Overview

In addition to investigating complaints, the Ombudsperson has authority to initiate investigations. The Ombudsperson uses this authority to consider issues from a broad systemic perspective. A systemic investigation is an investigation initiated by the Ombudsperson that is likely to result in findings and recommendations and a published Ombudsperson report.

Since its creation in 2007, the Systemic Investigation Team has completed eight major systemic investigations and has made hundreds of recommendations aimed at improving administrative processes and ensuring that a broad range of people in British Columbia are treated fairly. As a result of its work, the B.C. Ombudsperson Systemic Team has built a reputation as a leader in conducting systemic investigations with a small team and was asked by the Forum of Canadian Ombudsmen, the largest professional association for Ombudsman offices in Canada, to develop and deliver a training program on systemic investigations for small offices. The Systemic Investigation Team monitors the implementation of recommendations made and includes status updates in the Ombudsperson’s annual reports and on the office’s website.

Systemic Investigation Completed in 2012/2013

Implementation of Recommendations in Public Report No. 49, No Longer Your Decision: British Columbia’s Process for Appointing the Public Guardian and Trustee to Manage the Financial Affairs of Incapable Adults

On February 6, 2013, the Ombudsperson released Public Report No. 49, No Longer Your Decision: British Columbia’s Process for Appointing the Public Guardian and Trustee to Manage the Financial Affairs of Incapable Adults. This report examined the process for issuing certificates of incapability that result in the Public Guardian and Trustee of British Columbia assuming control over an adult’s financial and legal decision making. The investigation found that the process did not meet the requirements of fairness and reasonableness in a number of respects.

The investigation resulted in 21 findings and 28 recommendations which focused on improving practices followed by the Public Guardian and Trustee and the six health authorities, establishing provincial training for staff, and creating legally binding minimum requirements. The health authorities accepted all five of the recommendations made to them. The Office of the Public Guardian and Trustee accepted five of the seven recommendations made to it in full and one in part. The Ministry of Health accepted both of the recommendations made to it. The Ministry of Justice accepted 12 of the 14 recommendations made to it that were directed toward regulatory and legislative changes.

“What a great report your office issued yesterday. Finally, my clients are being heard.”

Lloyd Duhaime
Barrister & Solicitor
Since the report was released, the Ministry of Justice has taken some steps to implement some of the recommendations. Through orders-in-council, sections of the *Adult Guardianship and Planning Statutes Amendment Act, 2007* have been enacted. Provisions that amend the powers of the Public Guardian and Trustee to protect assets in urgent cases came into effect immediately (Recommendation 2). Additional provisions of the *Adult Guardianship and Planning Statutes Amendment Act, 2007* will take effect on June 30, 2014. These provisions include:

- Standardizing the criteria for deciding when a certificate of incapability is issued (Recommendation 16).
- Requiring guardians, where reasonable, to encourage the adult’s involvement in decision making that affects the adult (Recommendation 28).

**Systemic Investigations Completed in 2011/2012**

**Public Report No. 47 – The Best of Care: Getting it Right for Seniors in British Columbia (Part 2)**

On February 14, 2012, the Ombudsperson released Public Report No. 47, *The Best of Care: Getting It Right for Seniors in British Columbia (Part 2)*. This comprehensive and in-depth report makes 143 findings and 176 recommendations to the Ministry of Health and the five regional health authorities designed to improve home and community care, home support, assisted living and residential care services for seniors.

The majority of the report’s recommendations were aimed at the Ministry of Health. The ministry has not yet indicated whether it has accepted these recommendations. Despite this, we asked both the ministry and the health authorities to report on the progress made in implementing the recommendations as part of our yearly monitoring and update process.

Since our 2011/2012 annual report, the authorities have made progress towards implementing the Ombudsperson’s recommendations including:

- The Ministry of Health has revised the Home and Community Care Policy Manual to require health authorities to process an application for temporary rate reduction within 30 business days of the date the health authority receives complete supporting documentation (Recommendation 13).
- The Ministry of Health has amended its Home and Community Care Policy Manual to require that health authorities, when delivering services, require that staff report possible abuse and neglect (Recommendation 27).
- Northern Health enhanced the “compliments and complaints” section of its website by including information about how a member of the public can raise a concern about health or safety issues for assisted living clients (Recommendation 71).
- Information about substantiated assisted living complaints has been available through the Ministry of Health’s website since September 1, 2012 (Recommendation 88) and the list of serious incidents that must be reported to the Assisted Living Registry has been expanded to include missing persons, a police call and flood causing personal injury or building damage (Recommendation 86).
- All health authorities provide online access to summary inspection reports for *Hospital Act* facilities (Recommendation 95).
- As we have previously reported, the Ministry of Health has completed its review of the use of anti-psychotic drugs in residential care facilities.
The ministry released best practice guidelines for accommodating and managing the behavioural and psychological symptoms of dementia in residential care in October 2012. In March 2013, the ministry approved a training program that will be used as part of dementia care training to residential care providers in the province (Recommendation 145).

- The ministry released a *Provincial End-of-Life Care Action Plan for British Columbia* in March 2013 to guide planning for integrated primary and community care services, including ensuring end-of-life care choices are respected by health care providers (Recommendation 147).

- As of March 2013 the Vancouver Island Health Authority, Fraser Health Authority and Interior Health Authority are inspecting Hospital Act facilities using the same criteria as facilities licensed under the *Community Care and Assisted Living Act* (Recommendation 160). Fraser Health and Vancouver Island Health are conducting these inspections annually and Interior Health still is in the process of completing its first review of all sites. Both Northern Health and Vancouver Coastal Health have already implemented this recommendation.

More detailed updates on the status of our recommendations are available on our website.

**Public Report No. 48 – On Short Notice: An Investigation of Vancouver Island Health Authority’s Process for Closing Cowichan Lodge**


The investigation was the result of 46 complaints from people in the Cowichan area who were concerned about and directly affected by Vancouver Island Health Authority’s (VIHA) announced closure of a long established seniors’ residential care facility in Duncan.

The Ombudsperson found that VIHA acted unfairly by not following the appropriate process in seeking to close Cowichan Lodge with less than twelve months’ notice. The investigation resulted in six findings and six recommendations.

VIHA accepted and agreed to implement five of the six recommendations. Since our 2011/2012 annual report, VIHA has made progress toward meeting the recommendations, as follows:

- VIHA has developed a policy regarding permanent or temporary closures of VIHA funded and operated residential care facilities clarifying the circumstances under which a facility can seek an exemption from the twelve month notice requirement. The policy states that in such cases, all legislative and regulatory requirements must be adhered to and that consultation, engagement and ongoing communications with all affected stakeholders, including residents, family and staff, is required. A detailed engagement and communications strategy is also required (Recommendation 3a).

- VIHA’s policy regarding permanent or temporary closures of VIHA funded and operated residential care facilities also highlights the legal obligation to provide twelve months’ notice or seek an exemption (Recommendation 3b).

More detailed updates on the status of our recommendations are available on our website.