ACE NEWSLETTER

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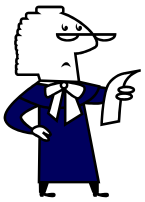

Adult Protection Legislation: How Far Can the Government Go In Protecting Adults?

By Graham Webb, Barrister & Solicitor

The Advocacy Centre for the Elderly (ACE) is seeking leave to intervene before the Supreme Court of Canada in the Nova Scotia adult protection case of J.J. v. Nova Scotia (Minister of Health). *This case pits the best interests of an adult brought under state supervision against the right of the state to impose whatever conditions it believes are reasonable. Experts and the lower court found it was in J.J.'s best interest to continue living in the area of the province where her relatives and husband live. However, the Nova Scotia Court of Appeal agreed with provincial officials that under the Nova Scotia adult protection legislation, she could be moved to another area of the province where she would be isolated and without visitors. ACE, and others, have obtained leave to intervene in order to argue that legislation that permits the state to override the best interests of the person violates the Canadian Charter of Rights and Freedoms. The case underscores some of the many difficulties with adult protection legislation.*

In October 2003, the Supreme Court of Canada gave a developmentally-disabled woman leave to appeal from an adult protection order in *J.J. v. Nova Scotia (Minister of Health)*, a decision of the Nova Scotia Court of Appeal that concerns the interpretation of the Nova Scotia *Adult Protection Act*. This case involves the right of vulnerable adults to make their own personal life choices, and the jurisdiction of a court to impose conditions on adult protection orders that are necessary to protect their best interests.

In 1999, the Nova Scotia government obtained a court order, pursuant to the Nova Scotia *Adult Protection Act*, that J.J. was an "adult in need of protection" on the basis that she was not able to care for herself. Under the Nova Scotia *Adult Protection Act*, an adult protection order must be made on notice to the adult in need of protection, must be in the person's "best interests" and must be renewed every six months or it will expire. This is no legal requirement that an "adult in need of protection" must be mentally incapable.

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In 1999, when an adult protection order was first obtained, J.J. was a 31-year-old married woman who had lived in Dartmouth, Nova Scotia her entire life. She had a long-standing mental illness and developmental disability that resembled a mild form of autism. J.J. had been hospitalized in 1998, and under this adult protection order, she continued to receive long-term inpatient hospital care in Dartmouth.

While in hospital, J.J.'s parents visited her weekly. Her husband, who is also developmentally disabled, visited her in hospital nearly every day, and J.J. stayed with him overnight at his home once each week. J.J. lived co-operatively with other hospital patients, and earned unsupervised passes into the community. While in hospital she obtained her very first job at a sheltered workshop in Dartmouth.

J.J.'s good progress in hospital caused her psychiatrist, occupational therapist, social worker and primary nurse to conclude that she no longer required inpatient hospital care, and that she should be placed back into the community. They felt that continued institutionalization could harm her progress and cause her to deteriorate. Rather, her caregivers felt that J.J. needed placement in a "small options" home, which would give her a detailed plan for structure, supervision and support that she required in a community-based setting.

Unfortunately, in 1996 the Nova Scotia government had stopped funding community placements of the type that J.J. required. The funding freeze came in the form of a moratorium that was imposed while the Nova Scotia government studied its community placement programs. By 2000 the moratorium was still in effect and a government-funded community placement was not available for J.J.

In 2000 the Nova Scotia government also decided to close the Dartmouth-area hospital where J.J. resided. When J.J.'s adult protection order came up for a six-month renewal, the Nova Scotia government applied to court to move her to another hospital 125 km away. J.J. had never lived in the area of the new hospital, and did not wish to go there. Her parents are of limited means and would not be able to see her weekly. Her husband, who also is of limited means and is not able to drive, would not be able to see her easily, if at all.

The Nova Scotia Supreme Court (Family Division) found that an involuntary move so far from her home would be highly disruptive to J.J.'s life, and would not be in her best interests. It decided in April 2002 that the Nova Scotia government does not have a unilateral power without restriction to intervene in the life of an adult in need of protection. It renewed the adult protection order but imposed a restriction prohibiting the government from placing J.J. in a facility outside of the Halifax-Dartmouth area.

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The **Advocacy Centre for the Elderly (ACE)** is a legal clinic for low income seniors 60 years of age and over, funded by Legal Aid Ontario. ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc.".

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The Nova Scotia government appealed the restriction imposed on its adult protection order. In February 2003, the Nova Scotia Court of Appeal allowed an appeal, returned the application to the Nova Scotia Supreme Court for reconsideration and struck out the restriction placed by the lower court on the adult protection order.

The Nova Scotia Court of Appeal found that the lower court had "no jurisdiction to order the Minister to adopt and finance any other plan" than the placement offered by the Minister. It held that "although the proposal [for community placement suggested by J.J.'s caregivers] . . . is probably in her best interest as found by the trial judge, it is not one being offered or approved by the Minister and no other person or agency has agreed to fund it." Therefore the Nova Scotia Court of Appeal held that "the choices available are the Minister's plan or no plan" at all.

Lately, the Nova Scotia government has decided (based on expert evidence) that J.J. is no longer in need of protection. It did not apply to renew the adult protection order when it last came up for renewal, and the order has lapsed. J.J. is no longer under the protection of the Nova Scotia government.

The Nova Scotia *Adult Protection Act* was debated in the Nova Scotia legislature in 1985, and enacted in 1989. It was introduced in response to a movement of seniors' groups to bring about adult protection legislation that would be designed to protect the "best interests" of vulnerable adults. It is sadly ironic that in the interpretation and implementation of this legislation, the best interests of an adult in need of protection may be so easily ignored by the draconian choice endorsed by the Nova Scotia Court of Appeal.

The interpretation of the Nova Scotia *Adult Protection Act* has an immediate and significant importance to Ontarians. In the last two sessions of the Ontario legislature, the Honourable Rick Bartolucci, who was then an opposition member but is now the Ontario Minister of Northern Development and Mines, introduced two private members' bills, Bill 230 (December 2002) and Bill 30 (May 2003), proposing an *Adult Protection Act* for Ontario that is very similar to the Nova Scotia act. It would have allowed the government of Ontario to intervene in the lives of vulnerable adults on the very same basis as the Nova Scotia *Adult Protection Act*. The Ontario legislation would also create a duty to report elder abuse and neglect to the Director of an Adult Protection Office. This same mandatory reporting requirement is in place under the Nova Scotia law.

Reported cases in Nova Scotia show that adult protection orders are most often made in response to situations of neglect, without proof of abuse or mental incapacity. As in the case of J.J., these adult protection orders do not offer any additional community-based supports and resources that would have a positive influence on the life of the vulnerable adult. In extreme cases the orders only serve to institutionalize already marginalized adults.

The Canadian Association for Community Living and People First of Canada, represented by ARCH, and ACE acting on its own behalf, have been granted leave to intervene by the Supreme Court of Canada in the *J.J. v. Nova Scotia (Minister of Health)* appeal. CACL, People First of Canada and ACE would all submit that an adult protection order which involuntarily moves J.J. away from her home and family is, as the trial

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judge found, against her best interests and would violate her *Charter* rights of equality, and of liberty and security of the person.

Section 15 of the *Charter* guarantees the right of the equal protection and benefit of the law. J.J., CACL and People First of Canada would argue that J.J. is treated differentially to her disadvantage, and is discriminated against on the basis of her developmental and other disabilities if the *Adult Protection Act* were interpreted as decided by the Nova Scotia Court of Appeal.

ACE would also intervene on the basis of section 7 of the *Charter*, which guarantees the right of "liberty and security of the person, and the right not to be deprived thereof except in accordance with the principles of fundamental justice." J.J.'s confinement to an institution against her wishes forms a deprivation of liberty. An involuntary move to a hospital so far from her community would interfere with her most intimate personal relationships and her own "fundamental personal choices". This state interference in her life would have a serious and profound effect on her psychological integrity, thereby compromising her security of the person. These interventions were found by the trial judge to be against J.J.'s best interests, and the Nova Scotia Court of Appeal did not disturb that finding.

ACE would submit that state interventions of this type, that do not accommodate J.J.'s best interests, are arbitrary because they are based on financial considerations without reference to the individual needs and circumstances of the vulnerable adult. Chief Justice MacLachlin, in dissent in *Rodriguez v. British Columbia (Attorney General)* (1993) (S.C.C.), held that arbitrariness is antithetical to the concept of fundamental justice, and on that basis would have found that assisted suicide laws were unconstitutional. Similarly, ACE would argue that an arbitrary state intervention that compromises the liberty and personal security of a vulnerable adult is not made in accordance with the principles of fundamental justice and thereby violates section 7 of the *Charter*.

Although a direct *Charter* challenge to the constitutional validity of the Nova Scotia *Adult Protection Act* has not been made, ACE and others would submit the legislation must be read in a way that is consistent with *Charter* values. A *Charter* breach would not arise if the legislation were properly interpreted and implemented in a way that respects all *Charter*-protected rights and freedoms, including the rights of equality and of liberty and security of the person. Adult protection legislation, to be constitutionally valid, should not authorize an adult protection order that violates the *Canadian Charter of Rights and Freedoms.*

In the meantime, the Nova Scotia government brought a motion to quash the appeal for mootness, since J.J. is no longer under government protection. The Supreme Court has denied the motion stating that "the Court is of the view that despite the fact that the issue is technically moot, there are good reasons for hearing this appeal, and the Court is prepared to exercise its discretion in that regard". The way in which an adult protection order is made continues to be of fundamental importance to any vulnerable adult in Nova Scotia who could be subjected to such an order.

Importantly, for Ontarians, the interpretation of the Nova Scotia *Adult Protection Act* could also have a chilling effect on vulnerable adults in Ontario, and their families, if adult protection

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legislation of the type proposed by the Honourable Mr. Bartolucci were introduced in Ontario. One might think that protecting the "best interests" of a vulnerable adult would be within the inherent jurisdiction of a court. However, if the Nova Scotia Court of Appeal decision in *J.J. v. Nova Scotia (Minister of Health)* were allowed to stand, courts could be saddled with a "take-it-or-leave-it" approach that does not add any resources and does not accommodate the best interests of a vulnerable adult.

ACE does not support adult protection of this type, and would hope at least that if enacted it would be read consistently with the *Canadian Charter of Rights and Freedoms*. ◊

June Is Seniors' Month

…. An annual celebration in which Ontario recognizes the contributions of the province's 1.54 million seniors. This year's theme is *Active Living: Active in Mind, Body and Spirit.* Regardless of mobility or ability, seniors are active in an increasing number of ways, and this year's theme recognizes that activity doesn't have one definition. Activity of all kind, not just physical, is acknowledged and celebrated. Increased activity leads to a healthier lifestyle and contributes to a healthy Ontario.

Seniors' Month activities are taking place in communities across the province. For a listing of events visit www.gov.on.ca/citizenship/seniors.

ACE 1984 – 2004
Celebrating 20 Years

ACE and U of T Law School are working to establish a lecture series on law and aging, the first of which will be delivered in connection with the November AGM. Chief Justice Roy McMurtry will be the AGM keynote speaker. Watch for further announcements.

Tribunal Decision Challenges Funding Structure of Ontario's Home Care System

By George T. Monticone, Barrister & Solicitor

A recent decision of the Health Services Appeal and Review Board in *Black v. CCAC Ottawa-Carleton* has the potential to rock the foundations of the Ontario home care system. The Board, in an order dated March 12, 2004, reversed the decision of the Community Care Access Centre (CCAC) to eliminate most of the Mr. Black's homemaking services. The services were reduced by the CCAC because of funding problems. The order directs the CCAC to revise Mr. Black's plan of service to restore most of the homemaking services that were taken away in April of 2002. The Board says that CCACs do not have legal authority to change a client's care plan because of funding concerns. CCACs can only alter a care plan if the client's needs and circumstances justify the change. Since many of the over 40 CCACs in Ontario reduce or eliminate services in the face of funding difficulties, this decision has profound implications for the delivery of home care in the province.

Unfortunately, Mr. Black's victory is somewhat of an illusion as the Board also ordered that the CCAC place him on a waiting list for those services that are to be restored to him that are not immediately available. Mr. Black is now on a waiting list for homemaking services. He does not know how long he will be on the waiting list or whether he will ever again receive homemaking services. This aspect of the Board's decision may be open to legal challenge.

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The Board has yet to release its decision with reasons. However, in the March 12th order, the Board commented that it found as a fact that Mr. Black's condition and circumstances and his requirements for service did not change during the relevant period of time. The Board also found that the reduction in services was the result of a shortage of resources at the CCAC (a shortage of funding). CCACs are funded almost entirely by the provincial government. The Board said that the CCAC's "authority to revise a plan of service is limited by section 22(2) of the *Long-Term Care Act* (LTCA) to "when the person's requirements change"." In other words, a CCAC has no legal authority to reduce or eliminate services being provided to a client because of funding shortages. It can only do so if the client's needs change.

The provincial government provides each of the CCACs in Ontario with a fixed amount of funding for the fiscal year. If the demand for services is higher than anticipated, the funding envelope will not cover the complete cost, with the result that persons who need services towards the end of a fiscal year will be completely denied. In order to avoid this drastic outcome, CCACs engage in a constant juggling act, adjusting service levels based on the amount of money left in the coffers and estimates of demand for the remainder of the year. This approach to service delivery results in clients feeling like they are at the end of a yo-yo string. They may for a time get services they need, then are told they can no longer have some of those services, only to find a few months later that some or all of the services are restored. Such a system is highly unsatisfactory, both for clients who depend on these important services, and CCACs who are constantly squeezed between legitimate client demands and the fixed amount of funding available to them.

The Board in the *Black* decision has said that this constant adjusting of service levels cannot continue as CCACs have no authority to parcel out services based on funding considerations. The decision has the implication that the provincial government must provide funding on an open-ended basis, to permit CCACs to continue providing services to those who need them, in much the same way as social assistance and other programs are funded. The *Black* decision supports what some home care advocates have been saying for many years. Home care services are too important to be funded on a fixed envelope basis. They should be seen as an integral part of the health care system and funded accordingly. ◊

New Nursing Home Complaints Hot Line

On January 22, 2004, the Provincial Government announced "*Infoline*", a new toll-free phone service designed to give the public a point of access to information and to make a complaint about a long-term care facility (a nursing home or home for the aged). *Infoline* will make a referral to the appropriate Ministry of Health and Long-Term Care regional office. The matter will either be forwarded to the regional office, or the caller will be provided with the contact information for the office. In either case, a *Compliance Advisor* from the regional office will provide the information and/or assist with any complaints. In the case of urgent problems, Registered Nurse *Compliance Advisors* are available to return calls in a timely manner. The *Infoline* Call Centre is located at Queen's Park and is open from 8:30 a.m. to 7:00 p.m., seven days a week.

Hotline number 1-866-434-0144

SENIORS ARE NOT BED BLOCKERS: The Real Story on Your Rights When Transferring from Hospital to a Long-Term Care Facility

By Judith Wahl, Barrister & Solicitor

Can a hospital discharge planner insist that I move from the hospital into a long-term care facility that I do not want to go to?

If I am a hospital patient, can the hospital staff tell me which facilities or kinds of facilities I must choose if I need long-term care but cannot move back home?

Does a hospital have the legal right to charge me $800 per day if I refuse to accept accommodation in a nursing home that I don't want to move to?

ACE staff are asked these questions almost weekly by seniors and their families from all over the province. Most hospitals in Ontario have policies directing that if a hospital patient no longer needs acute care, or is considered "stable", but still needs long-term care, that patient is asked to apply for admission to those long-term care facilities where beds are available or accept the first available bed. If the patient fails to cooperate, the hospital may threaten to charge a very large per diem of between $500 and $800 for every day the patient remains in the hospital. The seniors are accused of being "bed-blockers" if they refuse to transfer to a place where they don't want to live.

These hospital policies are highly questionable. As will be argued below, hospitals do not have the legal authority to create such policies. The policies seem to be an attempt to override the legislation dealing with the admission into long-term care, which legislation recognizes the senior's right to choose the long-term care facility where they wish to live.

Why is there a problem?

It is understandable that hospitals work to free up acute care beds for admissions from the emergency room and other parts of the hospital. However, forcing seniors into facilities that they do not want to go to is a recipe for disaster. Some of these forced placements are in locations far from the senior's family and friends, resulting in isolation from the very supports that the senior needs in order to adjust to long-term care, to recover from their illness, or to maintain a good quality of life. Some of these placements are in facilities that are inappropriate to the senior's care needs. Some long-term care facilities are not up to a good standard and it is understandable why a senior or their family may not want to move into that facility, even for a short period of time. In some cases the senior who has a low income can't move because there is no bed at a "basic" rate available in any long-term care facility in their catchment area. The available beds may all be in private or semi-private rooms that the senior cannot afford. This happens because facilities are permitted to keep 60% of the beds as preferred accommodation, regardless of whether there is a long waiting list for basic accommodation.

Hospitals face a very real problem in trying to meet the needs of all persons requiring acute care, but the solution is not to force seniors needing long-term care into facilities that are not of their choice. The shortage of acute care beds in hospitals is not caused by those needing

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long-term care. There are several reasons why this problem exists as already indicated including:

1. the lack of adequate home care in the community,
2. the shortage of supportive housing programs where people can get assistance with activities of daily living as well as accommodation,
3. the poor quality of care in some long-term care facilities which make them undesirable,
4. the shortage of the more affordable "basic" accommodation in long-term care facilities, and
5. the lack of beds in specific areas of the province that did not get additional beds in the expansion that took place over the last several years.

These problems need to be resolved on a larger scale. Individual seniors should not be asked to bear the burden of the problems in our health system by being forced to move into facilities that are not their choice.

What is the law that applies in these situations?

Regulation 965 of the *Public Hospital Act* states that if a patient is no longer in need of treatment in the hospital, the attending physician or certain other health professionals may order the discharge of the patient and communicate that discharge to the patient. Where such an order has been made, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order. The administrator of the hospital may grant permission for a patient to remain in the hospital for a period of up to twenty-four hours after the date set out in the discharge order. The decision needed to discharge a patient should be a medical decision.

There are four things that may happen when a patient gets a notice of discharge:

1. The hospital may allow the patient to remain in the hospital until the patient can find an appropriate long-term care facility.
2. The hospital may transfer the patient to the street or to a house.
3. The hospital may transfer the patient to a long-term care facility.
4. The patient may be charged a high per diem for remaining in hospital.

Transfer to the street or to a house

If the hospital decides to choose this alternative, and there is no care available at home or in the streets, the hospital or discharging doctor may be held liable for negligence if harm results**.** According to Regulation 856 of the *Medicine Act* dealing with "Professional Misconduct", doctors are under a general duty to not abandon patients in their care. For the purposes of the *Health Professions Procedural Code,* professional misconduct includes:

" Discontinuing professional services that are needed unless,

i. the patient requests the discontinuation,
ii. alternative services are arranged, or
iii. the patient is given a reasonable opportunity to arrange alternative services."

Transfer to a long-term care facility without consent

This alternative violates the *Nursing Homes*

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Act, Homes for the Aged and Rest Homes Act, and the *Charitable Institutions Act*. All these Acts require that the person applying to a long-term care facility must give consent prior to admission. This is why the Community Care Access Centre which acts as gatekeeper to admission to facilities always seeks the consent of the patient (or his or her substitute if the patient is not capable in respect to admission).

If the patient has not applied to a particular facility, or does not agree to go there, the hospitals cannot legally transfer the patient. The hospital cannot REQUIRE a patient to pick particular facilities of the hospital's choice. That is not a consent. The hospital cannot require a patient to pick facilities that only have short waiting lists or empty beds. These can be suggested or promoted to the patient but the patient can't be ordered to choose those particular facilities.

Charge patient to remain in hospital

This option is not legal except under certain circumstances. The *Canada Health Act* does not allow hospitals to charge patients for care and accommodation, but it does permit co-payments for chronic care in hospitals (s.19(1), s.19(2)). A physician must first consider whether a patient needs chronic care before charging the patient. Chronic care is not defined in the *Canada Health Act*.

The charge can only be for accommodations and meals, and not for medical services.

Regulations under the *Health Care Accessibility Act* permit hospitals to charge persons awaiting transfer to long-term care for accommodation and meals under section 10 of Regulation 552 of the Revised Regulations of Ontario (regulation under the *Health Insurance Act*). A person who is assessed by a physician as needing "chronic care and is more or less permanently resident in a hospital or other institution" may be charged a per diem. The rate that can be charged is equivalent to the daily rate charged in standard (basic) ward accommodation. There is no authority that would permit hospitals to charge the per diems that are usually quoted in these policies of $500 to $800 per day. The per diem that is "legal" is just over $40.00 per day!

What is the solution to this dilemma? Hospitals, Community Care Access Centres, long-term care facilities, and the Ministry of Health and Long-Term Care need to work with seniors' advocacy groups, nursing groups, representatives from other health provider groups, and other Ministries that deal with housing and social supports to address the real reasons that the backup is taking place in the emergency room. Seniors should not be forced to take accommodation in places that are not suitable to their needs or quality of life when the real answer to this problem must come from a systemic response across several sectors in health, housing, and social services. This is a challenge that the Government of Ontario needs to take on if appropriate care and services are to be provided to all Ontarians, including seniors.

For more detailed information on this issue, please see *Long-Term Care Facilities in Ontario - The Advocates Manual* (3rd edition - January 2004), published by the Advocacy Centre for the Elderly. Order forms for this manual are available on the ACE website at www.advocacycentreelderly or by calling ACE at 416-598-2656. ◊

BLUEPRINT FOR REFORM OF LONG-TERM CARE: Notes on the Monique Smith Report

By George T. Monticone, Barrister & Solicitor

At the request of the Honorable George Smitherman, Minister of Health and Long-Term Care, a blueprint for reform of Ontario's long-term care system has been released. A "*Commitment to Care: A Plan for Long-Term Care in Ontario*" was written by Monique Smith, MPP for Nipissing and Parliamentary Assistant to Minister Smitherman. The Report includes many proposals for change that would improve the quality of life for Ontario's 70,000 long-term care residents. The Smith Report was compiled after visiting over 20 facilities and interviewing a wide cross-section of stakeholders, and it may be obtained free of charge on-line at www.gov.on.ca/health (public information/ministry reports). The recommendations in the Report fall under five headings: Improved Quality of Life, Public Accountability, Standards and Compliance, Staffing and Administration, and Legislation and Funding. The brief discussion below highlights just some of the most significant recommendations.

Full credit must be given to Minister Smitherman for responding in a positive fashion to a recent series of media articles about the deplorable conditions found in some Ontario long-term care facilities. The Minister has promised a "revolution" to ensure "our loved ones in long-term care homes live out their days in dignity" (news release May 11, 2004).

Improved Quality of Life

The central recommendations in this section of the Report are philosophical in nature. The main message is that long-term care facilities must do more to create a "home" environment. This message underscores the guiding principle of the Resident's Bill of Rights that a facility "is primarily the home of its residents". Taken seriously, this principle has profound implications for life in a facility. Among other things, it implies that residents should not all be subjected to the same routine every day. Individual needs and preferences must be respected. A holistic approach to care based on individual resident needs is encouraged. Where possible volunteers and the community must be encouraged to participate in the life of the facility. The Smith Report recommends that money be made available for the creation of Family Councils to augment Residents Councils in each facility. The Ministry is also encouraged to do more to ensure that the public is better informed about long-term care.

The Report recommends that every home have at least one palliative care room in order to provide better care for those who are dying. In recognition of the blackout experienced in Ontario in August of 2003, the Report recommends that homes be required to have a power contingency plan.

Public Accountability

The Ministry has introduced a toll-free complaint line (ACTION line) that a resident or member of the public may use to make a complaint, ask a question, or express concerns (1-866-434-0144). In addition, the Ministry has already instituted surprise annual inspections of facilities and the Smith Report calls for surprise targeted inspections.

The Report calls for a number of other accountability measures including:

*shorter time-frames to address serious non-compliance issues (the Report suggests six weeks, however for some issues this may be far too long);

*a public website maintained by the Ministry with information to help someone choosing a facility to include annual inspection reports, checklists developed by advocacy groups such as Concerned Friends, and detailed factual information about each facility in Ontario --- Minister Smitherman promised to launch such a website within four months in his May 11, 2004 news release);

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*better measures for dealing with abuse, including a broader range of penalties for abusers;

*stricter enforcement of requirements for facilities to post information;

*consideration be given to developing an Ombudsman for residents in long-term care or a system of advocates (the work of ACE is commended in the Report and the suggestion is made that it play a more province-wide role)

Standards and Compliance

The Report recommends that clear, enforceable, resident-focused standards of care be developed. The process of changing existing standards of care is already well under way with the Ministry hosting several detailed consultations with stakeholders, including advocacy and consumer groups. Reforming care standards is the backbone of a serious reform of the long-term care system.

Currently "compliance advisors" perform a dual function for the Ministry. They both advise facilities as to what legislation and Ministry policies expect of them, and they also investigate complaints and conduct inspections. The Smith Report proposes that these two functions be split, and that a separate inspection/enforcement branch be created. Inspectors should carry out "tougher" inspections.

To ensure that better inspections are carried out, the Smith Report includes two major recommendations. Standards for conducting inspections should be developed. In addition, inspectors should be given a larger arsenal of enforcement measures to enable them to deal effectively and fairly with offences and infractions. A range of enforcement measures should be developed in recognition of the fact that offences vary from minor to very serious, and that some offences must be rectified swiftly whereas time may not be as critical a factor in other cases. The Report recommends a Risk Framework be developed identifying graded offences and a range of possible penalties. This approach is used in the United States, and a sophisticated "framework" has been developed that should prove to be a useful guide.

Annual inspection reports are to be posted in an easily accessible location with fines for failure to do so. The Report recommends that inspectors be required to review the annual inspection report with Residents' and Family Councils, and with the Board of Directors of the facility or at an annual general meeting convened for that purpose, to which residents, family members, and the local MPP are invited. It is also recommended that inspectors be required to provide copies of the annual inspection reports to the local Community Care Access Centre, the local MPP, Concerned Friends of Ontario Citizens in Care, and the ACE.

In order to ensure that individuals who would benefit from more care at home or in smaller community-based homes, the Report recommends redirecting funding to home care and other community alternatives. This recommendation acknowledges that some individuals are more appropriately cared for at home or in smaller settings than the typical long-term care facility.

Staffing and Administration

The Smith Report calls for increased funding to improve care given to residents. The Report goes on to say that such funding should be directed to achieving specific outcomes, and an annual review must be conducted to ensure that the funding is being used appropriately. To improve care, increased funding should go directly to nursing and care. Presumably this means that more nurses, health care aids, and personal support workers should be hired. The Minister has promised $191 million to hire 600 new nurses and 1400 other frontline staff including personal support workers, dietitians, activities coordinators, therapists, and nurse practitioners (news release, May 11, 2004).

The everyday life of residents would be greatly enhanced by three very specific recommendations in the Report. In the first place, it is recommended that more attention be paid to the

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activities/activation/recreation aspects of life in a facility to alleviate feelings of boredom, loneliness, and helplessness. Better training for staff responsible for this aspect of facility life, development of a "Best Practices" manual, and encouraging more physical activity are all recommended. Secondly, it is recommended that a dietitian not only review menus for facilities, but actually approve them, in an attempt to improve the quality of meals. Thirdly, more funding for lifts and other equipment necessary to transfer residents is recommended.

The Report estimates that 64% of residents suffer from dementia or cognitive impairment. In order to enable staff to deal with this reality, appropriate training for health care aids and personal support workers is recommended. The Report recommends specific training regarding abuse, communication skills, dementia, and palliative care for all staff.

Legislation and Funding

At present a facility is permitted to designate up to 60% of the beds in a facility as preferred accommodation (semi-private or private). Most homes maintain this 60/40 split between preferred and basic accommodation. The result is long waiting lists for basic accommodation in some homes, and empty beds designated as "preferred". This is because many seniors simply cannot afford the room rates for preferred accommodation. The Report recommends a review of the 60/40 split. This split was never based on anticipated needs of the population. Homes tend to maintain as many preferred beds as possible for financial reasons. A review of this split is most welcome.

The Smith Report recommends a consolidation of the three pieces of legislation governing long-term care facilities into one piece of legislation. This consolidation has been anticipated for a number of years. Other legislative reform called for in the Report includes a recommendation for whistleblower legislation to protect facility staff who report instances of abuse.

The Report recommends legislation that clearly requires facilities to provide medical records to residents or, where appropriate, to the resident's substitute decision-maker. While Canadian courts have recognized the right of access to medical records, facilities do not always acknowledge this.

The Report recommends a review of the funding formula. The present formula is based on the average level of care in the facility and the average level of care in the province. In other words, a facility is funded according to how its average level of care compares to the provincial average. However, the Report identifies a number of problems with the funding formula including: (1) no recognition of measures to promote wellness, (2) insufficient recognition of care needed to deal with residents suffering from dementia, and (3) a problem of timing as resident care levels often increases between the time it is measured and the time the funding is made available.

Looking to the Future

On the release of the Smith Report, Minister Smitherman promised new funding of $191 million for additional staff, and $340 million for new long-term care beds, as well as many other measures in line with the recommendations of the Report. Consultations are on-going in a number of areas, including the development of new standards of care. We can only applaud the Minister's comments that "In Ontario, the only standard for long-term care must be a high standard ---our mothers, fathers, and friends living in long-term care homes deserve no less" (news release, May 11, 2004). ◊