

ACE NEWSLETTER

Advocacy Centre
for the Elderly

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SPECIAL INSERT:

A Brand New World – Ontario's New *Long-Term Care Homes Act*

INADEQUATE PROTECTIONS FOR TENANTS OF RETIREMENT HOMES: ACE'S CONCERNS ABOUT BILL 21, THE *RETIREMENT HOMES ACT*

By: Judith Wahl, Executive Director & Staff Lawyer

The Ontario government introduced Bill 21, the *Retirement Homes Act* (the *RHA*), into the Legislature on March 30, 2010 and it quickly received Royal Assent on June 8, 2010 despite opposition from individuals and organizations across the province. As there is currently little or no government oversight of retirement homes, the Advocacy Centre for the Elderly (ACE) supports the purpose of the bill – to regulate retirement homes. However, we strongly oppose the *RHA* and the speed with which the government has passed this legislation.

The legislative process, from the introduction of Bill 21 to the limited debate and Royal Assent, has been very short. For instance, there was only one afternoon of public hearings before the Standing Committee on Social Policy. The Minister Responsible for Seniors, Gerry Phillips, would likely argue that there was sufficient time and discussion with stakeholders because the Ontario Seniors' Secretariat held consultations on retirement home regulation in 2007, which included meetings in five locations around the province with over 800 people in attendance, as well as the receiving written submissions.

However some advocacy and seniors organizations, including ACE, argued that the scope of the original consultation

was the general regulation of retirement homes, not the specific regulatory scheme contained in the *RHA*. Even where the consultation dealt with issues similar to those in the *RHA*, several stakeholders noted that the public did not want self-regulation by the retirement home industry but rather by government.

ACE has several concerns about the *RHA*. A detailed brief analyzing the *RHA* is available on the ACE website but the following is a summary of what we perceive to be the main problems.

1. Two-tiered health care: Retirement homes will be able to offer any level of care but without the same level of oversight as long-term care homes. ACE, as well as several other organizations, believes this will result in the privatization of health care for seniors and create a parallel system to long-term care homes. Tenants will be paying for health care services that would otherwise be covered by the government. It is expected that some long-term care home operators will change their homes to retirement homes as they will not only be able to operate the same business with a lower level of regulation but also charge more for the same services.

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A CALL FOR DIALOGUE ON GRADUATED DE-LICENCING OF OLDER DRIVERS

By: Graham Webb, Staff Litigation Lawyer



OLDER DRIVERS: A HOT-BUTTON TOPIC

In its April 2010 issue, the *Canadian Medical Association Journal* (the *CMAJ*) published a controversial editorial headlined “Driving retirement program for seniors: long overdue.”¹ In response to that editorial, Mrs. Jean Linz (an 89 year-old driver from Brockville, Ontario), Dr. Paul Hebert (editor-in-chief of the *CMAJ*) and I were interviewed by Anna Maria Tremonti on the national CBC radio program *The Current*.²

The de-licencing of older drivers is a hot-button topic. Whenever this issue is raised in the media, it draws angry statements berating the driving abilities of older drivers and demanding to get them off the road. This hostility towards older drivers is sadly misplaced.

Older drivers are also interested in better road safety. They would like other drivers not to drive at fast speeds, often dangerously swerving in and out of traffic. They would like not to be tailgated or be the victim of other aggressive driving habits. Older adults are usually cautious, safe drivers with good driving records. They are in favour of anything that would make our roads and highways safer for everyone.

CRASH RATES PER-KILOMETRE AND PER-DRIVER

It is true that older drivers consistently have a higher crash rate per kilometre driven than other age groups. However, it is also true that they are among the safest drivers on a per-driver basis. Generally, older drivers are risk averse, so they do not drive at excessively high speeds, on high-volume highways, at night, for long distances or in poor weather conditions.

While these two statistics may seem contradictory, they are not. Insurance companies are extremely adept at assessing risk. Older adults have the lowest automobile insurance rates for one reason: on a driver-by-driver basis, they are among the safest drivers on the road. They are less likely to be involved in a serious collision on a per-driver basis. Older adults have usually developed safe driving habits, such as driving at more moderate speeds, driving shorter distances and allowing more space between cars that compensate for a decrease in reaction time. Statistics showing that the fact that older drivers have a higher rate of collisions per kilometre drive is less important because they do not drive as far.

SCREENING AND TESTING OF MEDICALLY-IMPAIRED DRIVERS

Age alone is not an accurate measure of driving ability. Rather, declining driving ability is based on advancing medical conditions that affect driving. A medical condition that adversely affects driving ability can happen at any age. Focussing on age alone will not help make our roads safer.

What we need are effective programs to screen and test medically impaired drivers of all ages.

¹ Paul C. Hebert & Noni Macdonald, “Driving retirement program for seniors: long overdue” *Canadian Medical Association Journal* (20 April 2010) 182(7) at 645.

² An audio file of these interviews from March 16, 2010 is available online at <http://www.cbc.ca/thecurrent/2010/03/march-16-2010.html>.

The same screening and testing procedures that are used for older adults should be applied proactively to all drivers of all ages.

Screening and testing of driving abilities are like comparing apples and oranges. Screening is a method of identifying which drivers should be tested. Testing is a method of assessing which drivers are qualified to operate a motor vehicle. No one should permanently lose their licence based on a screening test alone. In some circumstances, such as when a person suffers from narcolepsy, screening may be used to temporarily suspend a licence. However, road testing or a proper medical evaluation is needed before a final decision can be made about a person's driving ability.

The editorial in *CMAJ* does make some very good points. The goal of the authors is not to get older adults off the road. Instead, they argue that a simple, widely applicable screening tool of driving ability is sorely needed. A cut-off age for drivers' licences is neither sensible nor appropriate because older adults' level of health and cognition vary widely.

Presently, the Ontario *Highway Traffic Act* requires every medical practitioner to report any patient to the Ministry of Transportation who "is suffering from a condition that may make it dangerous for the person to operate a motor vehicle."³ Once a report is made, the Ministry reviews the information and makes a decision to either allow the person to continue to drive, requests additional information from the physician or suspends the person's driver's licence.

The *CMAJ* editorial argues that physicians are unfairly called upon to be the primary gatekeepers of driving ability. ACE believes physicians should share responsibility with other health practitioners, police and other agencies in screening drivers. The Coroner's jury in the Elizabeth Kidnie inquest⁴ recommended that a diagnostic screening tool be developed for use by health practitioners to initially identify those persons who require more extensive evaluation of their ability to drive. It also recommended increased reliance on sources other than physicians to identify potentially medically impaired drivers.

However, even with better screening tools, physicians are still not qualified to ultimately determine who is able to operate an automobile.

The *CMAJ* editorial argues, and ACE agrees, that only government agencies, using standardized driving assessments, should be ultimately responsible for revoking a person's drivers' licence.

Driving assessments should always be carried out by government agencies that are responsible for drivers' licences. The licensing of drivers is a very profitable business for the government. The actual cost of the licensing process is a very small fraction of the cost of a drivers' licence. If drivers' licence fees were devoted to the better screening and assessment of drivers, governments could afford to more proactively screen and assess drivers of all ages.

ALTERNATIVES TO THE LOSS OF DRIVING PRIVILEGES

The loss of a drivers' licence is so damaging to a person's independence and well-being that it should only be taken as a very necessary and measured step. As an alternative to the complete revocation of a licence, the editorial in the *CMAJ* suggests that conditional licences could provide limitations on driving specific to the driver. For example, depending on the identified need of the individual, there could be restrictions on driving at night, using four-lane highways, driving during rush-hour traffic times or the distance travelled. The Kidnie inquest also recommended graduated licences as an alternative to outright suspensions.

The effects of the loss of one's driving privileges in our car-dependent society are profound. It can result in social isolation, a loss of independence and even deterioration in health. In the course of her radio interview, Mrs. Linz nearly came to tears when she described the effect on her family if she were to lose her licence. Where a loss of driving privileges is necessary based on one's medical condition, the resulting isolation and loss of independence can significantly disempower an older adult and facilitate elder abuse. We do not need emotional knee-jerk reactions to the public perception of older drivers. We do need an intelligent national dialogue on how to support older adult drivers as they age.

³ R.S.O. 1990, Chapter H.8, s. 203(1).

⁴ In 2002, ACE represented Canadian Pensioners Concerned at the inquest into the death of Elizabeth Kidnie, who was struck by a car operated by an 84-year old woman.

INADEQUATE PROTECTIONS

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As the *RHA* permits retirement homes to provide any level of care and services, more vulnerable seniors will utilize these services without fully understanding the implications. This opens the door for potential abuse due to the lack of protections against abuse, such as those provided in the *Long-Term Care Homes Act*, which requires reporting and intervention by the Ministry of Health and Long-Term Care.

A recent case at Cumberland Lodge in Ottawa, where the operator of a domiciliary hostel¹ and her daughter allegedly stole over \$300,000 from vulnerable tenants illustrates this point.² This is only the most recent example of those in authority stealing money from those who are under their care. While the *RHA* does not regulate this type of accommodation, even if it did apply, the legislation does little to prevent this from occurring. Moreover, the regulatory authority responsible for retirement homes would not have authority to deal with this type of situation.

2. Enhanced self-regulation and domination by the retirement home industry: The *RHA* creates an arms-length regulatory body, called the Retirement Homes Regulatory Authority (the Authority), to educate, license and inspect retirement homes. The affairs of the Authority will be supervised and managed by a Board of Directors. Despite assurances from the Minister, ACE is concerned that the Authority will be dominated by the industry or friends of retirement homes.. After the initial two years of operation, a majority of the members of the Authority will be appointed by the Board of Directors, resulting in a “closed shop”. This is a flawed model that will be difficult, if not impossible, to dislodge or amend. Power will be concentrated with minimal government accountability.³

3. Tenant rights and complaints—limited enforcement mechanisms: The *RHA* creates a Bill of Rights for tenants and deems the operator of the home and each tenant to have entered into a contract. While tenants may enforce their rights by pursuing a civil action, there are no special enforcement mechanisms available to tenants. While the ability to go to court is important, the reality is that civil actions are often expensive and take a long time to

be resolved. Tenants need quick action to ensure that their rights are enforced and they are receiving appropriate care.

Tenants may complain about contraventions of the legislation to the Registrar of the Authority and, in certain circumstances, the response of the Registrar may be reviewed by a Complaints Review Officer. Both the Registrar and Complaints Review Officer are solely accountable to the Authority. The decision of the Complaints Review Officer is final – the *RHA* indicates that there is no right of appeal or review outside the Authority.⁴ In contrast, operators who are denied a licence to operate a retirement home have a right to have a review by the License Appeal Tribunal and a further right of appeal to the Divisional Court.

4. Sanctioning of restraint and detention in secure units: The *RHA* permits the restraint and confinement of tenants in secure units. Tenants of retirement homes, unfortunately, do not have the same level of protections provided to residents of long-term care homes under the *Long-Term Care Homes Act*. While confinement in a secure unit in a long-term care home is considered a restraint, the *RHA* specifically states that *confinement* in a retirement home is not a restraint. We disagree with this section and do not believe it to be legally correct. If a person is prevented from leaving, he or she is restrained no matter what the legislation states.

5. Fees: The Authority has the ability to set, collect and use fees collected from retirement homes to carry out the objects of the Authority. The government has stated that it will fund the

¹ Domiciliary hostels are privately owned or non-profit residences that assist vulnerable adults to live in a supportive community environment. Residents are typically living with psychiatric or developmental impairments and/or are elderly. Basic services include 24-hour staffing with support; meals and snacks; medication management; furnished rooms (most are shared accommodation); assistance with daily living activities; housekeeping and laundry services. They also provide access to other on-site and community based services.

² Maria Cook, “Regulations may not have helped in Cumberland Lodge case: experts” *Ottawa Citizen* (29 May 2010).

³ For a critique of this model, please go to <http://www.web.net/ohc/> and see the legal opinion prepared by Sack Goldblatt Mitchell LLP for the Ontario Health Coalition

⁴ *RHA*, S.O. 2010, c. 11, s. 88(11).

Authority for the first two years but it is has not publicly pledged a specific amount. It is inevitable that the cost of regulation will be passed onto tenants in the form of higher prices. ACE is concerned that this will be detrimental to small and not-for-profit homes, which may be forced to provide fewer services or close.

6. **Limited definition of a retirement home:** This legislation only regulates homes occupied primarily by persons who are 65 years of age or older. However, there are many other similar types of accommodation, (such as domiciliary hostels, group homes and attendant care accommodation) which provide similar services but are not regulated by the *RHA* or elsewhere. This leaves an entire vulnerable population living in accommodation where their care is not regulated.

IS THERE ANYTHING THAT CAN BE DONE TO ADDRESS THE CONCERNS RAISED BY ACE AND OTHERS?

Before the *RHA* is proclaimed into force, the government must draft regulations. The *RHA* requires that there be at least 30 days for the public to submit written comments regarding these proposed regulations.⁵

ACE will definitely be participating in any public consultations. Once the Minister posts its draft regulations, ACE will be seeking input from interested seniors' organizations and individuals on the proposed regulations. If you are interested in participating in discussions with ACE, please contact us. After hearing from individuals and organizations, ACE will draft and post our submission on our website. This information may assist you in the preparation of your own comments.

You may also wish to contact your local Member of Parliament about the draft regulations or the *RHA*. Since there is no proclamation date yet, the government could still amend the legislation or choose not to implement it. While this is unlikely, the government may be persuaded to do so if there is a large public backlash against the legislation.

We encourage anyone with concerns about the *Retirement Homes Act* to speak to their Member of Parliament or participate in these important public consultations as the contents of the regulations will be fundamental as to how this act will be interpreted and implemented.

⁵ *RHA*, s. 121.

THE APOLOGY ACT: A HELP OR HINDRANCE?

By: Graham Webb, Staff Litigation Lawyer

The *Apology Act*¹ was proclaimed into force in Ontario on April 23, 2009. The purpose of this legislation is to permit a doctor to apologize to a patient for an error in treatment without that apology constituting an admission of fault or liability that could later be relied upon by the patient in a lawsuit. The effect of this new law is somewhat puzzling to lawyers who practice civil litigation. It is entirely possible that the new law could have the desired effect of promoting genuine apologies at an early stage, bringing closure to events that would otherwise result in lawsuits. This would certainly help prevent needless lawsuits where civil action is the only available avenue to find out what happened and to obtain some form of redress. However, the *Apology Act* might not result in fewer lawsuits. Worse, it could create even more legal complications for someone claiming damages or other financial compensation through the courts.



The *Apology Act* has a good purpose. It is part of an international movement largely initiated by the United States medical community to stop unnecessary medical malpractice litigation, as well as to identify and correct systemic problems. The theory is that if a physician were able to quickly apologize for a medical error without fear of legal consequences, such an apology would encourage open and honest communications with patients and their families and result in less litigation. It is believed that many patients who start medical malpractice actions do so because they feel there has been a lack of information about the error and a lack of sympathy or empathy from the medical professional or hospital.

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¹ S.O. 2009, c. 3, s. 3.

Without the protection of the *Apology Act*, it is felt that a physician is less inclined to make an apology knowing that it can be used in evidence as an admission of liability in any subsequent legal action. Furthermore, in some jurisdictions, a physician's medical liability insurance policy can exclude coverage where the physician compromises his or her defences to a medical malpractice action by making an apology or an admission of liability, potentially leaving the physician uninsured. This would be a very drastic result and is one of the circumstances that the *Apology Act* intended to overcome.

The first apology legislation was passed in Massachusetts in 1986. Since then British Columbia,² Manitoba,³ Saskatchewan,⁴ Alberta,⁵ Nova Scotia⁶ and Newfoundland⁷ have also enacted similar legislation.

One criticism of the *Ontario Apology Act* is that it is overly broad.⁸ An "apology" means "an expression of sympathy or regret, a statement that a person is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit fault or liability or imply an admission of fault or liability..."⁹ The new law states that an "apology" does not constitute an admission of fault or liability and cannot be taken into account in any determination of fault or civil liability.¹⁰ Furthermore, evidence of an apology is not admissible in any civil proceeding, administrative proceeding or arbitration as evidence of fault or liability of any person in connection with that matter.¹¹

While the *Apology Act* might possibly result in fewer civil lawsuits, many lawsuits for medical negligence and other causes will still ensue. The usual rules of evidence will still call for the plaintiff to prove every fact that is necessary to establish liability to the civil standard of proof, which is a balance of probabilities. Where fault or negligence is in issue, the use of an exclusionary rule for what would otherwise seem to be an admission of fault will be extremely problematic in some of those cases.

Ordinarily, an admission of fault is admissible evidence against the defendant. Sometimes a defendant will spontaneously and unintentionally say and do things that could only be taken as an admission of liability. For example, after a car accident, one driver may profusely apologize,

giving the impression that he or she was responsible for the collision. A bank manager, having discovered that a bank customer was defrauded by a bank employee, may apologize. A health practitioner, having committed a medical error, may spontaneously apologize to the patient or his or her family. Before the enactment of the *Apology Act*, all of these spontaneous or implied apologies would have been admissible in evidence against the defendant to a civil action. Now, these types of apologies that amount to an admission of fault might well be inadmissible in evidence.

Some lawyers have asked the question as to whether "an admission of liability wrapped up in an apology" will also become inadmissible.¹² For example, Professor Erik Knutsen of Queen's University Law School was quoted as saying that the *Apology Act*

could let potential defendants dodge responsibility in any future civil court proceeding since it removes the right of victims to use anything said in the apology in court – a break from hundreds of years of legal history. "As long as you stick 'I'm sorry' in front of it, the laws of evidence go into the twilight zone."¹³

² *Apology Act*, S.B.C. 2006, c. 19.

³ *Apology Act*, S.M. 2007, c. 25.

⁴ *Evidence Act*, S.S. 2006, c. E-11.2, s. 23.1, as amended by S.S. 2007, c. 24, s. 3.

⁵ *Evidence Act*, R.S.A. 2000, c. A-18, s. 26.1, as amended by S.A. 2008 c. 11, s. 2; S.A. 2009, c. 48, s. 1.

⁶ *Apology Act*, S.N.S. 2008, c. 34.

⁷ *Apology Act*, S.N.L. 2009, c. A-10.1.

⁸ Prue Vines, "Apologies and Civil Liability in England, Wales and Scotland: The View from Elsewhere" (October 2007), www.ssrn.com.

⁹ *Apology Act*, s. 1.

¹⁰ *Apology Act*, s. 2(1).

¹¹ *Apology Act*, s. 2(3).

¹² John J. Chapman, "The Year in Review: The Most Important Evidence Cases of the Past Twelve Months", *6th Annual Conference on Evidence Law for the Civil Litigator* (Toronto: Osgoode Professional Development, Sept. 23 and 24, 2009) at 5-8.

¹³ Stuart Laidlaw, "Saying Sorry is a Way Back to Grace," *The Toronto Star* (27 April 2009), <http://www.thestar.com/living/article/624703>.



According to lawyer John J. Chapman,

A cynic might see the U.S. legislation that inspired this trend as being designed to advance the interests of medical professionals who blurt out “I’m sorry” and who later seek to weasel out of their admission... Certainly, it will seem strange to many of us that a statement by a driver who says after an accident “I’m sorry – it was all my fault – I wasn’t paying attention and went through the stop sign” will no longer be admissible in court.¹⁴

Mr. Chapman also points out that the overall benefit of the *Apology Act* is not capable of being measured. There is simply no way of knowing whether more apologies will be made, and furthermore whether fewer lawsuits will result because of the changes in the law caused by the *Apology Act*. On the other side of the scale, it is nearly certain that more litigation will result over the exclusion of otherwise admissible statements, and that in some cases plaintiffs will be less able to prove their cases because of the inadmissibility of apology evidence.

In view of these issues, there is a real possibility

that apologies could now be deliberately and even strategically used to prevent an admission from otherwise being admissible evidence. For example, if a physician, while discussing the outcome of a medical procedure, discloses facts that amount to an admission of liability, the entire conversation might become inadmissible in evidence if the physician merely says “I am so sorry!” at the end.

Since the *Apology Act* is unlimited in scope and does not only apply to medical cases, the same defensive tactic may be made in any other situation involving a potential defendant. “I’m sorry” might well become the most useful words to prevent any admission of liability from being used as evidence of liability.

If the intended outcome of the *Apology Act* is to allow an honest and forthright discussion of medical mistakes and to prevent medical malpractice actions, it would have been better to clearly limit the scope of this law to medical cases. Instead, the *Apology Act* profoundly changes the way Ontario courts must treat admission of liability in all settings. At this early stage, it is impossible to know whether this new law will help or hurt those who have been already victimized by the actions of another.

¹⁴ *Supra* note 12 at 5-6.

RRSPS PROTECTED IN BANKRUPTCY

By: Rita Chrolavicius, Staff Lawyer

All Registered Retirement Savings Plans (RRSPs) and Registered Retirement Income Funds (RRIFs) are now exempt from seizure in bankruptcy, except for contributions made in the 12-month period leading up to the bankruptcy. This change took effect on July 7, 2008.

In the past, certain RRSPs and RRIFs were not protected from creditors in the case of bankruptcy. This meant that the trustee would take the RRSP or RRIF and distribute the funds to creditors of the bankrupt person. Some RRSPs, such as locked-in RRSPs or RRSPs with a life insurance component, were exempt in bankruptcy and could not be seized by the trustee and distributed to creditors.

Employees with company-sponsored or government-sponsored pension plans got automatic protection of their pension income in the case of bankruptcy. However, many workers and all self-employed individuals not having access to private employment pension plans had to set aside funds for their retirement by saving money in RRSPs. As it was seen to be unfair to offer bankruptcy protection in some cases but

not others, the *Bankruptcy and Insolvency Act* was amended to ensure consistent treatment of retirement plans.

Under the new legislation, all RRSPs and RRIFs are exempt from seizure in bankruptcy, with one small exception. To prevent abuse, funds contributed to the RRSP in the 12 months before the date of the bankruptcy are subject to seizure.

Under Ontario law, certain items are also exempt from seizure by a creditor or by a trustee in bankruptcy. The *Execution Act* includes the following exemptions:

- \$5,650 worth of necessary and ordinary wearing apparel;
- \$11,300 worth of furniture, equipment, food and fuel;
- A motor vehicle not exceeding \$5,650 in value; and
- \$11,300 worth of tools and other items ordinarily used by the debtor in the debtor's business or profession.

To discuss the cost and procedures necessary to declare bankruptcy, make an appointment with a trustee in bankruptcy. Most trustees offer a free initial consultation. Information can also be obtained from the Office of the Superintendent in Bankruptcy by calling 416-973-6486. Their website can be found at <http://www.ic.gc.ca/eic/site/bsf-osb.nsf/eng/home>.



MESSAGE FROM THE CHAIR: THE TRANSFORMATIVE WORK OF ACE

By: Sybila Valdivieso, Chair, Board of Directors

Welcome to the Summer 2010 edition of ACE's newsletter. As the first and oldest legal clinic in Canada focusing on the legal issues affecting low income seniors, ACE continues to be at the forefront, advocating on behalf of its clients and client community by contributing to both the discourse and the practice of elder law. The work of ACE is transformative as it facilitates not only individual client empowerment but systemic changes to the inequitable treatment of seniors.

The oral submission made by ACE to the Standing Committee on Social Policy of the Ontario Legislature on May 10, 2010 with respect to Bill 21, the *Retirement Homes Act, 2010*, is a clear example of ACE's transformative work. The *Retirement Homes Act* creates a regulatory authority to licence and regulate retirement homes. Despite the positive intentions behind the legislation, ACE is concerned about its potential effect on seniors. Among the concerns is the speed at which Bill 21 became law, as there was little consultation with seniors, the community most affected. I recommend that you read the comprehensive submission prepared by ACE which is available on their website, as well as the article by Judith Wahl in this newsletter about the new legislation.

The *Long-Term Care Homes Act, 2007 (LTCHA)* will be proclaimed on July 1, 2010, replacing the current laws governing long-term care homes. ACE has contributed to the development of this legislation over the course of the past few years by meeting with government officials, participating in stakeholder meetings and drafting submissions. Jane Meadus, ACE's Institutional Advocate, has said that the new legislation represents a "huge change in the long-term care landscape impacting our clients and our practice." The spirit of the *LTCHA* is to safeguard the rights of seniors residing in long-term care homes by improving the quality of care and the accountability framework of the homes. However, there are questions about

the ability of residents to enforce their rights given the power imbalance of being a resident in an institutional facility. For instance, the *LTCHA* provides for the establishment of the Office of the Long-Term Care Homes Resident and Family Advisor but the government has not given any indications that this Office will be created. Even if it were, this Office cannot advocate for residents because its legislated powers are limited to providing information. It also remains to be seen how well the *LTCHA* will address the systemic barriers faced by seniors such as their lack of knowledge of legal rights, discrimination based on ageism, the difficulties in pursuing legal actions and the resident's lack of involvement in the decision-making process.

As a result, the work of ACE remains crucial and ACE has prepared a special insert in this newsletter describing the major elements of the *LTCHA*. ACE will also be collaborating with CLEO (Community Legal Education Ontario) to rewrite the pamphlet "Every Resident" which provides a review of the rights included in the Residents' Bill of Rights.

ACE is also busy writing the fourth edition of the text *Long-Term Care Facilities in Ontario: The Advocate's Manual* (the Manual) to incorporate not only the *LTCHA* but to include materials of relevance to all older adults, no matter where they live. In this regard, I would like to thank our funder, Legal Aid Ontario, for the financial contribution provided to ACE towards the production costs of the Manual, which has become a trusted resource in the area of elder law in Ontario. The Manual will be made available sometime in 2011.

Finally, I wish to thank the Board of Directors of ACE, the entire staff of ACE and their fearless leader Executive Director, Judith Wahl, for their commitment to improving the legal rights of low income seniors in Ontario and for promoting the very important cause of access to justice.

NEWS AND ANNOUNCEMENTS

By: Lisa Romano, Staff Lawyer

THE LAWYER REFERRAL SERVICE IS NOW FREE!

The Lawyer Referral Service (LRS) is a service operated by the Law Society of Upper Canada that provides a caller with the name of a lawyer who will provide a free consultation of up to 30 minutes. Previously, there was a six dollar fee which appeared on your telephone bill.

When you call the LRS, a client service representative will answer your call and ask you where you want the lawyer to be located, what you want the lawyer to do for you and whether you will be applying for assistance from Legal Aid (not all lawyers take Legal Aid cases). Be sure to tell the client service representative if you have any special needs, such as language or accessibility requirements.

You will be given a referral number and the lawyer's phone number. It is your responsibility to phone the lawyer's office and leave a number where you can be reached. Someone will contact you within three business days to arrange for your consultation.

The purpose of the consultation is to help you determine your rights and options. Do not expect the lawyer to do any free legal work during this time.

You may not use the LRS to get a second opinion on the same issue from a different lawyer.

The LRS phone number is 1-800-268-8326 or 416-947-3330 (within the GTA). The LRS is available from 9:00 a.m. to 5:00 p.m., Monday to Friday.



HIGHER MONETARY LIMITS IN SMALL CLAIMS COURT

As of January 1, 2010, the Small Claims Court raised its monetary limit from \$10,000 to \$25,000.

You can still use the Small Claims Court if the amount of your claim is more than \$25,000. However, you will have to give up the right to recover any amount of money over \$25,000, as well as any future right to get this money in any other court action.

You cannot divide the amount of money you are claiming into separate cases. For example, if you want to claim \$40,000, you cannot have two cases where you ask for \$25,000 in one action and \$15,000 in the second action.

CONGRATULATIONS ON THE APPOINTMENT OF MINISTER PHILLIPS

Gerry Phillips became the new Minister Responsible for Seniors on January 18, 2010.

Mr. Phillips first entered provincial politics in 1987 when he was elected to the Ontario Legislature. Since that time, he has represented the province of Ontario in a number of diverse positions. Mr. Phillips served as Minister of Citizenship, Minister of Labour, Minister of Energy and Infrastructure, Minister of Government Services, Chair of Management Board of Cabinet and Minister of Citizenship and Immigration. In opposition, he has served as Finance and Native Affairs Critic and as Chair of the Economic Policy Committee for the Official Opposition.



As the Minister Responsible for Seniors, Mr. Phillips is responsible for the Ontario Seniors' Secretariat (OSS), which undertakes or influences policy initiatives in an effort to improve the quality of life of Ontario seniors and supports public education efforts for and about older Ontarians.

ACE congratulates Mr. Phillips on his new appointment.

NEW AND IMPROVED ACE WEBSITE

ACE recently launched its new and improved website. Our goal is to provide visitors with an easy to use website that contains information and links about the areas of law in which we practice. New features include different text size options (which allows people to adjust the size of the text), a search function and a link to make on-line donations to ACE. Our website can be found at www.ancelaw.ca.

LONG-TERM CARE HOME REPORTING BY THE ONTARIO HEALTH QUALITY COUNCIL

The Ontario Health Quality Council (OHQC) now provides information on its website about long-term care homes. The main purpose of the site is "to encourage residents, families and staff in homes to discuss this information together and work cooperatively on ideas to improve quality."

An independent body funded by the Ministry of Health and Long-Term Care, the OHQC has a mandate to monitor and report to Ontarians about access to publicly funded health services and related health human resources, consumer population health status and health system outcomes, in addition to supporting continuous quality improvement.

The majority of the data comes from the RAIMDS (Resident Assessment Instrument – Minimum Data Set), a standardized data collection tool which is beginning to be used in all long-term care homes throughout Ontario. The OHQC also uses provincial databases to gather information about access, emergency department visits and drug use, and data from a resident satisfaction survey from a sample of 30 homes conducted by the University of Toronto.

The reports look at different aspects related to the quality of long-term care, including whether the home is:

- Effective in keeping residents healthy;
- Safe;
- Resident-centred;
- Appropriately resourced;
- Accessible.

It is important to note that only 217 of the more than 600 long-term care homes are participating in this reporting system. All homes will be included in provincial results by 2011.

By the end of 2011, the OHQC has committed to having:

- Results from each of Ontario's long-term care homes;
- More results from resident and family satisfaction;
- More frequent updates (every three months);
- Trends over time (to see if quality is improving); and
- Comparisons with other provinces and countries.

The website also has individual results for over 70 homes concerning falls, pressure ulcers and worsening bladder function. More homes will be added over time.

This website can be accessed at http://www.ohqc.ca/en/ltc_landing.php.

DEPUTY JUDGES CAN HEAR CASES AFTER AGE 75

In the case of *Luis Alberto Felipa v. The Minister of Citizenship and Immigration*, [2010] F.C.J. No. 39, the Federal Court of Canada ruled that deputy judges continuing to preside when over the age of 75 does not violate the mandatory retirement provisions of the *Constitution Act, 1867* and the *Federal Courts Act*.

Felipa argued that the deputy judge hearing his immigration case did not have the jurisdiction to do so because he was 77 years old, over the age of mandatory retirement. However, several courts (the

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Federal Court, the Federal Court of Appeal, the Tax Court and the Court Martial Court of Appeal) were permitted by law to use deputy judges who were usually retired justices working part-time.

Federal Court Chief Justice Alan Lufy said in his decision that the mandatory retirement age provisions for federal and provincial superior court judges did not apply to deputy judges. Justice Lufy concluded that deputy judges are distinct because they do not hold the "office" of a federal judge and they are only deputy judges during their assignment. Deputy judges give flexibility to the Chief Justice of the Federal Court to add more judges when necessary. As a result, they are not subject to the same age limitations.

Evidence indicated that there have been approximately 27 deputy judges in the Federal Court over the age of 75 who have made about 2,000 rulings since 1971. If the Federal Court had agreed with Felipa, these decisions would have been in question.

ONTARIO WILL NOT REGULATE PERSONAL SUPPORT WORKERS

After years of debate, the Ministry of Health and Long-Term Care recently decided that it will not regulate personal support workers.

The workers who provide the majority of hands-on care in long-term care and retirement homes are

personal support workers (also known as health care aides). They also provide a great deal of care to individuals in their own homes through homecare and other programs. They must work under the supervision of a regulated health professional, which is usually a registered nurse. It is estimated that there are about 100,000 personal support workers in Ontario.

Most health professions in the province are self-regulated by governing bodies called colleges which set the standards for skills, knowledge and behaviour for their members. There are currently 23 colleges in Ontario that regulate health professionals including physicians, dental hygienists, dietitians and massage therapists.

ACE believes that personal support workers should be accountable to some form of government standards to ensure both protections to personal support workers and public safety to their clients. At a minimum, there should be a registry of personal support workers, which could be used to verify qualifications and employment history.

COMMENTS FOR THE EDITOR

Comments about this newsletter may be sent to the editor, Lisa Romano, via regular mail or email (romanol@lao.on.ca).



APPLICATION FOR MEMBERSHIP

Advocacy Centre for the Elderly*

2 Carlton Street, Suite 701, Toronto, Ontario M5B 1J3 • Phone: 416-598-2656 • Fax: 416-598-7924

Please feel free to photocopy this page and send it to ACE to become a member!

| | | |
|---|--|---|
| Name (Individual/Corporate): _____ | | |
| Corporate Contact (if applicable): _____ | | |
| Address: _____ | Apt.: _____ | |
| City: _____ | Postal Code: _____ | |
| Telephone (Home): _____ | Business: _____ | Email: _____ |
| MEMBERSHIP FEE (check one) | <input type="checkbox"/> Individual (\$10.00 enclosed) | <input type="checkbox"/> Corporate (\$25.00 enclosed) |
| In addition to my membership fee, a donation of \$ _____ is enclosed.** | | |

Your membership is important. If the fee presents financial difficulties, please feel free to join anyway.

Committee Membership: I am interested in seniors' issues and would consider membership on an ACE Committee. Yes No

Membership Expiry Date: Annual General Meeting, Fall 2010.

By-Law No.1, 14.9 states: No owner or management official of a long term care facility, or employee of any organization representing long term care facilities shall be eligible to be elected to the Board of Directors of the Advocacy Centre for the Elderly.

* ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc."

** A tax receipt will be issued for donations over \$10.00.