy Points

Residents, families or others concerned about the care in a residential care facility may have difficulty expressing their concern in a way that makes sense or appears to fall within the jurisdiction or the responsible body or authority. Advocates can help by

- Identifying that the licensed facility is not fully meeting the legislated requirements, and where possible,
- Identifying specific areas where the requirements are not being met by reference to the CCALA or the Regulations.

The Act gives medical health officers and their delegates (the licensing 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. Currently health authorities receive very few formal (licensing) complaints relative to the number of licensed facilities and beds. (21)

The Ombudsperson has criticized the fact that private hospitals are not required to be regularly inspected like residential care facilities, and has made recommendations to the health authorities on this matter. (22) Fraser Health now states it is conducting these regular inspections for private hospitals. (23)



### **Complaints against Private Hospitals**

The CCALA does not apply to facilities governed by the Hospital Act. Licensing officers are not authorized to investigate complaints about those facilities. As a result, older adults residing in facilities governed by the Hospital Act have fewer options for pursuing complaints than older adults who live in CCALA facilities, even though they have the same care needs delivered by similar persons in similar circumstances. (24)

### **How Licensing Complaints Are Investigated**

A Guide to Community Care Facility Licensing in British Columbia outlines the Ministry of Health's draft policy on investigation of licensing complaints. The health authorities have also developed their own policies to guide licensing investigations as well.

When a person complains that a facility is not complying with the CCALA or the Residential Care Regulations, licensing officers are expected to document and respond to the complaint in a timely and appropriate fashion. The specific steps that the licensing officer uses are:

1. determine whether the concern falls within their jurisdiction, and contact the agency that funds the facility, if applicable. [If the complaint involves a possible criminal matter, the licensing officer is expected to contact the police.]
2. determine the nature of the complaint and its urgency, including whether anyone in care is at risk and, if so, to what degree.
3. 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 CCALA or its Regulations. 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 expected to document all of these steps. Violations are categorized under one of ten categories: Care and/or supervision; Hygiene and communicable disease control; Licensing; Medication; Nutrition and food services; Physical facility, equipment and furnishings; Policies and procedures; Program; Records and reporting; and Staffing. (25)

If a licensing officer concludes that a contravention has occurred, the officer must then decide whether to recommend that the regional medical health officer take any steps to adjust the facility's licence (conditions, suspend or cancel). Medical health officers have the authority to attach terms and conditions to a licence, suspend or cancel a licence. Terms and conditions are requirements above and beyond those of the Act or Regulations.

"Terms and conditions may be used when a licensee needs more direction than the statutory requirements to ensure that the health or safety of persons in care is properly maintained." (26)

Some examples of licensing conditions include

- 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,
- requiring a facility to increase the hours of its on-site manager, (27) and
- requiring the facility to have a new manager. (28)

Compliance with terms and conditions is required to continue to operate the facility. Terms and conditions are written on the facility licence and posted at the facility. The operator can request reconsideration (or seek an appeal) when terms and conditions are attached to the license.

## **The Approach: Education and Progressive Compliance**

According to the Ministry of Health, the purpose of community care licensing is to prevent risk of harm. This is accomplished through working proactively with applicants for a community care facility licence, assessment of applicants, ongoing monitoring of the facilities, risk assessment, and inspection of licensed community care facilities. (29) New facilities are automatically considered high risk because they do not have a track record.

By law, the most recent routine inspection record is required to be accessible to residents and families. (30) However, the publicly available records are written and coded in a way that is not useful to the public to determine either the nature of the violations or how serious they are.

## **Local Ethics Committees**

Frequently health care matters in care facilities, particularly related to consent and treatment can lead to disputes between the health care providers and residents or their families, between family members or between health care providers. At least three health regions (Interior Health, Vancouver Coastal and Fraser Health) have a Clinical Ethics Committee or Clinical Ethics Services. (31) If the health care matter is unresolved by the facility staff or administration, the adult's family or the health care provider can request a review by the Clinical Ethics Committee. In theory, the Committee can offer confidential case consultations for patients, residents, families and/or health care staff members or teams. The Committee can review policies and guidelines entailing sensitive or disputed ethical implications.

The committee may be able to help with several types of issues including informed consent; improving communication about ethical concerns among health care team members; end of life decision making; advance directives/advance care planning; and decisions about clients living at risk. Interior Health policy specifically notes that health care providers must not provide major health care until the dispute with a temporary decisionmaker is resolved. (32) Each committee sets its own process.

It is not clear whether residents or families are aware of these as a problem resolution resource. Recent Canadian research on informal consultations suggest that while the consultations may help health care providers think through ethical considerations, they tend to be of less help to patients or families. Indeed patients are rarely involved in the deliberations involving their lives and families only slightly more often. (33)

## **The BC Care Aide and Community Health Worker Registry**

Under the Residential Care Regulations, operators have a responsibility to properly screen prospective employees (verifying their qualifications, character references, and conducting a criminal record check) before hiring, and to assure that people have the competence to carry out their defined duties. (34) There is also an ongoing responsibility to monitor employees' performance. (35)

In January of 2010, British Columbia became the first province in Canada to implement a registry for care aides and community health workers. The BC Care Aide & Community Health Worker Registry was established to help improve the educational standards of care aides ("health care assistants" or "HCA"s) in the province. Strictly speaking it is not a problem solving resource for residents, families, or advocates; but it can and is used by care facility operators to address problems that arise.



The Registry is a database of credentialed or “registered” care aides and community health workers working for, or wanting to work for, publicly funded employers in BC. (36) Access to the Registry is restricted to specific registered employers; all names and information contained in the Registry are confidential. Operators may use the Registry to assist them in screening candidates for positions.

Currently, any care aide who wants to seek employment with a publicly-funded health care employer must be registered with the Registry. So must the employers; some private employers have opted to participate voluntarily. To some extent, the Registry operates as a Regulatory College, although without the legal recognition accorded to other health professions. Instead it operates under a Letter of Understanding with bargaining associations. (37)

The Registry’s role is three fold: to ensure that all HCA students in the province receive the same level of training, to register those that have this training, and to track and respond to cases of alleged “abuse” by health care aides. The Registry has the ability to “de-register” care aides, and these individuals are then permanently prevented from seeking further positions with publicly-funded employers.

### **The Process**

Operators will have their own internal process for responding to suspected or actual abuse or neglect of a resident. They also have specific reporting responsibilities to the Ministry of Health. Under the terms of its contract with the Ministry of Health or with a health authority, an employer who receives public funding is required to report to the Registry any employee who has been suspended or terminated for alleged abuse of a client, patient, or resident. This report must be made in writing within seven (7) calendar days of the employee being notified of the suspension. A copy of the report is sent to the union if the employee is represented by a union. (38) The circumstances are investigated by the Registrar’s office.

The actual investigations are undertaken by five investigators with experience in labour relations and mediations appointed by the Registry’s Advisory Committee. The cost of the investigation is borne jointly by the employer, and the union. If the staff person is not unionized, the costs are borne by the Registry.

### **The Challenges**

Although the registry (and “deregistering”) system exists, a review of the provincial system pointed out that it has several limitations. The mandatory registry requirement for employment only applies to care aide workers seeking employment in publicly funded facilities. Unlike a Regulatory College, the Registry can only investigate serious misconduct (“abuse”) that is brought to its attention and cannot address other workers’ “competence” matters. The Registry is unable to compel reporting of abuse or operators’ participation in the investigatory process.

Some operators feel the investigation process lacks transparency and the cost of investigation is burdensome. As a result, some employers may simply circumvent the investigation/ de-registry process by terminating the employee without necessarily reporting the incidents. This leaves these workers open to seeking employment elsewhere in health, possibly in private care. (39)

Other issues that have been raised about the registry relate to: privacy considerations when it comes to sharing information for investigation, which affects investigators’ ability and authority to access health records, witnesses and licensing information; perceived partiality of investigator; multiple investigatory streams, and conflicting results; perceived loopholes in various processes; as well as questions about sustainable operating funding. There are also important philosophical differences around expectations between operators and the investigators whose background is in labour relations and mediation (“zero tolerance”, “just fire them” versus “graduated discipline”, without aides necessarily being dismissed and deregistered).

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1. Patient Care Quality Review Board Act, Bill, 41, 2008, s. 1
2. (2013) Patient Care Quality Office Resource Guide. Ministry of Health, p. 5. Online : [http://www.phsa.ca/Documents/PCQO/PCQOResourceGuideMoHS\\_PHS2012.pdf](http://www.phsa.ca/Documents/PCQO/PCQOResourceGuideMoHS_PHS2012.pdf) (Last accessed January 9, 2016). ["PCQO Resource Guide"]
3. See: PCQO Resource Guide. Also note: Murtaugh, J. (2012). Patient Care Quality Program Final Evaluation Report. Prepared for BC Ministry of Health. Online: <http://www.health.gov.bc.ca/library/publications/year/2012/patient-care-quality-program-evaluation-report.pdf> ["Murtaugh"] (Last accessed January 9, 2016). Notes that staff find the PCQ timelines challenging and unreasonable.
4. Murtaugh.
5. See Murtaugh, pg. 17, Figure 1. For 2014/15 data see Office of the Seniors Advocate, Monitoring Seniors Services, 2015. pages 19-20. Online: <https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/01/SA-MonitoringSeniorsServices-2015.pdf> ( Last accessed May 10, 2016).
6. Murtaugh, pg. 24.
7. Murtaugh.
8. Murtaugh, p. 21.
9. Murtaugh, p. 41
10. "Care quality complaint" means a complaint
  1. (a) respecting one or more of the following:
    1. (i) the delivery of, or the failure to deliver, health care;
    2. (ii) the quality of health care delivered;
    3. (iii) the delivery of, or the failure to deliver, a service relating to health care;
    4. (iv) the quality of any service relating to health care, and
  2. (b) made by or on behalf of the individual to whom the health care or service was delivered or not delivered.

"Health care" means anything that is provided to an individual for a therapeutic, preventive, palliative, diagnostic or other health related purpose, and includes (a) a course of health care, and (b) other prescribed services relating to individuals' health or well-being.
11. HCCCFAA, s.1
12. HCCCFAA, s.1
13. Patient Quality Care Review Board Act. Bill 41 (2008). Patient Care Quality Review Board, "Legislation" . Online: <http://www.patientcarequalityreviewboard.ca/legislation.html> (Last accessed January 9,2016).
14. Patient Care Quality Review Board. "About us". Online: <http://www.patientcarequalityreviewboard.ca/aboutus.html> (Last accessed January 9,2016)
15. For an example of appeal board issues potentially affecting the care of residents, See: SB, CB, SG & JN v. Vancouver Island Health Authority & Cowichan Lodge. 2008 BCCCALAB 6. (Application for Stay order pending appeal - Granted)
16. Patient Care Quality Review Board. 2013 Annual Report. Online: <http://www.health.gov.bc.ca/library/publications/year/2013/PCQRB-annualreport-1213.pdf> (Last accessed January 9,2016)
17. Patient Care Quality Review Board. "Frequently asked questions". Online : <http://www.patientcarequalityreviewboard.ca/faqs.html#Q20> (Last accessed January 9,2016)
18. Patient Quality Care Review Board Annual Report, 2011-12, pg.33. Online : <http://www.health.gov.bc.ca/library/publications/year/2012/PCQRB-annualreport-1112.pdf> (Last accessed January 9,2016) For other more recent data, see Patient Quality Care Review Board Annual Report, 2014-15. Online: <https://www>.

- patientcarequalityreviewboard.ca/pdf/PatientCare\_QRB\_2014-15\_Web.pdf (Last accessed May 10, 2016)
19. CCALA, s. 15.
  20. See Sivertson (Guardian ad litem of) v. Dutrisac [2011] B.C.J. No. 810, 2011 BCSC 558.
  21. Best of Care, Part 2, pg. 314.
  22. Ombuds, Best of Care, 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.
  23. Office of the BC Ombudsperson. June 2013. Update on Status of Recommendations- The Best Of Care: Getting It Right For Seniors In British Columbia (Part 2) Public Report No. 47 Pg. 8.
    1. March 2013 - FHA confirmed that it conducts and will continue to conduct annual inspections of residential care facilities governed under the Hospital Act in the same manner as CCALA facilities are inspected.
    2. October 2012- FHA has begun annual Hospital Act facility inspections. -January 2012
    3. FHA will collaborate with the Ministry of Health and other health authorities to develop and implement a standardized and consistent approach to the inspection of residential facilities governed under the Hospital Act.
  24. Ombuds, Best of Care Part 2, pg. 311
  25. Fraser Health. Inspection Category Definitions. Revised September 7, 2012.
  26. Ministry of Health. (February 2012). A guide to community care facility licensing in British Columbia, pg. 40. ["Community care licensing guide"]
  27. Ombuds, Best of Care, p. 348.
  28. See for example, WM v Bateman 2004 BCCCALAB 1. Online [http://www.ccalab.gov.bc.ca/dec/2004\\_BCCCALAB\\_1.pdf](http://www.ccalab.gov.bc.ca/dec/2004_BCCCALAB_1.pdf) (Last accessed January 9,2016)
  29. Community care licensing guide, pg. 4.
  30. RCR, Schedule D, Bill of Rights, s 4 (d).
  31. Vancouver Coastal Health. Clinical Ethics Services. Online : [http://alliedhealth.vch.ca/docs/Ethics\\_Brochure.pdf](http://alliedhealth.vch.ca/docs/Ethics_Brochure.pdf) (Last accessed January 9,2016)
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  33. Rudnick, A., Pallaveshi, L. , Sibbald, R.W. , & Forchuk, C. (March 2014). Informal ethics consultations in academic health care settings: A quantitative description and a qualitative analysis with a focus on patient participation. Clinical Ethics, 9(1),28-35.
  34. RCR, s. 38.
  35. RCR, s. 40 (1).
  36. Care Aide and Community Health Worker Registry. "About the Registry". Online: <http://www.cachwr.bc.ca/About-the-Registry.aspx> (Last accessed January 9,2016).
  37. The Registry's enabling framework is the Letter of Understanding (LOU) that was signed by HEABC, the Facilities Bargaining Association (FBA) and the Community Bargaining Association (CBA) in 2010. Appendix A of the LOU outlines the Registry's investigative and removal process. The Registry reports to the Executive Director at Health Match BC, the HEABC President /CEO, and the MOH.
  38. "Employers- Frequently Asked Questions" Online: <http://www.cachwr.bc.ca/About-the-Registry/Employer-FAQ.aspx> (Last accessed January 9,2016)
  39. Foerster, V.& Murtagh, J. (February , 2013) British Columbia Care Aide & Community Health Worker Registry: A Review, Ministry of Health, pg. iv. Online: <http://www.health.gov.bc.ca/library/publications/year/2013/bc-care-aide-registry-report.pdf> (Last accessed January 9,2016)

This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

## Directing Concerns to External Bodies

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### Directing Concerns to External Bodies

#### Police Services

A matter considered a crime in the community is also a crime in residential care. That includes if it is carried out by a staff member, administration, volunteer, family member, or another resident. If there is a suspected crime (such as assault or theft) in a residential care facility, the local police department should be contacted. Their role is to investigate to determine if there is evidence of a criminal offence. Their role is also in keeping the peace.

Police services can function as a sword and a shield in residential care facilities, in the sense they can be used for the benefit of the resident, or as a mechanism of control over residents and families. In some cases, health authorities have used adult guardianship law to obtain a Justice of the Peace Warrant to prevent family from removing a resident from the care facility. (1) Issues related to the use of police by operators to control access to the resident are described in the Chapter 4 “Legal Issues When Living in Residential Care”.

**Police investigations:** Police sometimes seek information from staff at the care facility about a resident or family member. Staff may erroneously believe they can simply share resident information with police inquiries.

Residents have a right to have their personal information kept private. As one health authority notes, the release of client personal information to police or designated/ delegated authority is not permitted unless:

- the client has provided informed consent,
- there is a lawful investigation,
- a court order, search warrant, notice to produce or other lawful instrument has been presented, or
- it is an urgent request (e.g. life and death). (2)

The term “lawful investigation” in this context means where there is an active investigation and file number. The police or other designated/delegated authority must also provide sufficient reasons why normal procedures are not reasonable in the circumstances (e.g. such as warrants, court orders). Operators must keep track of these police requests for information and how the request has been handled.

#### Information and Privacy Commissioner

Where the care issue deals with privacy of information or access to health information, the Office of the Information and Privacy Commissioner may be contacted for assistance. Common examples of privacy breaches include: where the care facility staff member has given personal information to a third party without consent, or the care facility has refused to allow the resident or their substitute decision-maker access to the resident’s records.

It should be noted that the Freedom of Information and Protection of Privacy Act (3) sets out the access and privacy rights of individuals, but only as they relate to the public sector. The Personal Information Protection Act (4) covers information privacy disputes and related matters between private citizens (e.g. where the resident is in a private pay bed) and is outside of the Commissioner’s jurisdiction.

## Human Rights Tribunal

British Columbia's Human Rights Code prohibits discrimination on several grounds, including:

- age,
- physical or mental disability,
- marital status, family status,
- race, colour, ancestry, place of origin,
- sex, sexual orientation
- religion

If a resident in a care facility experiences discrimination or harassment based on a protected ground, the resident can apply to the Human Rights Tribunal. The provincial Code, in contrast to the Canadian Charter of Rights and Freedoms, covers both public and private actors. It also does not matter whether or not there was any intention to discriminate.(5)

The BC Human Rights Code places an important responsibility on all private and public bodies providing services to accommodate those who would otherwise be discriminated against. The duty to accommodate includes making suitable policy, practice and resource adaptations. For example, that might include modifying or adapting a private operator's residential care practice or a Ministry of Health policy in order to alleviate or eliminate the harsher impact that the requirement had on a particular resident, or on a group of residents. This duty to accommodate is always in relation to the prohibited ground of discrimination. Human rights protections and the duty to accommodate are important.

The responsibility or "duty to accommodate" is significant; it exists up to the point where it would cause the operations "undue hardship". Significantly more effort and potential cost will be required to get to the point of "undue hardship" for larger residential care operations or government bodies, than for small facilities with fewer resources. Undue hardship to the business must be based on actual evidence, not just a belief that it will be inconvenient or cost money to make changes in order to avoid the discrimination.

In practical terms, the most significant value of the human rights remedy is probably the educative and interpretive provisions of the Code. These can be a useful, persuasive tool in good residential care advocacy. Most cases of discrimination in residential care will relate to section 8 of the BC Human Rights Code ("Discrimination in accommodation, service and facility"), or section 43 ("Non-retaliation"). The most common protected grounds in residential care would likely relate to the residents' physical and mental disability, age, race, marital or family status or sexual orientation.

It is possible, although challenging, to launch a "representative" case ("class action") complaint with the Tribunal, where a number of similarly situated persons are experiencing the same discrimination. (6) The Tribunal has the capacity to hear adverse effect discrimination and systemic discrimination cases, both of which are important and relevant in residential care.

Within the Code there is the opportunity to argue that residents have experienced "adverse effect discrimination". (7)This refers to a policy or practice that appears neutral (e.g., it applies to everyone), but imposes penalties, obligations or restrictive conditions that have a



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disproportionately negative effect on an individual or group because of some special characteristic of that individual or group that is protected by the Code. For example, this might occur if the services are only provided by English speaking care providers, but many of the residents in that facility speak Mandarin. These residents will likely be socially isolated, will not be able to understand any care instructions, and may be at greater risk of harm than other residents.

Adverse effect discrimination in services might occur where there is little if any effort to accommodate cultural and gender restrictions about receiving personal care. It may occur when the care facility foods are cooked off premise, or if the facility rules prohibited gifts of outside foods that met their cultural needs, and there was no accommodation for the cultural or religious preferences or dietary restrictions of a resident (e.g. kosher, halal, vegetarian). Culturally familiar foods, social and recreational activities are increasingly being recognized as important to strengthen cultural connectedness and maintain ethnic identity in residential care. (8) However, to amount to discrimination under the Code, it must be possible to draw a reasonable inference from the facts that there is a connection between the adverse discriminatory conduct and a prohibited ground of discrimination.

“Systemic discrimination” is discrimination that results from the simple operation of established procedures, none of which is necessarily designed to promote discrimination. For example, LGBT seniors point out that many aspects of care- from the way admission forms are worded to the day to day operations - effectively overlook even the possible existence of LGBT seniors in care, and treat them as “invisible”. The discrimination is then reinforced by the exclusion of the disadvantaged group (“obviously we don’t have any LGBT seniors in our resident population”). The exclusion fosters the belief, both within and outside the group, that the exclusion is the result of “natural” forces. To combat systemic discrimination, it is essential to create a climate in which both negative practices and negative attitudes can be challenged and discouraged.

One of the major challenges for residents whose human rights have been violated, is that these rights are treated as “personal rights”. The Human Rights Tribunal will not deal with the matter if the person dies after the matter has been referred to a Tribunal and before it has been heard by that Tribunal. (9) Unfortunately this means systemic forms of discrimination can continue by simply delaying and waiting for resident (human rights complainant) to die.

### **The Process**

British Columbia’s human rights system has had a “direct access” process since 2003 where cases can be brought to the BC Human Rights Tribunal. (10) About three to five percent of all complaints received go before the Tribunal. (11)

Complaints are received by the Tribunal Registrar who screens the complaints according to whether they are within the Tribunal’s jurisdiction and whether there is an apparent human rights claim. In recent years, in efforts to become “more efficient”, the Tribunal has “screened out” substantially more cases at first instance, an interesting development given that the Tribunal is purported to be “direct access.”(12)

The Tribunal has a settlement process to resolve received discrimination complaints at an early stage (within three to four months of application). The Tribunal itself is a highly legalistic and technically cumbersome process for most individuals, especially for those who are vulnerable. Complainants using the direct access process have a lower rate of success with the Tribunal than through the old Commission process. (13) Unrepresented complainants have a low chance at success in a hearing.(14)



### **Help with the Process**

The BC Human Rights Clinic (formerly known as the BC Human Rights Coalition) in partnership with the Community Legal Assistance Society (CLAS) runs a human rights clinic program that offers client services and public legal education. It may be able to provide legal advice and representation before this Tribunal. The Coalition has a number of qualifying criteria to determine initial client eligibility focusing on alternative redress processes, assistance from other legal or professional sources, financial status, the nature of the issue and whether there are systemic issues, the merits of the case and likelihood of success, and whether the case raises novel issues of law. (15)

Because other processes such as the Patient Care Quality Office and Patient Care Quality Review Tribunal exist in theory as an alternative redress, residents in care facilities may face a significant barrier to accessing this human rights resource. However this is only one of many barriers to drawing on this remedy. Other barriers include the timeliness, (16) access to legal representation, the resident's mental capacity (to retain services, instruct counsel), their physical frailty, and cost implications. Legal advocates in other jurisdictions have typically found older clients, especially those in long term care facilities unwilling to consider using this remedy.

In British Columbia, very few legal resources have had the opportunity to develop experience in arguing or hearing discrimination cases affecting older adults on any protected ground, with the notable exception of age related workplace discrimination. It is only very recently that the Human Rights Tribunal has begun hearing cases involving discrimination in accommodation or services affecting older adults. (17)

<b>Special note : BC Human Rights Code</b>
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<b>Discrimination in accommodation, service and facility.</b>
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8 (1) A person must not, without a bona fide and reasonable justification:
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- |   |
|---|
| <ul style="list-style-type: none"><li>• (a) deny to a person or class of persons any accommodation, service or facility customarily available to the public, or</li><li>• (b) discriminate against a person or class of persons regarding any accommodation, service or facility customarily available to the public because of the race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or class of persons.</li></ul> |
|---|

### **International Human Rights**

There are a number of international human rights conventions that can also be relied to support human rights (non discrimination) based arguments for people living in residential care, such as equitable access to wheelchairs. These include for example, the UN Convention on the Rights of Persons with Disabilities which Canada signed in 2007 and ratified it in 2010. (18) It places a responsibility on Canada to address the many barriers faced by persons of any age with a disability. The provincial and territorial governments are responsible for implementing rights in the Convention within their jurisdictions. From a human rights perspective, for example, a wheelchair is more than an assistive device for many people with disabilities; it is the means by which they can exercise their human rights and achieve inclusion and equal participation. (19)

## **Ombudsperson Office**

(20)The Ombudsperson is an independent officer of the Legislature appointed under the Ombudsperson Act. The focus of the Office is to ensure that every person in British Columbia is treated fairly in the provision of public services. The Ombudsperson has the responsibility to advise government on systemic causes of unfairness and to recommend changes to practices, policies and legislation that contribute to recurring unfairness.

### **Role, mandate, function**

The general function of the Ombudsperson is to oversee the administrative actions of government authorities. The Ombudsperson determines whether provincial ministries and public agencies have acted fairly and reasonably, and whether their actions and decisions are consistent with relevant legislation, policies and procedures. The Ombudsperson can

- respond to inquiries from the public,
- conduct investigations of complaints of individual cases.

The Ombudsperson can also consult with authorities to improve administrative practices by identifying issues, providing reasons, and making recommendations. The Ombudsperson provides reports to the Legislative Assembly about administrative fairness issues, the causes of recurring unfairness and how these can be remedied.

According to the Ombudsperson Office, the focus of administrative fairness to assure procedural fairness and effective public administration. This involves having appropriate legal authority; useful policies and procedures; clear public information; accessible programs; consistent standards of practice; adequate monitoring and enforcement; and timely and responsive complaint resolutions. (21)

The Ombudsperson has authority over a wide range of government departments and Ministries; perhaps one of the most relevant ones here is the Ministry of Health. From 2008 to 2009 the Ombudsperson carried out an extensive review of care for seniors in British Columbia, identifying a wide variety of situations where seniors and families were not being treated in a fair manner in home support and residential care services. (22) In 2012 the Ombudsperson also reviewed the circumstances under which certificates of incapability were being issued in British Columbia to declare persons (typically seniors) incapable of managing their financial affairs. (23) The Ombudsperson's review focused on whether the incapability certificate process was fair, and whether there were sufficient procedural safeguards to protect the person's rights.

### **Issues**

A wide variety of residential care issues potentially come under the scope of the Ombudsperson's mandate of assuring administrative fairness. These may include, for example, examining whether or not

- a health authority or other public body makes a decision affecting a resident's rights and provides adequate reasons, or has adequate procedural safeguards in place
- a public body acts within the actual scope of their authority, or uses a law intended for one purpose for a very different one,
- a policy seems to treat some people unfairly,
- a health authority provides operators with objective and enforceable standards of care,
- people are provided with sufficient information at the appropriate time to make informed decisions about admission, placement or transfer to a care facility,
- a public body has failed to act – e.g. a health authority “turns a blind eye” to care facility operators charging residents extra for services that are included in the accommodation fees paid.

### **Process**

Complaints to Ombudsperson may be made by a person or group of persons.(24) A complaint must be in writing. (25)The Ombudsperson is a resource of last resort; that is, the person must have gone through the other avenues first.

### **Available remedies**

The Ombudsperson can make recommendations which may or may not be acted upon by the public body. These recommendations are typically couched in language of “administrative fairness” and “natural justice” not whether the actions are legal. (26) The Ombudsperson’s work is guided by the democratic principles of openness, transparency and accountability.

### **The Public Guardian and Trustee (PGT)**

The Public Guardian and Trustee (PGT) has numerous roles. In the context of residential care, the PGT’s responsibilities can include investigating

- the personal care and health care decisions made by a representative or guardian, (27)
- the affairs of a representative, guardian or person holding a power of attorney, if the Public Guardian and Trustee has reason to believe that the interest in the trust, or the assets of the adult, may be at risk. (28)
- adult who is apparently abused or neglected, as defined in the Adult Guardianship Act. (29)



These investigations can also occur if the Public Guardian and Trustee has reason to believe the representative or guardian has failed to comply with his or her duties. The PGT responsibilities includes the power to investigate and audit the affairs, dealings and accounts of certain trusts. The PGT can handle disputes about substitute decision making.

The Public Guardian and Trustee (PGT) has jurisdiction over health care decisions, when no one is available or qualified from the list of substitute decision makers. The PGT office can authorize another person such as a friend of the adult to make substitute decisions. If there is no person to authorize, the PGT can take the role as Temporary Substitute Decision-Maker.

The PGT also has jurisdiction when there is a dispute between potential substitute decision-makers of equal rank about who is to be chosen to make decisions on the person’s behalf and the issue cannot be resolved by the health care provider. In those circumstances, the health care provider is required to contact a Health Care Decisions Consultant at the Public Guardian and Trustee. (30)

The PGT also has the authority to act as Committee of the Estate when a person is declared mentally incapable under the Patient Property Act. (31) This area of law on the role of the PGT and “incapability certificates” is undergoing major change at present, and a new approach is expected to be in place by the end of 2014.(32)

## **Directing Concerns to Review Boards**

### **Mental Health Review Board**

As noted in Chapter 3 (Legal Issues in Admission & Transfer), older adults are sometimes admitted to a hospital where they become involuntarily detained under the Mental Health Act and then involuntarily transferred to a residential care facility on “extended leave.” They can also be transferred from a care facility to a hospital and become involuntarily detained under the Mental Health Act. In both cases, they lose basic rights and can be treated without consent.

There is a formal process for medically certifying adults under the Mental Health Act. However, the adult does not have to be personally examined by a psychiatrist or even a physician in order to be involuntarily detained under the Mental Health Act. (33) The physician may operate on collateral information when “medically certifying” the person. This can sometimes lead to unnecessary loss of liberty. However, the Mental Health Review Board can review the continued involuntary detention of people “medically certified” under the Mental Health Act. (34)

#### **Purpose**

The Mental Health Review Board is an independent tribunal established to conduct review panel hearings under the Mental Health Act. The review panel makes a decision on only one issue - whether the person continues to meet the criteria to remain as an involuntary patient under the Mental Health Act. (35) It does not make decisions about treatment. However, if the person is no longer involuntarily detained, the treatment issues usually become moot.

The Board's mandate is based on involuntary patients' periodic rights to fair and timely reviews of their loss of liberty. Its function is to ensure that people admitted by physicians and detained involuntarily in the designated facilities have access to an objective review process.

The system is subject to the constitutional rights of section 7 of the Canadian Charter of Rights and Freedoms, (36) which states that “[e]veryone has a right 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.

#### **Composition**

The Mental Health Review Board is comprised of a chair and members appointed by the Minister of Health to conduct “review panel” hearings. A review panel must consist of a medical practitioner, a member in good standing of the Law Society of British Columbia or a person with equivalent training, and a third member who is neither a medical practitioner nor a lawyer.

Currently, the Board has 83 legal, medical and community members living in various locations throughout the province. A review panel is comprised of three or more members of the Board. After a hearing, the review panel decides whether a patient should be discharged from involuntary status. In the Lower Mainland, Community Legal Assistance Services delivers the Mental Health Law Program, which may be able to provide representation at a review panel hearing. Its resources are very limited.

### **Process**

A person is eligible to apply for a review within strict statutory time limits following the issuance of the second medical certificate. Board members must conduct hearings within either 14 or 28 days from the day the application is received unless the person waives this right.

Mental Health Review Board controls its own processes and makes rules respecting practice and procedure. It has considerable latitude in terms of who can attend, who can stay in the hearing, whether the patient can have a support person present throughout the hearing, and the allowable evidence.

If the Mental Health Review Board confirms the continuing need for the person's involuntary detention, this can be reviewed, but subject to the time frames in the Mental Health Act.

### **Remedies**

Basically the Mental Health Review Board's authority is limited to whether or not the person should continue to be an involuntary patient. The Review Board (review panel) does not make decisions about treatment. The review panel also does not inquire into whether a person's initial certification was justified.

<b>Special Note on Treatment</b>
<p>The Mental Health Review Board and review panels do not deal with treatment issues. The Mental Health Act permits a request for a second medical opinion on appropriateness of the treatment, within one month, three month and six month time frames under the Act. (37)</p> <p>Also if a patient, relative or other person has a complaint about the treatment provided to an involuntary patient, the complaints may be brought to the attention of several different parties. This includes the patient's physician, the director of a designated facility, the hospital administration, the patient care quality officer (a service available at all hospitals in BC to deal with patient complaints), the health authority, the College of Physicians and Surgeons of B.C., the College of Registered Nurses of B.C., the College of Licensed Practical Nurses of B.C., the College of Registered Psychiatric Nurses of B.C., or the provincial Ombudsperson. (38)</p>

## **Professional Colleges & the Health Professions Review Board**

If the concern in a care facility relates to the actions of a specific person who is a member of a professional college (e.g., doctor, nurse or social worker), a complaint can be brought to their professional College for investigation.

One of the major issues with relying on these regulatory bodies for residential care concerns is how long the complaint and investigation process takes. The College of Physicians and Surgeons notes for example, that the College tries to resolve complaints within six to eight months, but matters can take much longer. Decisions of the various professional colleges can be reviewed by the Health Professions Review Board. However, these reviews will be limited to the adequacy of the investigation and reasonableness of the decision ("disposition") by the college. Even if a matter is found in favour of the person who made the complaint, the review board can only redirect the matter back to the professional college.

Legal advocates working in institutional environments also note that regulatory colleges and review boards may not promote compliance or enforce the existing law (such as health care consent law) with their members, especially if the person's actions are simply considered a "standard practice". (39)

For example in one British Columbia case the Health Professions Review Board appeared to implicitly condone a physician's use of a consent to treatment given at admission when he prescribed a psychoactive medication to a cognitively impaired resident without consulting the family (a common occurrence in residential care). The Review Board accepted that the physician felt he had implied consent for "what was termed 'minor' forms of treatment such as painkillers and anti-diarrheal medications". (40) As noted throughout this manual, legally operators cannot request blanket consent to treatment at admission or any other time. The substitute decisionmaker cannot legally give it either

because it violates the underlying premise of giving “informed consent” based on the condition and information at hand. The Health Review Board referred to the physician’s actions simply as a “failure to communicate”, not as a breach of the resident’s legal rights around consent.

### **Community Care and Assisted Living Appeal Board**

Licensed residential care facilities can seek an exemption from certain sections of the Community Care and Assisted Living Act. Among other things this administrative tribunal (Board) is responsible for appeals dealing with the certification for care facilities and exemptions from the Act of certain standards or requirements. An operator is expected to show how the current regulations or standards cannot be met and how exemption will not increase the risk to the residents’ health and safety. (41)

People other than the operator or licensee can appeal these exemptions. (42) The appeal can be brought within 30 days by a resident or the resident’s agent or personal representative of a person in care, or resident’s spouse, relative or friend. (43) It has been used by residents’ families to appeal an operator’s efforts to close the facility without adequate notice. The Appeal Board is authorized by Community Care and Assisted Living Act.

### **Addressing Systemic Concerns: BC Seniors Advocate**

The BC Seniors Advocate was appointed in March 2014 and is the first position of its kind in Canada. The Advocate has a broad mandate to identify and examine systemic issues affecting the well-being of seniors, raise awareness about resources available to seniors, and make recommendations to government and others who deliver seniors’ services related to health care, personal care, housing, transportation and income support. The Seniors Advocate does not investigate individual complaints. The position is governed by the Seniors Advocate Act. (44)

The Seniors Advocate is responsible for:

- (a) monitoring the provision of seniors' services,
- (b) analyzing issues believed to be important to the welfare of seniors generally, and
- (c) advocating in the interests of seniors. (45)

The Advocate has authority to:

- (a) identify and analyze systemic challenges faced by seniors;
- (b) collaborate with persons who deliver seniors' services for the purpose of improving the efficiency and effectiveness of service delivery;
- (c) promote awareness, by seniors, their caregivers and their families, of systemic challenges faced by seniors, and of the resources available to seniors;
- (d) make recommendations to government and to persons who deliver seniors' services respecting changes to improve the welfare of seniors. (46)

The Seniors Advocate’s power to gather information is largely in relation to developing an advisory council, conducting research and consulting with persons who deliver seniors' services and with the public. The Seniors Advocate may request available data from provincial bodies such as the health authorities on matters that relate to seniors' services. The Seniors Advocate may also request information from public and private sector service providers, other than personal information. In January 2016, the Seniors Advocate released the first provincial report monitoring key services to seniors in health care, housing, transportation, income support and abuse. (47)

The Seniors Advocate Act provides a notable safeguard for residents in care facilities, their families and advocates in that the law specifically offers a protection from retaliation for people who provide information to the Seniors Advocate.

(48) However the Seniors Advocate Act does not identify penalties or repercussions if a person or organization contravened the protections from retaliation.

Like the BC Ombudsperson, the Seniors Advocate is limited by law to making recommendations to government, which public bodies may or may not act on.

## References

1. See Bentley v. Maplewood Seniors Care Society, 2014 BCSC 165.
2. Interior Health. Policy AL1500. Police -designated/delegated authority access to clients and client information.
3. Freedom of Information and Protection of Privacy Act [RSBC 1996] c.165.
4. Personal Information Protection Act [SBC 2003] c. 63.
5. BC Human Rights Code, [RSBC 1996] c. 210, s.2.
6. See for example, Cole and Joseph obo others v. Northern Health Authority and others, 2014 BCHRT 26, where a group in the Prince Rupert area argued that the hospital services available to First Nations people were significantly lower or deficient compared to those in other communities.
7. Ontario Human Rights Commission v. Simpsons-Sears Ltd. 1985 CanLII 18 (SCC), [1985] 2 S.C.R. 536.
8. Kolb. P.J. (ed.)(2007). Social work practice with ethnically and racially diverse nursing homes. Columbia University Press. p. 185.
9. British Columbia v. Gregoire, 2005 BCCA 585. The Court of Appeal held that the Tribunal did not have jurisdiction to proceed further upon the death of the complainant. However, for a bit more promising approach (outside of the human rights code) to actions surviving the death of the complainant, See Dudley v. Canada (Attorney General) [2013] B.C.J. No. 1191.
10. MacNaughton., H. "Lessons learned: the BC direct access Human Rights Tribunal" Online: [http://www.justice.gov.yk.ca/pdf/Heather\\_MacNaughton\\_Article.pdf](http://www.justice.gov.yk.ca/pdf/Heather_MacNaughton_Article.pdf) (Last accessed January 9, 2016) ["MacNaughton"]
11. In 2010-11, of 1063 complaints (828 filings) received by the BCHR Tribunal, only 38 made it to the Tribunal stage and 20 of these were dismissed. Online: [http://www.bchrt.bc.ca/shreddocs/annual\\_reports/2010-2011.pdf](http://www.bchrt.bc.ca/shreddocs/annual_reports/2010-2011.pdf) (Last accessed January 9, 2016). In 2012/1, 1028 complaints were received, of which 51 led to Tribunal hearings. Forty percent of complaints were rejected for filing at the first instance in 2012/13. (Pg. 2 of 2012/13 Annual Report). Online; [http://www.bchrt.bc.ca/shreddocs/annual\\_reports/2012-2013.pdf](http://www.bchrt.bc.ca/shreddocs/annual_reports/2012-2013.pdf) (Last accessed January 9, 2016)
12. There is currently no specific legal authority for the Tribunal Registrar to undertake the screening. In the 2012/ 13 BCHRT Annual Report, the Tribunal specifically asked the government to amend the Code to give the Tribunal Registrar authority to screen complaints.
13. MacNaughton, p.5.
14. The 2011-12 BCHRT annual report notes for example that Complainants with counsel succeeded in 56% of their cases. Without counsel, the complainants succeeded in only in 31% of the cases. Pg. 11. Online: [http://www.bchrt.bc.ca/shreddocs/annual\\_reports/2011-2012.pdf](http://www.bchrt.bc.ca/shreddocs/annual_reports/2011-2012.pdf). (Last accessed January 9, 2016). In 2012-13, complainants with counsel succeeded in 71% of the cases, those without counsel succeeded only in 36%, pg 9. Online: [http://www.bchrt.bc.ca/shreddocs/annual\\_reports/2012-2013.pdf](http://www.bchrt.bc.ca/shreddocs/annual_reports/2012-2013.pdf) (Last accessed January 9, 2016)
15. BC Human Rights Clinic. Online: <http://www.bchrc.net/> (Last accessed January 9, 2016)
16. The 2011-12 BCHRT Annual Report noted it was taking 280 to 400 days from application to resolution .
17. See: Perry v. Strata #49 Council, 2014 BCHRT 7. However, the complaint's case was dismissed not on the merits, but because the complainant did not specifically base her case on age discrimination.
18. Chantal, C. Canada and the Convention on the Rights of Persons with Disabilities, Social Affairs Division. 5 December 2012, HillNote Number 2012-89-E. Online: <http://www.parl.gc.ca/Content/LOP/ResearchPublications/2012-89-e.htm> (Last accessed May 1, 2014). Also see: World Health Organization. Guidelines

- on the provision of manual wheelchairs in less resourced settings. Online: [http://www.who.int/disabilities/publications/technology/English%20Wheelchair%20Guidelines%20\(EN%20for%20the%20web\).pdf?ua=1](http://www.who.int/disabilities/publications/technology/English%20Wheelchair%20Guidelines%20(EN%20for%20the%20web).pdf?ua=1) (Last accessed May 1, 2014) [“WHO Wheelchair Guidelines”]
19. WHO Wheelchair Guidelines, pg. 22.
  20. Ombudsperson Act [RSBC 1996] c. 340. [“Ombudsperson Act”]
  21. Office of the Ombudsperson. “Administrative fairness”. Online : <https://www.ombudsman.bc.ca/home/fairness-checklist> (Last accessed May 1, 2014).
  22. Document Review - staff reviewed documents obtained from the health authorities and provided to office by the public and other interested organizations. Information reviewed included: legislation, regulation and policies; government letters of expectations, international, national and provincial documents that establish basic principles and standards for the care of seniors, guidelines, directives and bulletins, statistics related to the population of seniors in B.C., organizational charts and job descriptions; program descriptions, policies, guidelines and public information; handbooks, brochures, booklets and online information about home and community care; information about programs and services offered in other jurisdictions; service agreements between health authorities and contracted service agencies; reports about seniors’ care in B.C. and other jurisdictions
  23. BC Ombudsperson (February 2013). No longer your decision: British Columbia’s process for appointing the public guardian and trustee to manage the financial affairs of incapable adults. Public Report No. 49. Online: <https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2049%20No%20Longer%20Your%20Decision-%20BC%27s%20Process%20for%20appointing%20> pdf (Last accessed January 9, 2016) [“No longer your decision”]
  24. Ombudsperson Act, s. 10(1).
  25. Ombudsperson Act, s. 10 (2).
  26. An administrative fairness checklist can be found in the Ombudsman’s 1990 Annual Report to the Legislative Assembly.
  27. Public Guardian and Trustee Act [RSBC 1996] c. 383, s. 17(2) (“PGTA”)
  28. PGTA, s. 17(1) (c), (d), and (e).
  29. PGTA, s. 17(1) (b).
  30. See section 16(3) Health Care (Consent) And Care Facility (Admission) Act [RSBC 1996] c.181 . Online: [http://www.bclaws.ca/Recon/document/ID/freeside/00\\_96181\\_01#section16](http://www.bclaws.ca/Recon/document/ID/freeside/00_96181_01#section16) (Last accessed January 9,2016)
  31. Patients Property Act [RSBC 1996] c. 349.
  32. These changes are the direct result of the recommendations made in the BC Ombudsperson 2013 report “No longer your decision.”
  33. BC Ministry of Health (2005) Guide to the Mental Health Act, pg. 11. Online: <http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf> (Last accessed January 9,2016)
  34. Mental Health Act, sections 25(2), 25(4.1) [“MHA”]
  35. Mental Health Review Board. Online: <http://www.mentalhealthreviewboard.gov.bc.ca/>(Last accessed January 9,2016).
  36. Constitution Act, 1982 (80). Part I Canadian Charter of Rights and Freedoms.
  37. MHA, s. 31.
  38. Mental Health Review Board. “Commonly asked questions. What are the limits of what the review panel can decide? “ Online: <http://www.mentalhealthreviewboard.gov.bc.ca/questions.html#> (Last accessed January 9,2016)
  39. Romano,L., Wahl, J.A. & Meadus, J. (2008). Submission to the Law Commission of Ontario concerning the law as it affects older adults. Advocacy Centre for the Elderly, pg. 7. Online: <http://www.advocacycentreelderly.org/>



- appimages/file/Law\_as\_it\_Affects\_Older\_Adults\_July\_2008.pdf (Last accessed January 9,2016).
40. See for example, Complainant vs. College of Physicians and Surgeons and 5 Registrants. 2011-HPA-219(a); 2011-HPA-220(a);2011-HPA-221(a);2011-HPA-222(a) Re: The College of Physicians and Surgeons of British Columbia (Grouped file No. 2012-HPA-G03). Online: [http://www.hprb.gov.bc.ca/decisions/2011-HPA-219\(a\);2011-HPA-220\(a\);2011-HPA-221\(a\);2011-HPA-222\(a\).pdf](http://www.hprb.gov.bc.ca/decisions/2011-HPA-219(a);2011-HPA-220(a);2011-HPA-221(a);2011-HPA-222(a).pdf) (Last accessed January 9,2016).
  41. VIHA. What is an exemption? Community Care Facilities Licensing Program. Online: <http://www.viha.ca/NR/rdonlyres/453B43E6-16A4-4BC7-A441-7B98CAD28996/0/WhatisanExemption.pdf> (Last accessed January 9,2016). See for example, Community Care and Assisted Living Appeal Board.
  42. CCALA, s. 16.
  43. CCALA, S. 30 (a) and (b)
  44. Bill 10, the Seniors Advocate Act, 2013. Online: [http://www.leg.bc.ca/39th5th/1st\\_read/gov10-1.htm](http://www.leg.bc.ca/39th5th/1st_read/gov10-1.htm)
  45. Seniors Advocate Act, s. 3 (1) [« SAA »]
  46. SAA, s.3 (2).
  47. Office of the Seniors Advocate. Monitoring Seniors Services, 2015. Released January 2016. Online: <https://www.seniorsadvocatebc.ca/wp-content/uploads/sites/4/2016/01/SA-MonitoringSeniorsServices-2015.pdf> (Last accessed May 10, 2016)
  48. SAA, s.9. “A person must not discharge, suspend, expel, intimidate, coerce, evict or impose a financial or other penalty on or otherwise discriminate against another person because the other person gives information to the Seniors Advocate or otherwise assists the Seniors Advocate in the fulfillment of the responsibilities of the Seniors Advocate under this Act.”

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

# A Final Note on Rights, Remedies and Problem Resolution in Residential Care

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On its face, residential care has a myriad of mechanisms available to address problems in this area. At the same time, there can be legislative gaps and systems may not function in ways that allow residents or families access to those problem resolution processes. Where there are apparently appropriate laws, public and private bodies always have a choice - to interpret and apply these narrowly and technically (which often leads to inaction), or more hopefully, to interpret them in ways that are supportive of good care for people living in British Columbia's residential care facilities.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## Chapter Five Resources and Appendix

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### Chapter Resources

#### Family/Resident Councils - Guidelines

(1) For more information about developing and implementing a resident or family council, see:

- Guidelines for the Development of Resident or Family Councils. Online:  
<http://www2.gov.bc.ca/gov/content/health/accessing-health-care/home-community-care/accountability/family-and-resident-councils> The Guideline can be downloaded from this page. (Last accessed January 9, 2016)
- Vancouver Island Health Authority. (2013). Resident/Family Council or Family Support Group Guide. Online : [http://www.viha.ca/NR/rdonlyres/76A64C84-5658-4496-9D0D-D13DB92CB5B8/0/resfamilycouncil\\_fam\\_support\\_grp\\_guide.pdf](http://www.viha.ca/NR/rdonlyres/76A64C84-5658-4496-9D0D-D13DB92CB5B8/0/resfamilycouncil_fam_support_grp_guide.pdf) (Last accessed January 9, 2016)
- Interior Health.(2014). Family Council Resource Guide. Online: <https://www.interiorhealth.ca/YourCare/HousingHealth/ResidentialCare/Documents/Family%20Council%20Resource%20Guide%20-%20821066.pdf> (Last accessed January 9, 2016)

#### Patient Care Quality Offices

For individual health authorities:

##### Fraser Health Authority

Contact the Patient Care Quality Office. Complaints can be made verbally, in person, by phone or in writing.

Patient Care Quality Office Fraser Health 11762 Laity St, 4th floor Maple Ridge, BC V2X 5A3

Tel: 1-877-880-8823 Fax: 604-463-1888 E-mail: [pcqoffice@fraserhealth.ca](mailto:pcqoffice@fraserhealth.ca)

Office hours are Monday to Friday from 8:30 a.m. to 4:30 p.m. Closed on weekends and statutory holidays.

Online: <http://www.fraserhealth.ca/your-stay/submit-feedback-about-your-care/patient-care-quality-office/> (Last accessed January 9, 2016).

##### Interior Health Authority

Interior Health Patient Care Quality Office 220 - 1815 Kirschner Road Kelowna, BC V1Y 4N7 Phone: 250-870-4669  
Toll Free Number: 1-877-IHA-2001 (1-877-442-2001) Fax: 250-870-4670 E-mail: Contact us by email  
Office hours: 8:30am - 4:30pm PST; Monday-Friday, excluding statutory holidays <http://www.interiorhealth.ca/YourCare/PatientCareQualityOffice/Pages/default.aspx>

#### **Vancouver Coastal Health Authority**

[www.vch.ca/your\\_stay/in\\_general/patient\\_care\\_quality\\_office/patient\\_care\\_quality\\_office](http://www.vch.ca/your_stay/in_general/patient_care_quality_office/patient_care_quality_office) <sup>[1]</sup>

Patient Care Quality Office Vancouver Coastal Health and Providence Health Care Room CP-380 – 855 West 12th Avenue Vancouver, BC V5Z 1M9 Tel: 1.877.993.9199 Fax: 604.875.5545 Email: [pcqo@vch.ca](mailto:pcqo@vch.ca)

Office hours are Monday to Friday, 8:30 a.m. - 4:30 p.m. The office is closed on statutory holidays.

#### **Vancouver Island Health Authority**

[www.viha.ca/patientcarequalityoffice/complaint.htm](http://www.viha.ca/patientcarequalityoffice/complaint.htm) <sup>[2]</sup>

#### **Northern Health Authority**

[www.northernhealth.ca/YourHealth/CommunityCareLicensing/Families/FilingAComplaint.aspx](http://www.northernhealth.ca/YourHealth/CommunityCareLicensing/Families/FilingAComplaint.aspx) <sup>[3]</sup>

### **Additional Resources**

British Columbia Ministry of Health. Guide to the Mental Health Act, 2005  
[www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf](http://www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf) <sup>[4]</sup>

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**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

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- [1] [http://www.vch.ca/your\\_stay/in\\_general/patient\\_care\\_quality\\_office/patient\\_care\\_quality\\_office](http://www.vch.ca/your_stay/in_general/patient_care_quality_office/patient_care_quality_office)  
[2] <http://www.viha.ca/patientcarequalityoffice/complaint.htm>  
[3] <http://www.northernhealth.ca/YourHealth/CommunityCareLicensing/Families/FilingAComplaint.aspx>  
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# 6-Consent and Capacity

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## Introduction to Consent and Capacity

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This chapter covers the law on consent, particularly as it relates to health care and care plans, and personal care matters in residential care. It introduces the mental capacity or capability needed to make specific decisions that frequently come up in residential care and the relationship between consent and capacity. [Consent in specific circumstances including visitors, restraints, medications, and monitoring technology are described in detail in the Chapter Four -Legal Issues When Living in Residential Care]. This chapter also discusses advance care planning and identifies important differences between the process of “advance care planning” and “advance directives” as a mechanism to give or refuse consent to certain kinds of treatment.

*There is a legal presumption that all adults are mentally capable, no matter how old they become, no matter what disability they may have, and no matter where they live, unless there are reasonable grounds to believe otherwise.(1) Just because a person lives in a long term care facility does not mean that he or she is incapable of making decisions.*

- Advocacy Centre for the Elderly

### Consent: An Area of Confusion

Consent may be one of the most misunderstood areas in residential care. In a closed environment where people are dependent on others for almost every aspect of their lives, being asked (having people seek permission to do something), and having control over what happens to oneself and one’s body in the day to day life of residential care becomes vitally important to physical autonomy and maintaining dignity as an adult. Consent is an important precondition that helps prevent treating residents as passive objects to whom food, care, or assistance is simply given, or on whom activities are imposed.

In residential care facilities, many residents have some degree of cognitive impairment or may have difficulty communicating. Staffing and administrative pressures stress the need for efficiency when interacting with residents. In these circumstances it can become easy for staff and others to want to turn to someone other than the resident for consent for what they want to do. Alternatively, they may prefer to take direction from a document, particularly where there is any uncertainty, without first speaking to the resident. However, if a resident is capable, under British Columbia law the health care provider must never rely on a substitute decisionmaker for consent, or on an advance directive or other legal document for instructions or to determine the resident’s wishes.

### Mental Capacity to Consent

*As a solicitor, it is important to keep in mind that capacity is task, time and situation specific. (2)*

Before a person can be considered to have consented or to have refused consent for particular type of decision or matter, they must first have the capacity to consent. Capacity is always issue or decision specific, and it is time specific. For older adults who are admitted to and live in residential care facilities, capacity to consent arises in the context of many types of decisions they make, including the capacity to make health care, personal care and financial decisions, capacity to enter into a contract, to name a substitute, to give a gift, and to retain legal counsel.

Consent relates to the particular task or decision or group of decisions at hand. For example, a person who lives in residential care may be mentally incapable of making decisions about management of his or her property and yet still be mentally capable of making decisions about health care. (3) Even if there has been a "formal" finding of incapacity by a physician or other health care provider, that finding relates to a particular type of incapacity. This still means that that same person may be able to make other types of decisions.

Different decisions also require different types and different levels of capacity. (4) Capacity to execute a power of attorney is different than capacity to manage property. (5) It has been suggested the capacity to give instructions about personal care decisions may be "higher" than capacity to execute a Representation Agreement for Personal Care. Capacity to give or refuse consent to complex surgery is higher than capacity to consent or refuse consent to receiving medical treatment for a minor cut or abrasion.

## **Presumption of Capability**

British Columbia's Adult Guardianship Act (6) and Representation Agreement Act (7) emphasize every adult is presumed to be capable of making decisions about the adult's personal care, health care, legal and certain financial affairs, until the contrary is demonstrated.(8) The Health Care (Consent) and Care Facility (Admission) Act (9)(HCCCFA) similarly reaffirms the presumption in the context of health care, as does the Powers of Attorney Act(10) in the context of financial matters.

The question of capability and the presumption associated with it, always relate to the specific decision at hand. A medical diagnosis by itself is not indicative of an individual's mental capacity. Even for conditions such as dementia, where people tend to assume there may be diminishing capability to make decisions, health research shows there is considerable heterogeneity among people with the diagnosis on the extent of impairment they have and whether it affects their ability to make decisions.

Mental capability can be affected by many things, including dementia, delirium, depression and drugs. (11) As a result, whether or not the person is mentally capable at the time can fluctuate.

Presumption of capability, however, is a starting point and can be rebutted. There are numerous instances in which it can be demonstrated that the resident is not capable of making a particular decision. This does not necessarily require a formal assessment of the person's mental capability.

## **Misuses of Presumptions**

In a care facility, the presumption on capability may be misused or it may be overlooked. In some instances residents will be treated as capable of making certain decisions when actually they are not. Typically this may occur when they are compliant or passive ("non resistive") when it comes to care. In other instances, residents may be approached by staff or others in ways in which resistance is gradually worn down and where they acquiesce with what is being proposed. The resident simply accedes to what the health care provider is doing or would like to see accomplished, because they do not know or feel they have alternatives or have a choice.

In other instances, the residents may have a specific diagnosis that people tend to equate with incapacity. The residents may have difficulty communicating or expressing their wishes, or perhaps they have scored below a threshold on a particular test. A health care provider or other person may incorrectly presume the resident is incapable when actually the resident is capable, and as a result the resident is not asked and is left out of the consent process.

Both health care law and adult guardianship law in British Columbia recognizes these tendencies and tries to address some of them, especially related to communication difficulties. The health care consent law specifically notes that " an adult's way of communicating with others is not, by itself, grounds for deciding that he or she is incapable of

understanding."(12) The health care consent law also places a duty on health care providers to “communicate in an appropriate manner”, when seeking an adult's consent to health care or deciding whether an adult is incapable of giving, refusing or revoking consent. (13)This includes communicating in a manner appropriate to the adult's skills and abilities, and allowing the adult's spouse, or any near relatives or close friends to help the adult to understand.(14)

## How is Capability Determined?

British Columbia's health care law does not define “capability”. Instead, the focus is on the health care providers determining whether or not the person demonstrates understanding of the information the health care provider is giving and that the information given actually applies to him or her. (15)

In general, there is an expectation that any threshold for determining what constitutes a “minimally accepted level of understanding, appreciation or reasoning” should be decision-specific. (16) The threshold may also depend, in part on balancing risk against benefits. For example, higher thresholds need to be associated with situations where “being wrong” carries greater danger for the person. (17) For example, setting the threshold for capacity to consent to sexual activity in residential care too low may leave some residents vulnerable to exploitation and risk their personal safety. This, however, is not always included as a consideration.

## Understanding Tests of Incapability

There is no one standard formal test that is used to determine if a person is mentally capable of making a specific type of decision. In 2009, the Office of the Public Guardian and Trustee commissioned a study to review tools being used to formally assess incapability. The report specifically noted that none of the commonly used capacity assessment tools had actually been tested to see how well they applied in the context of British Columbia's law.(18)

The Mini Mental Status Examination [“MMSE”] is one of the most commonly used tools used to assess capacity. Families members may be told a resident scored 22 out of 30 or 14 out of 30 on the “Mini Mental”, and consequently the person is mentally capable or is not mentally capable. This screening tool was never intended to be used as a diagnostic tool on its own, nor was it developed as an assessment of capacity.(19)

There are four standards generally accepted in research and practice as required for evidence that someone is capable of decision-making. These are: a) being able to understand information; b) being able to “appreciate”, i.e., applying information to their own circumstances and realizing the consequences for them; c) being able to reason how they came to a decision; and d) making a choice. Expressing a choice is seen as a lower threshold than reasoning, and being able to understand information is a less stringent test than appreciation. (20) Yet these markers do not translate very well for the real life decisions in residential care, nor are they legal standards.

## References

1. ACE (2004). Advocacy Centre for the Elderly. Long-Term Care Facilities in Ontario: The Advocate's Manual. Chapter 7 Decision Making , page 7.7 [“ACE: Decisionmaking”]
2. Goddard,J., Whaley, K.A., & Likwornik, H. Capacity to grant or revoke power of attorney. Online: <http://whaleyestatelitigation.com/blog/2008/11/capacity-to-grant-or-revoke-power-of-attorney/>(Last accessed January 9, 2016)
3. ACE: Decisionmaking, p. 7.8 and 7.9.
4. ACE: Decisionmaking.
5. Desormeaux v. Kicz (7 July 2000), Court File No. A-8757/2000 (Ontario Superior Court of Justice) at par.17.
6. Adult Guardianship Act, [RSBC 1996] c. 6, [“AGA”]

7. Representation Agreement Act [RSBC 1996] c. 405. [“RRA”]
8. AGA, s. 3 (1)
9. Health Care (Consent) and Care Facility (Admission) Act [RSBC 1996] c. 181, s. 3. [“HCCCFA”].
10. Power of Attorney Act [RSBC 1996] c. 370.
11. BC Law Institute (2013). Report on Common Law Tests of Capacity, BCLI Report. No. 73. p. 13-16. Online: [http://www.bcli.org/wordpress/wp-content/uploads/2013/09/2013-09-24\\_BCLI\\_Report\\_on\\_Common-Law\\_Tests\\_of\\_Capacity\\_FINAL.pdf](http://www.bcli.org/wordpress/wp-content/uploads/2013/09/2013-09-24_BCLI_Report_on_Common-Law_Tests_of_Capacity_FINAL.pdf) (Last accessed: January 9, 2016) [“BCLI Capacity”]
12. HCCCFA, s.3 (2). Also AGA, s. 3 (2) specifically notes “An adult’s way of communicating with others is not grounds for deciding that he or she is incapable of making decisions about [the adult’s personal care, health care and financial affairs].
13. HCCCFAA, s.8.
14. HCCCFAA, s.8 (a) and (b).
15. O’Connor, D. (2009). Assessing incapacity: review of tools. Public Guardian and Trustee, page 10. Online: [http://www.trustee.bc.ca/pdfs/STA/Incapacity\\_Assessments\\_Review\\_Assessment\\_Screening\\_Tools.pdf](http://www.trustee.bc.ca/pdfs/STA/Incapacity_Assessments_Review_Assessment_Screening_Tools.pdf) (Last accessed: January 9, 2016)[“O’Connor”]. O’Connor notes that unlike some jurisdictions, the notion of ‘appreciation’ is not actually used in BC’s health care consent law. However, the ideas underpinning it are arguably captured in the standard that the person recognizes that the information applies to him or her.
16. O’Connor, p. 10
17. O Connor, p. 10.
18. O’Connor, p. 3.
19. O’Connor, p. 25.
20. O’Connor, p. 9.

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# Health Care Consent

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The legal requirements for health care consent are set out in Health Care (Consent) and Care Facility (Admission) Act (HCCCFA). The Act outlines how health care consent is obtained and the few instances in which consent is not required.

The six general rules regarding health care consent are:

1. Adults can only be given health care with their consent (1) (s. 5, HCCCFA)
2. Adults are presumed to be capable of giving consent. (2) (s. 3, HCCCFA)
3. Adults must be approached first for a decision about health care.
4. Adults can withdraw their consent, as long as they are mentally capable.
5. Consent is specific to the health care the person agreed to. (s. 9 (2) HCCCFA)
6. Health consent must be freely given and informed.

Most adults, including many of those living in residential care facilities, can make their own treatment decisions. A resident can give informed consent when there is appropriate communication between the health care provider and the resident, along with necessary information and support. [See Tips at end] To provide health care without consent, irrespective of whether it is for minor or major treatment is an assault.

<b>Noteworthy: Demonstrating Consent</b>
A resident's consent can be shown in a variety of ways. Consent can be inferred by the resident's actions, given verbally or be evidenced in a written form.

## The Conditions of Health Care Consent

The conditions for consent in residential care include:

- The individual resident has been adequately informed.
- The individual resident is capable of giving or refusing consent.
- There has been no coercion, fraud or misrepresentation.
- There actually is a choice.

The same conditions apply when a substitute decisionmaker is making the decision for the resident.(3) Consent to health care must be voluntary. No one can pressure or force the resident or a substitute decision-maker to decide in a particular way, or deliberately give wrong information to influence the decision. Health care providers must provide residents and substitute decision-makers with the information that a reasonable person would require in order to make a decision about proposed health care. This includes information about:

- The condition for which the health care is proposed.
- The nature of the proposed health care.
- The risks and benefits of the proposed health care.
- Alternatives to the proposed health care.

The amount of details needed depends on the type of care that would be provided and type of decision to be made, with more intrusive acts and greater risks to the individual more likely to require more detail. The information must be sufficient, specific and based on sound information. The information also needs to be provided in a timely and appropriate manner, taking into account the individual's abilities, age, culture, language and preferences. Residents and substitute decision-makers need be provided adequate time, plus an opportunity to ask questions and receive answers.



Health care providers must not use coercion, fraud or misrepresentation in the consent process. Health care providers must be sensitive to the difference in power between health professionals and clients and do not misuse that power to influence clients' decision making.

Health care providers must respect the right of clients and substitute decision-makers to seek further information or another opinion and to involve others in the decision-making and consent process.

**Noteworthy: Consent is Specific to Issue and Time**

Health care consent law is clear - the consent applies only to the specific health care to which an adult has consented.(4) For that reason, efforts to gain written consent from residents or their substitute for certain types of events in the future, such as health care treatment (blanket consent) are not legally valid.

## **Who Must Seek Consent for Health Care?**

The Health Care (Consent) and Care Facility (Admission) Act specifically applies to health care providers and social workers. (5) Health care providers covered by the Act include physicians, dentists, registered and licensed practical nurses, physiotherapists, occupational therapists, optometrists, chiropractors and sixteen other groups of regulated health professionals. For a list see the Health Care Consent Regulation (6) and BC Health Regulators.(7) The residential care aides (staff who provide most of the day to day care) are not currently covered by these acts. The expectation apparently is that their supervisors will seek consent for health care.

## **What is Meant by “Health Care”?**

The Health Care (Consent) and Care Facility (Admission) Act describes “health care “ in the context of “treatment” and clearly sets out that all health care treatment requires consent. Health care is defined broadly as “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health”. The types of treatments covered can include:

- an individual treatment (e.g. a broken foot, a tooth extraction, surgery)
- a series or sequence of similar treatments or care over a period of time for a particular health problem (medication regime, rehabilitation therapy, wound care, ongoing treatment for pain or migraines),(8) as well as
- a “plan for minor health care”

The last type refers to a plan developed by health care providers that “deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition. “ For example, a care plan might involve helping to manage the health of a person who has diabetes. A health care plan is also a component of care planning required for each individual resident upon admission (See below).

A plan for minor health care is not a blanket approval process, where consent is only required once. Instead, by law, the plans must be revisited (and specifically, the consent “expires no later than 12 months from the date consent for the plan was given”). Withdrawing consent for any aspect of health care treatment is an option at any point, if the capable person so decides.

The Supreme Court of Canada in *Cuthbertson v. Rasouli* (9)(an Ontario case) considered what the terms “treatment” and “health related purpose” meant in the context of (withdrawing) life support. In *Rasouli* the Court noted these two terms are not confined to procedures that the patient's health care providers consider as a medical benefit to the person. Rather, the focus is on why it is being done -- "treatment" is broadly defined as "anything that is done" for one of the enumerated purposes (therapeutic, preventative, palliative, diagnostic and cosmetic) or "other health-related purpose". In *Rasouli*, the

Court also emphasized that treatment includes stopping treatment.

## Consent Rights

With respect to health care rights, the Health Care (Consent) and Care Facility (Admission) Act states every adult has the right to:

- (a) give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,
- (b) select a particular form of available health care on any grounds, including moral or religious grounds,
- (c) revoke consent,
- (d) expect that a decision to give, refuse or revoke consent will be respected, and
- (e) be involved to the greatest degree possible in all case planning and decision making. (10)

<b>Noteworthy: Forms versus Consent</b>
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Signing a consent form is not the same as giving consent.
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## The Consent Process

One of the many common misunderstandings in this area of residential care, is that having a signed consent form is the same as “consent”. It is not. Consent is predicated on communication, understanding and choice.

Effective communication is essential to ensuring that resident’s decisions about his or her own health care are understood, expressed and respected by everyone involved. Communication and decision-making about health care is often an ongoing process. While residents may consent to an initial plan for care, there can be a need for health care providers to re-establish consent. This might arise for example if the health care provider is contemplating changes to the plan or believe resident may be reconsidering the decision.

## How Does a Person Give Consent?

(11)Decisions about health care must be voluntary. No one can pressure or force the person to decide in a particular way, or deliberately give wrong information to influence decision.

People can give consent in different ways—by speaking, by writing, or through behaviour, such as nodding or making a sign that the person agrees. Although behaviour may count as consent— for example, offering an arm for an injection when requested, opening their mouth, or complying with a course of treatment—cooperating is not always the same thing as giving informed consent.(12)



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## Exceptions to Requiring Consent

### Are there circumstances in which the person's consent to health care is not required?

Consent is not possible when the adult is unconscious, mentally incapable of making that particular decision, or, otherwise unable to give consent. Consent is not required:

- for preliminary examinations such as triage or assessment,
- when the person needs urgent or emergency health care, (\*)
- when the adult is incapable, and there is no committee, representative, advance directive or TSDM available.
- when the person needs involuntary psychiatric treatment under the Mental Health Act.

(\*) Health care provider cannot just wait for things to become urgent or an emergency

## Health Care at the Margins

It is not always automatically apparent what is or is not "health care". The law describes two kinds of health care in the context of substitute decisionmakers' mandates:

### Minor health care

which includes matters such as regular checkups, routine tests, basic dental and eye care, immunizations, medications, and other care that is not major health care.

### Major health care

which includes matters such as surgery, risky or complex tests, any treatment involving a general anesthetic, radiation, chemotherapy, and kidney dialysis.

The public might assume that almost anything done in a health care setting such as a private hospital, extended care unit of a hospital or residential care facility would be "health care". Similarly they may assume anything involving technology or medical equipment; prescribed by a physician; done by a nurse, nurse practitioner, or care worker was "health care " or "treatment "; and anything physically intrusive in a care setting is "treatment". However a recent British Columbia case (*Bentley v. Maplewood Seniors Care Society*, a case involving spoon feeding a woman in care with advance dementia) suggests that health care is more narrow than commonly assumed.(13)

As the traditional nursing tasks have increasingly become delegated or transferred to care workers, the lines between "health care " tasks involving informed consent and other kinds of care that residents might receive, have become increasingly blurred. The matter of health care is sometimes becoming less about what is being done, than who is doing it.

## Areas of Confusion Around Health Care Consent in Residential Care

As noted, the Health Care (Consent) and Care Facility (Admission) Act sets out the requirements for health care providers to follow to ensure that a capable resident (or their substitute decision-maker when the resident is incapable) provides consent before health care is given. However family members of residents with dementia often find a resident has been given an antipsychotic or other medication without the resident's or substitute decision-makers' knowledge or informed consent. This is in spite of the fact that the family may be the legally recognized health care decision-maker for the mentally incapable resident. About one half of all residents in British Columbia care facilities are prescribed psychoactive medications.(14) The medications are often used in response to anxiety, wandering, verbal and restless behaviours. Many commonly used psychoactive medications prescribed in care facilities have been shown to have serious side effects on people who are frail and elderly. These effects include sedation, higher risks of falls and hip

fractures, Parkinson's disease-type symptoms, cardiovascular events (stroke and heart attack), and a greater risk of death.(15)

In June 2005, Health Canada issued an advisory notice about the use of atypical antipsychotic medication in the treatment of behavioural disorders in elderly patients. Health Canada specifically pointed out these medications are not approved for use in elderly patients with dementia. In some instances, operators (many of whom may not have training in health care, particularly geriatric health care) are unaware that some of these medications are not suitable for older people, and can have serious side effects.

The use of these medications is a health care intervention; as such it comes under the Health Care (Consent) and Care Facility (Admission) Act consent requirements. However the use of the medication also potentially becomes a form of chemical restraint,(16) also bringing it under the Residential Care Regulations rules on restraints. (17) Depending on the circumstances, the misuse of restraints may also fall under the Adult Guardianship Act abuse definition. (18)

The safeguards, such as consent, for chemical or other restraints are not covered by the laws governing some facilities. As the Ombudsperson Report has noted "There are no legislated requirements in the Hospital Act that limit the use of restraints in private hospitals or extended care facilities". (19)

Recent best practice guidelines for dementia care from the Ministry of Health have been beneficial in raising awareness of the responsibility of health care providers to seek consent for use of the medication or other intervention before treatment. (20) The guidelines stress:

*"With few exceptions it is paramount that the resident's closest family or friend (of whom one of is likely the resident's authorized substitute decision maker) should be included in the consent seeking process."* (21)

## **Information Rights**

An adult has the right to relevant information given in an appropriate manner to be able to make an informed decision. The information rights necessary for authorized substitute decision maker to exercise informed content about restraints on behalf of an incapable resident's are similar to a resident's information rights. The guidelines note:

*"[t]he capable resident/family, or the incapable resident's authorized substitute decision maker, should be informed of the benefits and risks of the recommended treatment, the clinical implications of refusing treatment, and be given the opportunity to ask questions of the health care provider (and have them answered) before providing a decision. Any potential adverse effects from the use of antipsychotics, such as the increased risk of stroke or death, should also be discussed when antipsychotic medications are considered medically appropriate."* (22)

However, even these guidelines seem to be based on the assumption that the main goal is to "get the consent", as opposed to informing the decisionmaker and exploring alternatives. The best practice guidelines are accompanied by a "decisionmaking algorithm to support person-centred care for persons with behavioural and psychological symptoms of dementia". Basically this is a process to help guide the practitioner to make decisions.

Consent is recognized as a component of that resident/ patient decision-making, but again it is specifically described in the context of medications. It is important to recognize that health care consent is required for any health care intervention.

## Exploiting Consent Loopholes?

When the person falls under the Mental Health Act is one of the few exceptions for when consent is required. (23) This provision is one of the ways in which health care consent requirements are sometimes circumvented in care facilities. In a 2011 review of antipsychotic drugs use in British Columbia's residential care facilities, health care providers confirmed if the authorized decision-maker refuses medication or other appropriate treatment that the health care provider has proposed to manage behaviour and feels is appropriate.

“... then the practice is to send the resident to a hospital that is designated under the Mental Health Act. In these designated settings, the patient may be certified under the Mental Health Act, and involuntary treatment, including medication, may be provided without the consent of the patient or their authorized decision maker.” (24)

## References

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2. HCCCFAA, s. 3.
3. HCCCFAA, s. 10.
4. HCCCFAA s.9 (2).
5. Health Care Consent Regulation. B.C. Reg. 20/2000, s. 3 (c ) and 3 (i) . See Health Professions Act RSBC 1996, c. 183.
6. B.C. Reg. 20/2000, Health Care Consent Regulation.
7. Online: <http://bchealthregulators.ca/#list-of-colleges> (Last accessed: January 9, 2016)
8. HCCCFAA, s. 1.
9. Cuthbertson v. Rasouli [2013] S.C.J. No. 53; [2013] A.C.S. no 53; 2013 SCC 53; 310 O.A.C. 19; 449 N.R. 313; 2013 EXP-3330; J.E. 2013-1818; 5 C.C.L.T. (4th) 1; 364 D.L.R. (4th) 195; 2013 Carswell Ont 14113
10. HCCCFAA, s. 4
11. Nidus. Your rights and the law. Online: [http://nidus.ca/PDFs/Nidus\\_Info\\_HCC\\_Your\\_Rights\\_and\\_the\\_Law.pdf](http://nidus.ca/PDFs/Nidus_Info_HCC_Your_Rights_and_the_Law.pdf) (Last accessed: January 9, 2016). [“Nidus, Rights”]
12. Nidus, Rights.
13. Bentley v. Maplewood Seniors Care Society, 2014 BCSC 165.
14. Ministry of Health. (2011). A review of the use of antipsychotic drugs in British Columbia's residential care facilities. Page 8. Online: <http://www.health.gov.bc.ca/library/publications/year/2011/use-of-antipsychotic-drugs.pdf> (Last accessed: January 9, 2016). [“Antipsychotic drug review”]
15. Antipsychotic drug review, pg. 8.
16. Residential Care Regulation, B.C. Reg. 96/2009, s. 1 defines "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”. [“RCR”]
17. RCR, Division 5, “Use of Restraints” s. 73- s.75, and s. 84.
18. Adult Guardianship Act , s. 1 ““abuse” means the deliberate mistreatment of an adult that causes the adult (a) physical, mental or emotional harm, or (b) damage or loss in respect of the adult's financial affairs, and includes ... overmedication, withholding needed medication, ...
19. BC Ombudsperson. The Best of Care: Getting It Right for Seniors in British Columbia (Part 1), p. 284. [“Ombuds, Best of Care, Part 1”]
20. Ministry of Health. (2012) Best practice guideline for accommodating and managing behavioural and psychological symptoms of dementia in residential care- a person-centered interdisciplinary approach. Online: <http://www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf> (Last accessed: January 9, 2016). [“Dementia

Guideline”]

21. Dementia Guideline, p.12-13
22. Dementia Guideline, p.13.
23. Mental Health Act, [RSBC 1996] c. 288.
24. Antipsychotic drug review, page 21.

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## Care Planning

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When a person is being admitted to the residential care facility for more than 30 days, the operator is required to develop an individualized care plan for the person. (1) Sections 81 and 82 of the Residential Care Regulation sets out the components of a care plan. (2) The operator has a responsibility to ensure the care plan is properly implemented, reviewed if there is a substantial change in circumstances, and if there is no change, the plan must be reviewed at least once a year.

By law, the resident’s care plan must be developed (and later reviewed or modified) to the extent reasonably practical, with the participation of the resident, or if the person in care is not capable of participating, with the resident’s “representative”. (3) The term “representative” as it is used in the Residential Care Regulation means a person with authority under the Health Care (Consent) and Care Facility (Admission) Act (including a TSDM) or the Patients Property Act, or under an agreement under the Representation Agreement Act to make health or personal care decisions on behalf of the adult. (4) This is a relatively circumscribed group.

In some instances, particularly where the resident has not formally appointed his or her own substitute decision-maker, the health care provider relies on the statutory list of substitute decision-makers. Some health care providers in residential care skirt the process and turn to the person they feel will be most supportive of the decisions they want to make, as opposed to one who knows what the resident wants best. The care plan is also required to be developed in a manner that takes into account the unique abilities, physical, social and emotional needs, and cultural and spiritual preferences of the person in care. (5) The care plan is not intended to be a one way process of care providers deciding what is needed or they believe is in the resident’s best interest. Residents have the right to have it developed “on the basis of his or her unique abilities, physical, social and emotional needs, and cultural and spiritual preferences.” That typically involves information from the residents and those who know the resident well.

### Consent and Care Plans

Several important consent issues come up in the context of the care plans. First, care planning frequently becomes conversations among care providers only; the resident is treated as incapable and therefore excluded. A 2011 review also found families in British Columbia experience challenges in interacting with health care professionals and residential care facility staff. These included:

- family were not being effectively included in the care plan development
- their legal authority as health care decision makers (including as temporary substitute decision-makers) was not recognized and respected
- their consent was not sought when treatment options are considered and provided.

Specifically family might not be informed about the care conference or were given short notice; people might not be advised of their role and how they might participate more effectively; residents and others are not given real opportunities to help inform the care process; and key persons such as physicians were not part of the conference. (6)

Informed consent is typically based on having good information. The BC Ombudsperson's Best of Care report has identified the following concerns from residents and their families:

- lack of adequate understanding of the level of care that seniors are entitled to receive in residential care facilities;
- reluctance to raise concerns about the level of care that facilities provide, in part because they were not confident about what residents were entitled to receive or what their rights were;
- the risk of raising concerns because residents were dependent on others for their care;
- lack of good understanding of the legal obligations of facility operators;
- difficulty determining who was responsible for the delivery of specific services and with whom concerns about these services could be raised. This was especially true when service delivery was contracted out to third parties. (7)

## **Rights Associated with Care Plan Consent**

The provisions of the Health Care (Consent) and Care Facility (Admission) Act also apply to residents of long-term care facilities. A Care Plan involves a combination of health care and personal care decisions, as well as in some instances, financial decisions. (8)The resident has the right to participate in the assessment of his or her physical and mental capabilities, needs, and preferences, as well as in developing and revising a plan of care.

In order to be able to participate meaningfully, residents have the right to have someone explain to them, in language and terms that the residents understand, what has been assessed and how, as well as the proposed plan of care. After being informed (in plain language) of the consequences of any proposed treatment, and of not receiving the treatment, the resident has the right to give or refuse to give informed consent. (9)

Residents have the right to request and receive a "second opinion" from an independent health care professional, regarding any aspect of their care. The resident has the right to be involved in, and receive independent advice regarding any aspect of the resident's care. This includes any decision regarding the resident's discharge or transfer from the facility, and would also include any decision regarding transfer of the resident within a facility, (i.e., moving to another room or wing).

## **Advance Care Planning - Advance Care Plan and Advance Care Directives**

Advance care planning is the communication process between a capable adult, family or other key people in their lives, and health care providers to ensure that the adult's beliefs, values and wishes for future health care are known in the event that the adult is incapable of making health care decisions when the health care is required. (10) Although advance care planning is supposed to be an ongoing process of communication, health care providers are often given the impression that it is a linear process and that once the documentation is done, the process is complete.

Advance care planning was originally intended as a process by which people could exert their autonomy over what happened to them, in the event they became incapable and were no longer able to directly express those wishes. Unfortunately it has sometimes become a process done to and imposed on the older adult, as opposed to done with the older adult.



An advance care plan is a written summary of a capable adult's beliefs, values and wishes for future health care, in the event the adult is incapable when the health care is required. The plan may simply be a statement of wishes, or it may include an advance directive or a representation agreement in which the adult names another person to make health care decisions on behalf of the adult.

An advance directive is a legal document that provides consent or a refusal for certain types of health care before the need for health care arises. It is a capable adult's written instructions expressed directly to their health care provider, or to their representative if they have named one in a representation agreement.

Advance directives are legally binding documents and only apply to health care. To be a valid advance directive, it must comply with the legal requirements for the instructions, plus comply with the law on how it is signed and witnessed.(11) Under the Health Care (Consent) and Care Facility (Admission) Act, an advance directive:

- must not be mandatory - an adult must not be required to have an advance directive as a condition of receiving any good or service. (12)
- may not include anything that is prohibited by law or an instruction to omit to do anything that is required by law.
- cannot include instructions about any types of health care restricted for a temporary substitute decision-maker.

## **Consent and Advance Care Directives**

As noted in the chapter on admissions, in recent years, more and more care facility operators are inquiring at admission whether the person has an advance directive. Accreditation processes and mandated health care system tools such as the Resident Assessment Instrument - Minimum Data Set (RAI MDS) may leave the health care providers with the belief the residents must have advance directives, and may leave them with erroneous or incomplete information about the difference between informed consent and advance care plans. (13)

Unfortunately residents and families are sometimes given the impression the resident must have an advance care directive or other advance care planning as a condition for admission or to remain there. The law is clear- advance care directives are not mandatory and cannot be required as a condition of receiving services. (14) The Public Guardian and Trustee specifically notes:

*"You do not have to make an advance directive. It's your choice. It is one tool that you can use to plan for your future. A service provider may not require you to make one as a condition of receiving goods or services."*

## **What can care providers do?**

Just because a senior has moved into a long-term care facility does not automatically mean that he or she needs an enduring power of attorney, representation agreement or advance directive. The senior may continue to manage his or her own finances during any period of time that he or she is a resident there. However, when a senior moves into a long-term care facility, it may be a good time to consider whether he or she wants to prepare these documents to address possible future needs or whether he or she wants some help with financial management or other decisions, now, while he or she is still capable.



## **What are the capability requirements to make an Advance Directive?**

The person must be capable of understanding the type of health care instruction it deals with and the consequences of giving or refusing consent to it. The person must also understand that if the person makes an advance directive and the instruction applies to the specific health care situation arising while the person is incapable, a health care provider will only follow the instruction. They will not select someone to be a temporary substitute decision-maker.

## **Common Areas of Misunderstanding for Advance Health Care Consent**

### **Standardized Forms**

In recent years British Columbia has been moving to develop standardized health care planning and end of life intervention orders. A recent review of health care planning and related policy documents in use in Canada, including one from British Columbia pointed out a number of common errors in the forms:

- They failed to distinguish between and confused consent to treatment, prior capable wishes, values and beliefs (advance care planning), and physician orders based on the standard of care; (15)
- They left the erroneous impression that substitute decisionmakers can express new wishes on behalf of residents, whereas they can only recount prior capable wishes expressed by the person;
- They seemed to suggest that physicians can directly implement advance directives, without utilizing the substitute decisionmakers or anyone else to interpret whether the advance directive actually applied in those circumstances.\* (16)

One of the documents reviewed was Medical Orders for Scope of Treatment (MOST) developed by Fraser Health and promoted by the Ministry of Health.(17) This is a system of medical orders and standardized forms to be used across care settings that record physicians' orders regarding end-of-life medical interventions, along with standardized forms recording patient advance care plans. The MOSTs are to be reviewed at least once a year.

Tucked in the documents among many details is the observation "As long the adult is capable of providing consent, consent should always be sought from the adult directly and not from their MOST order, Committee of Person/Personal Guardian, Representative, Advance Directive, or Temporary Substitute Decision Maker (TSDM)." This point is very important, but it is given little prominence in the overall scheme. Like many other policy and education documents on advance care planning, MOST and the policy documents that accompanied it contained the common legal errors noted above.

### **Tick Box Forms**

Advance care planning and advance care directives, in particular, have been widely promoted in health. The original efforts began as ways of expressing patient autonomy. In recent years, the rationale in health care policy shifted more to cost reduction, in part predicated on the belief that older adults especially at the later stages of life were "using more than their fair share of health resources". (18) Many advance care planning forms are tick-box forms: forms which require patients to choose from a narrow field of pre-selected options for future care. The use of tick-box advance care planning forms appears to be widespread.

It has been pointed out these forms unduly restrict the wishes that may be solicited from people, and the information expressed in these forms may not be particularly useful to a future substitute decisionmakers ("if indeed one is consulted").

The forms also generally make no attempt to place the person's expression of wishes in the context of their current health condition, or to discuss the risks and benefits of treatment. Instead, they simply request that people express their future

wishes about, for example, whether they want to be hospitalized and receive antibiotics, without grounding the application of that wish in likely hospitalizations relating to the patient's present health condition. It has been pointed out that these level-of-care forms in particular seem to be used frequently as consents although they are being portrayed as advance directives. They are completed without the information required for a valid informed consent.

## References

1. The Residents Bill of Rights notes under "Commitment to care" that "An adult person in care has the right to a care plan developed: (a) specifically for him or her, and (b) on the basis of his or her unique abilities, physical, social and emotional needs, and cultural and spiritual preferences."
2. S. 81(3) of the RCR note that the care plan needs to address ten areas : medication, "behavioural intervention"; use of restraints; oral health care; nutrition (including therapeutic diets); recreation and leisure; fall prevention; "elopement risk"; any condition or requirement associated with the resident's admission to the community care facility under the Mental Health Act.
3. HCCCFA defines "representative" in this manner means a person authorized by a representation agreement to make or help in making decisions on behalf of another and includes an alternate representative. This would seem to limit the support for anyone who does not have a representative under the Representation Agreement Act. However as noted,
4. Nothing in this regulation confers on the person any greater authority to make health or personal care decisions than the person has under those Acts or an agreement under the Representation Agreement Act.
5. The Residents Bill of Rights notes under "Commitment to care" that "An adult person in care has the right to a care plan developed: (a) specifically for him or her, and (b) on the basis of his or her unique abilities, physical, social and emotional needs, and cultural and spiritual preferences."
6. Antipsychotic drug review, pg. 18.
7. Ombuds, Best of Care, Part 1.
8. ACE: Decisionmaking,
9. ACE : Decision Making.
10. Ministry of Health. (July 18, 2012) Advance care planning - frequently asked questions. Online: <http://www2.gov.bc.ca/gov/content/family-social-supports/seniors/health-safety/advance-care-planning> (Last accessed: January 9, 2016).
11. AGA, s. 3 (1)
12. Health Care (Consent) and Care Facility (Admission) Act, s. 19.91.
13. Wahl, J., Dykeman, M.J., & Gray, B. (January 2014). Health Care Consent And Advance Care Planning In Ontario- Legal Capacity, Decision-Making and Guardianship. Commissioned by the Law Commission of Ontario, p. 203 and 205. Online: <http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ace-ddo.pdf> ["ACE\_ LCO"] (Last accessed: January 9, 2016).
14. HCCCFA, s. 19.91.
15. ACE\_ LCO, p. 205.
16. While advance directive can be directly relied on by physicians in British Columbia, they have to ascertain whether the advance directive applies in the situation, and if the advance directive is part of a representation agreement, the representative may be the interpreter.
17. Fraser Health. Medical Orders for Scope of Treatment (MOST) and Advance Care Planning (ACP). [Date Approved: June 13, 2012.]
18. Malpas, P.J. (May, 2011). Advance directives and older people: Ethical challenges in the promotion of advance directives in New Zealand. *Journal of Medical Ethics: Journal of the Institute of Medical Ethics.* 37(5). pp. 285-289.

This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

## Personal Care and Consent

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### What is Personal Care?

The term “personal care” is used very loosely in legal and health care fields without much regard to what it really means. In some frameworks, personal care decisions include anything that is not a financial or legal matter, and health care becomes just one specific type of personal care decision, with its own special requirements.

Most legal descriptions of “personal care” have been developed in the context of giving someone formal legal authority to assist the other person with decisions “in the event the person needs help speaking up for himself or herself due to the challenges that can come with ageing as well as in case of illness, injury or disability”. Personal care decisions in this authority context are described as covering:

- living arrangements (where the person will live and with whom);
- assessment and planning for support or services;
- arranging and managing support or services;
- managing staff who are paid privately to provide care;
- diet;
- exercise;
- spiritual matters;
- care of pets;
- personal safety; and
- participation in activities.

The Representation Agreement Act describes “personal care” as including matters respecting

- the shelter, employment, diet and dress of an adult,
- participation by an adult in social, educational, vocational and other activities,
- contact or association by an adult with other persons, and
- licences, permits, approvals or other authorizations of an adult to do something. (1)

In a care facility, some aspects of personal care are referred to as the “basic ADLs” (activities of daily living). These consist of tasks related to areas of “self care” where the person may need assistance including:

- bathing and showering
- bowel and bladder management
- dressing
- eating
- feeding (setting up food and bringing it to the mouth)
- functional mobility (moving from one place to another while performing activities)
- personal device care
- personal hygiene and grooming
- toilet hygiene.

Each of these personal care areas involves assistance with the activity, often with a degree of close personal, and in some cases intimate contact such as touching between staff and residents. Because these involve personal contact, they always require the resident's consent and cooperation. Intruding on the resident's personal physical integrity without consent and cooperation in these circumstances may be considered an assault and battery.

In residential care, personal care includes the most intimate types of contact. It can include washing the person in a bath or shower, or in bed, washing hair, cleansing the person's mouth, and eye care), movement (which can include: touching to move the resident to bed, moving the resident from lying to sitting, lateral transfers, helping the person to sit back in a chair, moving the person from sitting to standing, and walking), nutrition and fluid intake (including help with eating and drinking, feeding tubes, and feeding tube care), toileting (include using a toilet or bedpan, suppositories, enemas, feces specimens, urine specimens, and catheter care), observation and monitoring (including measuring and recording temperature, blood pressure, pulse, and respiratory rate), and care of the person immediately following death. Personal care involves cultural and religious preferences, such as whether to continue to eat kosher food.

It is well recognized that circumstances where people intrude on the resident's personal physical integrity without consent and cooperation may be considered an assault and battery in criminal law, as well as at common law. Most care facility operators and staff recognize the fundamental importance of respecting the person's physical integrity, and will stop or modify their approach to care if the resident appears to be resistive, refusing or not cooperating with the activity that others want to happen. Failure to do that may constitute "abuse", under Adult Guardianship Act and the Residential Care Regulations . (2)At the same time under the same laws, failing to provide needed care or assistance may be neglect.(3)



## **Determining a Resident's Capacity to Make Personal Care Decisions**

As with health care decisions, a resident is presumed to be capable of making personal care decisions unless there is evidence to lead a reasonable person to believe that the resident is not capable of making that particular decision. Most personal care decisions that residents of long-term care facilities face may be categorized as decisions related to personal assistance services.

The representation agreement (described in Chapter 7 "Substitute Decisionmaking") is a formal mechanism for people to express their wishes as to personal care decisions (where they wish to live, whether they would want to continue to have kosher meals, the type of lifestyle he or she wants to lead, etc.) and to choose someone to speak on their behalf about those preferences after incapacity.

## **References**

1. Representation Agreement Act [RSBC 1996] c. 405, s. 1 ["RRA"]
2. See for example, RCR, Schedule D. "physical abuse" means 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;
3. AGA defines "neglect" as "any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage or loss in respect of the adult's financial affairs, and includes self neglect.

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## Other Consent Issues

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There are many other complex areas of a person's life where consent issues may arise when living in residential care. Several of these areas are discussed more generally in the Chapter 4 Legal Issues When Living in Residential Care. However, one area of consent raises special considerations; this relates to intimacy, specifically to consent for sexual relations. To a large extent, the literature on sex and people residing in care facilities has focussed on the harmful aspects, such as unwanted contact, "sexual aggression" (1) and "sexual abuse".(2) However, there have been efforts over the years to separate out harmful expressions from desired and perceived beneficial ones. (3)

### Intimacy and Sexual Relations

The issue of intimacy and sex comes up in many different ways in residential care. This includes having a private place to be intimate; expressions of intimacy between residents who may or may not be partners; people with different "levels" of capacity; whether a husband has a "right" to continue to have sexual relations with his wife who has dementia; and whether a woman with dementia who erroneously believes this person is her spouse is "consenting". These are sometimes characterized as consent issues, as privacy and quality of life issues, and other times as risk management matters.

British Columbia legislation does not refer to consent for sexual activity and there is no test to determine whether a person is able to consent to sexual activity. It has been suggested that if a test were to exist it would likely be similar to the common law test of capability of consenting to any activity (most often to health care). That test is whether or not the person has the capacity to understand the "nature and consequences" of their decision, similar to the criminal law test of capability to give consent to sexual activity. (4)

Since there is no legislated or common law test with regards to sexual consent capability, it follows that there is no law that expressly provides for substitute decision-making in this area. (5)

<b>Substitute decision-making for sex?</b>
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Substitute decision-making in this context means non-interference. The decision-maker recognizes, accepts and "allows" the parties (one or both of whom may be cognitively impaired) may act on their desires if they wish and as they wish. This would occur where there are indications from both parties that touching or other intimacy is desired.
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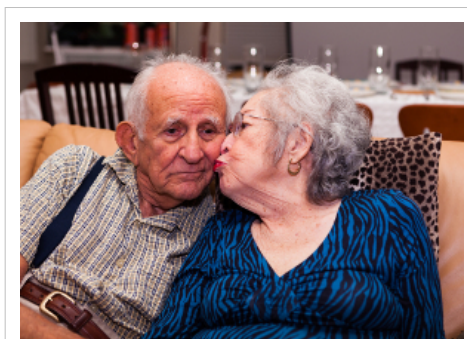
At present, substitute decision-making in this area does occur in residential care. However it more often involves family saying "no to sex" or "no" to other forms of intimacy based on their personal views about sex or other intimacy outside of marriage or intimacy generally "at our mother's age". In other instances, it is based on their interpretation of the parent's earlier life actions and values as a person without dementia. Family may expect staff to actively monitor and stop or redirect any relationships. The parties may be separated to different floors or even moved to a different facility.

It has been suggested that using a high threshold of understanding the "nature and consequences" of their decision, for all types of intimacy in residential care would effectively shut out these types of personal relations and decisions. Instead, it is important to look at the particular type of activity, and whether there appear to be harmful effects for this individual. The area is further complicated by the fact that the Residential Care Regulations states "consenting sexual activity" between residents is not considered "sexual abuse", but does not indicate who can "consent" or what consent looks like in this context.

Section 271 of the Criminal Code of Canada defines “Sexual assault”. A person may be convicted if it can be proven that the other person had not given consent. Section 273.1 of the Code makes clear that reliance on the fact that the other person is not objecting is insufficient to avoid being charged and convicted if it is determined that “the complainant [was] incapable of consenting to the activity”. According to section 273.2 the person must take “reasonable steps...to ascertain that the complainant was consenting.”(6)

The courts have repeatedly stated that whether or not a complainant had sexual consent capability depends on the facts of each situation. In *R. v. R. (R.)*, 2001 CANLII 3091, the Ontario Court of Appeal, specifically noted “...where one of the participants has demonstrable mental limitations, the threshold of responsibility escalates exponentially.” (7) Unfortunately this does not help our understanding very much where both persons in residential care facilities have “demonstrable mental limitations”.

## What Constitutes Consent in the Context of Intimacy and Sex?



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In *R. v. J.A.* (8), the Supreme Court of Canada considered whether the Criminal Code of Canada (9) framed consent as requiring a conscious, operating mind throughout sexual activity and whether a person who subsequently did not have an operational mind at the point of sex, could consent in advance.

The court decided the Criminal Code makes it clear that an individual must be conscious throughout the sexual activity in order to provide the consent. Consent to sex in the case was described in the context of ensuring that women and men are not the victims of sexual exploitation and to ensure that individuals engaging in sexual activity are capable of

asking their partners to stop at any point.

The Court emphasized that jurisprudence has consistently interpreted consent as requiring a conscious, operating mind, capable of granting, revoking or withholding consent to each and every sexual act. The jurisprudence also establishes that there is no substitute for the complainant’s actual consent to the sexual activity at the time it occurred. It is not sufficient for the accused to have believed the complainant was consenting: he must also take reasonable steps to ascertain consent, and must believe that the complainant communicated her consent to engage in the sexual activity in question.

## Tips to Facilitate Communication

Communication can be strengthened by giving explanations in ways best understood by the resident and by using a combination of strategies. These might include:

- Giving verbal explanations.
- Using visual aids and handouts.
- Asking clients for feedback about what they understand.
- Asking clients if they have any questions.
- Engaging any family or friends who are supporting the client to help the client understand.
- Using plain language and age-appropriate terminology.
- Using the services of a qualified interpreter if a language barrier exists.
- Providing information through an alternate mode (e.g., using sign language, speaking in the client's mother tongue).

## References

1. Rosen, T. Lachs, M.S. Pillemer, K. (2010). Sexual aggression between residents in nursing homes: literature synthesis of an under-recognized problem. *Journal of the American Geriatrics Society*, 58, 1070–1079.
2. See for example, Ramsey-Klawnsnik, H. & Teaster, P.B. (2012). Sexual abuse happens in healthcare facilities—what can be done to prevent it? *Generations*, 36 (3), 53- 61.
3. See for example: McSherry, B. & Somerville, M.A. (1998). “Sexual activity among institutionalized persons in need of special care” 16 Windsor Year Book. Access to Justice, 90 -139; Vancouver Coastal Health. (2009). Supporting sexual health and intimacy in care facilities: guidelines for supporting adults living in long-term care facilities and group homes in British Columbia, Canada. Online: [http://www.sfu.ca/uploads/page/04/FacilitiesLicensing\\_SupportingSexualHealthandIntimacyinCareFacilities2.pdf](http://www.sfu.ca/uploads/page/04/FacilitiesLicensing_SupportingSexualHealthandIntimacyinCareFacilities2.pdf) [“Vancouver Coastal Health, Sex.”] (Last accessed: January 9,2016).
4. Vancouver Coastal Health, Sex.
5. Vancouver Coastal Health. Sex, p. 19.
6. Vancouver Coastal Health. Sex, p. 19.
7. Vancouver Coastal Health. Sex, p. 19.
8. R. v. J.A. 2011 SCC 28.
9. Criminal Code (R.S.C., 1985, c. C-46)

This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

## Chapter Six Resources and Appendix

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### Chapter Resources

- **BC Law Institute (2013)**. Report on Common Law Tests of Capacity. Online: [www.bcli.org/wordpress/wp-content/uploads/2013/09/2013-09-24\\_BCLI\\_Report\\_on\\_Common-Law\\_Tests\\_of\\_Capacity\\_FINAL.pdf](http://www.bcli.org/wordpress/wp-content/uploads/2013/09/2013-09-24_BCLI_Report_on_Common-Law_Tests_of_Capacity_FINAL.pdf) [1]
- **Public Guardian & Trustee**. (2005). Consent to health care Online : [www.trustee.bc.ca/pdfs/STA/Consent\\_Health\\_Care\\_March\\_2005.pdf](http://www.trustee.bc.ca/pdfs/STA/Consent_Health_Care_March_2005.pdf) [2]
- **Ministry of Health**. (July 2011). Health Care Providers' Guide to Consent to Health Care
- **Restrictions on the Authority of a Temporary Substitute Decision Maker**
- **Ministry of Health**. (2013). my voice: expressing my wishes for future health care treatment. Advance care planning guide. Online: <http://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf> [3]
- **Ministry of Health**. (2011). A review of the use of antipsychotic drugs in British Columbia’s residential care facilities. Online: [www.health.gov.bc.ca/library/publications/year/2011/use-of-antipsychotic-drugs.pdf](http://www.health.gov.bc.ca/library/publications/year/2011/use-of-antipsychotic-drugs.pdf) [4]
- **Ministry of Health**. (2012). Best practice guideline for accommodating and managing behavioural and psychological symptoms of dementia in residential care- a person-centered interdisciplinary approach. Online: [www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf](http://www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf) [5]
- **Vancouver Coastal Health**. (2009). “Supporting sexual health and intimacy in care facilities: guidelines for supporting adults living in long-term care facilities and group homes in British Columbia, Canada,” Online:

[www.sfu.ca/uploads/page/04/FacilitiesLicensing\\_SupportingSexualHealthandIntimacyinCareFacilities2.pdf](http://www.sfu.ca/uploads/page/04/FacilitiesLicensing_SupportingSexualHealthandIntimacyinCareFacilities2.pdf) <sup>[6]</sup>.

Proposes guidelines aimed to help administrators and clinical leaders develop their own guidelines to support healthy and safe sexual expression for adults living in care facilities.

- **Alzheimer Knowledge Exchange.** "Intimacy, sexuality and sexual behaviour in dementia. How to develop practice guidelines and policy for long term care facilities. "Online: <http://www.akeresourcecentre.org/files/Sexuality/Intimacy,%20Sexuality%20and%20Sexual%20Behaviour%20in%20Dementia.pdf>
- **Supporting Sexual Health and Intimacy in Care Facilities - A pocket guide.** May 2013. Spinal Cord Injury Organization of BC. Online: [www.sfu.ca/uploads/page/04/SexualHealthIntimacyPocketGuide.pdf](http://www.sfu.ca/uploads/page/04/SexualHealthIntimacyPocketGuide.pdf) <sup>[7]</sup>

### General Reading

(Please note, although these resources are useful for general discussions, they are based outside of the British Columbia legal context)

- **Attorney General Ontario.** (2005) Guidelines to conducting capacity assessments. Online: [www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity/2005-06/guide-0505.pdf](http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/capacity/2005-06/guide-0505.pdf) <sup>[8]</sup>

## Appendix: Examples

### Examples of Financial Decisions in Residential Care

Financial / legal (property) decisions which specifically relate to residents of long-term care facilities

- contracting with the long-term care facility for payment of the accommodation fees and fees for other services,
- the management of the resident's trust account, if any, at the facility, and
- the management of the "comfort allowance" or other pocket money.

### Examples of Legal and Personal Care Decisions in Residential Care

Personal Care decisions which specifically relate to residents of long-term care facilities

- the decision for admission to a facility,
- decisions about medical treatment and the resident's care plan,
- decisions about personal assistance services,
- all the basic decisions about diet, clothing, and hygiene, and
- decisions about the use and application of safety devices and physical restraints.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**



## References

- [1] [http://www.bcli.org/wordpress/wp-content/uploads/2013/09/2013-09-24\\_BCLI\\_Report\\_on\\_Common-Law\\_Tests\\_of\\_Capacity\\_FINAL.pdf](http://www.bcli.org/wordpress/wp-content/uploads/2013/09/2013-09-24_BCLI_Report_on_Common-Law_Tests_of_Capacity_FINAL.pdf)
- [2] [http://www.trustee.bc.ca/pdfs/STA/Consent\\_Health\\_Care\\_March\\_2005.pdf](http://www.trustee.bc.ca/pdfs/STA/Consent_Health_Care_March_2005.pdf)
- [3] <http://www.health.gov.bc.ca/library/publications/year/2013/MyVoice-AdvanceCarePlanningGuide.pdf>
- [4] <http://www.health.gov.bc.ca/library/publications/year/2011/use-of-antipsychotic-drugs.pdf>
- [5] <http://www.health.gov.bc.ca/library/publications/year/2012/bpsd-guideline.pdf>
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# 7-Substitute Decision-Making

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## Introduction: A Right to Decide

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This chapter describes key mechanisms for making decisions on behalf of an adult who is living in a residential care facility. It also describes some of the common legal issues that come up in residential care in the context of substitute decision-making.

Today, older adults have a wide array of means to help them with life decisions, even if they become mentally incapable of making and expressing their own decisions. Just because an older adult moves into a residential care facility does not automatically mean that he or she needs an enduring power of attorney, representation agreement or advance directive. The older adult may continue to manage his or her own finances and make health care as well as other personal decisions while residing in the care facility and mentally capable of making the decision.(1)

Nevertheless, when an older adult moves into a care facility, it may be a good time to consider whether he or she wants to prepare these documents to address possible future needs or whether he or she wants some help with financial management or other decisions, now, while he or she is still capable. (2)It is however very important that people in contact with the older adult, including the staff, administration, operators and family or friends understand what these “future planning “ documents, as well as substitute decision making laws permit people to do on behalf of the older adult, and what they do not permit. (3)

### **Promoting Future Planning - What can care providers do?**

#### *Can a long-term care facility administrator require the prospective resident to execute future planning documents?*

A residential care facility administrator cannot require an older adult to execute a power of attorney or any future planning document as a condition of admission or to remain in the facility. For example, section 3.1 of the Representation Agreement Act stresses that a representation agreement cannot be mandatory. (4)Similarly, s. 19.91 of the Health Care Consent and Care Facility (Admission) Act emphasizes that “An adult must not be required to have an advance directive as a condition of receiving any good or service.” (5) If the older adult decides to prepare a power of attorney, the administrator cannot require him or her to use that facility's "standard form" documents.

It may be appropriate for a facility administrator or staff member to ask the older adult and his or her family whether the older adult has prepared any future planning documents and ask to see a copy. This helps to determine the persons with authority, as well as their scope of authority. The facility administrator or staff member may even provide the new resident and his or her spouse, partner, family or close friend with information about these documents to help the new resident plan for future property management or to pay residential care bills. Some facilities provide this information as a matter of courtesy to assist residents. (6) However, as a resident of a long-term care facility, whether the older adult decides to prepare any of these documents is ultimately that person's choice and decision.

## References

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This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.

# Types of Substitute Decision-Making in Residential Care

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## Statutory Substitutes - Temporary Substitute Decision-Making for Health Decisions

### The Basics

British Columbia has a system for appointing temporary substitute decision makers for health care decisions. Unlike some jurisdictions, British Columbia does not have a statutory process that would identify a substitute to make personal care decisions on behalf of a mentally incapable adult.

An adult may become incapable of consenting to a minor or major health care decision and may not have made her or his own arrangements to appoint someone (e.g. through a representation agreement). Typically no committee of the person has been appointed either. In these circumstances, a health care provider can select a Temporary Substitute Decision Maker (TSDM) to make health decisions on behalf of the individual. The selection is based on the hierarchy set out by the statutory list under the Health Care Consent and Care Facility (Admission) Act. (1)

To qualify as a TSDM who can give, refuse or revoke substitute consent to health care for an adult, a person must:

- (a) Be at least 19 years of age,
- (b) Have been in contact with the adult during the preceding 12 months,
- (c) Have no dispute with the adult,
- (d) Be capable of giving, refusing or revoking substitute consent, and
- (e) Be willing to comply with the duties. (2)

From the listed order below, the health care provider must choose the first person who is available and qualifies:

- (a) The adult's spouse; (3)
- (b) The adult's child;
- (c) The adult's parent;
- (d) The adult's brother or sister;

- (d.1) the adult's grandparent;
- (d.2) the adult's grandchild;
- (e) Anyone else related by birth or adoption to the adult;
- (f) A close friend of the adult;
- (g) A person immediately related to the adult by marriage. (4)

A health care provider is not required to do more than make the effort that is reasonable in the circumstances to comply with this section. (5)

If there is no one listed who is available or qualifies, or if there is a dispute about who is to be chosen as a temporary substitute decision-maker, the health care provider must “choose” a person authorized by the Public Guardian and Trustee. (6)

### **The authority of a Temporary Substitute Decision-Maker**

A person chosen as a TSDM has the authority to decide whether to give or refuse substitute consent to health care. (7) The TSDM is limited by the ‘temporary’ nature of their authority. A TSDM is only selected when the health care provider determines the adult is incapable and a decision needs to be made. A TSDM’s authority only lasts for that specific decision or set of decisions.

The authority of the TSDM applies to the particular health care decision at hand. While TSDMs can consent to a “plan for minor health care” (see below), they cannot give “blanket consent” for future health care. In part, this is because health care consent requires “informed consent”; the TSDM or any other substitute would not have the information on the person’s future condition and available options at that point of decision-making. Consent to a plan for minor health care by a TSDM “expires” or needs to be revisited after one year. (8)

### **Definition of Health Care (Health Care Consent)**

“Health care” means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes:

- (a) a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem,
- (b) a plan for minor health care that
  - (i) is developed by one or more health care providers,
  - (ii) deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and
  - (iii) expires no later than 12 months from the date consent for the plan was given, and
- (c) participation in a medical research program approved by an ethics committee designated by regulation.

### **Duties of a temporary substitute decision-maker**

The TSDM does not make decisions in a vacuum. Before giving or refusing substitute consent, the TSDM must consult with the adult to the greatest extent possible, even if the person is considered “mentally incapable”. (9) This can help determine the person’s current wishes as well as revisit the person’s values, wishes and beliefs. The TSDM must comply with any instructions or wishes the adult expressed while she or he was capable. (10) TSDMs who have been authorized by the Public Guardian and Trustee must also consult with any near relative or close friend of the adult who asks to assist. (11)

If the adult's instructions or wishes are not known, the TSDM must decide to give or refuse consent in the adult's "best interests". (12) This means the TSDM must consider:

- the adult's current wishes, known beliefs and values;
- whether the adult's condition or well-being is likely to be improved by receiving the proposed health care, or by not receiving it
- whether the expected benefit to the adult is greater than the risk of harm; and
- whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care. (13)

A TSDM has the authority to refuse substitute consent to health care that would otherwise be necessary to preserve life. However, this can only occur if there is substantial agreement among the health care providers caring for the adult that (a) the decision to refuse substitute consent is medically appropriate, and (b) the person has made the decision in light of adult's known instructions and wishes expressed while he or she was capable (or if this is unknown, based on the adult's best interests).

### **The TSDM has a right to request information**

In order to give an informed health care decision including a plan of care, the person chosen as a TSDM has the right to all information and documents to which the adult is entitled and that are necessary for the person to make the decision. (14)

### **Duty to disclose information**

Health care providers or anyone else, such as administration, have an active duty to disclose any information or document that the TSDM would need to make the informed health care decision (including for a plan of care), even if those documents or information would otherwise be considered privileged and confidential.(15)

### **End of responsibility**

The TSDM's authority ceases if the adult becomes capable, or if the person no longer qualifies as the TSDM. (16) If the TSDM wants to be relieved of the authority to give or refuse substitute consent, the health care provider may choose another person in accordance with the statutory list to assume that authority.(17)

### **Protection from liability**

A health care provider or the operator of a care facility is entitled to rely on the accuracy of the information given to them to establish (a) someone's eligibility to be chosen as TSDM (18)( "I am John's son and we get along fine") or (b) someone's authority to give, refuse or revoke consent to health care, unless it is not reasonable to rely on that information. (19)

### **Restrictions on authority of a TSDM**

There certain types of health care decisions that a TSDM would not have the authority to make for older adults in hospital or residential care. These are set out in the Health Care Consent Regulation, and include (20):

- Electroconvulsive therapy (unless it has been recommended in writing by the adult's treating physician and at least one other medical practitioner who has examined the adult);
- Any experimental health care that involves "a foreseeable risk to the adult that is not outweighed by the expected therapeutic benefit";
- Psychosurgery;
- Removing tissue while alive to be implanted in another person (e.g. donating a kidney) or for medical education;

- Participating in a health care or medical research program that has not been approved by any of the research ethics committees listed in the regulations;
- Any treatment, procedure, or therapy that uses negative stimuli to produce a change in behaviour (i.e. exposing the person to pain, fear, sound, heat, light so they will not behave in a certain manner).

The term "experimental health care" as it is used here refers to any health care that deviates from standard professional practice, and has not been approved by a research ethics committee recognized by the regulations.

A person also cannot give or refuse consent for these types of health care in an Advance Directive (described below). They may be included in a customized Section 9 Representation Agreement.

### **Collection of personal information**

Health care providers are authorized to collect personal information about an adult from any person if this is necessary for the health care providers to carry out their duties or functions under the Health Care Consent and Care Facility (Admission) Act.(21) That may include for example, needed information about who might be the potential TSDMs.



### **Common Legal Issues around TSDMs**

There are several legal issues that arise in residential care facilities related to substitute decision-makers for health, personal care or finances. Some of these, such as when the substitutes make decisions based on their own wishes or interests not the older adult's, are described later in the chapter. The TSDM system for health care decisions, however, encounters two special legal problems in residential care.

#### **Choosing a TSDM**

There is a common misunderstanding that a TSDM can be chosen based on an adult's known wish without any legal documentation of this choice (i.e., representation agreement).

#### **“Jumping the queue”**

As previously noted, a health care provider is not required to do more than make the effort that is reasonable in the circumstances when selecting an available, qualified person as a TSDM.(22) One issue that arises in the residential care setting from time to time is when a health care provider decides to “jump” certain people on the TSDM list or give priority to an equally or lower situated (but favoured) person. This may occur when the health care provider in residential care considers some persons in a family as easier to contact, easier to deal with, or more likely to agree with the course of action being presented (e.g., use of psychoactive medication).

#### **“Have no dispute”**

The law requires that to qualify as a TSDM, the potential candidate must have been in contact with the adult during the preceding 12 months, and “have no dispute with the adult”. People may interpret this as meaning there has been no overt conflict, as opposed to the more common fundamental differences over values and approaches to personal health decisions. It is very difficult for health care provider to know the life history within families, the nature of relationships, and whether the potential TSDM has substantially different values than the person for whom she or he would be making decisions.

Unlike some family disputes over money, health care differences tend to be less obvious to others. Significant differences in perspective may not surface until the person becomes physically, mentally or socially vulnerable, or when a health crisis develops. The situation is further complicated by the fact that the expressed wishes are open to interpretation or the person may have expressed different wishes to different people at different points in time. An ethics committee, where available, may help families and others sort out some of these matters.

Some health care providers working in residential care may acquiesce to a strong minded person becoming the older adult's TSDM, even where other family members feel the person is imposing his or her wishes on the health care decisions to be made. These types of situations should be referred by the health care provider to the Health Care Decisions Consultant with the Public Guardian and Trustee Office for resolution.

## Other Tools by Which People are Given Authority as Substitutes

### Financial Decisions

There are a number of common financial decisions that need to be made by or on behalf of residents in care facilities. These include but are not limited to:

- contracting with the residential care facility for payment of the accommodation fees and fees for other services,
  - the management of the resident's trust account, if any, at the facility, and
  - the management of the "comfort allowance" or other pocket money.
- (23)



### Power of Attorney

The power of attorney is a legal document which many older adults, family as well as people working in residential care facilities find confusing. This document allows an adult to appoint another person (referred to as the "attorney") to deal with business, income and property on the person's behalf, as well as to make financial and legal decisions. A power of attorney can be very specific or very broad.

It is very common to hear about an individual who has been given a power of attorney and who is now making a wide range of non-financial decisions on behalf of a resident. More often than not, the person does not have the legal authority to do that.

The legal requirements for a valid power of attorney, as well as the responsibilities are set out in the Power of Attorney Act. It is very important for the facility administration to know if there is a power of attorney, who has authority under it, and the scope of that authority.

The power of attorney normally ends if the adult becomes mentally incapable. If the adult wants the power of attorney to continue even if the adult becomes mentally incapable of making financial decisions, an enduring power of attorney is required.

**Changes to British Columbia's Power of Attorney Act came into effect on September 1, 2011. Enduring power of attorneys signed before then will generally still be valid. But any enduring power of attorney signed on or after September 1, 2011 must follow all the new laws.**

### **Definition of Financial Affairs for Enduring Power of Attorney**

Under the Power of Attorney Act, s. 1 "financial affairs" includes an adult's business and property, and the conduct of the adult's legal affairs.

### **Enduring Power of Attorney**

An enduring power of attorney permits an adult to appoint another person to make financial and legal decisions for the adult, even if the adult later becomes mentally incapable of making decisions. (24) It is different from an ordinary (non-enduring) power of attorney, which ends if the person granting the power becomes mentally incapable. The laws related to the enduring power of attorney changed in 2011. There is now a specific test for mental capacity for people to execute an enduring power of attorney. (25)

To create a valid enduring power of attorney, the document must be properly signed, and must state:

- whether the attorney (the person appointed to make decisions) can act while the adult appointing is capable or only while the adult is incapable, and
- that the attorney's authority continues despite the adult's incapability.

An enduring power of attorney made after September 1, 2011 must also be signed by the Attorney. It must be signed and witnessed a second time at the point when the attorney is going to begin using the authority. (26)

Power of attorney is a shared responsibility to make financial and related legal decisions. The Power of Attorney Act specifically acknowledges that as long as the individual remains mentally capable, the individual can still make decisions even though she or he may have signed an enduring power of attorney document. (27)

There are different rules for enduring powers of attorney than for non-enduring ones when there is more than one appointed attorney. Enduring powers of attorney (as well as representation agreements, advance directives, nomination of committee and related documents) can be voluntarily registered with the NIDUS Personal Planning Registry. (28) Authorized care providers can check with NIDUS to determine if any of these documents has been registered for a particular individual.

### **Ending an enduring power of attorney**

An enduring power of attorney can be suspended (29) or can end under a number of conditions The enduring power of attorney ends with the resident's death. (30)

While mentally capable, a resident can also end ("revoke") or change an enduring power of attorney that the resident has given. (31) To do this, the resident must give written notice to the attorney(s) that the authority is ending or changing. Written notice that the power of attorney is being revoked needs to be given to any financial institution or other third party (such as the care facility administration) where the attorney may have previously used the enduring power of attorney to act on the person's behalf. The original documents and any copies should be destroyed (to prevent misuse by the terminated attorney). If people do not know the power of attorney has been terminated, and the attorney continues to act, those transactions are not necessarily invalidated. (32)

To cancel or revoke a power of attorney dealing with land, a document called a "Notice of Revocation" must be filed in the Land Title Office where the land is registered. The court can also terminate a power of attorney – this might happen if the attorney abuses their power.

The person granted the power of attorney can resign. This is done by letting the adult and any joint attorneys know in writing. (33) However, if the other adult is no longer mentally capable, the attorney must also give written notice of the resignation to the adult's spouse, near relative or, a person known to be "close friend of the adult". (34) "Close friend" here means an "adult who has a long-term, close personal relationship involving frequent personal contact with the adult". (35)



However, it does not include anyone who receives compensation for providing personal care or health care to the adult.

An enduring power of attorney also automatically ends if the attorney is the spouse (either married or common-law) and the marriage or marriage-like relationship ends. (36) This occurs unless the document specifically states that the power of attorney will continue to be in effect if the marriage or marriage-like relationship ends.

The Power of Attorney Act also sets out additional circumstances under which it automatically ends, including:

- if the attorney becomes bankrupt
- if the attorney is convicted of an offence described in the Power of Attorney Act or an offence where the grantor was the victim. (37)

### **When there are problems**

Anyone can make a report to the Public Guardian and Trustee if the person:

- believes that the adult is (or was at the time) incapable of making an enduring power of attorney, or changing or revoking it. (38)
- is concerned there has been fraud, abuse or neglect by the person granted the enduring power of attorney, (39)
- believes undue pressure has been used to induce an adult to make, change or revoke an enduring power of attorney. (40)

People can also report the attorney to the Public Guardian and Trustee if they are concerned that the attorney is incapable of acting as an attorney, or failing to comply with an enduring power of attorney or with their duties as an attorney.(41)

The Public Guardian and Trustee is required to promptly follow up on the report, and may investigate the validity of the report.(42) Depending on the investigation outcome, the Public Guardian and Trustee has a number of options. These include to

- take no action;
- apply to the court for an order to confirm;
- revoke or change the power of attorney;
- advise the person who made the report to apply to the court for an order;
- make a report to a designated agency under section 46 of the Adult Guardianship Act; take steps under the Patients Property Act (43) to become a committee; or
- take any action that the Public Guardian and Trustee considers necessary.

### **Springing Power of Attorney**

A "springing power of attorney" also grants authority over financial and legal matters. It is distinctive because it is signed by the person granting the power but does not take effect immediately. Instead it only comes into effect once a specific event set out in the document and predetermined by the person who granted the power of attorney has occurred. The power to act on the person's behalf has been created but it lies dormant. It is later brought to life (or springs into effect) when the specified event happens. For example, the person might specify the authority does not begin until a doctor has issued a letter issued that the person granting the power of attorney has lost capacity to make financial decisions.

The BC Court of Appeal case *Goodrich v. British Columbia (Registrar of Land Titles)*, (44) first recognized the springing power of attorney. In 2011, a number of laws affecting adult guardianship and planning statutes were amended (45) and now the law formally recognizes the right to create a springing power of attorney.

### **Banking Power of Attorney**

A 'Bank' Power of Attorney is made by using forms provided by a financial institution in order to have authority over financial matters related to a specific account or transactions within that institution. In the past, older adults and family were frequently informed by bank staff that only their institution's forms could be used. That was not correct.

In December, 2013 the Canadian Bankers Association (CBA) outlined the circumstances in which a Power of Attorney might be questioned by a bank, and the steps the bank would take to review it. (46)The CBA specifically stated that the bank's power of attorney forms are for the customer's convenience, and not a bank's requirement. (47)Although this new policy directive may exist, people may still encounter many problems in trying to use their own power of attorney forms at banks when aiding older adults, including those residing in care facilities.

The CBA also noted that banks generally allow payment of bills related to the adult's personal living expenses (e.g. nursing home bills, rent, utilities) from their assets held with the bank even where it has questions related to a power of attorney, the instructions to the Attorney, or the client's capacity.(48) The Canadian Bankers Association further stated if an individual brings bills to the bank to be paid, banks may consider allowing payment even without a power of attorney – usually after trying to speak with the client. This can be challenging for residents in care facilities who have little if any access to the bank anymore because of their physical or mental limitations. It has been pointed out that banks may be violating federal human rights law by failing to provide services in a way that is accessible to older and disabled clients.(49)

***"It is not the policy of any bank to insist on clients using the bank's own form of POA."***

**- Canadian Bankers Association, 2013**

Banks state they experience a number of common difficulties with improperly prepared power of attorney documents. These include vague language, a lack of clarity, undated documents and changes made in the document that are not initialled. There can also be concerns with whether a customer was mentally capable when the power of attorney was granted.

The 'Bank' POA may only allow the attorney to deal with financial affairs at that specific institution – for example, to manage the person's bank account, and pay bills from it. The attorney however would not be able to use the Bank's POA as authority to contract on the resident's behalf with the care facility, to act at a different financial institution, to deal with Canada Revenue Agency about taxes or to release any needed tax information in order to the Health Authority in order to determine if the resident is eligible for a subsidized residential care rate.

A bank power of attorney form may also have a standard clause that revokes previous powers of attorney. This may undo some careful advance planning if the bank's power of attorney form is signed.

### **Obligations under a Power of Attorney**

As a result of changes to the law in 2011, any person granted an enduring power of attorney or other power of attorney now has specific legal duties which she or he owes to the person who granted the power of attorney. These duties existed in common law and include to:

- act honestly and in good faith;
- exercise the care, diligence and skill of a reasonably prudent person; and
- act within the authority given in the enduring power of attorney. (50)

The attorney has a duty to keep and produce financial records, plus copy them at the request of the adult. (51)This is an important duty to know for people acting as attorneys or in a person's decision about who to appoint as an attorney.

**People granted Power of Attorney now have a specific duty when managing the adult's financial affairs to give priority to the adult's personal and health care needs.**

This duty contains some specific (and significant) responsibilities. An attorney must now make reasonable efforts to determine the status of an adult's property and liabilities. The attorney must keep and produce a current list of the adult's property, liabilities, accounts and other records respecting the exercise of the attorney's authority under the enduring power of attorney. (52) In addition, the attorney must preserve all invoices, bank statements and other records necessary to create full accounts respecting the receipt or disbursement of capital or income.

People granted the enduring power of attorney now have a specific duty when managing the adult's financial affairs to give priority to the adult's personal and health care needs. (53) That would include paying the care facility bills. Consequently, an attorney must work closely with the adult. The attorney needs to be aware of the adult's financial position, the assets and liabilities, plus needs to be familiar with the adult's estate and future health care planning. The attorney also has a specific duty to encourage the adult's independence and involvement in any decision-making affecting the adult. (54)

Other duties of the attorney include:

- to not dispose of property that is subject to a specific gift in the adult's will (except if the disposition is necessary for the attorney to perform her or his duties, for example to pay the adult's bills)
- to keep the adult's personal effects at the disposal of the adult
- to invest the adult's property only in accordance with the British Columbia Trustee Act (unless the power of attorney states otherwise). (55)

#### **Care providers cannot be authorized to act as an attorney.**

The Power of Attorney Act also sets out who may be named as an attorney and who cannot be a witness. For example, the potential attorney must not be someone who provides personal care or health care services to the adult for compensation, or who is an employee of a facility in which the adult resides and receives personal care or health care services. (56)

#### **Powers of the Person Granted the Power of Attorney.**

Under a power of attorney, the attorney stands in the shoes of the person granting the power of attorney for financial and legal decisions. In order to properly carry out the duties, she or he has the same legal rights to same legal rights to information and records as the adult for whom the attorney is acting would. The attorney also has the legal right to request information and records that relate to the financial matters and authority that has been granted to the attorney. (57) So for example, in the context of residential care, that would mean the bills and expenses. It would not normally include access to medical information. (58)

#### **Common Legal Issues around the Power of Attorney**

Several common legal issues can arise in residential care with respect to the power of attorney (POA). These include:

- that people are unaware that just because the resident has given a POA, the mentally capable resident still retains power over those decisions;
- the person who granted the power of attorney may not be aware that she or he can revoke it if desired;
- the person who holds the power of attorney is acting beyond the scope of authority; and
- the person who holds the power of attorney is failing to act (generally, a failure to pay, resulting in the possibility of eviction or discharge).

There can be questions about the capacity of the older adult to give a power of attorney in the first place, to change or revoke it, especially when the documents are created or modified after moving into residential care. There may also be questions about the capacity of the older adult to act on his or her own. There may be disputes among step-children, children of prior relationships, as well as the subsequent spouse or partner about the power of attorney.

In some cases a power of attorney has been obtained by an individual with improper motives from an incapable or vulnerable adult before or while the adult is living in a residential care facility. (59) There may be questions or concerns about the attorney misappropriating the grantor's money or other assets. (60) Some people may exert undue influence, or gain the authority under suspicious circumstances including by fraud or through forgery. Disputes can also arise where one or several attorneys have acted without the knowledge or approval of the others under a joint power of attorney. (61)

### **The Resident Retains Power**

One of the biggest challenges that many residents face having granted a power of attorney or other legal document is that staff often turn to that designated person or the document, and ignore the resident in decision-making. It is important to remember just because the resident has given someone a power of attorney, the resident still retains all the ordinary rights to information, plus the power and authority to make her or his own financial decisions, as long as the resident is mentally capable. The mental capability to make a specific financial decision can be different than the mental capability needed to grant the enduring power of attorney.

The capacity to make a financial decision depends on the specific decision. For example, the mental capacity of a resident to decide on what to spend her or his "comfort allowance" may be an easy threshold for many residents to meet.

In residential care, there can be considerable overlap over whether a matter is a financial decision, a personal care decision, or a health decision. For example, whether the person will live in shared room or a private room in the facility can affect their physical health and mental state; it can affect with whom they can associate and their privacy, plus it will have financial implications. Where there are different types of decision-makers for a decision, the responses can become quite contradictory.

### **What the Administration Can Legitimately Ask**

The care facility administration can ask whether the person moving to the facility has specific planning documents. They need to know this in order to know to whom they may need to contact for certain decisions, if the resident becomes incapable of making that decision. However, it is far less clear whether (or who among) the care facility staff can or should know about the details of the documents, and access them. It is also unclear whether the facility should simply be able to keep a copy as part of resident's records. It is quite common for administration to be aware in a general sense that a planning document exists and that someone has authority, but they may not necessarily know its scope or if it is the most current resident's document.

### **Acting Beyond the Scope of Authority**

Many people, including staff, family and the general public are unaware of what authority a power of attorney gives. It is common for staff to be told by a person holding a power of attorney that the staff should not permit a certain person or people to visit the resident. It is also common for staff to accede to the person with the power of attorney and to permit that person to make health care decisions. Neither action is legal.

An enduring power of attorney only covers financial decisions and the related legal matters. The person with a power of attorney has no authority to make decisions other than those. Whether to have visitors, and which visitors to have are personal care decisions; and treatment is a health care decision.

Some persons with the power of attorney may also have authority in other kinds of situations. For example, they might also be the highest eligible person to act as a temporary substitute decision maker for health decisions if the resident has become mentally incapable of making the specific health care decision. However, that authority is separate and distinct from the authority given by the power of attorney.\

### **A Person Granted Power of Attorney Failing to Act**

This typically shows up in two ways: (a) not providing for the older adult's "extra needs" and (b) as a failure to pay the care facility bills on behalf of the resident. Some of these situations occur when the adult or the attorney completely misunderstands the nature and scope of the document and their responsibility. Other situations reflect a conflict of interest, if the attorney will inherit money that is not spent on the older adult. Still other circumstances reflect problems of the attorney's general mismanagement, errors of judgement or where the attorney has abandoned the responsibility. (62) Of course, there may be systematic looting of the adult's estate by previously trusted friends or relatives, which can occur without detection for a long period.

#### **(i) Not providing for the older adult.**

As previously noted, the person granted power of attorney has a legal duty to give priority to the person's personal and health needs exercising the responsibility as attorney. (63) Residents pay for care and services at the facility. In most instances, the amount of co-payment will leave the resident with a small amount for personal needs for what has traditionally been called a "comfort allowance". This may be held in a special account in the facility or the person with the power of attorney may have control of the money.

The person granted the power of attorney might ignore the staff's requests for additional funds for the resident's basic or special needs such as undergarments or other clothing, haircuts, eyeglasses, hearing aid, or dental work. Unfortunately this omission can reflect an ageist attitude that "it doesn't matter - the person in care doesn't need anything new, as she will likely not need it much longer." The person granted the power of attorney may be interested in preserving as much of the estate as possible, to the detriment of the resident's day to day quality of life. This type of action clearly violates the attorney's responsibilities under the Power of Attorney Act. While the attorney is not expected to pay for items out of his or her personal resources, the person should be drawing from the resident's available resources.

- **Comfort allowance (Minimum disposable income allowance).**

For subsidized beds in licensed care facilities, the amount contributed by the resident is based on their income, to a set maximum. The rates set by government create a "buffer", (minimum disposable income allowance sometimes referred to as a "comfort allowance"). About two thirds of residents in BC care facilities depend on this amount to cover expenses beyond what the facility charges for basic care (64). The comfort allowance is for the personal and recreational needs of the recipient, (i.e., haircuts, personal laundry, television rental, tobacco products, or transportation to recreational activities, and wheelchair rental).

#### **(ii) Financial disputes**

Because the person with the power of attorney has a responsibility to pay, that person may question the bills coming from the care facility. Many of the costs covered when a person is in a hospital are not covered when a person moves to a residential care facility. The person with a power of attorney may have legitimate questions over whether the item or charges are "chargeable" and "non chargeable". (65) [For more details, see Chapter 4 Legal Issues When Living in Residential Care]

It has also been noted that the person who controls the pocketbook (who has the Power of Attorney, or is the Committee of Estate) may not always see eye to eye with the individual who makes decisions about the person (e.g. Committee of Person, Representative for Personal Care). (66) This can lead to financial disputes.

#### **(iii) Failure to pay**

In some instances, the failure to pay may be a simple oversight by the person granted the power of attorney, or reflect the person's lack of financial management skills. (67) In other instances, it may reflect a broader problem with the person holding the power of attorney, including potential financial misuse or abuse.

The care facility administration may bring the matter of non payment to the attention of the resident, which may cause the resident confusion and significant distress. Unfortunately in some of these “failure to pay “instances, the care facility administration may threaten the resident with eviction for non-payment. [Whether this is ever appropriate is discussed under Discharge & Eviction in the Chapter 4 on Legal Issues When Living in a Care Facility).

## Personal, Health and Other Decisions

### Representation Agreements

The Representation Agreement Act allows a person to appoint someone as their legal representative to handle financial, legal, personal care and health care decisions, if the person is unable to make them on her or his own.

**Changes to BC’s Representation Agreement Act came into effect on September 1, 2011. Representation agreements signed before then will generally still be valid. But any representation agreements signed on or after September 1, 2011 must follow all the new laws.**



A representation agreement is a legal document by which an adult can choose someone they trust to be their legal representative. The representative may then make decisions for the person, if the older adult is incapable of doing so on his or her own. Representation agreements also permit for supportive decisionmaking ( helping the person with decisions, rather than necessarily making the decision for them).

Depending on the type of document, a representative may be given decision-making authority for personal care, health care, and, the routine management of financial affairs, including legal matters. That person can be almost anyone the older adult chooses, including a family member, friend, or someone else. A person cannot appoint anyone who is paid to provide them with personal or health care or who is an employee of a facility through which they receive personal or health care. (68)

### Types

There are two types of representation agreements:

- Section 7 standard agreement – to cover routine financial legal, and personal care and health care matters (“straightforward, everyday decisions”)
- Section 9 extended agreement – to deal with complex personal care and health care matters.

A Section 9 agreement is needed if the representative will make decisions such as refusing life support if the individual becomes terminally ill.

#### • (i) Section 7 (“Standard”) Representation Agreements

A section 7 representation agreements (sometimes referred to as an RA7 for Finances and RA7 for Personal and Health Care) is a limited agreement that allows the adult to name a representative to make straightforward, everyday decisions about personal care and health care treatments, as well as routine management of financial matters. The capability requirements for making a section 7 representation agreement are different than those for making other legal documents. Individuals may make this type of agreement even if they are considered incapable of making a power of attorney or a will, if they cannot make a contract or cannot make their own financial or legal decisions, health or personal decisions independently. (69)

In a section 7 representation agreement, an adult may authorize his or her representative to help the adult make decisions (or to make decisions on behalf of the adult) about any or all of the following:

- the adult's personal care;
- routine management of the adult's financial affairs, including,
  - bill payment,
  - receiving and depositing pension and other income,
  - purchasing food, accommodation and other services necessary for personal care,
  - making certain investments
- most major health care and minor health care,\* as defined in the Health Care (Consent) and Care Facility (Admission) Act; (70)
- obtaining legal services for the adult and instructing counsel to deal with any legal proceedings on the adult's behalf, except divorce proceedings. (71)

There is no specific test of capability for section 7 representation agreement. If the person's capability is questioned, Representation Agreement Act says people must take into account all relevant factors. The Act offers some examples of those factors, including

- Does the adult express choices and preferences and express feelings of approval or disapproval of others?
- Is the relationship with the other characterized by trust? (72)
- How does the person communicate choices and preferences, their likes and dislikes?

**The agreement should name a monitor**

Generally speaking, unless the representative is the adult's spouse, a section 7 representation agreement that covers routine payment of bills must name another person as a "monitor" to help ensure that the representative lives up to their duties. Otherwise the agreement must specifically state that a monitor is not required. (73)

A representative who is authorized to do anything referred to in section 7 (1) (b) must keep the adult's assets separate from the representative's assets. (74)

• **(ii) Section 9 Agreements ("non standard" or "enhanced" agreement)**

A section 9 representation agreement allows the adult to name a representative to make decisions about personal care and health care treatments, including decisions about accepting or refusing life support and life-prolonging medical interventions. A representative named in a section 9 representation agreement may not make decisions about financial matters. This would require the addition of an enduring power of attorney.

A Section 9 agreement is required where the representative needs to deal with complex personal care and health care matters. It is also needed in order for a representative to make decisions such as refusing life support if the person becomes terminally ill.

Section 10 of the Representation Agreement Act sets out the test of capacity for creating a valid section 9 agreement:

*"An adult may authorize a representative to do any or all of the things referred to in section 9 unless the adult is incapable of understanding the nature and consequences of the proposed agreement.*

## **General Matters for all Representation Agreements**

### Signing Requirements

Two witnesses are needed when the person giving the authority signs a representation agreement (unless one of the witnesses is a lawyer or notary, in which case only the lawyer's or notary's signature is required). There are also specific restrictions on who can be a witness. (75)

### The Representative's duties

For both types of agreements, representatives have enumerated duties and obligations under the law. These include:

- to consult with the individual, as much as is reasonable, to determine the person's wishes;
- to act honestly and in good faith;
- to take into account the person's current wishes, and if the individual is unable to express their wishes at that time, to take into account any wishes or instructions that the person may have given while capable of doing so;
- to act within the authority granted by the representation agreement;
- to keep individual's assets separate from the representative's assets;
- to keep proper records including creating and maintaining a list of the person's property and liabilities. (76)

### Lawyer involvement

The law does not require the person to consult a lawyer to make a representation agreement. However, a lawyer can help the person and the potential representative (s) to understand the wide range of issues that arise with a representation agreement.

### Registering the documents

The representation agreement and documents such as enduring power of attorney can be voluntarily registered at the Nidus Personal Planning Resource Centre & Registry. Hospitals, banks and government services can search the registry to find out who the attorney or representative is if they need to know. See [www.nidus.ca](http://www.nidus.ca) <sup>[1]</sup>.

## **Common Legal Issues Arising Around Representation Agreements**

The most common legal issues that arise around representation agreements for adults in residential care facilities relate to the circumstances in which these were created, especially if executed after the resident moves to the facility. Many adults have few options in later life about who, if anyone, they can reasonably choose to be a representative. Like other legal documents, there may also be concerns about the capacity of the individual at the time the agreement was signed, the spectre of undue influence, and conflicts about the decisions being made by the representative.

Canadian research has indicated that supported decision-making with vulnerable adults is challenging within the current health care and financial context. People given the authority to help with decisions often move by necessity or frustration, to a more direct substitute decision-making and plenary approach, because that is what the broader system forces them into doing. (77)

Representatives have identified that even though they have the legal authority as substitutes to make decisions about the care and well-being of the resident, many decisions in residential care such as medication changes, are still made without their knowledge or consent [examples of exclusion from care planning are provided in the Chapter 4 on Legal Issues When Living in Residential Care]. Representatives also point out they often lack needed information from the facility care providers in order to make informed decisions. The Patient Care Quality Office has stated to concerned family members that it will not deal with concerns related to representation agreements, even if the situation involves areas over which the Office normally has jurisdiction (such as resident's rights or quality of care). (78)



## Court Appointed Substitutes - Adult Guardianship/Committeeship



A committee is an individual appointed by the BC Supreme Court to make personal, medical, legal, or financial decisions for someone who is mentally incapable and cannot make those decisions. The person must be found to be mentally incapable under the Patients Property Act.

To become a committee, the individual is appointed by an order under the Patients Property Act. Among other things, the court application requires affidavits from two doctors stating the person is not able to manage their financial and legal affairs (or their personal and medical decisions) and explaining why.(79)

A committee of the person makes personal and medical decisions for someone who is not mentally capable, including decisions about where the person will live. Usually a family member or close friend will do this. Rarely, the Public Guardian and Trustee will agree to be committee of the person. Only the court can appoint a committee of the person. A committee of the estate makes financial and legal decisions for someone who is not mentally capable. A family member or close friend, a trust company, or the Public Guardian and Trustee of British Columbia can fill this role.

### Important Legislative Change

A major 2013 report “No Longer Your Decision” by the Office of the British Columbia Ombudsperson made a number of recommendations to the Ministry of Justice for legislative or regulatory changes related to committeeship and how people are determined to be mentally incapable. (80) The Ministry committed to implementing eleven of those recommendations by July 1, 2014.

As a result, the Adult Guardianship Act may finally replace the Patients Property Act as the law in B.C. (81) Two major changes have been noted:

- The criteria for deciding when a certificate of incapability is issued will be standardized.
- Guardians will be required, where reasonable, to encourage the adult’s involvement in decision making that affects the adult.

The information given below, however, is based on the current system.

A committee of the estate can be appointed by the court. The Public Guardian and Trustee can also be appointed as committee of the estate by a certificate of incapability under the Patients Property Act. No one else can be appointed this way.

Generally the committee has the same powers to deal with the person's estate and affairs as the person had when they were capable. However the court can restrict the committee’s powers. A committee cannot make a will or estate plan for the person, vote on their behalf, or consent to marriage for them. Committees have a fiduciary responsibility; they must put the person’s interest ahead of their own and cannot mix their assets with the other person’s.

As long as they are mentally capable, a person can nominate someone they would prefer to be their own committee, in case they ever need one. The court will usually follow the person’s guidance. There are specific formal processes and a simple document to nominate a committee.

The responsibilities as a committee can include:

- handling the person's property,
- doing the person's banking,

- paying the person's expenses,
- budgeting for the person's family,
- selling the person's personal property and real estate,
- entering into contracts for the person and operating the person's business,
- dealing with any lawsuits involving the person,
- filing the person's income tax returns,
- applying for the person's pension and other benefits,
- making medical decisions for the person,
- deciding where and how the person should live.

The Public Guardian and Trustee reviews all applications for committees. A Committee of Person may consent or refuse to consent to health care necessary to preserve life. The Court may set limits on the Committee. Where there is a Committee of Person, the health care provider must obtain consent from the Committee. A Committee of Person cannot override the Mental Health Act regarding involuntary treatment.

Having a committee appointed has a major effect on existing legal documents it terminates a power of attorney, including an enduring power of attorney. (82) It usually terminates a representation agreement as well.

## **Substitute Decision-Making Through Instructions - Advance Care Directives**

An advance directive is not substitute decision-making. It is a set of instructions to health care providers. However in effect it can make the health care provider the substitute decision-maker for health care decisions in specific circumstances.

### **The Basics**

Advance directives are recognized by Part 2.1 of the Health Care Consent and Care Facility (Admission) Act. They must be in writing and witnessed by two people.(83) There are prohibitions on who can be witnesses. The advance directive can be changed or revoked by the person, if the person changes her or his mind at some point in the future.

Advance directives have a specific test for mental capacity which people must meet to use this document for themselves. (84) The person is presumed to be mentally capable of understanding the nature and consequences of the proposed advance directive. However a person is not considered capable, if the adult does not understand that:

- (a) the scope and effect of the health care instructions set out in the advance directive (basically that a health care provider may not provide to the adult any health care for which the adult refuses consent in the advance directive), and
- (b) a temporary substitute decision-making will not be chosen to make decisions on the adult's behalf for any matter that is covered in the advance directive.(85)

The BC Ministry of Health has developed an advance directive form for individuals to use when undertaking advance care planning, but using the form is optional.

### **Does the health care provider always have to follow the advance directive?**

There are certain circumstances in which health care providers are not required to follow an advance directive. These include if:

- the “directions” in the advance directive are unclear, or do not apply to the treatment in question.
- the wishes and values of the person change after writing the advance directive (but while the person is still mentally capable).
- there have been significant improvements in medical treatment since the advance directive was made.
- the instructions are illegal. (86)

Also if the health care decision falls into one of the exceptions set out in section 19.8., e.g. it is not covered by the advance directive. (87) The advance directive will not be followed if there is a “committee of the person” or representation agreement in effect (unless the representation agreement states that certain decisions are to be as set out in the advance directive and not made by a representative).

### **Common Legal Issues with Advance Directives**

Advance directives can provide consent or refuse consent to health care. Although people have often expressed their wishes formally or informally to family, friends or care providers, advance directives are a relatively new recognized legal document in British Columbia. Advance directives have typically been considered as geared to “end of life care”, and may not be well suited for what happens in providing day to day health care for people living in residential care facilities.

In other jurisdictions, advocates have found that when health care providers know there is an advance directive or similar legal document, they may not communicate with the mentally capable older adult to determine the person’s wishes about their health care. Instead, they rely on the document and in some cases, apply it inappropriately to situations the person likely never intended (for example, not being treated for ordinary health conditions, or conversely, treating the advance directive as consent). (88) At a minimum, the advance directive must set out what treatment is being refused and in what circumstances.

Advance directives have several positive aspects

- they can open lines of communication;
- provide direction of care;
- give the person control over decisions and
- may relieve family stress.

On the other hand, there have been several negative aspects of advance directives identified. These include that the advance directives

- are often too “procedure”- oriented (focused on the formal requirements);
- require extensive interpretation;
- may be ineffective when most needed;
- may lead to “under-treatment”, and
- are pre-made, so the decision is not based on complete information. (89)

The Canadian Bar Association noted the potential for coercion in advance directives. They also found that advance directives are often filled in by or with health care administrators, in the absence of discussions with other health care or legal professionals. (90)

Health care providers in British Columbia note they are beginning to have older adults come to them with very lengthy advance care directives drafted by individuals or lawyers. The documents may be vague statements of wishes that the

person wants the health care provider to respect. At the other end of the spectrum, the document may identify multiple conditions and contingencies, including many situations the people are unlikely to face (in effect, a “shopping list of possibilities”). Both situations make it difficult for the health care provider to determine whether or not the advance directive can or should be followed.

Advance directives are subject to the exceptions in section 19.8 of the Health Care Consent and Care Facility (Admission) Act. Each exception is open to personal and professional judgment, as well as significant differences of opinion on when and how the advance directive can or should be overridden. As noted the chapter on Consent & Capacity, health care consent is based on “informed consent”. That means not only knowing what the options are, but how these apply to this person in this situation at this point in time. Consent must be informed, given voluntarily; and not be obtained through misrepresentation or fraud.

## References

1. Health Care (Consent) and Care Facility (Admission) Act [RSBC 1996] c. 181 [“HCCCFA”]
2. HCCCFAA, s. 16 (2)
3. “Spouse” includes people in “marriage-like relationships”, covering both formalized and common law marriages, as well as same sex marriage-like relationships. HCCCFA, s. 1
4. HCCCFAA, s. 16 (1).
5. HCCCFAA, s. 16 (4).
6. HCCCFAA, s. 16 (3).
7. HCCCFAA, s. S. 17(1).
8. HCCCFA, s. 1 “health care” subsection (b) (ii)
9. HCCCFA, s. 19 (1) (a) (i).
10. HCCCFA, s. 19 (1) (b).
11. HCCCFA, s. 19 (1) (a) (ii).
12. HCCCFA, s.19 (2).
13. HCCCFA, s. 19 (3). Also NIDUS, Health Care Consent: Restrictions on the Authority of a Temporary Substitute Decision Maker. Online: [http://www.nidus.ca/PDFs/Nidus\\_Info\\_Restrictions\\_on\\_Authority\\_TSDM.pdf](http://www.nidus.ca/PDFs/Nidus_Info_Restrictions_on_Authority_TSDM.pdf) (Last accessed: May 1, 2014).
14. HCCCFAA, s. S. 17 (6).
15. HCCCFAA, s. S. 17 (8).
16. HCCCFA, s. 17 (2.2) (a).
17. HCCCFAA, s. S. 17 (5).
18. HCCCFAA, s. 33 (2) (a).
19. HCCCFAA, s. 33 (2) (b).
20. Health Care Consent Regulation B.C. Reg. 20/2000, as amended, s. 5. [“HCCCFA Reg”]
21. HCCCFAA, s. 33.1.
22. HCCCFAA, s. 16 (4).
23. ACE, Manual.
24. Power of Attorney Act [RSBC 1996]c 370, s. 1 [“POAA”]
25. POAA, s. 12 (2). Adult may make enduring power of attorney unless incapable.
  1. 12 (1)An adult may make an enduring power of attorney unless the adult is incapable of understanding the nature and consequences of the proposed enduring power of attorney.

2. (2) An adult is incapable of understanding the nature and consequences of the proposed enduring power of attorney if the adult cannot understand all of the following:
  1. (a) the property the adult has and its approximate value;
  2. (b) the obligations the adult owes to his or her dependants;
  3. (c) that the adult's attorney will be able to do on the adult's behalf anything in respect of the adult's financial affairs that the adult could do if capable, except make a will, subject to the conditions and restrictions set out in the enduring power of attorney;
  4. (d) that, unless the attorney manages the adult's business and property prudently, their value may decline;
  5. (e) that the attorney might misuse the attorney's authority;
  6. (f) that the adult may, if capable, revoke the enduring power of attorney;
  7. (g) any other prescribed matter.
26. POAA, s. 17 (1).
27. POAA, s. 27 (1).
28. Online: [www.nidus.ca](http://www.nidus.ca) (Last accessed: May 1, 2014).
29. The enduring power of attorney or a representation agreement for property is suspended if the person granting the power has been "certified" under the Patient Property Act. [RSBC 1996] c. 349, s. 19.1.
30. POAA, s. 30 (4) (b). For some people, the duties may continue but only under other legal authority, e.g. as executor of will, administrator of the estate, representative grant.
31. POAA, s. 28.
32. POAA, s. 31 (3).
33. POAA, s. 35 (2).
34. POAA, s. 35.
35. POAA, s. 35 (1).
36. POAA, s. 29 (2) (d) (i).
37. POAA, s. 29 (2) (d).
38. POAA, s. 34 (2) (a).
39. POAA, s. 34 (2) (c) (i).
40. POAA, s. 34 (2) (b).
41. POAA, s. 34 (2).
42. POAA, s. 34 (3).
43. Patients Property Act, [RSBC 1996] c. 349. {"PPA"}
44. *Goodrich v. British Columbia (Registrar of Land Titles)*, [2004] BCCA 100
45. Adult Guardianship and Planning Statutes Amendment Act, 2007, Bill 29.
46. Canadian Bankers Association. Consumer Information. "Protecting yourself from financial abuse". Online: <http://www.cba.ca/en/consumer-information/92-protecting-yourself-from-financial-abuse/695-powers-of-attorney-bank-requirements> {"CBA, 1"} (Last accessed: May 1, 2014).
47. Canadian Bankers Association. Preventing Financial Abuse. Online: <http://www.cba.ca/contents/files/misc/msc-preventing-finabuse-print-en.pdf> {"CBA, 2"} (Last accessed: May 1, 2014).
48. CBA, 2, *ibid*.
49. L. Beachell, of the Council of Canadians with Disabilities, comment in Tomlinson, K. (Nov. 12, 2012). "RBC blocks housebound senior from getting her money ." CBC News. Online: <http://www.cbc.ca/news/canada/british-columbia/rbc-blocks-housebound-senior-from-getting-her-money-1.1210222> (Last accessed: May 1, 2014).
50. POAA, s. 19(1).
51. POAA, s. 19(1).

52. POAA, s.19.
  53. POAA, s. 19.
  54. POAA, c.370, 19 (3) (c).
  55. POAA, s.19 (3).
  56. There is an exception made where the individual working the facility is a child, parent or spouse of the adult.
  57. POAA, s. 32 (1) (a) and (b); also, s. 32 (2).
  58. Arguably, there are situations where access to health information might seem to be necessary, e.g. to determine payment of certain medical bills. Whether the attorney could request is debatable, though.
  59. K. Whalley, Power of Attorney Pitfalls. Online: [http://whalleyestatelitigation.com/resources/WEL\\_PowerofAttorneyPitfalls.pdf](http://whalleyestatelitigation.com/resources/WEL_PowerofAttorneyPitfalls.pdf) ["Whalley"] (Last accessed: May 1, 2014).
  60. Whalley, *ibid*.
  61. Whalley, *ibid*.
  62. Gordon, R. M. (1992). Material abuse and powers of attorney in Canada: a preliminary examination. *Journal of Elder Abuse and Neglect*, 4 (1-2). 173-193. ["Gordon"]
  63. POAA, s. 19
  64. Government of BC. (November 2009), p. 3. Online: "Home and Community Care Information Guide for the New Residential Care Rate Structure," Also see: [http://cupe.ca/updir/Residential\\_LTC\\_charges\\_and\\_income\\_allowances\\_across\\_Canada-2.pdf](http://cupe.ca/updir/Residential_LTC_charges_and_income_allowances_across_Canada-2.pdf) (Last accessed: May 1, 2014).
  65. Health and Community Care Policy Manual. 6. F- Residential Care, "Benefits and Allowable Charges" (October 15, 2012)
  66. Mclellan Herbert. Estate litigation 2011: contested committee applications. Online: <http://www.mclellanherbert.com/Estate-Litigation-2011-Contested-Committee-Applications.pdf> (Last accessed: May 1, 2014).
  67. Gordon.
  68. An exception is made if that person is their child, parent or spouse.
  69. RAA, s. 8 (1).
  70. It does exclude the types of major health care identified in the regulation, such as ECT, psychosurgery; experimental health care; medical research; negative stimulus (aversive) therapy; tissue removal for implantation.
  71. RAA, s. 7 (1)
  72. RAA, s. 8 (2)
  73. RRA, s. 12 (1)
  74. RRA, s. 16 (9)
  75. RRA, s. 13
  76. RRA, s. 16
  77. Canadian Centre for Elder Law. (March 2014) Understanding the lived experiences of supported decision-making in Canada: A Study Paper. Prepared for Law Commission of Ontario. Online: <http://www.lco-cdo.org/capacity-guardianship-commissioned-paper-ccel.pdf> (Last accessed: May 1, 2014).
  78. As a result, these matters would likely either be unresolved or go to court.
  79. PPA, s. 3 (1) sets out the court application process. Under the Patients Property Act, there are two processes for appointing a committee. The Supreme Court can appoint a public agency or private individual committee of estate and/or person by court order. Health authorities can appoint a committee of estate and that committee of estate must be a public agency, namely the Public Guardian and Trustee. Pg. 28.
- Office of the British Columbia Ombudsperson. (February 2013). No longer your decision: British Columbia's process for appointing the Public Guardian and Trustee to manage the financial affairs of incapable adults. Public Report No. 49.

Online: <https://www.bcombudsperson.ca/sites/default/files/Public%20Report%20No%20-%2049%20No%20Longer%20Your%20Decision-%20BC%27s%20Process%20for%20appointing%20the%20pdf> (Last accessed January 9, 2016). ["Ombuds, No longer your decision"]

1. Ombuds, No longer your decision.
2. Bill 32 -- 2006 Adult Guardianship and Personal Planning Statutes Amendment Act, 2006.
3. POAA, s. 30 (3).
4. HCCCFA, s.19.5.
5. HCCCFA, 19.1 (2).
6. HCCFA, s. 19.1.
7. HCCCFA, s. 19.8.
8. HCCCFA, s. 19. 1 (2).
9. See for example, Canadian Bar Association. (June 2010). Advance Care Planning. National Elder Law, Health Law, and Wills, Estates and Trust Law Sections, CBA. Online: <http://www.cba.org/cba/submissions/pdf/10-46-eng.pdf> at pg. 4 ["CBA, Elder Law"] (Last accessed: May 1, 2014).
10. Applegate, K., Crissman, C. , Morgan, B. & Reid, B. "Advance Directives." University of Kentucky, Department of Philosophy. Also see Sabatino, C. (October 2007). Advance Directives and Advance Care Planning: Legal and Policy Issues. American Bar Association, Commission on Law and Aging. U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Online: <http://aspe.hhs.gov/daltcp/reports/2007/adacplpi.pdf> Last accessed: April 22, 2014. Sabatino notes that conventional advance directives appear to have had relatively little impact because too few people make use of the legal tools; and when they do, they do not understand the forms they complete nor the future decisions that might have to be made. The forms themselves do not provide much guidance; the persons' goals and preferences for care may change; and even if providers know one exists, it often does not affect care.
11. CBA, Elder Law.

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## References

[1] <http://www.nidus.ca>

# Chapter Seven Resources and Appendix

**Table 1 Summary of Substitute Decision Making Tools**

	Power of Attorney	Representation Agreement	Advance Directive	Committee of Guardian(1)
	<i>TSDM</i> <i>/General/Enduring/Springing</i>	<i>SECTION 7 AND</i> <i>SECTION 9</i>		<i>Of Person/Of Estate</i>
		<i>RA7 Fin/RA7 P&amp;HC</i>		
<b>Does it still function if resident is incapable?</b>	Yes (only)/ No/ Yes/ Yes	Yes/ Yes/ Yes	Yes (only)	Yes (only) / Yes (only)
Does it cover...?				
<b>Health Decisions</b>	Yes(only)/ No/ No/ No/ No	No/ Yes(ii)/ Yes (iii)	Yes/ Yes	No
<b>Personal Care</b>	No/ No/ No/ No	No/ Yes/ Yes(iii)	No	Yes/ No
<b>Finances</b>	No/ Yes/ Yes/ Yes/	Yes(iv)/ No/ No (v)	No	No/ Yes
<b>Legal</b>	No/ May(i)/ Yes/ Yes	Yes/ No/ No	No/	No/ Yes

- (i) If specified, or if needed to carry out duties
- (ii) Major and minor, but certain exclusions
- (iii) As specified in document
- (iv) Routine finances, if specified
- (v) Cover by add enduring power of attorney.

## Other Resources

### Power of Attorney, Enduring Power of Attorney, and Representation Agreements

For more information about these documents and arrangements see:

- Information for Temporary Substitute Decisionmakers Authorized by the Public Guardian and Trustee. [Public Guardian and Trustee]
- Power of Attorney and Representation Agreements [Canadian Bar Association's BC Branch]
- Incapacity Planning: Representation Agreements and Enduring Powers of Attorney [BC Ministry of Justice]
- Nidus Personal Planning Resource Centre and Registry [ a Voluntary Registry System for Representation Agreements, also provides information on Representation Agreements]
- It's Your Choice: Personal Planning Tools (PDF) from the Public Guardian and Trustee of B.C.
- Enduring Power of Attorney Form
- The Public Guardian and Trustee of British Columbia offers detailed information on powers of attorney, representation agreements and court orders appointing a committee to look after the affairs of a person who is mentally incapable.

Website: [www.trustee.bc.ca](http://www.trustee.bc.ca) <sup>[1]</sup>

- The British Columbia provincial government's website provides information on incapacity planning and the forms that can be used at [www.ag.gov.bc.ca/incapacity-planning](http://www.ag.gov.bc.ca/incapacity-planning).



## **Undue Influence**

For a useful legal practice tool about undue influence, see BC Law Institute. Undue Influence Reference Aid. This is a 4 page chart that can be found in the Appendix of “Recommended Practices for Wills Practitioners Relating to Potential Undue Influence: A Guide.” (2011). BCLI Report No. 61.

Online: [www.bcli.org/project/project-potential-undue-influence-recommended-practices-wills-practitioners](http://www.bcli.org/project/project-potential-undue-influence-recommended-practices-wills-practitioners) <sup>[2]</sup> (Last accessed June 26,2014)

## **References**

1. Patients Property Act [RSBC 1996] c. 349 [“PPA”].

**This information applies to British Columbia, Canada. Last reviewed for legal accuracy by BC Centre for Elder Advocacy and Support, June 2014.**

## **References**

[1] <http://www.trustee.bc.ca>

[2] <http://www.bcli.org/project/project-potential-undue-influence-recommended-practices-wills-practitioners>