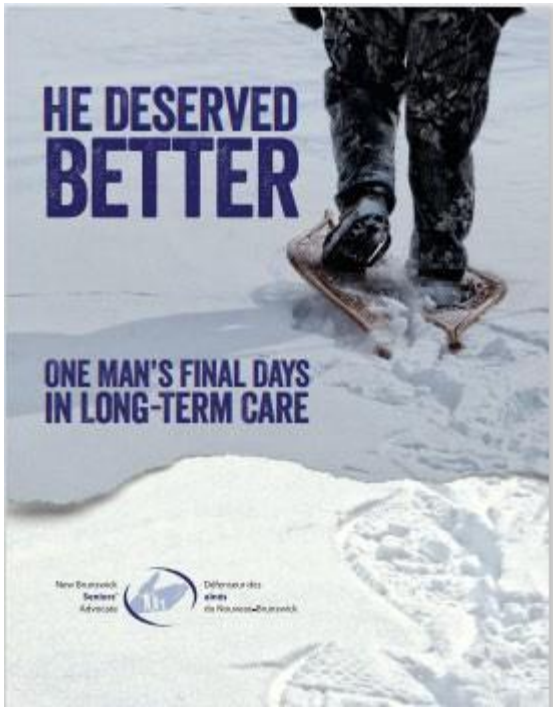

PROGRESS REPORT

Recommendation monitoring review

He Deserved Better

A review of the progress of recommendations from the Advocate's report.

July, 2023

New Brunswick Seniors' Advocate
Défenseur des aînés du Nouveau-Brunswick

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Introduction

In 2022, the Office of the Child, Youth and Seniors' Advocate began the practice of recommendation monitoring. The Advocate now provides updates on the status of recommendations that have been made to departments and other authorities under the Advocate's oversight mandate.

This report contains the specific recommendations made in the *He Deserved Better* report of 2022, the Department of Social Development's description of decisions and actions taken in response, and the Advocate's comments on progress achieved.

The purpose of a monitoring report is to provide the Legislative Assembly with current information on the actions of government departments to assist with legislative oversight.

Child, Youth and Senior Advocate Act

Section 23- Recommendation of Advocate

23(1) If, after conducting an investigation or review of an authority's services, the Advocate makes a recommendation to the authority, the Advocate may request that the authority notify him or her within a specified period of the steps that the authority has taken or proposes to take to give effect to the recommendation.

23(2) If, after the period specified under subsection (1), the authority does not act upon the recommendation of the Advocate, refuses to act on it or acts in a manner unsatisfactory to the Advocate, the Advocate may send a report respecting the recommendation to the Lieutenant-Governor in Council and, after doing so, may report on the matter to the Legislative Assembly.

23(3) The Advocate shall include in a report made under subsection (2) a copy of any response provided by the authority respecting the Advocate's recommendation.

23(4) If the Advocate makes a recommendation under subsection (1) and the authority does not act on the recommendation to the Advocate's satisfaction, the Advocate shall inform the petitioner of the recommendation and may include any additional comments.

Implementation Scale

Alternative Solution
- Recommendation was not completed, but an alternative solution which met the intent of the recommendation was provided with sufficient justification.

Fully Implemented
- Actions taken fully implement the recommendation. All aspects of the recommendation have been implemented or will be in the next calendar year.

Largely Implemented
- Actions taken meet the majority of the key deliverables for implementation; only negligible requirements remain. There is a timeline for implementation identified.

Partially Implemented
- Actions taken only implement part of the recommendation. The recommendation is acted upon; however, deficiencies remain and important requirements have not been met.

Limitedly Implemented
- Actions taken only implement a small part of the recommendation; requirements are only fulfilled to a limited degree by actions taken, resulting in significant deliverables needing to be implemented.

Insufficently Explained
- Information provided does not include sufficient justification for inaction and/or evidence for meeting the intent of the recommendation.

Not-accepted
- Recommendation not accepted by Authority

Forward from the Advocate

One year ago, my predecessor Norman Bossé released *He Deserved Better*. The report stemmed from an incident in which a man lost his life following a physical assault by another resident of the same nursing home. The review found that there were previous physical altercations and that the man spent his final days expressing fear of exactly the fate that befell him. In all the talk of statutes, regulations, and reports, we cannot lose sight of the fact that a man died afraid and in pain.

No one has argued that this is acceptable. No one could possibly make that argument. People who work in long-term care are decent and compassionate. No one in government has been indifferent to the safety of seniors. We have seen thoughtful discussions following the report. In some cases, those discussions have led to meaningful improvements in training, standards, and investigation protocols. We have noted those positive developments in this follow-up Progress Report wherever we saw positive change.

In other cases, we have concerns. We have noted here our concerns that on several recommendations there has been a reticence to act that is inconsistent with the public oversight we owe vulnerable seniors. In those areas – regulating nursing home interactions with families, ensuring that violence in nursing homes has a specific protocol, reporting on violent incidents to families and the public, robustly funding inspections and reporting – there is a deference to the private nature of nursing homes that has created a culture problem in long-term care.

Age takes its toll on all of us. When we begin to lose the autonomy we had in our youth, it is scary. It is not always the obvious limitations that are most frightening. It is when we lose control over the tiny decisions we take for granted when we are healthy. Choosing when and what we eat, when we get to go outdoors, the simple joy of choosing when we sleep and wake up. Surrendering these tiny autonomies to others is an act of great trust. When that trust is broken, the anxiety is palpable. And trusting others to keep us safe in our own home is certainly one of the greatest trusts a person can place upon another.

This is a public trust given by a vulnerable person. Even if government uses private operators to provide the service, the trust is still a public one. We note that when nursing homes lack capacity, vulnerable seniors are cared for in public hospitals by public employees. The trivia of who owns the building and signs the paycheques does not alter the public trust involved in caring for vulnerable seniors.

In so many ways, government meets this call when public trusts and vulnerable people collide. Childcare facilities are rigorously regulated and inspected. Independent school districts answer to the Minister. Professions that involve a public trust and a power imbalance – doctors,

lawyers, psychologists, massage therapists – all have delegated authority on the condition of having their own robust statutory and regulatory oversight.

In the matter of vulnerable seniors, we receive some departmental responses which imply that the government cannot use the powers clearly contained within the plain language of regulations. There is a reticence to issue clear protocols to advise families when a loved one is physically harmed. There is an implied dichotomy between the administrative process of improvement and opening up nursing homes to the scrutiny of families and the public.

When a vulnerable senior is physically harmed in the place where they live, this cannot be seen as merely a teaching tool for the system. That dehumanizes the vulnerable senior. We believe that these need to be reported to families and inspectors because someone needs to care for the safety of the person, not just the management of the system. In fact, we believe that anyone with power over vulnerable people must welcome accountability. We expect it of childcare workers, of police who take control of citizens after an arrest, of prosecutors who bring charges, of politicians who make laws the rest of us follow. When one is on the receiving end of violence, especially when one is vulnerable, trauma and fear are natural and real reactions. Understanding the aggressor's lack of capacity does not require erasing the needs and experience of the person harmed.

Two reports, by the New Brunswick Nurses Union and the Association francophone des aînés du Nouveau-Brunswick, have spelled out in great detail the human cost when there is a real or perceived lack of accountability. Families and seniors stop speaking out for fear of retribution. The system begins to get too comfortable at keeping peace among those in power instead of responding with urgency to the needs of the vulnerable people it serves. This office recently highlighted a practice in the school system where union and management negotiated away children's rights to have their disability accommodated. The peace served the adults with power – just not the children who are supposed to be the focus of the school system. The same false peace – private homes and government agree that government can't act – is creeping into long-term care. We have seen the Nursing Home Association of New Brunswick insist that it should help direct independent reviews, as if it is a normal thing. We see it in the insistence that public reporting of bad outcomes is at odds with the system learning from those outcomes. If the Legislature intended this culture of deference, then it is free to do so. In this report and the larger long-term care report to come, we will meet our duty to make sure that elected officials are fully informed of the choice before they decide.

It is the nature of public watchdogs that we highlight the areas that need to be improved, and sometimes spend too little time noting the good work that came because of great effort and professionalism of the public service. It bears repeating – in about half the recommendations we are able to cite positive developments. That is to the credit of the Department and the professionals in the nursing home sector. We see professionalism and compassion in the public service every day. When we challenge assumptions that need to be revisited, we do not do so because we do not believe in the system or the people who run it. We do so because we know they are capable of doing better every day. And because the trust seniors place in them demands it.

Kelly A. Lamrock, K.C.
Seniors' Advocate

Executive Summary

Recommendation	Advocate's comment	Overall rating
1-It is recommended that the Department of Social Development develop evidence-based best safety practices for all nursing homes to implement. Nursing homes should be obligated to incorporate these practices as a minimum requirement to comply with the adequate care standards. Inspectors must review each nursing home's services description for compliance and must interview random staff to determine if adequate care standards for safety are being followed in practice.	The Advocate considers this recommendation met within the scope of the Report and is satisfied with the response. There are legitimate questions as to whether or not there are adequate inspection resources and whether or not the governance model provides the Government of New Brunswick with an adequate role in the governance of nursing homes, and these will be addressed in the Long-Term Care Review underway.	**Fully Implemented**
Recommendation	**Advocate's comment**	**Overall rating**
2- It is recommended that the Department of Social Development undertake a thorough review of best practices in violence mitigation, and develop a comprehensive policy and practice structure, in collaboration with the Seniors' Advocate and representation from: nursing homes, the Nurses Association of New Brunswick, the New Brunswick Council of Nursing Home Unions, the Association of New Brunswick Licensed Practical Nurses, the New Brunswick Association of Nursing Homes and academic experts from New Brunswick post-secondary institutions.	The Advocate has concerns with the Department's partial rejection of this recommendation. The Advocate does acknowledge the Department's openness to working with experts and stakeholders on policies and procedures that reflect best practices in care for those suffering from dementia. This is urgent and welcome, as projects suggest a coming increase in service demand beyond New Brunswick's capacity and preparation. The Advocate has concerns about the Department's resources to carry out this work in time to meet the looming demand but is satisfied that the Department's understands the urgency. The Legislature must vote to provide them the budget to make that sense of urgency real. The Advocate has concerns that, when dementia is a factor in violent behaviour, the Department is giving too little consideration to the rights of other residents to protection and follow-up services. It is true that when one resident becomes violent with another, the aggressor may lack capacity to understand the nature and consequence of the act and that it would be inappropriate to treat the matter as a punitive one. The Department would be on solid ground to make that point. However, the introduction of physical attacks and harm does raise new and urgent issues around protecting other residents from physical attacks. We cannot lose sight of the fact that violence creates risks and ongoing harm for those on the receiving end. It is its own phenomenon. We note that childcare facilities require reporting of injuries arising from violence, even though toddlers are not held to adult standards of accountability. If a resident is engaging in physical assaults on other residents, even when those actions result from a lack of capacity, there should be processes in place to protect other residents and to provide those on the receiving end with care to ensure that their anxiety and fear is addressed. Those processes should be from the perspective of the resident harmed, not just a detail in a plan centered around the resident who escalated. If consequences are inappropriate, that suggests a greater need for protective protocols. Avoiding a punitive approach does not justify minimizing a protective one.	**Partially Implemented**
Recommendation	**Advocate's comment**	**Overall rating**

3- It is recommended that: A. The Department of Social Development amend practice standards to obligate reporting of major incidents to both the Liaison Officer and Adult Protection within 24 hours and ensure that there is staff available to respond. As part of the annual inspection, the Department of Social Development require Liaison Officers to review with nursing home management their duty to report major incidents to Nursing Home Services and Adult Protection. C. The Department of Social Development develop a universal incident report form to be used by all nursing homes in the province, with Liaison Officers delivering training to nursing home management on how to use the form. This incident report form must be completed by nursing home staff for all incidents that cause harm to residents, and each completed form must be signed by a resident's family member. The incident report form must not include any identifying information about other residents. D. The Department of Social Development's Nursing Home Services practice standards be amended to require mandatory inclusion of all major incidents in a resident's record whether they are the victim or aggressor, as part of the comprehensive care plan. This requirement should also be explicitly stated in the Nursing Homes Act.	The Department has suggested they have taken an Alternative Solution. The Advocate does not see this recommendation as being accepted by the Department. With regards to Response 3D, the Advocate differs with the Department's reasoning. The Department is implying that the presence of administrative improvement tools reduce the need for more public accountability. In fact, public accountability is one way to ensure that the administrative improvement actually takes place. The Advocate wishes to guard against the notion that a private organization should always be trusted to deal with any negative outcomes "in-house". The care of nursing home residents is a public trust – power over vulnerable people – carried out with significant amounts of public dollars. When a resident is physically harmed, it is not simply an internal teaching moment to be noted in internal processes. It triggers a responsibility to those harmed to both deal with the trauma of the event and to assure them that they are safe and protected. The Advocate believes that the original recommendation would be a vital part of ensuring that this happens. The traumatic effects of violence on the party being harmed are not mitigated by a lack of capacity of the perpetrator, even if the perpetrator deserves compassion and treatment instead of a punitive approach	**Partially Implemented**
Recommendation	**Advocate's comment**	**Overall rating**
4- It is recommended that beyond the transparency and accountability aspects of publishing individual annual nursing home inspections, the Department of Social Development report publicly, annually, on aggregate data resulting from inspections. Such reporting must identify nursing homes with multiple and persistent non-compliance with the law and practice standards.	The Advocate is pleased with the Department's acceptance of the recommendation and believes that the work done to date has merit. Elected officials should note that the Department likely requires more resources for inspection and reporting if they are to be reasonably expected to deliver results in a manner timely enough to guide real change.	**Limitedly implemented**
Recommendation	**Advocate's comment**	**Overall rating**
5- It is recommended that: A. The Department of Social Development create a standardized complaint process, in consultation with the Seniors' Advocate, to ensure a consistent province-wide system for nursing home complaint, response and appeal processes with fidelity to administrative fairness and rights-respecting practices. The Department also ensure effective monitoring of this complaint process system by establishing a Provincial Nursing Home Complaints Committee B. The Department of Social Development ensure that each nursing home appoints its own Complaints Committee to hear complaints that have not been satisfactorily addressed by the nursing home, and that these committees are comprised of individuals from the	The Advocate recognizes the Department's positive initial work in this regard. The Department has noted its limited role and authority in resident complaints. Whether their role should be limited is another question, and one that the Advocate will continue to review. Since the release of *He Deserved Better* there have been articulate and important interventions from groups such as the Association francophone des aînés du Nouveau-Brunswick on the fear of reprisals and the chilling effect that exists in long-term care. This is one reason why we continue to insist on safeguards against retaliatory discharges in sectors, and this will be explored further in the Long-Term Care Review currently underway.	**Limitedly implemented**

Board of Directors, family members, and residents. Each nursing home Complaints Committee must report regularly to the Provincial Complaints Committee on issues raised within the nursing home. C. The Department of Social Development confirm that Resident/Family Committees are in place in each nursing home as per the Standards. The role of these Resident/Family Committees must be clearly defined in the Standards. In addition to providing orientation and communication to new residents and their families, the Resident/Family Committees should offer a platform for members to share concerns regarding resident care, with a responsibility to forward issues to the nursing home Complaints Committee as needed. If a resident/family is still not satisfied and is seeking further recourse even after speaking with the nursing home's Liaison Officer, they should be advised to contact the Office of the Seniors' Advocate. All nursing homes must prominently display posters with information about how to reach the Seniors Advocate's Office and include the Seniors' Advocate brochure in all resident registration packages.		
Recommendation	**Advocate's comment**	**Overall rating**
6- It is recommended that the Department of Social Development guarantee comprehensive training for all nursing home staff on violence-reduction interventions, with mandatory reporting to the Department to ensure that all staff have received training.	The same concerns expressed under Recommendation 2 exist here – the Advocate is concerned that the Department is failing to recognize the unique and urgent protection issues that arise when physical violence occurs. It may be that a violence-response protocol will steer many cases into a good dementia policy. However, not all assaults are the result of dementia, and violence deserves its own policy and response as it would in any workplace or living situation. Schools and government workplaces have protective policies for violence that do not presume capacity or punishment. Seniors deserve the same protection when they are vulnerable and in care. That said, the Advocate is pleased to see the Department looking at using statutory reform to ensure training standards across the sector.	**Limitedly implemented**
Recommendation	**Advocate's comment**	**Overall rating**
7- It is recommended that the Department of Social Development's Adult Protection investigations in nursing homes take measures to ensure a comprehensive harm prevention approach informs all investigations to assess and address the risk to all residents, even if the Adult Protection referral relates to only one or a few residents. The Adult Protection investigator must ensure comprehensive documentary disclosure is obtained to ensure that all relevant information (e.g., charts and incident reports) for all affected residents is considered. Formal interviews must also be conducted with affected residents, their family members, as well as staff who provide direct care, rather than addressing all questions to management staff. Adult Protection investigations should follow a template to ensure that comprehensive harm prevention approaches are enforced and that the scope of review is not unreasonably limited. Staff training should be offered to ensure that more robust investigation techniques are adopted consistently in accordance with the practice standards.	The Advocate is satisfied with the Department's response and closes this recommendation.	**Fully implemented**

Recommendation	Advocate's comment	Overall rating
8- It is recommended that: A. The Department of Social Development should create new, detailed Adult Protection practice standards for nursing homes, that adequately address the particular situations of abuse and neglect that can occur in these facilities and provide guidance as to how to curb and address resident to resident violence so as to minimize all risks of harm. B. The Department of Social Development establish a behavioural incident review process wherein monthly reports of all critical injuries and behavioural management incidents in long term care are produced and reviewed at the provincial level through monthly meetings of Adult Protection officials with the participation of the Seniors' Advocate's Office.	While there is an alternate solution proposed by the Department, the Advocate sees the Department's alternatives as reasonable and will engage with the Department to explore the possibility of consensus on an alternate approach. A key boundary condition -- departmental regulation of nursing homes -- will also be explored in the Long-Term Care Review.	**Alternative Solution**
Recommendation	**Advocate's comment**	**Overall rating**
9- It is recommended that the province enact amendments to the Child, Youth and Senior Advocate Act to give a clear legislative mandate to the Advocate to carry out geriatric death and critical injury reviews arising from reported cases of abuse or neglect in nursing home and long-term care in New Brunswick and that additional resources be allocated to the Seniors Advocate to allow for the hire of additional staff to effectively carry out this new mandate.	Following the review process, the Advocate has chosen to withdraw this recommendation. While the Advocate will continue to insist upon reviewing authorities that have the mandate, authority, and resources for oversight in these areas, it is not clear that the Advocate's Office is the only (or even the best) locus for that authority	**Withdrawn**
Recommendation	**Advocate's comment**	**Overall rating**
10- It is recommended that the Department of Social Development ensure Adult Protection social workers undergo mandatory initial and annual training on the Practice Standards, and in all investigations, they should complete a checklist document to ensure the Standards have been followed.	The Advocate recognizes the good work on training that has been done by the Department. Making this training mandatory, rather than recommended, would fully satisfy, and close this recommendation.	**Largely implemented**
Recommendation	**Advocate's comment**	**Overall rating**
11- It is recommended that the Department of Social Development ensure that prior to notice of discharge of any resident of a nursing home, the nursing home must be required to notify both the Department and the Seniors' Advocate, with contact information for the resident and/or the resident's substitute decision-maker. The Department should then be required to institute a rapid response procedure to assess the validity of the discharge. When there is no irremediable safety concern, a process of mandatory mediation should be instituted between family and nursing home. The Department should also engage in a consultation with the Seniors' Advocate and other relevant stakeholders in regard to a review of protections in the Nursing Homes Act to guard against unfair discharge practices.	The Advocate has concerns that the discharge power nursing homes hold is creating a chilling effect upon residents and families raising concerns and complaints. Some work on the process has been done and that has merit. In particular, the protocols for alternate placement and Departmental review are a step in the right direction. However, the need for automatic notice to some oversight body is not a negligible detail. Having an external set of eyes on all discharges as a regular part of the process will be a disincentive to retaliatory discharges. Retaliatory discharges may well be blessedly rare. However, it does occur. Giving seniors and their families the security of automatic external notice will create needed trust in the system. If the practice is rare there is no operational reason for nursing homes to resist notifying the Advocate's Office of discharges. The Advocate will work with the proposed quarterly reporting system and revisit this issue in the Long-Term Care Review.	**Alternative Solution**
Recommendation	**Advocate's**	**Overall rating**

	comment	
12- It is recommended that the Department of Social Development amend Nursing Home Services practice standards to ensure supportive interactions with family and insist upon the compassionate care needed to uphold human dignity, including throughout the grieving process and in relation to funeral rites.	The Advocate would acknowledge that there may well be a number of ways to achieve this policy goal. Had the Department proposed alternate solutions, they would be respectfully considered. The Department's assertion that this would be beyond the scope of their authority, however, is troubling to the Advocate. On its face, this is simply not so. Section 31 of the *Nursing Homes Act* provides that regulations may be made for a number of things, including: • respecting the officers, staff and employees of nursing homes and prescribing their duties, responsibilities and qualifications for employment; and • requiring in-service training programs to be provided to staff and employees of nursing homes. • respecting the services, care, facilities and amenities that nursing homes shall provide and governing and prescribing the staff requirements and duties of staff in respect of the care and services that shall be provided to residents. The Department would be free to make the argument that to use these powers in this case would be unwise. The argument actually being made by the Department is more sweeping. It is a claim that the Department is powerless to do so even if it is in the public interest. This is clearly at odds with the plain reading of the Act and the intent of the elected Legislature. As an Officer of that Legislature, the Advocate must call this out. As noted in the forward, there is a culture of deference to private interests in long-term care which is at odds with other instances where government entrusts private actors to carry out public trusts and serve vulnerable populations. The balance between private interests and public regulation needs to be carefully reviewed, and this response from the Department is indicative of the need for a careful review of some of the casual assumptions that have developed in long-term care. This issue, specifically and generally, will be referred to the current long-term care review.	**Not accepted**
Recommendation	**Advocate's comment**	**Overall rating**
13- It is recommended that a committee comprised of senior management from the Department of Social Development and the Department of Health should lead a comprehensive consultation with all relevant stakeholders, with the goal of thoroughly amending the Nursing Homes Act, Regulations, and Practice Standards, to ensure protection of human rights.	The Advocate believes that the Department has broadly addressed this recommendation by co-operating with the Advocate on the broader review underway. The Advocate will refer this issue to the broader Long-Term Care Review underway and close this recommendation as written.	**Largely Implemented**

Authority's self-assessments and Advocate responses

Recommendation 1

Authority responsible: Social Development

It is recommended that the Department of Social Development develop evidence-based best safety practices for all nursing homes to implement. Nursing homes should be obligated to incorporate these practices as a minimum requirement to comply with the adequate care standards. Inspectors must review each nursing home's services description for compliance and must interview random staff to determine if adequate care standards for safety are being followed in practice.

Departmental Response:

Do you accept the recommendation? **Yes**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Fully Implemented**

Nursing Home inspectors (Liaison Officers (LOs)), currently inspect on safety in nursing homes (NHs) through their annual inspections and through spot checks done in response to various triggers (major incident reports, concerns from resident/families, not meeting care hours etc.)
Each standard has one or more measures of compliance that must be met. How the measures of compliance are assessed varies based on the nature of that measure of compliance. Inspections are based on a combination of observation, reviewing documentation, and conversations with NH staff. Examples of how LOs measure compliance include:

- *reviewing NHs policies and procedures,*
- *auditing resident charts,*
- *reviewing the standardized interRAI assessment tool (LTCF),*
- *bedside care audit,*
- *bath audit,*
- *discussions with residents, staff and families,*
- *review of employee records (health, education, certification),*
- *review of meeting minutes (resident committee), etc.*

The NH Standards Manual is continuously being reviewed and updated to incorporate best practices. It is available online at DEPARTMENT OF SOCIAL DEVELOPMENT NURSING HOME SERVICES STANDARDS (gnb.ca). *Social Development (SD) NH Standards represent the minimum requirement. NHs are required to have policies and procedures in place to ensure that their operations meet the Department's standards. NH leaders (and the organizations representing them) have the responsibility to ensure the*

NH's policies and procedures meet those minimum requirements and have been developed using best practices.

When the Department is revising its NH Standards, best practices are drawn from various sources, for example Healthcare Excellence Canada, National Standards (e.g. HSO's LTC Services Standards), RNAO (Registered Nurses Association of Ontario) Best Practice Guidelines, Canadian Institute for Health Information (CIHI), CCPA (Canadian Institute for Policy Alternatives), CPSI (Canadian Patient Safety Institute), CADTH (Canadian Drug and Health Technology Agency); Jurisdictional Scans, National Institute on Aging (NIA), NANB (Nursing Association of New Brunswick), CNA (Canadian Nurses Association).

The following Standards have recently been updated:

- *Standard A-VII: Discharge of Residents (May 2022),*
- *Standard A-V-1: Resident Concerns (May 2022),*
- *Standard D-I-2: Infection, Prevention and Control (October 25, 2022),*
- *Standard B-I-1: Care Staff Monitoring (October 25, 2022),*
- *Standard C-II-1: Employee Requirements (October 25, 2022), and*
- *Standard A-VIII-1: Major Incident reporting (November 30, 2022).*

Each time a Standard is updated, the leadership of NHs are notified and provided with a memo outlining the changes. LOs will provide additional support for NH leadership on new and revised standards, including providing recommendations of how to meet compliance.

Advocate's Comments:

Implementation rate: **Fully Implemented**

Next review period: **Recommendation Closed.**

The Advocate considers this recommendation met within the scope of the Report and is satisfied with the response. There are legitimate questions as to whether or not there are adequate inspection resources and whether or not the governance model provides the Government of New Brunswick with an adequate role in the governance of nursing homes, and these will be addressed in the Long-Term Care Review underway.

Recommendation 2

Authority responsible: Social Development

It is recommended that the Department of Social Development undertake a thorough review of best practices in violence mitigation, and develop a comprehensive policy and practice structure, in collaboration with the Seniors' Advocate and representation from: nursing homes, the Nurses Association of New Brunswick, the New Brunswick Council of Nursing Home Unions, the Association of New Brunswick Licensed Practical Nurses, the New Brunswick Association of Nursing Homes and academic experts from New Brunswick post-secondary institutions.

Departmental Response:

Do you accept the recommendation? **Other**
Social Development supports work to improve dementia-care, including collaborative work as part of a committee/working group to improve policy and practice structure. The focus would include reviewing best practices in ensuring the safety of residents in the midst of responsive behaviours, as outlined below in the alternative solution to achieve the intended outcome.

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Alternative Solution**

The Department recognizes the importance of ensuring all nursing home staff are equipped with appropriate training to prevent and mitigate any escalation in responsive behaviour. The Department currently mandates through Standard C-II-1 (Employee Requirements) that there is in-service training for dementia-care, prevention of abuse, behaviour management, pain management and end of life care.

Reviews of evidence and best practices in reduction of aggressive behaviour have already taken place, identifying numerous evidence-based approaches that can be used by NH operators in training staff. An example of this would be the Gentle Persuasive Approaches (GPA). A proposed alternative solution to the recommendation is to amend the existing standard to include language requiring NHs to use a validated, evidence-based approach for behaviour management education. The Department looks forward to continued collaboration with the Department of Health and other partners on improving dementia-care in the province.

There currently exists a collaborative group: The Nursing Home Workplace Violence Prevention Working group that aims at providing tools for employers to reduce incidents of workplace violence. https://www.worksafenb.ca/safety-topics/nursing-homes/ This is a collaborative between NBANH, NBNH, WSNB and NBCCSA.

*The Department is responsible to ensure the provision of adequate care to **all** nursing home residents and has Standards in place to ensure each individual resident's care needs are being met (including but not limited to the following standards: B-II-1: Care Plan, B-III-1: Resident Care). The Department does not label residents as victims or aggressors/assailant, nor do we use language like "violence mitigation". The Department takes a person-centered approach to care, also referred to as resident-centered, and as such, requires NHs to create individualized care plans to meet the needs of their residents, including responsive behaviors (which can occasionally be aggressive in nature).*

Standard B-II-1: Care Plan requires regular assessments of a variety of aspects of resident well-being and safety. Through Momentum software and interRAI LTCF assessments, NHs have the ability to monitor outcome scales for residents in a variety of clinical areas, one example being the ABS (aggressive behavior scale) which can provide insight into the frequency and intensity of certain responsive behaviors that can trigger a review of the care plan to help mitigate these behaviours.

Advocate's Comments:

Implementation rate: **Partially Implemented**

Next review period: 4/1/2024

The Advocate has concerns with the Department's partial rejection of this recommendation. The Advocate does acknowledge the Department's openness to working with experts and stakeholders on policies and procedures that reflect best practices in care for those suffering from dementia. This is urgent and welcome, as projects suggest a coming increase in service demand beyond New Brunswick's capacity and preparation. The Advocate has concerns about the Department's resources to carry out this work in time to meet the looming demand but is satisfied that the Department's understands the urgency. The Legislature must vote to provide them the budget to make that sense of urgency real.

The Advocate has concerns that, when dementia is a factor in violent behaviour, the Department is giving too little consideration to the rights of other residents to protection and follow-up services. It is true that when one resident becomes violent with another, the aggressor may lack capacity to understand the nature and consequence of the act and that it would be inappropriate to treat the matter as a punitive one. The Department would be on solid ground to make that point. However, the introduction of physical attacks and harm does raise new and urgent issues around protecting other residents from physical attacks. We cannot lose sight of the fact that violence creates risks and ongoing harm for those on the receiving end. It is its own phenomenon. We note that childcare facilities require reporting of injuries arising from violence, even though toddlers are not held to adult standards of accountability.

If a resident is engaging in physical assaults on other residents, even when those actions result from a lack of capacity, there should be processes in place to protect other residents and to provide those on the receiving end with care to ensure that their anxiety and fear is addressed. Those processes should be from the perspective of the resident harmed, not just a detail in a plan centered around the resident who escalated. If consequences are inappropriate, that suggests a greater need for protective protocols. Avoiding a punitive approach does not justify minimizing a protective one.

Recommendation 3

Authority responsible: Social Development

It is recommended that:

A. The Department of Social Development amend practice standards to obligate reporting of major incidents to both the Liaison Officer and Adult Protection within 24 hours and ensure that there is staff available to respond. As part of the annual inspection, the Department of Social Development require Liaison Officers to review with nursing home management their duty to report major incidents to Nursing Home Services and Adult

Protection.

B. The Department of Social Development develop a universal incident report form to be used by all nursing homes in the province, with Liaison Officers delivering training to nursing home management on how to use the form. This incident report form must be completed by nursing home staff for all incidents that cause harm to residents, and each completed form must be signed by a resident's family member. The incident report form must not include any identifying information about other residents.

C. The Department of Social Development's Nursing Home Services practice standards be amended to require mandatory inclusion of all major incidents in a resident's record whether they are the victim or aggressor, as part of the comprehensive care plan. This requirement should also be explicitly stated in the Nursing Homes Act.

D. The Department of Social Development's Nursing Home Services practice standards be amended to require mandatory inclusion of all major incidents in a resident's record whether they are the victim or aggressor, as part of the comprehensive care plan. This requirement should also be explicitly stated in the Nursing Homes Act.

Departmental Response:

Do you accept the recommendation? Other

SD has implemented alternative solutions as outlined below. SD has taken action on the first three parts of the recommendation and therefore sees it as largely implemented. SD has concerns with the 4th part of the recommendation as written. A resident's record is not the recommended place to track incidents associated with responsive behaviour, including aggressive behaviour. Momentum software is used to track these incidents. It enables care staff to monitor incidents over time to identify when a resident's care plan needs to be adjusted from a well-being and harm reduction perspective.

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Alternative Solution**

Recommendation 3A: Standard A-VIII-1: Major Incident Reporting was updated and posted on December 1, 2022. The NH must notify the next of kin and LO within 24 hours of a major incident. Where applicable, the nursing home must report to Adult Protection, Coroner, Public Health or other agencies as per their respective notification requirements. It is currently not mandated under the Family Services Act to report to Adult Protection.

Recommendation 3B: LOs provide orientation with new NH leadership. Changes made to NH Standards are communicated to all NHs and the LO provides further explanation of how the NH can meet the areas of compliance during inspections. NH leadership also has access to the Department's nursing consultants for assistance interpreting Standards.

Recommendation 3C: Part of the revised Standard A-VIII-1: Major Incident Reporting includes the requirement for the nursing home to use the Momentum Software incident reporting system for all

major incidents. The revised process includes a streamlined notification process of emailing the Department with the Momentum Major Incident Report Number. This new process improves efficiency and confidentiality of resident information.

Next of kin (who have permission to receive resident information) must be notified of major incidents as per the Standard and details of the incident are shared with the next of kin; however, signing of the actual incident report is not accepted as a recommendation. Incident reports are tools to assist NH leadership in identifying gaps in safety to make changes to policies/practices as required. The administrator is required to sign off on incident reports. Incident reports are not part of the resident record and will not be shared with family.

The Department agrees that a measure of compliance that could be added to Standard A-VIII-1 would be for the NH operator to have a policy and procedure documenting major incident disclosure requirements. https://www.healthcareexcellence.ca/en/resources/patient-safety-and-incident-management-toolkit/incident-management/disclosure/

Recommendation 3D: The Department has concerns with this portion of the recommendation. Major incidents include not only responsive behaviour, including aggression but also include accidents. Momentum software is used to track these incidents, including a tool that helps care staff to track incidents over time to see when a resident's care plan needs to be adjusted from a well-being and harm reduction perspective. All information related to specific incidents will continue to be captured in a resident's file or progress notes as per the documentation standards required by Registered Nurse and Licensed Practical Nurse professional associations.

Advocate's Comments:

Implementation rate: **Partially Implemented**

Next review period: 4/1/2024

The Department has suggested they have taken an Alternative Solution. The Advocate does not see this recommendation as being accepted by the Department. With regards to Response 3D, the Advocate differs with the Department's reasoning. The Department is implying that the presence of administrative improvement tools reduce the need for more public accountability. In fact, public accountability is one way to ensure that the administrative improvement actually takes place. The Advocate wishes to guard against the notion that a private organization should always be trusted to deal with any negative outcomes "in-house". The care of nursing home residents is a public trust – power over vulnerable people – carried out with significant amounts of public dollars. When a resident is physically harmed, it is not simply an internal teaching moment to be noted in internal processes. It triggers a responsibility to those harmed to both deal with the trauma of the event and to assure them that they are safe and protected. The Advocate believes that the original recommendation would be a vital part of ensuring that this happens. The traumatic effects of violence on the party being harmed are not mitigated by a lack of capacity of the perpetrator, even if the perpetrator deserves compassion and treatment instead of a punitive approach.

Recommendation 4

Authority responsible: Social Development

It is recommended that beyond the transparency and accountability aspects of publishing individual annual nursing home inspections, the Department of Social Development report publicly, annually, on aggregate data resulting from inspections. Such reporting must identify nursing homes with multiple and persistent non-compliance with the law and practice standards.

Departmental Response:

Do you accept the recommendation? **Yes**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Limitedly Implemented**

InterRAI Long Term Care Facility is an assessment tool that is mandated for use in NB NHs through the NH Standards. All residents are required to have an assessment done every 3 months, at a minimum. interRAI LTCF is a newer version of the MDS 2.0 interRAI assessment that many other provinces currently use. Your Health System website published every December can show data for NB as a whole or by individual nursing home. CIHI indicators are available publicly available here: https://www.cihi.ca/en/topics/long-term-care/indicators . To ensure transparency the Department has linked the "Your Health System" page on the Nursing Home Services webpage.

Advocate's Comments

Implementation rate: **Limitedly Implemented**

Next review period: 4/1/2024

The Advocate is pleased with the Department's acceptance of the recommendation and believes that the work done to date has merit. Elected officials should note that the Department likely requires more resources for inspection and reporting if they are to be reasonably expected to deliver results in a manner timely enough to guide real change.

Recommendation 5

Authority responsible: Social Development

It is recommended that:

A. The Department of Social Development create a standardized complaint process, in consultation with the Seniors' Advocate, to ensure a consistent province-wide system for nursing home complaint, response and appeal processes with fidelity to administrative fairness and rights-respecting practices. The Department also ensure effective monitoring of this complaint process system by establishing a Provincial Nursing Home Complaints Committee

B. The Department of Social Development ensure that each nursing home appoints its own Complaints Committee to hear complaints that have not been satisfactorily addressed by the nursing home, and that these committees are comprised of individuals from the Board of Directors, family members, and residents. Each nursing home Complaints Committee must report regularly to the Provincial Complaints Committee on issues raised within the nursing home.

C. The Department of Social Development confirm that Resident/Family Committees are in place in each nursing home as per the Standards. The role of these Resident/Family Committees must be clearly defined in the Standards. In addition to providing orientation and communication to new residents and their families, the Resident/Family Committees should offer a platform for members to share concerns regarding resident care, with a responsibility to forward issues to the nursing home Complaints Committee as needed. If a resident/family is still not satisfied and is seeking further recourse even after speaking with the nursing home's Liaison Officer, they should be advised to contact the Office of the Seniors' Advocate. All nursing homes must prominently display posters with information about how to reach the Seniors Advocate's Office and include the Seniors' Advocate brochure in all resident registration packages.

Departmental Response:

Do you accept the recommendation? **Yes**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Limitedly Implemented**

The Department agrees a dedicated team is required to address the volume of requests, either from residents, families, stakeholders, etc. The Department welcomes the support of CYSA in future planning of a team and complaints committee.

Changes have been made to standard A-V-1: Resident Concerns which was amended and posted in April 2022. The revised standard requires that each nursing home is required to display posters and information sheets for the purpose of familiarizing their employees and residents with the roles and responsibilities of the Seniors' Advocate. Each nursing home must prominently display contact information for the Senior's Advocate Office within the facility and explain to residents / next of kin or legal representatives their right to contact the Seniors' Advocate.

A measure of compliance in Standard A-V-1: Resident Concerns is that a resident/family committee is in

place, which holds meetings at least on a quarterly basis. Minutes of those meetings are created and maintained by the nursing home. Defining the role of the committee would be operational and up to the committee members themselves when the terms of references are established.

Currently residents and families can reach out to the Nursing Home's board of directors if they are not getting the assistance, they are seeking from the Nursing Home's leadership. If the board is also unsuccessful in assisting, the resident/family can reach out to the department (through Liaison Officer or ministerial correspondence). Once "Complaints Committee" is defined and established, a revised resident and family committee standard can be developed outlining the process for forwarding issues as determined once committee in place, as per recommendation 5.

Advocate's Comments:

Implementation rate: **Limitedly Implemented**

Next review period: 4/1/2024

The Advocate recognizes the Department's positive initial work in this regard. The Department has noted its limited role and authority in resident complaints. Whether their role should be limited is another question, and one that the Advocate will continue to review. Since the release of *He Deserved Better* there have been articulate and important interventions from groups such as the Association francophone des aînés du Nouveau-Brunswick on the fear of reprisals and the chilling effect that exists in long-term care. This is one reason why we continue to insist on safeguards against retaliatory discharges in sectors, and this will be explored further in the Long-Term Care Review currently underway.

Recommendation 6

Authority responsible: Social Development

It is recommended that the Department of Social Development guarantee comprehensive training for all nursing home staff on violence-reduction interventions, with mandatory reporting to the Department to ensure that all staff have received training.

Departmental Response:

Do you accept the recommendation? **Other**
SD is taking an alternative approach to meet the desired outcomes.
Provide a self-assessment indicating how much of the recommendation has been implemented.
Please provide an explanation for your response below: **Alternative Solution**

Best practices for ensuring the safety of all residents and addressing responsive behaviours among residents living with dementia currently exist and are widely available through the resources listed in the

recommendation above (Recommendation #1 and #2). The Department is interested in advancing training solutions related to dementia-care. The Department is seeking funding to expand this area and exploring various avenues. SD notes that dementia-care would be a collaborative initiative with the Department of Health and other key partners.

Training is presently recorded and monitored at the Nursing Home level. SD has a Standard in place which allows for auditing of Employee information including Professional Licensing Requirements, Certifications, Orientation, In-Service Training, On-going Education, and Employee Records. SD is aiming to enhance this with a possible legislative amendment that would allow us to mandate this training to build greater expertise in this complex area across the sector.

Advocate's Comments:

Implementation rate: **Limitedly Implemented**

Next review period: 4/1/2024

The same concerns expressed under Recommendation 2 exist here – the Advocate is concerned that the Department is failing to recognize the unique and urgent protection issues that arise when physical violence occurs. It may be that a violence-response protocol will steer many cases into a good dementia policy. However, not all assaults are the result of dementia, and violence deserves its own policy and response as it would in any workplace or living situation. Schools and government workplaces have protective policies for violence that do not presume capacity or punishment. Seniors deserve the same protection when they are vulnerable and in care. That said, the Advocate is pleased to see the Department looking at using statutory reform to ensure training standards across the sector.

Recommendation 7

Authority responsible: Social Development

It is recommended that the Department of Social Development's Adult Protection investigations in nursing homes take measures to ensure a comprehensive harm prevention approach informs all investigations to assess and address the risk to all residents, even if the Adult Protection referral relates to only one or a few residents. The Adult Protection investigator must ensure comprehensive documentary disclosure is obtained to ensure that all relevant information (e.g., charts and incident reports) for all affected residents is considered. Formal interviews must also be conducted with affected residents, their family members, as well as staff who provide direct care, rather than addressing all questions to management staff. Adult Protection investigations should follow a template to ensure that comprehensive harm prevention approaches are enforced and that the scope of review is not unreasonably limited. Staff training should be offered to ensure that more robust investigation techniques are adopted consistently in accordance with the practice standards.

Departmental Response:

Do you accept the recommendation? **Yes**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Fully Implemented**

We are pleased to see the Seniors' Advocate recognizing the importance of a well informed and complete investigation. In 2015, an Adult Protection Investigative Guide was developed by the Department. This guide was reviewed and updated in 2018, and again in 2020, and 2022 along with the delivery of training on the guide. This guide includes three separate investigation checklists, including one specific to nursing homes. SD has updated the standards and guide. Training with new standards was provided in November 2022 and online training on investigative interviewing is available.

The Department is currently exploring the option of enhancing New Brunswick's Adult Protection legislation.

Based off the He Deserved Better report the following has been updated in the Adult Protection standards:

1. *Practice standard 7: Conducting an Investigation*
2. *Practice standard 8: Suspicious Death of an Adult*
3. *Practice standard 9: Interviewing*
4. *Practice standard 10: Adult Protection Investigations Guide and Checklist Templates*
5. *Practice standard 11: Investigation Verification/Conclusion*
6. *Practice standard 19: Event Documentation*

The following sections of the AP Investigations Guide have also been revised:

1. *1 (1A and 1B): General Adult Protection Investigations - Investigation Process; General Adult Protection Investigations Checklist Template*
2. *2 (2A and 2B): Adult Protection Investigations in ARF Facilities - Investigation Process; AP Investigations in ARF Facilities Checklist Template*
3. *3 (3A and 3B): Adult Protection investigations in Nursing Homes – Nursing Homes Investigation Process; AP Investigations in nursing homes Checklist Template*

Advocate's Comments:

Implementation rate: **Fully Implemented**

Next review period: **Recommendation closed.**

The Advocate is satisfied with the Department's response and closes this recommendation.

Recommendation 8

Authority responsible: Social Development

It is recommended that:

A. The Department of Social Development should create new, detailed Adult Protection practice standards for nursing homes, that adequately address the particular situations of abuse and neglect that can occur in these facilities and provide guidance as to how to curb and address resident to resident violence so as to minimize all risks of harm.

B. The Department of Social Development establish a behavioural incident review process wherein monthly reports of all critical injuries and behavioural management incidents in long term care are produced and reviewed at the provincial level through monthly meetings of Adult Protection officials with the participation of the Seniors' Advocate's Office.

Departmental Response:

Do you accept the recommendation? **Other**
SD has taken an alternative approach to address the recommended outcome.

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Alternative Solution**

A. Social Development has updated Adult Protections standards as outlined in response for recommendation 7. While Adult Protection will make recommendations when practices need to be addressed in order to address risk, such as with resident-to-resident violence, Social Development does not have the mandate or expertise to provide guidance to homes on how to manage these risks. Recommendation to contact other professionals or organizations may be provided as means to address these issues. The Nursing Home Services Standards require operators to provide education and training on behavior management, prevention of abuse, and dementia care. The Department also provides training modules and eLearning on a variety of topics, including dementia care. updated standards and guide. Partly addressed, other part is addressed in recommendation above (care plan).

B. The recommendation to implement a monthly behavioural incident review process was discussed with the Senior's Advocate and there was openness to consider an alternative solution. Social Development has agreed to discuss further how the department may meet the intent of this recommendation without it having to be as prescriptive as monthly meetings on all behavioural incidents across the 72 nursing homes that exist today. The initial approach was seen to be resource intensive for both the Department and the Advocates office.
a projectThe Department is exploring the review and enhancement of Adult Protection legislation.

Advocate's Comments:

Implementation rate: **Alternative Solution**

Next review period: 4/1/2024

While there is an alternate solution proposed by the Department, the Advocate sees the Department's alternatives as reasonable and will engage with the Department to explore the possibility of consensus on an alternate approach. A key boundary condition -- departmental regulation of nursing homes -- will also be explored in the Long-Term Care Review.

Recommendation 9

Authority responsible: Executive Council Office

It is recommended that the province enact amendments to the Child, Youth and Senior Advocate Act to give a clear legislative mandate to the Advocate to carry out geriatric death and critical injury reviews arising from reported cases of abuse or neglect in nursing home and long-term care in New Brunswick and that additional resources be allocated to the Seniors Advocate to allow for the hire of additional staff to effectively carry out this new mandate.

Departmental Response:

Do you accept the recommendation? **No**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Not accepted**

Since the Child, Youth and Senior Advocate Act is not under the mandate of the Department of Social Development, this recommendation will be forwarded to the Executive Council Office for consideration and appropriate action. This recommendation is outside of the scope of Social Development to address.

Advocate's Comments:

Implementation rate: Not Applicable

Next review period: **Recommendation withdrawn.**

Following the review process, the Advocate has chosen to withdraw this recommendation. While the Advocate will continue to insist upon reviewing authorities that have the mandate, authority, and resources for oversight in these areas, it is not clear that the Advocate's Office is the only (or even the best) locus for that authority

Recommendation 10

Authority responsible: Social Development

It is recommended that the Department of Social Development ensure Adult Protection social

workers undergo mandatory initial and annual training on the Practice Standards, and in all investigations, they should complete a checklist document to ensure the Standards have been followed.

Departmental Response:

Do you accept the recommendation? **Yes**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Largely Implemented**

Provincial training occurred in November 2022, which included recent updates to the standards and interview guide as listed in Recommendation 7.
There was an additional change to standards to require Adult Protection workers to add the checklist in the investigation file. There is work underway to develop a training plan for the Adult Protection Program. Once the plan is approved, it will be shared with the Seniors' Advocate office.

Legislative review related to Adult Protection is being explored and scoped.

Advocate's Comments:

Implementation rate: **Largely Implemented**

Next review period: 4/1/2024

The Advocate recognizes the good work on training that has been done by the Department. Making this training mandatory, rather than recommended, would fully satisfy, and close this recommendation.

Recommendation 11

Authority responsible: Social Development

It is recommended that the Department of Social Development ensure that prior to notice of discharge of any resident of a nursing home, the nursing home must be required to notify both the Department and the Seniors' Advocate, with contact information for the resident and/or the resident's substitute decision-maker. The Department should then be required to institute a rapid response procedure to assess the validity of the discharge. When there is no irremediable safety concern, a process of mandatory mediation should be instituted between family and nursing home. The Department should also engage in a consultation with the Seniors' Advocate and other relevant stakeholders in regard to a review of protections in the Nursing Homes Act to guard against unfair discharge practices.

Departmental Response:

Do you accept the recommendation? **Other**
An alternative solution has been taken to support the recommended outcome.

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Alternative Solution**

The Department introduced amendments to Regulation 85-187 under the Nursing Homes Act to protect residents from unnecessary discharge by introducing four specific criteria for resident discharge.

SD offers supports when needed and appropriate to avoid resident discharge. Further, when options have been exhausted and discharge cannot be avoided, the nursing home and the Department work with a resident / family to help them find an alternate placement including providing them with a list of nursing homes in the area, a list of available nursing home beds and considering what other supports might be required by the resident (discharge planning). The NH Discharge of Residents Standard has been revised and requires that:
- Nursing homes ensure that every effort is made to ensure that residents' needs are met; a discharge is the exception and only occurs when all other options / efforts have been exhausted; and,
- Nursing homes must ensure that the resident / their next of kin or legal representative is kept informed and given an opportunity to participate in the discharge planning and that the resident's wishes are taken into consideration.

In addition, the NHs can make a referral to Adult Protection if they foresee that the safety or security of the residents would be at risk due to the planned placement.

SD will update the Standards to ensure that nursing homes establish a process to maintain the continuity of care for a seamless transition to an alternate placement.

SD made changes to the NHA, regulations and standard, effective April 1, 2022. Prior to discharge, the NH operator is required to notify the resident, next of kin/legal representative or if no legal representative on file, the Director of ACR, and the minister 30 days before the date of discharge. Acceptable circumstances for discharge have been added to the regulations. Through the dispute resolution process as outlined in Standards A-V-1: Resident Concerns, any issues that may lead to resident discharge should be thoroughly explored. SD and the Seniors Advocate do not need to be involved in the nursing home operations/dealings with the resident and/or legal representative unless issues have been identified through major incidents or resident/family concerns addressed to the department or the CYSA.

Resident Advocate/Complaints committee add support in this area. Nursing Homes are required to make readily available/visible information about the Child, Youth and Senior's advocate. These ensure that residents and/or their families have access to information about the Senior's advocate, including contact information.

If nursing homes do not follow the regulation and standard for resident discharge, they will receive an infraction. If SD identifies a systemic issue related to improper resident discharges, as Regulator, a path to trusteeship would be considered. Resident discharge, among numerous other topics is being

considered within analyses related to the need for an enhanced compliance framework.

SD is open to having a working group with the CYSA and will report quarterly to the CYSA on resident discharges. SD sees the objective behind the recommendation as having been met.

Advocate's Comments:

Implementation rate: **Alternative Solution**

Next review period: 4/1/2024

The Advocate has concerns that the discharge power nursing homes hold is creating a chilling effect upon residents and families raising concerns and complaints. Some work on the process has been done and that has merit. In particular, the protocols for alternate placement and Departmental review are a step in the right direction. However, the need for automatic notice to some oversight body is not a negligible detail. Having an external set of eyes on all discharges as a regular part of the process will be a disincentive to retaliatory discharges. Retaliatory discharges may well be blessedly rare. However, it does occur. Giving seniors and their families the security of automatic external notice will create needed trust in the system. If the practice is rare there is no operational reason for nursing homes to resist notifying the Advocate's Office of discharges. The Advocate will work with the proposed quarterly reporting system and revisit this issue in the Long-Term Care Review.

Recommendation 12

Authority responsible: Social Development

It is recommended that the Department of Social Development amend Nursing Home Services practice standards to ensure supportive interactions with family and insist upon the compassionate care needed to uphold human dignity, including throughout the grieving process and in relation to funeral rites.

Departmental Response:

Do you accept the recommendation? **No**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Partially Implemented**

SD does not agree that this recommendation is in line with its scope as regulator of NHs to ensure the overall wellbeing and safety of residents and notes that there are many nursing home workers providing compassionate care to residents and compassionate support to families as they grieve the loss of a loved one. Social Development is mandated to ensure adequate provision of services for residents. Social Development does not agree that a lack of compassionate care for families as they grieve the loss of a

loved one is a systemic issue that should be regulated. There are many factors to consider: role of regulator; other residents living at the NHs (especially individuals in shared rooms with a deceased resident); and the needs of other NB seniors waiting for placement in NHs.

We have several standards that presently address this recommendation an example of this is Standard B-III-1: Resident Care. Additional Standards that include provisions to ensure residents needs and preferences are being met, such as the requirement for a comprehensive care plan, as indicated in Standard B-II-1: Care Plan. Standards B-VII-1 and B-VIII-1 also address the requirement to establish appropriate activation activities and to ensure that the residents psychosocial needs are being met.

Standard A-V-1: Resident Concerns, was amended after the He Deserved Better report, additional measures of compliance were added to the standard, including the requirement for each NH is required to have a dispute resolution process that involves the resident and their next of kin. As per the requirements outlined in the standard the environment must be conducive to residents, staff, family and advocates or representatives, and visitors being able to raise issues or express concerns without fear of repercussions.

Advocate's Comments

Implementation rate: **Not accepted**

Next review period: 4/1/2024

The Advocate would acknowledge that there may well be a number of ways to achieve this policy goal. Had the Department proposed alternate solutions, they would be respectfully considered.

The Department's assertion that this would be beyond the scope of their authority, however, is troubling to the Advocate. On its face, this is simply not so. Section 31 of the *Nursing Homes Act* provides that regulations may be made for a number of things, including:

- respecting the officers, staff and employees of nursing homes and prescribing their duties, responsibilities and qualifications for employment; and
- requiring in-service training programs to be provided to staff and employees of nursing homes.
- respecting the services, care, facilities and amenities that nursing homes shall provide and governing and prescribing the staff requirements and duties of staff in respect of the care and services that shall be provided to residents.

The Department would be free to make the argument that to use these powers in this case would be unwise. The argument actually being made by the Department is more sweeping. It is a claim that the Department is powerless to do so even if it is in the public interest. This is clearly at odds with the plain reading of the Act and the intent of the elected Legislature. As an Officer of that Legislature, the Advocate must call this out.

As noted in the forward, there is a culture of deference to private interests in long-term care which is at odds with other instances where government entrusts private actors to carry out public trusts and serve vulnerable populations. The balance between private interests and public regulation needs to be carefully reviewed, and this response from the Department is indicative of the need for a careful review of some of the casual assumptions that have developed in long-term care. This issue, specifically and generally, will be referred to the current long-term care review.

Recommendation 13

Authority responsible: Social Development

It is recommended that a committee comprised of senior management from the Department of Social Development and the Department of Health should lead a comprehensive consultation with all relevant stakeholders, with the goal of thoroughly amending the Nursing Homes Act, Regulations, and Practice Standards, to ensure protection of human rights.

Departmental Response:

Do you accept the recommendation? **Yes**

Provide a self-assessment indicating how much of the recommendation has been implemented. Please provide an explanation for your response below: **Limitedly Implemented**

The department agrees that a Resident Bill of Rights should be incorporated into future legislation relating to LTC homes.

We are always happy to collaborate with our partners to support the well-being and safety of NH residents. The Nursing Homes Act, the regulations thereunder and the Nursing Home Services Standards are solely under the mandate of the Department of Social Development. The Department reviews its legislation, regulations, policies, and standards regularly. This can be seen in the recent amendments to the Nursing Homes Act and the General Regulation, which were undertaken after consultation with stakeholders and a review of similar legislation across Canada. The Department is continuing to review its legislation, programs and services to identify areas for improvement.

Advocate's Comments:

Implementation rate: **Largely Implemented**

Next review period: 4/1/2024

The Advocate believes that the Department has broadly addressed this recommendation by co-operating with the Advocate on the broader review underway. The Advocate will refer this issue to the broader Long-Term Care Review underway and close this recommendation as written.