

ACE NEWSLETTER

Advocacy Centre
for the Elderly

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DISCHARGE FROM HOSPITAL TO LONG-TERM CARE: ISSUES IN ONTARIO¹

By: Jane E. Meadus, Institutional Advocate & Staff Lawyer

Hospitals in Ontario are overcrowded. Thousands of people are on waiting lists for long-term care homes (LTCHs). As a result, people requiring long-term care are confronted with a variety of “policies” and “programs” developed to “deal” with these issues despite the legislation governing placement.

In Ontario, LTCHs are publicly funded and governed by the *Long-Term Care Homes Act, 2007 (LTCHA)* which was enacted on July 1, 2010.² This legislation, while having some changes, substantially continued the rights that applicants for placement into LTCHs had under the previous legislation.³

Between January 1 and November 30, 2010, the Advocacy Centre for the Elderly (ACE) had over 145 requests for assistance relating to discharge from hospital. Patients requiring admission to other care settings or requiring additional care in the home are often told that they must comply with hospital or Community Care Access Centre (CCAC) policies. Hospital policies may require the patient or substitute decision-maker (SDM) to select



possible LTCHs from a “short list” where a bed is available or where a bed will soon be available. If they do not comply with the policy, the hospital threatens to charge the non-OHIP “daily rate” which ranges anywhere from \$500 to \$1,500 or more per day. Hospitals may also require the patient/SDM to sign a “contract” indicating that they “agree” with this policy. In fact, no

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¹ This article updates and amalgamates two previous articles prepared by ACE called “First Available Bed Policies & Discharge to a Long-Term Care Home from Hospital” and “The Role of Community Care Access Centres in Admission to Long-Term Care from Hospital.”

² S.O. 2007, c. 8.

³ *Charitable Institutions Act, Homes for the Aged and Rest Homes Act and Nursing Homes Act.*

MESSAGE FROM THE CHAIR

By: Timothy M. Banks, Chair, Board of Directors

I am grateful for the opportunity to introduce myself as the new Chair of the Board of Directors of ACE. My connection to ACE began when I was a law student. I volunteered at ACE through Pro Bono Students Canada. I kept in touch over the years and am honoured to return as a member of the Board of Directors and the new Chair.

When I was a law student I was impressed with the important work that ACE was doing and I continue to see the enormous value in their work and their ability to make a meaningful difference in the quality of lives of older adults in Ontario.

This is a very interesting time to be involved in clinic law in Ontario. The Ontario system of clinic law has matured over the past 25 years and ACE has evolved with it. ACE continues to evolve and is about to embark on a new phase under the continued leadership of our talented Executive Director, Judith Wahl, and ACE's superb lawyers and staff. This new phase will focus on streamlining our administrative costs where possible, raising funds for new initiatives and greater outreach across the province through the use of technology and other innovative methods that we are working on developing.

While our Executive Director, lawyers and staff have enormous energy, we can always use the assistance of our clients and community stakeholders. You can help us in a number of ways. If you have not yet had the opportunity to visit the revamped website, please do! It is a mine of information and is part of ACE's outreach strategy to older adults across Ontario. Please pass along the web address – www.ancelaw.ca – to anyone who may need ACE's services or may be interested in our work. If there is a legal issue pertaining to older adults that you would like us to address, let us know. We may not be able to deal with all issues due to the limitations of our mandate but we will do our best. Finally, if you can afford a donation to ACE, however small, we would appreciate the support. We are grateful for the on-going support of Legal Aid Ontario for most of our budget. However, with your financial help, we can expand and do more to advocate on behalf of older adults in Ontario. ACE is a registered charity and issues tax receipts for donations of \$10.00 or more. Please see our website or call us for more information on giving.

BETTER GIS BENEFITS FOR EMPLOYED LOW INCOME SENIORS

By: Rita Chrolavicius, Staff Lawyer

On July 1, 2008, changes came into effect which benefits low income pensioners who choose to continue working and who receive employment income. The amendment to the *Old Age Security Act* increased the Guaranteed Income Supplement (GIS) employment income exemption to \$3,500 from the previous maximum of \$500.

The GIS is a monthly benefit provided to low income seniors who receive Old Age Security benefits. The amount of the benefit generally decreases as the income of the senior increases.

For every \$2.00 of income that a senior may receive from other sources, such as CPP income or interest income, the senior receives \$1.00 less in GIS benefits. Income from employment is treated differently, in that some of the employment income is not included in the calculation of "income" for purposes of calculating GIS entitlement.

Now, the first \$3,500 of employment income received by seniors is exempt from the calculation of "income" for GIS purposes. Employment income still counts as income for tax purposes.

UPDATE ON THE *RETIREMENT HOMES ACT*

By: Lisa Romano, Staff Lawyer

The regulation of retirement homes is undergoing a radical transition in Ontario with the passage of the *Retirement Homes Act, 2010 (RHA)*. The *RHA* has created a third-party regulatory authority with the power to license homes, conduct inspections, investigate complaints, enforce the law and develop care and safety standards. Both our submission to the Standing Committee on Social Policy and an article in ACE's Summer 2010 Newsletter outlined our concerns about the draft legislation.

The *RHA* received royal assent on June 8, 2010. Certain sections of the *RHA* have already been proclaimed and it is expected that the remaining sections will come into effect sometime in 2011.

Before the law can come into effect, however, the regulations must be drafted. Regulations are subsidiary pieces of legislation which provide the legislative details. Regulations can be more easily changed by the Lieutenant Governor in Council, while statutes are harder to change as they must be passed by elected members of government.

During the months of August, September and October, the Ontario Seniors' Secretariat met

with four expert roundtables comprised of a variety of stakeholders. Lawyers from ACE sat on each roundtable. The purpose of the roundtables was to provide input to the government on the potential content of the regulations.

The government is required to give the public 30 days to submit written comments on the proposed regulations. It is our understanding that draft regulations will be released in January or February 2011.

Once the draft regulations are posted, ACE will be seeking input from interested seniors' organizations and individuals. If you would like to participate in the consultation process, please contact ACE. Once the regulations are released, we will prepare written submissions on the draft regulations which will be posted to our website.

We encourage anyone with concerns about the *RHA* to speak to their Member of Provincial Parliament, to be involved in ACE's consultations or to make formal submissions to the government, as the regulations are the keystone to how the *RHA* will be interpreted and implemented.

NEW MINISTER RESPONSIBLE FOR SENIORS

Sophia Aggelonitis became the new Minister Responsible for Seniors on August 18, 2010. She was also appointed Minister of Revenue on the same day.

Ms. Aggelonitis was first elected to the Ontario legislature in 2007. Since that time, she has served as the Minister of Consumer Services and is currently a member of several cabinet committees, as well as the Chair of the Restaurant and Hospitality Caucus.

As the Minister Responsible for Seniors, Ms. Aggelonitis is responsible for the Ontario Seniors' Secretariat, which develops 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 Ms. Aggelonitis on her new appointment.

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ADMISSION INTO LONG-TERM CARE HOMES AND DISCHARGE POLICIES

(...continued from page 1)

one is required to sign such a contract. CCAC policies may prevent patients from applying for LTC from hospital.

Placement into a long-term care in Ontario is regulated by the *LTCHA* and its regulations. The placement coordinator from the CCAC must work with the applicant or their SDM, if the person is incapable, to ensure the needs of the person are met. No role in the placement process is given to hospital workers, such as discharge planners or social workers, in the *LTCHA*.

After a determination is made by the care team at the hospital that the person requires admission to a long-term care home, the patient/SDM will be asked to complete an application. In most cases, the patient/SDM will agree to do so.⁴ While awaiting placement in hospital, the person will usually be designated by the physician as “Alternate Level of Care” or “ALC.” This simply means that the person is in hospital awaiting a different type of care somewhere else that is not presently available.

Once the person is assessed by the CCAC as being eligible for admission to a LTCH, the person will be asked to choose homes. The regulations to the *LTCHA* state that a person may choose up to five LTCHs.⁵ This is the maximum number of homes that a person/SDM can choose, unless the person is on a crisis waiting list. While an applicant/SDM does not have to apply for the maximum number, we encourage people to do so if at all possible when they are awaiting placement from hospital. Hospitals are not appropriate places to stay for great lengths of time when the patient does not require acute care. The person/SDM must act “reasonably” when applying to long-term care from hospital as there are other hospital pressures in play.

Hospitals often have policies requiring applicants

⁴ Where the patient or substitute decision-maker refuses to consent, the process will either be discontinued or one of a number of hearings may be heard pursuant to the *Health Care Consent Act*. These will not be discussed in this article.

⁵ O. Reg. 79/10, s. 166(1)(d).

⁶ S.O. 1996, c. 2, Sched. A.

to make one of the following so-called “choices”: accept the first available bed in any long-term care home; return home to wait for their home of choice; go to a retirement home to await their home of choice; or pay the “daily rate” for the hospital bed.

Consent for admission into a LTCH is regulated by both the *LTCHA* and Part III of the *Health Care Consent Act (HCCA)*.⁶ It is up to the person/SDM to choose the homes where they want to apply. Valid consent, as defined in the *LTCHA*, is required prior to placing the person on the waiting list for a home, as follows:

Elements of consent

46(1) The following are the elements required for consent to admission to a long-term care home:

1. The consent must relate to the admission.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud.

Informed consent

(2) A consent to admission is informed if, before giving it,

- (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the admission; and
- (b) the person received responses to his or her requests for additional information about those matters.

Same

(3) The matters referred to in subsection (2) are:

1. What the admission entails.
2. The expected advantages and disadvantages of the admission.
3. Alternatives to the admission.
4. The likely consequences of not being admitted.

Where there is an SDM, they are required to comply with specific rules set out in the *HCCA*:

Principles for giving or refusing consent

42(1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility shall do so in accordance with the following principles:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

Best interests

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and
- (c) the following factors:
 1. Whether admission to the care facility is likely to,
 - i. improve the quality of the incapable person's life,
 - ii. prevent the quality of the incapable person's life from deteriorating, or
 - iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.
 2. Whether the quality of the incapable person's life is likely to improve,

remain the same or deteriorate without admission to the care facility.

3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.
4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

The requirements on SDMs are restrictive: they can **only** make their decision based upon these principles.

This list is exhaustive: nowhere in the *LTCHA*, *HCCA* or their regulations are there any other principles that the SDM is required to take into consideration. There is no mention of hospital policy, the requirements of the acute care system, or any other programs to be considered when making this decision. As the government has chosen not to include this in the recently enacted *LTCHA*, legislation, hospitals cannot "override" by creating their own law or policy.

The question then becomes whether the hospital is required to keep the person while they for their choice of home. Many homes have lengthy waiting lists. Does the hospital have to keep the person until their choice is available?

The regulations to the *Public Hospitals Act* require a person to leave the hospital no later than 24 hours after a discharge order has been made.⁷ Looking at this provision, it would appear that once a patient no longer requires treatment, they must be discharged from hospital, with the only exception being a 24 hour grace period. However, the reality is that there are many people in hospital who no longer require treatment but are allowed to stay until a LTCH bed becomes available.

Hospitals rely on this section of the legislation to require people to comply with their internal policy. However, we do not believe that this is supportable in law. First, the regulations to the *Health Insurance Act* specifically contemplate

⁷ R.R.O., Reg. 965, s. 16.



that patients will have to wait in hospital until a long-term care bed is available. The daily fee that can be charged while the person is waiting for placement from hospital is limited and set by the provincial government: it is the same amount that a resident in basic accommodation at a LTCH is charged (minus any applicable rate reductions).⁸ Second, if this section was applied across the board, it would mean that **everyone** who required long-term care would be discharged within 24 hours of no longer requiring acute care, whether a bed was available or not, which is not the case. Third, the hospital owes a duty of care to the patient, meaning that a patient cannot be discharged to the community if this is unsafe. This

⁸ The rate is currently \$53.23 per day. The provincial government adjusts the rate annually on July 1st.

⁹ The *Retirement Homes Act*, 2010, S.O. 2010. c. 11, has been passed but only certain sections have been enacted as the regulations are being drafted. This statute will, for the first time, provide some oversight and regulation to the care provided in privately run retirement homes. However, retirement homes will still be part of the private-pay system and no one can be forced into a retirement home if they are eligible for publicly funded long-term care.

includes requiring patients to go a retirement home to wait for a LTCH placement. Retirement homes are unregulated and not part of the health care system – one cannot be forced into a retirement home as an alternative to a LTCH bed.⁹

There is also often disagreement as to what an “acceptable” bed means. Obviously, not every “available” bed is appropriate for every person awaiting placement from hospital. For example, one person may require a bed on a secure unit while another person does not. This is often the crux of the discharge issue – the hospital believes a bed is suitable while the patient/SDM disagrees.

Placement into homes which are not of a person’s choosing can be detrimental to both their physical and mental health. Homes may be located far from families and other support systems, leading to deleterious effects on the person’s health, including death. In other cases, there may be available beds because the homes themselves are unsatisfactory in some way. Luckily, both the *LTCHA* and the *HCCA* ensure that it is up to the person/SDM to make the placement decision: nowhere does the law give this role to hospital staff.

Hospital policies also frequently misstate the legislation surrounding the “crisis” designation. According to the regulations to the *LTCHA*, a person shall be placed in the “crisis category (1)” by the placement coordinator if the applicant requires immediate admission as a result of a crisis arising from the applicant’s condition or circumstances.”¹⁰ Local Health Integration Networks (LHINs) are also now able to designate hospitals as being in “crisis” if the hospital is “experiencing severe capacity pressures.”¹¹ Even when a hospital is designated as being in crisis and ALC patients are moved to the top of the list, they are not required to take any bed that simply becomes available. The designation means that the person goes to the top of the crisis waiting list for all the homes that they have chosen, and they are no longer limited to only five LTCH choices.¹²

The only case heard to date on the issue of discharge from hospital to long-term care is *Duffy v. OHIP*,¹³ which was an appeal after a denial of OHIP benefits. Mrs. Duffy, a patient at Joseph Brant Memorial Hospital, was awaiting placement in long-term care. Although applications for three homes had been submitted, the hospital required that more homes be added.¹⁴ When this was not done, OHIP was advised that the patient had been discharged but remained in hospital. OHIP payments for the bed were discontinued and the hospital began to charge Mrs. Duffy \$120 per day for the bed. An appeal was brought before the Health Services Appeal Board by Mrs. Duffy who argued she was entitled to OHIP coverage for the hospital fees. The Board held that the rate being charged by the hospital appeared completely arbitrary and there was insufficient evidence that the appellant or her family had been advised of the discharge policy. In any event, the Board concluded, it was clear that a discharge did not simply mean “to leave the hospital on the day of discharge” as had been argued by OHIP but in fact meant an appropriate placement into long-term care. Therefore, the Board ruled in favour of Mrs. Duffy and ordered coverage of the fees by OHIP.

This case does not mean that an applicant can simply wait in hospital for a specific long-term care home, for example where that home has

a three-year long waiting list, unless it can be proven that that home is the only one which can meet the person’s needs. Applicants and their SDMs must act “reasonably” when making their choices. However, there is no clear definition of what reasonable means and it will change in each individual situation. In addition, staying in hospital may be often not in the best interest of the person. Hospitals do not provide the same assistance and social programming as LTCHs. The likelihood of the patient deteriorating while waiting for placement, including loss of mobility and incontinence, are high. Finally, staying in hospital for prolonged periods of time increases the chance of contracting hospital borne infections, such as *MRSA*, *VRE*, and *C. Difficile*. One must weigh all of these considerations when making a placement decision.

Generally, the main issue is whether the facilities choices made by the person or the SDM are appropriate. Legally, the hospital or CCAC cannot simply disagree and ignore the decision. If the patient is evaluated as being incapable of making the placement decision, their authority to make that decision passes to their SDM. However, this cannot be done merely because the team does not like the decision of the person/SDM. If it is the decision of the SDM which is unacceptable, the CCAC (and only the CCAC) may challenge the decision of the SDM by bringing an application to the Consent and Capacity Board (CCB) alleging that the SDM is not complying with the statutory principles for giving or refusing consent set out in the *HCCA*.¹⁵ There is no ability to challenge the decision of the competent person who is not “complying” with “hospital policy” regarding choices.

¹⁰ O. Reg. 79/10, s. 171(1). Similar wording appears in the *Health Care Consent Act* which states that pertaining to admission, a “crisis means a crisis relating to the condition or circumstances of the person who is to be admitted to the care facility: *HCCA*, s. 39.

¹¹ O. Reg. 79/10, s. 171(4).

¹² O. Reg. 79/10, ss. 164(4) and 171.

¹³ Health Services Appeal Board (February 4, 1999).

¹⁴ At the time, the legislation did not include a maximum number of homes that could be applied to. The hospital in this case was requesting that 10 homes be included in the application.

¹⁵ *HCCA*, s. 54.

PLACEMENT FROM HOSPITAL: ISSUES WITH THE CCAC

CCAC placement coordinators are delegated specific placement duties under the *LTCHA*, which cannot be designated to others, such as hospital social workers or discharge planners. The placement coordinator authorizes the admission of the person to the LTCH. The CCAC must comply with specific rules regarding the eligibility and admission process, including the following:

- If a person/SDM applies to the placement coordinator for a determination of eligibility for placement into long-term care, the placement coordinator **must** find the person eligible if they meet the criteria set out in the regulations.¹⁶
- The placement coordinator authorizes admission only to LTCHs **as selected by the person/SDM**.¹⁷
- The placement coordinator shall, if requested by the person/SDM, assist the person in selecting homes.¹⁸
- The placement coordinator should use the following criteria when assisting the person in choosing a home – namely, the person's preferences relating to admission based on ethnic, spiritual, linguistic, familial and cultural factors.¹⁹
- The placement coordinator can approve eligibility or authorize admission to a specific nursing home only if the person/SDM **specifically applies** for such admission.²⁰ Therefore, if there is no specific consent given authorizing an application for that home, there is no way the person can be considered for that bed. While there may be an “available” bed in a home which meets specific criteria (i.e., a basic room for a female), the placement coordinator cannot determine its appropriateness unless authorized to do so by the person/SDM.

- If a person has already applied for five homes, their eligibility for admission cannot even be **considered** for another home until the person removes one of their choices from the list.²¹ Again, a home can only be removed from the choice sheet with the express consent of the person/SDM.

Nothing in the legislation makes the application process any different for patients in hospital than it would be for applicants living in the community.

Refusal of the CCAC to Take the Application

CCAC staff cannot refuse to take an application for placement. The legislation is clear that the CCAC placement coordinator **must** take an application and determine eligibility upon request.²² For example, the CCAC cannot require that the person return home or comply with hospital policies before they will accept an application.

It is also the obligation of the placement coordinator to ensure that consents are valid, meaning that they comply with the *LTCHA* and the *HCCA*. If LTCH “choices” are made based upon misinformation, such as applicants/SDMs being told that they **must** choose from a short list or that they **must** choose a specific home, then the consent is not valid and cannot be accepted by the placement coordinator. Therefore, it is up to the placement coordinator to ensure that the rules have been explained to the person/SDM and there has been compliance with the rules. In fact, where there is an SDM, the placement coordinator has an obligation to advise them of the decision-making rules contained in the *HCCA*.²³

Refusal of the CCAC to Accept Choices or Changes

The person/SDM not only has the right to choose LTCHs, but can also amend choices or withdraw consent to LTCHs any time prior to a bed offer being made. This is important as people may initially include certain “choices” because they felt they had no other option due to “hospital policy.” If this occurs, the person/SDM should immediately contact the placement coordinator to change their choices. Placement coordinators cannot refuse to make such changes on the basis it will violate “hospital policy.” They cannot agree to accept the change only if other criteria are met, such as the discharge planner “approving” the change or exchanging one “short list” home for another, as this is also contrary to the legal requirements.

¹⁶ *LTCHA*, s. 43(1) and O. Reg. 79/10, s. 155(1).

¹⁷ *LTCHA*, s. 44(1).

¹⁸ *LTCHA*, s. 44(3).

¹⁹ *LTCHA*, s. 44(4).

²⁰ *LTCHA*, s. 43.

²¹ O. Reg. 79/10, s. 166(1)(d).

²² *LTCHA*, s. 43(4).

²³ *M.A. v. Benes*, 1999 CanLII 3807 (ON C.A.).

The right to withdraw consent or to change choices is absolute. The law does not allow the placement coordinator to restrict the person's choices in long-term care.

Refusal of the CCAC to Take an Application from Hospital Patients

Some CCACs are now refusing to take applications for LTCHs from hospital patients or are only accepting such applications under strict circumstances. Generally, this is associated with the new "Aging at Home Strategy" of the Ministry of Health and Long-Term Care. Under this strategy, increased funding has been made available to people to facilitate their return to home by providing increased hours of care in the home on a time-limited basis.

While this program is laudable in theory, there have been increasing problems in practice. Patients are being told by the CCAC that they must return home before a LTCH application will even be taken. As discussed above, this is contrary to the legislation which requires that an application must be taken and eligibility determined, upon request. Due to this policy, people who cannot be managed at home or who have no home to return to, are being told that they have to leave hospital before they are allowed to even apply. Such rigid policies only serve to assist hospitals with their bed capacity issues, and are not only against the interest of the patient, but may be dangerous to the person that the CCAC has an obligation to assist.

While "wait at home" and "home first" strategies or programs may be beneficial to many people, they are not a universal panacea and are not appropriate for all. Utilization of these programs is not mandatory and the person must be allowed to apply to LTCHs, have their eligibility determined and to be provided with all the information necessary to decide whether such a program is right for them in their individual circumstances. The CCAC cannot require persons to enter these programs by threatening to withhold other types of services.

Requirement for Admission into a Retirement Home

Some applicants are told that they must go to a retirement home pending placement in a LTCH. As previously mentioned, retirement homes are not part of the publicly funded system, nor is

the care in them presently regulated. While the placement coordinator has an obligation to advise the applicant about other options that the person may wish to consider,²⁴ there is no obligation on the person to go to a retirement home when they qualify for publicly funded long-term care.

Refusal to take an Application and Determine Ineligibility

It is clear that where requested, the placement coordinator must take an application for admission and determine eligibility. Placement coordinators cannot simply refuse to take an application because they have pre-determined that the person might be ineligible. If no application is taken, the person's right to apply to have the finding of ineligibility reviewed by the Health Services Appeal and Review Board has been negated.²⁵

CONCLUSION

The new *Long-Term Care Homes Act* clearly sets out the rights of applicants for long-term care, supporting the model of consent and choice of the individual. Neither hospitals nor CCACs have the right under the legislation to make "choices" for the individual who wishes to be placed into long-term care. The system enshrined in legislation is based upon individual choice and, if the person is incapable of making decisions about admission to long-term care, what the SDM determines to be in the person's best interest. It is hoped that by having the correct legal information, the applicant/SDM will have the tools to better advocate for their rights.

NOTE: On December 6, 2010, Ontario's Auditor General tabled his annual report with the Legislative Assembly. Section 3.02 of the report, called "Discharge of Hospital Patients," highlights the problems of patients staying in hospital for systemic reasons. While we agree with much of what was said, there is cause for concern as to the repercussions of these statements on those in hospital awaiting placement in long-term care. ACE will be publishing a critique shortly.

²⁴ O. Reg. 79/10, s. 154(1).

²⁵ *LTCHA*, s. 43(8).

THE FIFTH ANNUAL CANADIAN CONFERENCE ON ELDER LAW – A RESOUNDING SUCCESS



Photos taken by Janice Williams, Law Commission of Ontario

Celebrating ACE and Ontario's legal clinics: John McCamus, Chair of the Board of Directors at Legal Aid Ontario, Judith Wahl, Executive Director at ACE, and Lenny Abramowicz, Executive Director at the Association of Community Legal Clinics of Ontario.

The fifth annual Canadian Conference on Elder Law took place on October 28-30, 2010 at the Sutton Place Hotel in Toronto. The conference was hosted by the Canadian Centre for Elder Law (CCEL), Law Commission of Ontario (LCO) and ACE.

The LCO was launched in September 2007 as an independent body funded by the Law Foundation of Ontario, Ministry of the Attorney General, Osgoode Hall Law School and the Law Society of Upper Canada. The Deans of Ontario's law schools also support the LCO. It has a mandate to develop recommendations for provincial law reform to increase access to justice. The LCO has undertaken a project to develop a coherent framework for the

law as it affects older adults and the conference was intended to contribute to this work.

The CCEL is a national not-for-profit organization based in Vancouver, British Columbia, dedicated to improving the lives of older adults in their relationship to the law and conducts research, provides outreach and public legal education on elder law issues. The CCEL has been the host of the previous conferences.

2010 CONFERENCE OVERVIEW

The theme of the conference was "Developing an Anti-Ageist Approach to the Law" which reflects and supports the LCO's multi-year project to develop a

holistic and principled framework for the law as it affects older adults. The conference explored three key issues: ageism and the law, access to justice and law reform for older persons.

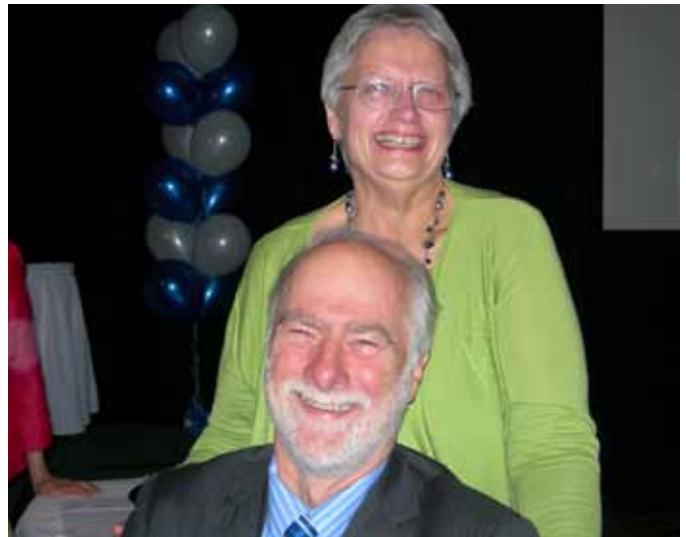
The conference started with a meeting of the World Study Group on Elder Law on October 28th. Law professors, practitioners and other professionals from around the world who are interested in law and aging issues met to present new and emerging research and ideas.

The organizers are grateful to the interesting and illustrious speakers who participated in the conference. The following is a list of some of the plenary sessions:

- A keynote address from Mr. Justice Murray Sinclair, Chair of the Truth and Reconciliation Commission;
- A panel of faculty from Ontario's law schools discussing the role of law schools in responding to Canada's aging demographic;
- A dialogue on the shifting to a rights-based approach to elder law, featuring Dr. Jane Barratt, Secretary General of the International Federation on Ageing, Professor Joan Gilmour, Professor at Osgoode Hall Law School, and Barbara Hall, Chief Commissioner of the Ontario Human Rights Commission;
- A panel discussion on law reform and older adults by Dr. Patricia Hughes, Executive Director of the LCO, Justice Marcia Neave of the Supreme Court of Victoria, Court of Appeals in Australia, and Frances Patterson, Q.C., Public Law Commissioner of the Law Commission of England and Wales; and
- The Distinguished Lecture on Elder Law by Judge Nancy Flatters of the Alberta Provincial Court.

The conference included 25 breakout sessions, focusing on a diverse array of issues including: the use of technology to improve access to the law for older adults; gender, age and the law; involving older adults in the law reform process; family relationships, conflict and the law of capacity and guardianship; and the development of effective complaints mechanisms to protect the rights of older adults.

The presentations at the World Study Group, plenary events and workshops were stimulating and thought provoking. We are certain that they made a significant contribution to the development of elder law in Canada.



Judith Wahl and Roger Smith, Director of JUSTICE.

Conference papers and presentations will be posted to the CCEL website shortly.

A CELEBRATION OF ACE AND LEGAL CLINICS ACROSS ONTARIO

On October 29th, there was a reception and dinner to celebrate the role of ACE and Ontario's legal clinics in advancing the rights of older adults and access to justice. The reception was generously sponsored by the Association of Community Legal Clinics of Ontario. The speaker at dinner was Roger Smith, Director of JUSTICE, an all-party reform and human rights organization working to improve the legal system and quality of justice in the United Kingdom.

THANK YOU

The Board and staff of ACE were delighted to collaborate with the LCO and CCEL on this important event. Particular thanks go to the LCO (especially Lauren Bates, staff lawyer) and Kim Appleton, the conference organizer. Together with ACE, they were primarily responsible for on-site organization and developing the conference program. We would also like to thank the staff of the CCEL for organizing the World Study Group and contributing to the organization of the conference and on-site staffing.

MOVING FORWARD

As a result of this conference, which demonstrated the interest and need for more education on the law pertaining to older adults, ACE plans to develop and participate in elder law practice programs for lawyers, older adults and organizations working with older adults.

FIRE SAFETY IN RESIDENCES FOR OLDER ADULTS

By: Lisa Romano, Staff Lawyer



On January 19, 2009, four elderly residents died tragically and six others were critically injured as a result of a fire at Muskoka Heights Retirement Residence. The home did not have a sprinkler system as it was not legally necessary due to the age of the building. There was approximately \$825,000 worth of damages to the retirement home; however, it is estimated that the cost of adding sprinklers would have only been between \$22,000 and \$41,000. In October 2010, the retirement home corporation and the administrator were convicted of violating the *Fire Protection and Prevention Act*.

This fire raised the issue – yet again – about whether there should be mandatory sprinkler systems in all Ontario retirement and long-term care homes.

This article will briefly review the findings of inquests into fire safety, fire prevention laws, inspections and charges initiated by various fire chiefs from across the province in response to the fact that homes that do not have sprinklers and recent announcements made by the provincial government about law reform in this area.

INQUESTS

According to Tim Beckett, President of the Ontario Association of Fire Chiefs, Ontario witnessed two of the largest retirement home fires in all of North America.

Fires at Extendicare in Mississauga in 1980 resulted in the death of 25 older adults and eight deaths at the Meadowcroft Retirement Home in Mississauga in 1995. In 1997, three older adults died due to a fire in a veterans' wing of Toronto's Sunnybrook Hospital. Each of these fires resulted in a separate coroner's inquest. Each coroner's jury recommended the retroactive installation of sprinklers in all Ontario retirement homes and long-term care homes.

ACE represented the Alzheimer Society of Ontario, an intervener, at the Meadowcroft inquest. Recommendations from the coroner's jury included changing the *Fire Code* to require sprinkler retrofits in all residential care buildings in Ontario with more than eight residents. Instead of following this recommendation, the provincial government amended the *Building Code* to

require sprinklers for residential care facilities built after 1997.

The Office of the Chief Coroner recently announced that an inquest will be held into the deaths of the four residents who died following the fire at Muskoka Heights Retirement Residence. The inquest will focus on fire safety in retirement homes. A date for the inquest has not yet been scheduled. ACE will follow this inquest with great interest and provide updates in future newsletters.

THE LEGISLATION

The *Ontario Fire Code* is a regulation made under the *Fire Protection and Prevention Act* which provides a set of uniform fire safety standards for existing buildings. The Office of the Fire Marshal, which is part of the Ministry of Community Safety and Correctional Services, is responsible for administering the *Fire Code*. The *Fire Code* is considered to be a companion document to the *Building Code*.

The *Building Code* is a regulation pursuant to the *Building Code Act*. Unlike the *Fire Code*, which applies to all structures, the *Building Code* only applies to new construction, as well as any substantial renovation or change of use of existing buildings. The *Building Code* is administered by the Ministry of Municipal Affairs and Housing and enforced by municipalities. It sets out minimum provisions respecting the safety of buildings with reference to public health, fire protection and structural efficiency. Many of the provisions in the *Building Code* pertain to fire protection.

Changes to the *Building Code* which came into force on April 1, 2010 require all new multi-storey residential buildings higher than three stories to have sprinkler systems.

ORDERS AND CONVICTIONS UNDER THE FIRE PROTECTION AND PREVENTION ACT

The Ontario Association of Fire Chiefs supports and advocates for the retroactive installation of sprinklers in all Ontario retirement homes and long-term care homes. Ralph Dominelli, the Fire Chief at the City of Orillia Fire Department, has said that a combination of smoke alarms and automatic fire sprinklers can cut the risk of dying in a fire by 82%. According to the Canadian Automatic Sprinkler Association, the average

cost to retrofit a building is about \$2.50 to \$3 per square foot.

Some fire chiefs in Ontario have attempted to use their discretionary authority under section 21 of the *Fire Protection and Prevention Act* to mandate the installation of sprinklers or increase in staffing levels. Section 21 gives authority to fire chiefs to order measures to protect the public where the *Fire Code* is considered deficient. For example, the Niagara Falls Fire Department used section 21 to order some facilities to proceed with retrofits. In one case, the Cavendish Manor Retirement Home appealed the decision to the Ontario Fire Marshal, who overturned four orders but upheld one order. Cavendish Manor then agreed to the retrofit the home with sprinklers.

After the fire at Muskoka Heights Retirement Residence, six charges were laid against the retirement home corporation and administrator under the *Fire Protection and Prevention Act*. Both the owner of the home and the administrator pleaded guilty to failing to “ensure supervisory staff be instructed in the fire emergency procedures” and failing to “implement the fire safety plan provisions for conducting fire drills for the supervisory staff.” The owner was fined a total of \$62,500, including \$25,000 for each guilty charge and a 25% victim fine surcharge. The administrator was fined a total of \$18,750, including \$7,500 for each guilty charge and a 25% victim fine surcharge. According to Fire Chief Dominelli, “this is the first time in Ontario that the administrator of a care occupancy has been convicted under the *Fire Protection and Prevention Act*.”

GOVERNMENT TO CONSULT ON FIRE SAFETY

The Ministry of Community Safety and Correctional Services is currently consulting on how to improve fire safety in residences geared towards older adults, people with disabilities and other vulnerable Ontarians. The Ministry released a consultation paper on their website at the end of November and interested parties have until March 28, 2011 to comment and respond. The information obtained from the consultations will help the government to determine what further action is needed on fire safety enhancements in the homes where these Ontarians live.

MORRISON v. HOOPER: NO LEGAL DUTY FOR ADULT CHILDREN TO SUPERVISE OLDER ADULT PARENTS LIVING INDEPENDENTLY

By: Graham Webb, Staff Litigation Lawyer

In August 2010, Madam Justice Janet Wilson of the Ontario Superior Court of Justice decided in *Morrison v. Hooper*, 2010 ONSC 4394 (CanLII) that there is no duty in law for a child to supervise an older adult parent who is living independently.

The plaintiff, Anna Morrison, was 84-years old when she was crossing the street two blocks from her home on December 3, 2003. Unfortunately, she was struck by the vehicle belonging to the defendant, Muriel Hooper, and suffered serious injuries. Mrs. Morrison, her daughter Arlene Young, and her son Ron Morrison sued Ms. Hooper. The driver not only defended the legal action but brought a counterclaim against Ms. Young and Mr. Morrison. Ms. Hooper alleged that “at the time of the accident Mrs. Morrison was mentally incompetent such that her judgment and appreciation of danger was impaired,” and that Ms. Young and Mr. Morrison “failed to properly supervise [her] conduct . . . [which] caused or contributed directly to the accident.”¹

The court was asked to decide whether there may be a legal duty on a child to supervise an elderly parent who is living independently. The driver argued that the issue of whether a child can be liable for an elderly parent had not yet been determined by the court, and that the issue was factually based and should be decided in the context of all the facts. Mrs. Morrison’s son and daughter argued that there is no duty in law for a child to supervise an elderly parent who is living independently, and that for a host of policy reasons the law should not be extended to impose such a duty upon children of aging parents.

The court heard that Mrs. Morrison had a documented medical history of suspicious paranoia

since 1999. She thought others were taking her money. She was suspicious of family members and others when it came to financial matters. Her children were concerned for her well-being and began seeking advice that same year.

In September 2002, her children obtained advice from a geriatric psychiatrist who had seen Mrs. Morrison. The geriatric psychiatrist was of the opinion that Mrs. Morrison was competent to decide about a nursing home placement and too high-functioning for a nursing home. As an alternative, she suggested that Mrs. Morrison be assessed for “mental and financial competence.” Another option was “to force Mrs. Morrison into a psychiatric hospital against her will, with a police escort, to undergo a psychiatric assessment.”² The geriatric psychiatrist felt it was likely that Mrs. Morrison would become worse over time and the children would have a better chance to take control of her situation at a later date. Mrs. Morrison’s children chose not to force her to have an assessment against her will. Mrs. Morrison’s family physician also did not act on the geriatric psychiatrist’s advice.

Despite these difficulties, Mrs. Morrison still exhibited much independence. Mrs. Morrison continued to live in Toronto, while her son resided in Ottawa and her daughter in Mississauga. She also drove until the summer before the accident and did her own banking. On the day of the accident, she was walking home from the bank when she was struck by the defendant’s vehicle.

The driver argued that given the advice received from the geriatric psychiatrist, her children had a duty to force Mrs. Morrison to have an assessment. Had the assessment taken place, the accident might have been avoided because Mrs. Morrison might have had more supervision on the day of the accident. She also argued that the involvement of Mrs. Morrison’s children made them caregivers giving rise to a positive duty of

¹ *Morrison v. Hooper*, 2010 ONSC 4394 (CanLII) at paras. 3 and 10.

² *Ibid.*, at para. 39.

care that, if responsibly exercised, might have avoided the accident.

In reaching its conclusion, the court applied a test outlined in *Anns v. Merton London Borough Council*, [1978] A.C. 728 (H.L.). Under the first part of this test, the court considered whether there was a sufficient proximity between Mrs. Morrison and her children “such that, in the reasonable contemplation of the children, carelessness on their part may likely lead to a pedestrian accident involving Mrs. Morrison giving rise to a duty of care.”³ The court held that a duty of care may exist if foreseeability of harm is present and there is a special link or proximity between the parties in three different types of situations. The first situation

...rests on the special vulnerability of the plaintiffs and the formal powers of the defendants. The law recognizes that the autonomy of some persons may be permissibly violated or restricted, but, in turn, requires that those with power exercise it... ‘with it a corresponding duty to take care for the safety of, and to properly supervise the student, whether he or she is a child, an adolescent or an adult.’⁴

Justice Wilson concluded that:

[A]n elderly parent living independently from the children is not in a special relationship of vulnerability with the children in a corresponding position of power. Children do not owe a duty to proactively force elderly parents to submit to an unwanted assessment. An elderly person living independently, even with some difficulties, is autonomous, unless judged otherwise by the court after consultation with expert capacity specialists.⁵

The court then looked at the second branch of the *Anns* test to determine whether there “are any considerations which ought to negative, or to reduce or limit the scope of the duty or the class of persons to whom it is owed.”⁶ The court concluded that “even if there was a *prima facie* duty to act, there are a host of public policy reasons why imposing such a duty upon the children of elderly parents should not occur.”⁷ It found that “to extend a duty of care to children of elderly parents living independently would create

chaos in litigation. It would add cost and delay as tactics emerge sidetracking the main focus of the issues . . . ”⁸ Furthermore,

Seeking advice and discussing issues of medication did not mean that the children became caregivers to their mother. To impose the legal duty of responsibility flowing from this type of consultation would undermine important collaboration between the medical profession and children of aging parents to problem solve in the best interest of an elderly parent.⁹

Finally, “to attach civil liability to responsible children doing their best with the help of social services and the medical profession to assist aging parents facing difficult transitional issues would have a terrible chilling effect of discouraging children from assuming, not their legal obligation, but their moral obligation to their parents.”¹⁰

The court therefore concluded that “there is no legal duty for a child to take proactive steps to force an unwilling elderly parent into a geriatric assessment. An elderly person’s autonomy is to be respected.”¹¹

Madam Justice Wilson’s decision is the correct decision and supportive of the rights of older adults. The court was asked to place older, cognitively impaired adults living independently in the same category as children or young adults living under the supervision of another more responsible person. Had the court accepted this interpretation, it would have created a legal duty for adult children to initiate unwanted and highly intrusive interventions into the lives of their aging parents. The refusal of the court to take that path affirms the ability of both parents and adult children to plan their own care needs with mutual respect and common sense.

³ *Ibid.* at para. 17.

⁴ *Ibid.* at para. 20.

⁵ *Ibid.* at para. 21.

⁶ *Ibid.* at para. 15.

⁷ *Ibid.* at para. 27.

⁸ *Ibid.* at para. 28.

⁹ *Ibid.* at para. 29.

¹⁰ *Ibid.* at para. 30.

¹¹ *Ibid.* at para. 26.

HOLIDAY HOURS

ACE will be closed on the following days during the holiday season:

- Monday, December 27
- Tuesday, December 28
- Monday, January 3

Seasons greetings and best wishes for the new year!

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).

ELECTRONIC NEWSLETTERS

To receive a copy of this and future newsletters electronically, please send an email to gillardt@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 2011.

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.