



Law Reform  
Commission of  
Saskatchewan

# Civil Rights in Saskatchewan Long-term Care Facilities

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## Final Report

May 2013

Elderly people and others in long-term care are entitled to the same respect as other citizens. Violation of civil rights of long-term care residents is a form of abuse which may range from life threatening abuse to simple disrespect for the autonomy and privacy of residents. The focus of this paper is on violations of the rights of residents, particularly when they do not involve physical abuse, and particularly when they may not be effectively addressed by existing protocols designed to deal with more blatant forms of abuse. Responses to the *Consultation Paper* highlighted that long-term care staff, residents, and resident families and supporters may be unfamiliar with rights in long-term care, including how to assert these rights and seek remedy for their breach. New steps should be taken to ensure civil rights are recognized in long-term care. This *Final Report* sets out the Commission's proposals to improve civil rights in long-term care facilities.

The Law Reform Commission of Saskatchewan was established by *An Act to Establish a Law Reform Commission*, proclaimed in force in November, 1973, and began functioning in February, 1974.

The Commission is incorporated by an Act of the Saskatchewan Legislature. Commissioners are appointed by Order in Council. The Commission's recommendations are independent, and are submitted to the Minister of Justice and Attorney General of Saskatchewan for consideration.

Projects are initiated by the Commission in response to suggestions from the public and the legal community, or at the request of the Minister of Justice and Attorney General. After preliminary research, the Commission usually issues background or consultation papers to facilitate consultation. Tentative Proposals may be issued if the legal issues involved in a project are complex. Upon completion of a project, the Commission's recommendations are formally submitted to the Minister of Justice and Attorney General as final proposals.

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## **SUMMARY OF RECOMMENDATIONS**

1. A residents' bill of rights should be required for all long-term care homes.
2. Legislation should set out a minimum standard for a residents' bill of rights, with each long-term care home drafting its own document.
3. Legislation should provide a default residents' bill of rights to apply in the event a long-term care home does not draft its own.
4. Each long-term care home should be required to prominently post its residents' bill of rights.
5. Legislation should provide an enforcement mechanism for the residents' bill of rights.
6. Reporting incidents of abuse against residents should be mandatory for staff and operators of long-term care homes. Those who report abuse should be protected from any and all adverse consequences arising from the reporting, provided that those who report the abuse have not participated in the abuse.
7. An independent agency to investigate abuse in long-term care need not be created at this time. Long-term care residents and their supporters should be educated on the processes already in place for investigation of allegations of abuse.
8. An additional independent advocate for residents of long-term care need not be created at this time. Long-term care residents and their supporters should be better educated on the existence and role of Quality of Care Coordinators/Client Representatives and Ombudsman Saskatchewan.

### **1. INTRODUCTION**

In Saskatchewan, long-term care facilities include "special care homes" and "personal care homes." Personal care homes, although licensed and monitored by Saskatchewan Health, are privately owned and operated and are regulated by *The Personal Care Homes Act*.<sup>1</sup> Special care homes are designated by the Minister under *The Regional Health Services Act*,<sup>2</sup> and are operated by Regional Health Authorities directly or through an affiliation contract.

Elderly people and others in long-term care are entitled to the same respect as other citizens. As the Canadian Network for the Prevention of Elder Abuse (CNPEA) observed,

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<sup>1</sup> SS 1989-90, c P-6.01.

<sup>2</sup> SS 2002, c R-8.2.

“[r]esidents of nursing homes and other institutional settings have all the rights of other adults. They do not ‘leave their rights at the front door.’”<sup>3</sup> CNPEA also noted that “[m]any residents are unaware that they have the same rights as people in the community, and should not have to experience abuse, neglect or violation of their rights.”<sup>4</sup>

Violation of civil rights of long-term care residents is a form of abuse. A factsheet on forms of abuse prepared for the Federal/Provincial/Territorial Ministers Responsible for Seniors in Canada described “violation of rights” as

ignoring older adults' entitlement to basic rights and freedoms that other adults often take for granted. Violation of rights may include restricting visitors, or restricting the person's liberty, freedom, rights to privacy, and access to information or available community supports. Violation of rights can also include making decisions about the older adult's health, personal care, or finances without the person's consent (or where the person is not capable, his or her chosen substitute decision maker). In some cases, rules or policies may violate an older adult's rights.<sup>5</sup>

Violations of civil rights may range from life threatening abuse to simple disrespect for the autonomy and privacy of residents. Some violations of rights, such as inappropriate use of physical restraints, would be recognized as abusive by almost everyone. Others are perhaps more subtle examples of abuse, but still affect the quality of life of the victim. For example, competent residents may be denied the right to leave the facility to visit a nearby coffee shop. The facility may adopt such a policy out of concern for the safety of residents, but it is nevertheless a violation of a competent adult's autonomy.

Studies across Canada have shown that abuse in long-term care facilities occurs, and that active measures are necessary to control it.<sup>6</sup> Saskatchewan long-term care facilities

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<sup>3</sup> Canadian Network for the Prevention of Elder Abuse (CNPEA), *Abuse in institutions*, online: CNPEA, <<http://www.cnpea.ca>>.

<sup>4</sup> *Ibid.*

<sup>5</sup> Penny Bain & Charmaine Spencer, *Types of Abuse and Neglect: World Elder Abuse Awareness Day, Factsheet 3* (Federal/Provincial/Territorial Ministers Responsible for Seniors in Canada, April 2009), online: SeniorsBC, <<http://www.seniorsbc.ca>>. The other types of abuse described are physical abuse, emotional abuse, financial abuse, sexual abuse, spiritual abuse or neglect, and neglect.

<sup>6</sup> Elizabeth Podnieks et al, *National Survey on Abuse of the Elderly in Canada: The Ryerson Study* (Toronto: Ryerson Polytechnical Institute, 1990); Saskatoon Council on Aging Older Adult Abuse Task Force, “Older Adult Abuse Prevention Initiatives” (Presentation delivered at ONPEA 2009 National Perspectives on Elder Abuse: Join the Conversation, Toronto, 3-4 November 2009), online: ONPEA, <<http://www.onpea.org>> (in Saskatchewan); Charmaine Spencer, *Abuse and Neglect of Older Adults in Institutional Settings* (Ottawa:

are aware of abuse issues. Almost all have protocols to deal with abuse, and most have educational programs to familiarize staff with the problem of abuse.<sup>7</sup> The purpose of this report is not to review these efforts in detail, but rather to focus on violations of the rights of residents, particularly when they do not involve physical abuse, and particularly when they may not be effectively addressed by existing protocols designed to deal with more blatant forms of abuse.

While most elders are mentally competent, they tend to be treated as less than fully responsible and competent, particularly if they have been admitted to long-term care.<sup>8</sup> However, the law presumes that an adult is competent unless found to be incompetent by a court, or certified incompetent by examining physicians.<sup>9</sup> Even if a person is incompetent, the right to be respected as an individual is not extinguished. Both lawmakers and caregivers increasingly recognize that the wishes and autonomy of adults with diminished capacity should be respected as much as the circumstances permit. For example, *The Adult Guardianship and Co-decision-making Act* provides:

This Act shall be interpreted and administered in accordance with the following principles:

- (a) adults are entitled to have their best interests given paramount consideration;
- (b) adults are entitled to be presumed to have capacity, unless the contrary is demonstrated;
- (c) adults are entitled to choose the manner in which they live and to accept or refuse support, assistance or protection, as long as they do not harm themselves or others and have the capacity to make decisions about those matters;
- (d) adults are entitled to receive the most effective, but the least restrictive and intrusive, form of support, assistance or protection, when they are unable to care for themselves or their estates;
- (e) adults who have difficulty communicating because of physical or mental disabilities are entitled to communicate by any means that enables them to be understood;

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Health Canada, 1994). A study conducted by the College of Nurses of Ontario is particularly interesting in this context. It found that 43% of incidents of abuse reported by Ontario community health care nurses were “verbal.” Many violations of civil rights would fall into this category: *Speak out to Stop Abuse...10 Facts About Client Abuse in Community Care* (College of Nurses of Ontario, 1997).

<sup>7</sup> For example, several Saskatchewan special care homes use the training provided by The Eden Alternative. “The Eden Alternative is an international not-for-profit organization dedicated to transforming care environments into habitats for human beings that promote quality of life for all involved. It is a powerful tool for inspiring well-being for Elders and those who collaborate with them as care partners,” online: Eden Alternative <<http://www.edenalt.org>>.

<sup>8</sup> Law Commission of Ontario, *A Framework for the Law as It Affects Older Adults: Advancing Substantive Equality for Older Persons through Law, Policy and Practice* (Toronto: April 2012) at 54, 56.

<sup>9</sup> See *The Adult Guardianship and Co-decision-making Act*, SS 2000, c A-5.3; *The Mentally Disordered Persons Act*, RSS 1978, c M-14.

(f) adults are entitled to be informed about and, to the best of their ability, participate in, decisions affecting them.<sup>10</sup>

An inevitable tension between paternalism and autonomy in caregiving institutions may make recognizing violations of civil rights more difficult than other forms of abuse. CNPEA commented that “[i]n institutional settings, some forms of abuse are not always obvious. Subtle emotional harms may occur such as treating older people like children (infantilization) and disregarding their wishes.”<sup>11</sup>

The Law Reform Commission of Saskatchewan became interested in this topic after participation in the Canadian Conference on Elder Law in 2006. Ontario Advocacy Centre for the Elderly (ACE) lawyer Judith Wahl spoke to the Conference about her experience dealing with violations of civil rights in Ontario long-term care facilities. She suggested that this form of abuse may too easily “fall through the cracks.” The scope of the problem in Ontario was recognized only because of ACE’s active role as an advocate for individual residents. Discussion among Saskatchewan delegates at the Conference revealed that little is known about the scope of the problem in Saskatchewan. The Commission subsequently undertook to investigate issues of civil rights in Saskatchewan long-term care facilities.

### **1.1. Consultation Paper**

The Commission issued *Consultation Paper: Civil Rights in Saskatchewan Long-term Care Facilities* in August 2010.<sup>12</sup> The *Consultation Paper* included a review of an empirical study of the status of civil rights in Saskatchewan special care homes, performed by Professor Doug Surtees.<sup>13</sup> Following the results of the study, the *Consultation Paper* examined initiatives in other jurisdictions that address the civil rights of residents in

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<sup>10</sup> *Supra* note 9, s 3.

<sup>11</sup> *Supra* note 3. As CNPEA suggests, these attitudes can become ingrained in institutional culture, becoming “systemic abuse,” described as “practices that take away a person’s independence and dignity. Systemic abuse happens in settings where other people are making decisions for the person who has a disability”: *ibid*.

<sup>12</sup> Law Reform Commission of Saskatchewan (LRCS), *Consultation Paper: Civil Rights in Saskatchewan Long-term Care Facilities* (August 2010), online: LRCS <[www.lawreformcommission.sk.ca](http://www.lawreformcommission.sk.ca)> [*Consultation Paper*].

<sup>13</sup> This study did not include personal care homes, but the results can likely be extrapolated to them. For details of the study, see Part 2 of *Consultation Paper, ibid*.

long-term care facilities and considered their application in Saskatchewan. The paper concluded by asking a series of questions:

1. Are protections for the civil rights of residents in long-term care (special care and personal care homes) adequate at present?
2. Should a residents' bill of rights be required for all long-term care homes? If so, should it be legislated, or should each facility be required to adopt its own bill of rights?
3. Should investigation of complaints of abuse (including violations of civil rights) be mandatory? If so, should an independent investigative agency be designated to investigate, recommend, and direct remedies for abuse?
4. Should an independent advocate to represent residents and their interests be created?

The Commission received comments from a government ministry, health regions, a volunteer organization focused on older adults, and interested individuals. We thank all those who contributed to this project, either through responding to the *Consultation Paper* or by participating in Professor Surtees's study.

Responses to the *Consultation Paper* generally affirmed that current protections for the civil rights of residents in long-term care are inadequate. Many of the respondents highlighted that long-term care staff, residents, and resident families and supporters may be unfamiliar with rights in long-term care, including how to assert these rights and seek remedy for their breach. There may not be a lack of rights *per se*, but a lack of awareness of rights within the setting of long-term care facilities. New steps must be taken to ensure civil rights are recognized in this setting.

This Final Report sets out the Commission's proposals to improve civil rights in long-term care facilities.

## **1.2. Need for reform**

In his empirical study, Professor Surtees found that:

The perception that residents and their families lack a voice came through loud and clear in interviews with family members. Families sometimes felt as if they had to learn how to maneuver through the health region structure in order to try to be heard. They felt as if they were at a disadvantage because this was the first time they had faced these issues, while staff faced them regularly. Many family members



indicated they were concerned about retaliation against their loved one if they intervened too much. Residents were often seen as powerless, and residents without families as the ones in the worst situation.<sup>14</sup>

Part of the perception that residents' rights are not respected may reflect poor communication, both between long-term care homes and residents, and between the homes and residents' families. But poor communication may itself evidence an atmosphere in which respect for rights is not given sufficient priority. Although long-term care operators are aware of issues of abuse, the impression left by the survey is that there is less institutional concern and less urgency to address violations of civil rights than residents and their families think is required.

There is wide agreement that improved education for staff and administrators is an indispensable step toward improving the living conditions of residents in long-term care.<sup>15</sup> At present, the training in abuse awareness provided to staff of long-term care facilities is uneven. Programs referred to by respondents to Professor Surtees's survey vary in focus, and there does not appear to be much emphasis in them on protection of civil rights or communication with residents and families.<sup>16</sup> The Ministry of Health and Regional Health Authorities could address many of the issues raised in this paper by developing workshops or presentations to educate staff of long-term care homes, residents and their families, and the public. Handbooks and training programs on abuse and protection of rights in long-term care are available.<sup>17</sup>

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<sup>14</sup> *Ibid.*

<sup>15</sup> Saskatoon Council on Aging Older Adult Abuse Task Force, *supra* note 6; Law Commission of Ontario, *supra* note 8 at 158-59.

<sup>16</sup> In response to Professor Surtees's survey, 18 of 27 special care homes indicated that they had not had staff seminars, either on- or off-site, concerned with increasing respect for the civil rights of residents: "It appears that a significant number of special care homes are staffed by people who do not have the opportunity to attend educational seminars aimed at increasing the respect for civil rights of residents. A reasonable assumption is that increased knowledge of civil rights will result in increased respect for civil rights": *Consultation Paper*, *supra* note 12 at 2.3.2.

<sup>17</sup> See e.g. Joanne Preston & Judith Wahl, *Abuse Education, Prevention and Response: A Community Training Manual for those who want to address the Issue of the Abuse of Older Adults in their Community*, 3d ed (Advocacy Centre for the Elderly (ACE), December 2002); Jean Kovak & Teresa Lukawiecki, *Stand by Me: Preventing Abuse and Neglect of Residents in Long-term Care Settings* (Ottawa: Health Canada, 2001); *Long-Term Care Facilities in Ontario: The Advocate's Manual*, 3d ed (Advocacy Centre for the Elderly (ACE)); Karl Pillemer, Diane A Menio & Beth Hudson Keller, *Abuse-Proofing Your Facility: A Practical Guide for Prevention of Abuse in Long Term Care Facilities* (Clifton Park, NY: Delmar Learning, 2003).

As important as education is, however, it may not be enough in itself to effectively address abuse and rights issues. The law protecting the rights of residents in long-term care could be clarified and expanded to more directly address issues of abuse and civil rights.

The problem is not that there are no legal remedies for abuse and violations of rights. Civil rights are protected under Saskatchewan law.<sup>18</sup> Abuse may give rise to criminal prosecution or a civil law suit. Saskatchewan legislation imposes certain specific duties on long-term care homes.<sup>19</sup> A recent Public Legal Education Association of Saskatchewan (PLEA) pamphlet, *Your Rights in a Special Care Home*, gathers and lists some of these legal protections in order to bring them to the attention of residents and care providers.<sup>20</sup>

The Commission has reviewed recent initiatives in other jurisdictions and the recommendations of organizations and researchers involved with abuse and rights issues in institutions. Several legal mechanisms have been identified that may enhance protection of civil rights of residents in long-term care facilities.

## **2. RESIDENT'S BILL OF RIGHTS**

### **2.1. Mandatory bill of rights**

CNPEA included policy deficiencies in discussing how systemic problems may contribute to the problem of neglect and abuse: "An abuse-free environment starts from the top. If the staff members or volunteers do not know what to do or how to handle situations in a positive manner, they will rely on what they do know."<sup>21</sup> Professor Surtees's report highlighted a correlation between a lack of a residents' bill of rights and a lack of respect for the civil rights of residents.<sup>22</sup>

A residents' bill of rights has been advocated as a vehicle to clarify the rights of residents and inform residents, their families, and institutional staff about those rights.

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<sup>18</sup> See e.g. *The Saskatchewan Human Rights Code*, SS 1979, c S-24.1.

<sup>19</sup> See e.g. *The Regional Health Services Act*, *supra* note 2; *The Housing and Special-care Homes Regulations*, Sask Reg 34/66.

<sup>20</sup> Online: PLEA, <<http://www.plea.org>>.

<sup>21</sup> CNPEA, *supra* note 3 at 8.

<sup>22</sup> *Consultation Paper*, *supra* note 12 at 2.3.4.

Saskatchewan's *Personal Care Home Regulations* contains a list of residents' rights.<sup>23</sup> No legally-sanctioned bill of rights for residents in Saskatchewan special care homes exists, but the list of rights in PLEA's *Your Rights in a Special Care Home* amounts to a bill of rights that could be adopted by special care homes. Most of the special care homes which responded to the survey indicated that they have adopted, or were in the process of adopting, a bill of rights.<sup>24</sup>

In Manitoba, all long-term care homes must adopt a residents' bill of rights that meets a legislated minimum standard.<sup>25</sup> Both Ontario and British Columbia have legislated specific bills of rights for long-term care residents.<sup>26</sup> In the United States, the Federal Department of Health has encouraged the use of residents' bills of rights, and many states have adopted them in law.<sup>27</sup>

The residents' bills of rights examined by the Commission have much in common. All include general statements confirming the human rights and dignity of residents. The first enumerated right in the PLEA bill of rights is a good example of the language typical of these statements: "You have the right to be treated with dignity and respect and to be free from harassment, neglect, and physical, emotional or financial abuse."<sup>28</sup> Some develop this theme in more detail than others, for example, by recognizing a resident's right to practice their religion and attend religious services.<sup>29</sup> The Saskatchewan personal care homes' list of residents' rights differs from most of the bills of rights examined by the Commission by including some very specific rules, for example, that residents have the right "to receive visitors privately at the home between the hours of 9 a.m. and 9 p.m. without giving prior notice to the licensee."<sup>30</sup>

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<sup>23</sup> *The Personal Care Homes Regulations, 1996*, RRS, c P-6.01, Reg 2.

<sup>24</sup> *Consultation Paper*, supra note 12 at 2.3.4. See e.g. Saskatoon Health Region (SHR), *Resident Rights and Responsibilities* (2012), online: SHR <<http://www.saskatoonhealthregion.ca>>.

<sup>25</sup> *Personal Care Homes Standards Regulation*, Man Reg 30/2005, s 2-4. Note that all Manitoba long-term care facilities are considered "personal care homes."

<sup>26</sup> *Long-Term Care Homes Act, 2007*, SO 2007, c 8, s 3; *Community Care and Assisted Living Act*, SBC 2002, c 75, s 7, Schedule 1. The Ontario bill of rights is explained in Community Legal Education Ontario (CLEO), *Every Resident: Bill of Rights for people who live in Ontario long-term care homes* (December 2011).

<sup>27</sup> See e.g. *Montana Long-Term Care Residents' Bill of Rights*, MCA 50-5-1101; *Resident Bill of Rights (Nursing Homes)*, Minn Stat §144A.44.

<sup>28</sup> *Supra* note 20.

<sup>29</sup> See e.g. *Long-Term Care Homes Act, 2007* and *Community Care and Assisted Living Act*, supra note 26.

<sup>30</sup> *Supra* note 23, s 34(1)(g).

Responses to the *Consultation Paper* overwhelmingly supported a mandatory residents' bill of rights for all long-term care homes. Only one response suggested that a bill of rights may not be necessary, as other avenues, such as regional or provincial policy guidelines, may give residents the same protection and respect. The Commission believes that the accessibility of a residents' bill of rights is a benefit over the already existing avenues.

### **Recommendation**

**1. A residents' bill of rights should be required for all long-term care homes.**

### **2.2. Legislated or self-directed content**

A residents' bill of rights is a useful educational document for staff, residents, and their families, regardless of its legal status. However, giving a bill of rights legal recognition has additional benefits. Legal recognition gives the bill of rights "official status" that emphasizes the importance of the document and encourages compliance. Most of the bills of rights examined by the Commission seem to rely heavily on the assumption that an officially-sanctioned bill of rights will encourage staff to respect residents' rights, and encourage residents and their families to complain if they feel rights have been ignored. Further, legal recognition ensures that basic rights are enunciated for all long-term care residents.

A residents' bill of rights can be given legal recognition in several ways. The most straightforward is the approach adopted in Ontario and British Columbia: legislating a uniform bill of rights applicable to all long-term care facilities.<sup>31</sup> Manitoba, however, requires each long-term care home to develop a bill of rights in consultation with its residents, and sets out a minimum standard.<sup>32</sup>

Those respondents who supported a mandatory bill of rights diverged in opinion on whether the bill should be legislated or individually adopted by each facility. Some suggested that a legislated residents' bill of rights would help ensure equal rights across care homes. Others envisioned a legislated guideline, requiring each individual care

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<sup>31</sup> *Supra* note 26.

<sup>32</sup> *Supra* note 25.

home to adopt its own bill of rights in accordance with the guideline. It was suggested that a “residents’ bill of rights won’t work if it comes top down.”

The Commission prefers the Manitoba approach because it actively engages the facilities and the residents in designing protections for civil rights. Engaging these parties will assist in furthering the education function of the bill of rights. This approach also has the benefit of addressing several concerns expressed in response to the *Consultation Paper*. A minimum core content of rights prescribed by law ensures a baseline of equal civil rights in long-term care homes while, at the same time, allowing individual homes a role to play in enunciating these rights. For example, this would allow each facility to set its own visiting hours to conform to a legislated guideline stating that residents must be allowed to receive visitors at reasonable hours, instead of simply imposing exact hours upon facilities through legislation.

Individual care homes would have to expend resources to create a bill of rights in order to conform to a legislated guideline. This may be problematic, as both the *Consultation Paper* and responses to it highlight a lack of available resources, and note that the lack of resources already affects the respect of civil rights in long-term care homes. A “default” bill of rights, one that could be relied on if an institution did not create its own document, would allow institutions that wish to take a more hands-on approach the ability to do so, while not imposing any extra burdens on those that do not. The statement of rights published by PLEA and the Manitoba *Personal Care Homes Standards Regulation* would provide appropriate foundations for the minimum requirements for, and the “default,” residents’ bill of rights.

**Recommendations**

- 2. Legislation should set out a minimum standard for a residents’ bill of rights, with each long-term care home drafting its own document.**
- 3. Legislation should provide a default residents’ bill of rights to apply if a long-term care home does not draft its own.**

### **2.3. Posting the bill of rights**

Most of the special care homes which responded to the survey indicated that they have adopted, or were in the process of adopting, a bill of rights, but not all of those homes had made an effort to promote the bill of rights to residents and their families.<sup>33</sup> *The Personal Care Homes Regulations, 1996* requires the list of residents' rights to be posted in a "prominent place in the home."<sup>34</sup> Ontario, Manitoba, and British Columbia each have similar requirements.<sup>35</sup> Accessibility and publicity are necessary to ensure that residents' bills of rights are effective. Legislation mandating residents' bills of rights should also require that each facility prominently post its bill of rights.

#### **Recommendation**

**4. Each long-term care home should be required to prominently post its residents' bill of rights.**

### **2.4. Enforcing the bill of rights**

Perhaps the most effective way to "give teeth" to residents' bills of rights is to provide clearly how the bill may be enforced. As the Ontario Advocacy Centre for the Elderly suggested:

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... If one does not bring problems to the attention of the authorities, the problem may never be fixed. By being proactive, the homes can be improved for not only an individual resident but all of the residents living there.<sup>36</sup>

Ontario's *Long-term Care Homes Act, 2007* provides that:

A resident may enforce the Residents' Bill of Rights against the licensee as though the resident and the licensee had entered into a contract under which the licensee had agreed to fully respect and promote all of the rights set out in the Residents' Bill of Rights.<sup>37</sup>

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<sup>33</sup> *Consultation Paper, supra* note 12 at 2.3.4.

<sup>34</sup> *Supra* note 23, s 35.

<sup>35</sup> *Long-Term Care Homes Act, 2007, supra* note 26, s 79; *Personal Care Homes Standards Regulation, supra* note 25, s 4(2); *Community Care and Assisted Living Act, supra* note 26, s 7(1)(c.1)

<sup>36</sup> Jane E Meadus, *Complaints in long-term care homes* (ACE, July 2010) at 1, 7.

<sup>37</sup> *Supra* note 26, s 3(3).

The Ontario Act also provides that every long-term care home will have written procedures to initiate a complaint with the home, and for the home to deal with the complaint.<sup>38</sup> The regulations to the Act set out how a complaint must be dealt with:

1. The complaint must be investigated and resolved where possible, and a response must be provided to the complainant within 10 business days of receipt of the complaint.
2. For those complaints that cannot be resolved within 10 business days, an acknowledgment of the complaint must be provided within that time, including the date by which the complainant can reasonably expect a resolution.
3. The response to the complainant shall include what the home did to resolve the complaint, or indicate that the home believes the complaint is unfounded and the reasons for that belief.<sup>39</sup>

Complaints about egregious matters (abuse, misappropriation of funds, unlawful conduct) must be reported by the care home to the Minister.<sup>40</sup>

In British Columbia, if rights under the *Community Care and Assisted Living Act* are breached, a care quality complaint may be made to a patient care quality office (PCQO) under the *Patient Care Quality Review Board Act*,<sup>41</sup> but a right of action, as in section 3(3) of the Ontario Act, is specifically excluded.<sup>42</sup> A care quality complaint is a complaint about the delivery of, or the failure to deliver, health care or a related service, or a complaint about the quality of health care or a related service.<sup>43</sup> The Patient Care Quality Review Boards suggest that a patient first discuss the complaint with the person or unit providing the service. If the response from the person or unit does not address the patient's concerns, a care quality complaint is appropriate.<sup>44</sup> Once a PCQO has received a complaint, it must acknowledge the complaint and inform the complainant of the next steps of the process within two business days.<sup>45</sup> The PCQO must confirm

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<sup>38</sup> *Ibid*, s 21.

<sup>39</sup> O Reg 79/10, s 101(1) [*LTC Regulations*].

<sup>40</sup> *Long Term Care Homes Act, 2007*, *supra* note 26, s 24; *LTC Regulations*, *supra* note 39, s 103.

<sup>41</sup> SBC 2008, c 35.

<sup>42</sup> *Supra* note 26, Schedule 1.

<sup>43</sup> *Supra* note 41, s 1.

<sup>44</sup> "Patient Care Quality Complaints: Overview" (2008), online: British Columbia Patient Care Quality Review Boards <<http://www.patientcarequalityreviewboard.ca>>.

<sup>45</sup> British Columbia Ministry of Health, *Patient Care Quality Review Board Act*, section 6(1)(d) ministerial directive (nd).

that the complaint is within its jurisdiction and, if so, proceed with an investigation. The investigation must be completed within 30 business days, unless the complainant agrees to an extension.<sup>46</sup>

The Manitoba *Personal Care Homes Standards Regulation* requires each operator to establish a written policy for dealing with complaints made by residents and others about the home's care, services or environment, in accordance with any guidelines established by the health region.<sup>47</sup> An outline of how to lodge a complaint must be posted in a prominent and easily accessible location in the care home.<sup>48</sup>

There is no formal complaint procedure established by legislation or regulation for long-term care homes in Saskatchewan. The *Personal Care Homes Regulations, 1996* require that the enumerated rights be “respected,” but do not specifically provide for enforcement other than a general ability to make a complaint to the home or the Minister.<sup>49</sup> Because operators of Saskatchewan personal care homes are licensed by the province, violations of the bill of rights may be grounds for reviewing a license or otherwise disciplining a licensee.

Although there is no formal complaint procedure for special care homes, many health regions have established guidelines to follow in making a complaint. For example, the Regina Qu’Appelle Health Region on its website directs patients who have “questions, concerns or compliments” to:

1. Talk to those directly involved in your care such as your doctor, nurse or other health care professionals.
2. Talk to the supervisor or manager if you are not comfortable talking to those directly involved.
3. Contact the Client Representative if you are not satisfied.<sup>50</sup>

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<sup>46</sup> *Ibid.*

<sup>47</sup> *Supra* note 25, s 40(1).

<sup>48</sup> *Ibid.*, s 40(2).

<sup>49</sup> *Personal Care Homes Regulations, 1996*, *supra* note 23, s 24(1)(c), 34(2). See also Manitoba’s *Personal Care Homes Standards Regulation*, *supra* note 25, s 4(1), 40.

<sup>50</sup> “Your Voice Matters” (Regina Qu’Appelle Health Region (RQHR), August 2009), online: RQHR <<http://www.rqhealth.ca>>. See also Seniors’ Health and Continuing Care, *Having Your Say*, brochure (Saskatoon Health Region (SHR), 2012); SHR, *Client Representative Services*, brochure (SHR, 2010). Client representatives are also known as quality of care coordinators. Each health region has a quality of care coordinator, as does the province.



The Ministry of Health expands on these directions:

If you are unable to resolve your concerns with the health region or Saskatchewan Cancer Agency [Client Representative], call a Provincial Quality of Care Coordinator.

If you do not feel your complaint was handled fairly and other avenues of appeal are ineffective, complaints about public services can be investigated by the Office of the Provincial Ombudsman.<sup>51</sup>

The Ministry of Health also advises patients who are concerned with the conduct or competency of their health care provider to contact the health profession association of the provider if the issue cannot be resolved with the provider or his or her supervisor.<sup>52</sup>

Quality of care coordinators are focused on resolving complaints from patients and family members respecting access to, coordination of, or quality of, service delivered in Saskatchewan health care facilities, including long-term care. The coordinators' purpose is:

- to help ensure appropriate and timely access to quality health care services.
- to help ensure that any patient concerns about the service delivered to them are heard and addressed.
- to help the system learn from patient and family concerns so that the quality of care is improved and the system becomes more transparent and patient-family centered.<sup>53</sup>

Ombudsman Saskatchewan takes complaints about the unfairness of provincial government agencies, including Regional Health Authorities and the health regions they oversee. The Ombudsman can review programs, policies, and decisions to determine whether they are fair to citizens. Individual complaints may be investigated, and the Ombudsman may attempt to negotiate or mediate where appropriate. If a policy or administrative decision is found to be unfair, the Ombudsman will make recommendations for improvement.<sup>54</sup>

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<sup>51</sup> Ministry of Health, "Concerns about Health Care You Receive" (Government of Saskatchewan, 2012), online: Government of Saskatchewan <<http://www.health.gov.sk.ca>>.

<sup>52</sup> *Ibid.*

<sup>53</sup> Saskatchewan Cancer Agency (SCA), Regional and Provincial Quality Care Coordinators et al, *Resources for Health Complaints*, brochure (April 2011).

<sup>54</sup> *Ibid.*

The Ombudsman describes the current situation respecting making a health care complaint in Saskatchewan:

We...know that the health care system is a complicated and highly regulated system with the regulatory professional associations already providing oversight. The associations have the expertise and mandate to review the clinical practice of their professional members. Further, each health region and the Ministry of Health have Quality Care Coordinators and Client Representatives who provide patient navigation and advocacy services. With those services already in place, the Ombudsman jurisdiction to examine matters of administration provides the remedy for issues of fairness. Matters of administration in a public health care system are generally decisions about how health services are planned, organized and provided by the system to the public and are typically bound by legislation, regulations and based on policies and procedures.<sup>55</sup>

One respondent to the *Consultation Paper* suggested that resolution of a rights complaint should occur at the level closest to care and in the least intrusive manner possible. The current complaints guidelines put in place by the Regional Health Authorities and the Ministry of Health address this concern by starting with the people directly responsible for the patient's care.

Although Saskatchewan has several methods available to make a health care complaint, the interviews conducted by Professor Surtees suggest that patients are not always aware of appropriate complaints procedure, and are not always satisfied with the handling of complaints. Setting out the complaints procedure(s) in detail, in a readily accessible manner, would make the complaint process more transparent, certain, and publically accessible. Legislation could require that the residents' bill of rights clearly indicate that breach of the bill of rights is grounds for a complaint, and further require that the complaint procedure be included in, or posted with, the residents' bill of rights.

**Recommendation**

**5. Legislation should provide an enforcement mechanism for the residents' bill of rights.**

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<sup>55</sup> Joni Sereda, "A Health Ombudsman, or An Ombudsman for Health?", *SRNA Newsbulletin* 13:4(Fall 2011) 34 at 35.

### **3. REPORTING AND INVESTIGATING ABUSE**

#### **3.1 Mandatory reporting**

Mandatory reporting of abuse in long-term care, like similar requirements adopted to deal with child abuse, may focus attention on abuse and increase the number of complaints. For example, the number of reports in Manitoba has risen almost every year since the *Protection for Persons in Care Act* requiring mandatory reporting was adopted, and stood at 1,722 in the 2010-11 reporting year.<sup>56</sup> Experience with mandatory reporting suggests that it will improve outcomes only if there are resources to handle the increased volume of complaints. Otherwise, reporting legislation may create a false sense that the problem of abuse is being addressed: “Reporting legislation does not create solutions to abuse problems - it is only a means of people referring to a particular service to investigate.”<sup>57</sup>

Mandatory reporting legislation may itself be an abuse of the rights of competent adults:

Whether the reporting is voluntary or mandatory, this type of reporting legislation has been extensively criticized as an ageist and inappropriate response to a difficult and complex issue.

It has been called ageist because it is based on children’s legislation and does not reflect the rights of adults (such as the right to make informed choices) when made to apply to adult problems.

Seniors are NOT children, they are adults. As adults, all older adults have the right to liberty and the right to choose how to live. It is unlikely that anyone wants to live in an abusive situation, however, some adults choose to live in abusive situations even after their options, in terms of leaving/getting out of this situation, have been explained. Adults also have the ability to make choices to remove themselves from difficult situations that are harmful and to take steps to seek help to address the abuse. Adults may choose the form of help, and the degree of help, that they want.<sup>58</sup>

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<sup>56</sup> Personal care homes generated 88.5% of the reports from 2006-11. From 2006-11, full investigations were required in 2% of all reports, and of those, 74% were “founded”: *Protection for Persons in Care: Annual Report 2010-11* (Manitoba Health, 2011).

<sup>57</sup> Preston & Wahl, *supra* note 17 at 28.

<sup>58</sup> *Ibid* at 27. See also J Harbison et al, *Mistreating Elderly People: Questioning the Legal Response to Elder Abuse and Neglect* (Halifax, NS: Dalhousie University Health Law Institute, 1995).

Several provinces, including Alberta, Manitoba, Ontario, and Nova Scotia, require mandatory reporting of incidents of abuse in long-term care homes.<sup>59</sup> Although all of these provinces except residents from required reporting of abuse against themselves, only Nova Scotia makes reporting optional for individuals who are not staff or operators of a long-term care home.<sup>60</sup> The language in Manitoba's *Protection for Persons in Care Act* is representative:

A service provider or other person who has a reasonable basis to believe that a patient is, or is likely to be, abused shall promptly report the belief, and the information on which it is based, to the minister or the minister's delegate.<sup>61</sup>

In Manitoba, the "minister" is the Minister of Health, and the "minister's delegate" is the Protection for Persons in Care Office (PPCO).<sup>62</sup> As a corollary to mandatory reporting, each of the Acts forbid retribution against both those who report incidents of abuse in good faith and those residents alleged to have suffered the abuse.<sup>63</sup> CNPEA suggests that protecting those who report abuse is an important part of reporting legislation:

Having legal protection and internal supports for staff and others reporting abuse or neglect in institutional settings is very important. It recognizes the importance of addressing the harm early, helps to encourage people to raise their concerns without fear of retaliation. It is necessary to avoid the person who is reporting the problem or concern having to risk the loss of his or her job.

This is very important. Staff may be reluctant to speak up. Some may view reporting abuse or neglect as a futile effort, because the problem is systemic. Others may feel intimidated, have divided loyalties, or want to protect their coworkers.<sup>64</sup>

In its recent report, British Columbia's Ombudsperson agreed with the general approach taken by these provinces, but most specifically by Nova Scotia, by recommending that

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<sup>59</sup> Alberta: *Protection for Persons in Care Act*, SS 2009, c P-29.1, s 7(1); Manitoba: *The Protections for Persons in Care Act*, CCSM, c P144, s 3(1); Ontario: *Long-Term Care Homes Act*, *supra* note 26, s 24(1); Nova Scotia: *Protection for Persons in Care Act*, SNS 2004, c 33, s 5(1).

<sup>60</sup> Alberta: *supra* note 59, s 7(6); Manitoba: *supra* note 59, s 4; Ontario: *supra* note 26, s 24(3); Nova Scotia: *supra* note 59, s 6(1), 7.

<sup>61</sup> *Supra* note 59, s 3(1). A private member's bill to adopt a mandatory reporting and investigation system similar to Manitoba's was introduced in Saskatchewan a decade ago: Bill 205, *An Act respecting the Protection of Persons in Care*, Saskatchewan, 2002.

<sup>62</sup> *Protection for Persons in Care: Annual Report 2010-11*, *supra* note 56 at 3.

<sup>63</sup> Alberta: *supra* note 59, s 18; Manitoba: *supra* note 59, s 10, 11; Ontario: *supra* note 26, s 26; Nova Scotia: *supra* note 59, s 13, 14.

<sup>64</sup> CNPEA, *supra* note 3 at 14.

staff and operators of long-term care facilities be required to report information indicating abuse, and that the individuals reporting, and the residents at issue, be protected from adverse consequences arising from the reporting.<sup>65</sup>

Abuse of older adults was one of the five issues that the Legislative Secretary for the Long-Term Care Initiative reported on to the Saskatchewan Minister of Health in 2010.<sup>66</sup> She found that increased awareness and education about the abuse of older adults was required, and that additional supports should be available for individuals dealing with abuse of older adults.<sup>67</sup> The Legislative Secretary did not recommend mandatory reporting, however, suggesting that “government should ensure the proper resources are in place for follow-up and investigation” beforehand.<sup>68</sup>

Responses to the *Consultation Paper* differed greatly with respect to mandatory reporting of abuse. Some respondents suggested that residents and their families should control the reporting of abuse. In contrast, others argued that because residents and their families are often reluctant to report abuse, reporting should be mandatory.

Requiring residents of long-term care homes to report incidents of abuse against their will could be considered an abuse in itself. However, requiring staff in those institutional settings to report abuse is quite different. There is a public responsibility to deal with abuse in public institutions. Requiring the staff and operators of long-term care homes to report observed incidents of abuse may be a significant way to recognize that responsibility.

Under the *Saskatchewan Critical Incident Reporting Guideline, 2004*,<sup>69</sup> a health care organization (defined in *The Regional Health Services Act*<sup>70</sup> to include special care

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<sup>65</sup> British Columbia, Office of the Ombudsperson, *The best of care: getting it right for seniors in British Columbia (Part 2)*, vol 1 (public report no 47 to the Legislative Assembly of British Columbia, February 2012) at 84, 91 [*The best of care*].

<sup>66</sup> Saskatchewan, Legislative Secretary to the Minister of Health: Long-term Care Initiative, *Focus on the Future: Long-term Care Initiative* (Regina, SK: Ministry of Health, 2010). The four other issues reported on were: accessibility of personal care homes, home care supports, feasibility of developing a seniors’ secretariat, and falls prevention.

<sup>67</sup> *Ibid* at 22.

<sup>68</sup> *Ibid* at 23.

<sup>69</sup> *Saskatchewan Critical Incident Reporting Guideline, 2004* (September 1, 2004), adopted under *The Critical Incident Regulations*, c R-8.2 Reg 3, s 3(1).

homes) must report to the Ministry of Health instances of sexual assault that occur on the health care organization's, or the Regional Health Authority's, grounds, and must report physical or sexual assault against a patient "by an employee, member of the medical staff, or an individual under contract with an RHA or HCO."<sup>71</sup> However, the *Guideline* does not address how the health care organization is made aware of the assault – there is no system in place for patients, families of patients, or staff to make complaints of abuse.

The Commission recommends that legislation require staff and operators of long-term care homes to report abuse. The legislation should also protect those who report abuse from adverse consequences arising from the reporting, provided that the person who reports the abuse has not participated in the abuse. If a resident is abused by an employee of the long-term care home or by a member of a health care profession, the abuse may also be grounds for employer or professional association discipline.

**Recommendation**

**6. Reporting incidents of abuse should be mandatory for staff and operators of long-term care homes. Those who report abuse should be protected from any and all adverse consequences arising from the reporting, provided that those who report the abuse have not participated in the abuse.**

### **3.2 Mandatory investigation**

Investigation is an institutional response to complaints. Under the *Protection of Persons in Care Acts* in Manitoba, Nova Scotia and Alberta, and the *Long-Term Care Homes Act, 2007* in Ontario, the Minister or his designate is required, upon receiving a complaint, to inquire as to whether further investigation is required.<sup>72</sup> If so, the Minister is empowered to appoint an investigator, with powers under the Act, who will eventually report back to the Minister.<sup>73</sup>

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<sup>70</sup> *Supra* note 2, s 2(1)(a), (h).

<sup>71</sup> *Supra* note 69, s VI(c), (e).

<sup>72</sup> Alberta: *supra* note 59, s 11; Manitoba: *supra* note 59, s 5(1); Ontario: *supra* note 26, s 25; Nova Scotia: *supra* note 59, s 8(1).

<sup>73</sup> Alberta: *supra* note 59, s 11(5); Manitoba: *supra* note 59, s 5(2); Ontario: *supra* note 26, s 25; Nova Scotia: *supra* note 59, s 8(2).

The PPCO in Manitoba is an independent investigating agency appointed as an investigator. The PPCO describes its role as:

- receiving reports of alleged abuse on a dedicated reporting line;
- conducting inquiries by reviewing and analyzing all alleged abuse reports for validity and nature of complaint;
- conducting investigations on incidents of alleged abuse where reasonable grounds to believe abuse occurred exist;
- issuing directions to health facilities to improve policies and/or processes that address the identification, reporting, prevention and management of patient abuse;
- conducting follow-up audits of selected facilities that have received directions;
- acting as a resource to Manitoba Health and regional health authorities on abuse related issues;
- providing education for the public, health care staff and organizations about the PPCA [*Protection of Persons in Care Act*], and on the identification, reporting, prevention and management of abuse;
- developing and distributing public information related to the PPCA; and
- making referrals of professionals to professional regulatory bodies for investigation.<sup>74</sup>

Responses to the *Consultation Paper* that addressed the issue of investigation supported mandatory investigation of abuse and the designation of an independent investigative agency as a means to objectively investigate, recommend, and direct remedies for abuse. One response highlighted some principles that should be followed:

- resolution at the level closest to care and in the least intrusive manner possible;
- the importance of timely resolutions, confidentiality and privacy of the individuals involved; and,
- recognition of the roles of family and other persons supporting, and in some circumstances speaking for, the resident.

Saskatchewan does not have an independent agency to investigate allegations of abuse. Criminal abuse may be reported to, and investigated by, the local police service. Instances of physical and sexual abuse against patients by employees of a long-term care home must be reported by the health care organization to the Ministry of Health under the *Saskatchewan Critical Incident Reporting Guideline, 2004*.<sup>75</sup> Once abuse has been reported under the *Guideline*, the health care organization or the Regional Health Authority is required to investigate the “critical incident” and file a report with the

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<sup>74</sup> *Protection for Persons in Care: Annual Report 2010-11*, *supra* note 56 at 4-5.

<sup>75</sup> *Supra* note 69, s VI(c), (e).

Minister.<sup>76</sup> Although investigation is mandatory in these circumstances, there is no provision in the guidelines or regulations for interviewing, or reporting the results of the investigation to, the complainant if he or she was involved. *The Critical Incident Regulations* protect confidentiality by prohibiting the names of the parties involved to be included in the report to the Minister.<sup>77</sup>

Investigating instances of physical and sexual abuse that are brought to the attention of the long-term care home is already mandatory. Although there is no independent investigative agency for this purpose, the Commission does not recommend that one be created at this time. Rather, the Commission encourages the Ministry of Health, the Regional Health Authorities, and the long-term care homes to educate long-term care residents and their supporters on the processes already in place for investigation of allegations of abuse. This may be conveniently done in concert with education on the residents' bill of rights. ACE's comment on complaints may be equally applied to reports of abuse: "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."<sup>78</sup>

#### **Recommendation**

**7. An independent agency to investigate abuse in long-term care need not be created at this time. Long-term care residents and their supporters should be educated on the processes already in place for investigation of allegations of abuse.**

#### **4. CREATING AN INDEPENDENT ADVOCATE**

The Saskatoon Council on Aging has argued that advocacy is essential to protect the rights of long-term care residents.<sup>79</sup> The experience of ACE in Ontario has been that violations of civil rights and low-level structural abuse are more likely to be caught by the activities of an advocate than an investigator.<sup>80</sup> An advocate should be able to act

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<sup>76</sup> *The Critical Incident Regulations*, *supra* note 69, s 8, 9.

<sup>77</sup> *Ibid*, s 10.

<sup>78</sup> *Supra* note 36 at 1.

<sup>79</sup> *Supra* note 6.

<sup>80</sup> Judith Wahl (Address delivered at the Canadian Conference on Elder Law, October 2006), [unpublished].



on behalf of a client by lobbying for changes in care or house rules, negotiating, and even bringing appropriate legal action.

The British Columbia Ombudsperson recommended that its government establish a program to assist seniors and their families with navigating the long-term care system and bringing forward concerns and complaints.<sup>81</sup> The Ombudsperson suggested that

Advocacy and support play a critical role in a system where seniors are vulnerable and face barriers to raising concerns. ...Access to advocacy and support is an essential complement to an effective complaints process, particularly where complainants face physical and cognitive challenges and are highly dependent on the services they receive and the individuals they may complain about. ...[N]ot all seniors have family or friends who can advocate for or support them when care concerns arise. Without advocacy and support, the concerns of these seniors may never be raised or addressed.<sup>82</sup>

In the course of the British Columbia Ombudsperson's investigation, families stated that it wasn't always clear to them who was responsible for responding to complaints. They also told the Ombudsperson that they were sometimes reluctant to raise concerns because they didn't want to be labeled as complainers and feared that the care their loved ones received would suffer.<sup>83</sup>

In her consultations on the Long-term Care Initiative, the Legislative Secretary to the Saskatchewan Minister of Health found that:

There was general agreement that an...advocate would be desirable but there was not a strong desire to see public dollars used on the development of another 'bureaucracy' when there are other outstanding needs and concerns. In some instances, there was even a strong negative reaction to creating another 'bureaucracy'.<sup>84</sup>

The Legislative Secretary recommended the establishment of a toll-free number for "senior-related" inquiries, the creation of a Seniors' Secretariat within the Ministry of Health using existing human resources, and the establishment of a council of seniors to advocate on behalf of seniors to government.<sup>85</sup>

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<sup>81</sup> *The best of care*, *supra* note 65 at 72.

<sup>82</sup> *Ibid* at 71.

<sup>83</sup> *Ibid* at 71-72.

<sup>84</sup> *Supra* note 66 at 15.

<sup>85</sup> *Ibid* at 17.

Responses to the *Consultation Paper* favoured the existence of an advocate to represent residents and their interests. Many responses highlighted existing institutions that partially serve this function, such as the Quality of Care Coordinators/Client Representatives and Ombudsman Saskatchewan, whose roles were examined in Part 2.4. However, many of the other responses stated that an independent advocate should exist without discussing, or even making reference to, these existing institutions.

The Quality of Care Coordinators/Client Representatives and Ombudsman Saskatchewan provide a foundation for independent advocacy for residents of long-term care in Saskatchewan. Because these agencies are already in place and available to residents of long-term care, the Commission does not recommend creation of an additional independent advocate for residents of long-term care. However, residents and their supporters should be better educated on the existence and role of these agencies. The Commission's fifth recommendation, that legislation address enforcement of the residents' bill of rights, would go some way to improving education on these matters.

**Recommendation**

**8. An additional independent advocate for residents of long-term care need not be created at this time. Long-term care residents and their supporters should be better educated on the existence and role of Quality of Care Coordinators/Client Representatives and Ombudsman Saskatchewan.**