

**Written Submission  
to the  
Standing Committee on Social Policy**

on

**Bill 140, *An Act respecting long-term care homes***

**Respectfully Submitted By:**

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## A. INTRODUCTION TO ACE

The Advocacy Centre for the Elderly (ACE) is a specialty community legal clinic that was established to provide a range of legal services to low income seniors in the Province of Ontario. The legal services include individual and group client advice and representation, public legal education, community development, and law reform activities. ACE has been operating since 1984 and is the only legal clinic in Canada with a specific mandate and expertise in legal issues of the older population.

ACE currently employs five lawyers and three support staff. Since its opening in 1984, legal issues of residents in long term care homes have been a primary focus of work. Annually, ACE receives over 2500 new client contacts. Of these, approximately a third can be identified as directly involving issues in long term care and other health facility settings.

In response to this demand and need for expertise in long term care and health facility legal issues, ACE created the position of "**Institutional Advocate**" in 1988. The institutional advocate, who is a lawyer, is responsible for providing legal services to clients who need advice or assistance with legal issues in long-term care homes, hospitals, psychiatric facilities, and other institutional settings. Other staff also provide advice and representation to these clients because of the volume of work although the majority of clients living in these settings are assisted by the Institutional Advocate.

Having a lawyer dedicated to working on long term care issues has helped ACE develop a specific expertise in these legal problems, as well as an understanding of the long term care system. From this volume of work, ACE has identified a number of significant systemic legal issues in long term care, such as failure to get health care consent, abuse of residents, inappropriate use of restraints and secure units, inappropriate terms in admission contracts, inappropriate admission and advance care planning documents. In response to these issues, ACE has continually advocated for legislative and policy changes in long term care from 1984 to date.

In an effort to assist other advocates (both lay advocates and lawyers), as well as seniors and their families engaging in advocacy on long term care issues, ACE published *Long-Term Care Facilities in Ontario: The Advocate's Manual* in 1998. Now in its third edition, this 600+ page manual is a roadmap to the long-term care system in Ontario, and includes chapters on institutional long-term care, home care, and retirement homes, as well as chapters on other issues such as substitute decision-making, powers of attorney, and advocacy.

ACE lawyers are in high demand as speakers on long term care home issues and residents' rights. Numerous presentations on these issues have been made by ACE at the local, provincial national and international levels.

ACE brings this experience and expertise of advocating for residents and families of residents in long term care and this experience in the critical analysis of the legal issues in long term care to this response to Bill 140.

## **B. OVERVIEW**

ACE strongly supports the *Long-Term Care Homes Act, 2006*, subject to the principles outlined below and the recommendations found in this submission. We commend the government for its broad consultation process and its thorough review of the three different pieces of legislation currently covering long-term care homes in Ontario. We look forward to a similarly thorough consultation and review process on the Regulations that will be made under this Bill.

Our specific recommendations to improve the Bill are found in Part C, below. However, our support of the Bill is premised on the following three principles: sufficient funding, accessibility to all Ontarians who qualify for long-term care, and transparency.

### **Sufficient Funding**

Simply put, the long-term care system in Ontario will not work unless the government provides funding that is sufficient, consistent and predictable.

Funding must be allocated to meet the ongoing care needs of residents.

Funding must be allocated to regularize the staffing at long-term care homes so that residents' care is assured of appropriate skill, expertise, compassion, and continuity.

Funding must be allocated to train all staff of long-term care homes in all matters relevant to the care of vulnerable seniors. This includes funding for training on managing the increasing levels of dementia among long-term care home residents.

Funding must be allocated to the enforcement of this legislation, so that its compliance and enforcement framework is respected and maintained.

Funding must be allocated to revitalize "B" and "C" beds to bring them up to the standards expected of new beds and redeveloped "D" beds.

Funding must be allocated to create new beds across the province in anticipation of the fact that Ontario's aging population will require care in greater numbers, and for higher acuity needs.

ACE does not take the position that the legislation must include a requirement for minimum hours of care. In our view, focusing on minimum hours has the following risks:

- the number of hours is not related to the quality of care a resident receives;

- the minimum number risks becoming a ceiling, rather than a floor;
- the “care” provided is not always hands-on care, so the calculation of time could be skewed;
- a task may take some staff members longer than others to complete, but the minimum number of hours does not take expertise or experience into account;
- minimum hours of care do not lend themselves to easy comparison across jurisdictions, because there are many variables among the long-term care systems within Canada and in other jurisdictions.

While we do not recommend minimum hours of care, it is our position that the long-term care system must be funded to meet the assessed care needs of the residents. Funding must be tied to acuity.

In this respect, we note that previous legislation stated that the Ministry “shall” provide funding for long-term care homes, whereas the *Long-Term Care Homes Act, 2006*, states that the Ministry “may” provide such funding. We would encourage the government to commit publicly to sufficient, consistent, and predictable funding for this crucial sector of the health care matrix in Ontario.

ACE strongly supports a regulatory system where the Ministry controls the outlay of public monies to service providers, according to clearly articulated expectations and responding appropriately to the needs of long-term care home residents. This framework demonstrates accountability with public funds and ensures that services are provided to people wherever needed.

### **Accessibility**

Long-term care homes are part of the publicly funded health care system in Ontario. They must be accessible to all Ontarians who have a demonstrated need for ongoing nursing care. Long-term care applicants must not be screened out or denied access because of their income level. Every applicant with the required health needs, whether or not the person is a senior, has a right to access the care provided in this system.

Further, the principle of accessibility must recognize Ontario’s multicultural and multiethnic population. Applicants to long-term care must be treated equally and with respect. After being admitted to a long-term care home, residents must be provided with services and programs that are culturally appropriate.

## **Transparency**

The operation and regulation of long-term care homes in Ontario must be carried out according to the principles of openness and transparency. Families who put their loved ones into the care of others must be assured of appropriate access to information about the long-term care home's operation and compliance with legislation, regulations and policies. In particular, as detailed in our submission, the compliance and enforcement framework of the legislation must be transparent in order to ensure public accountability of the long-term care homes and of the Ministry.

At the same time, however, the protection of residents' privacy must be paramount. Personal information, including about physical and mental health, finances, and family matters, must be treated with the utmost respect and, in particular, must be dealt with according to all applicable legislation. The Bill must therefore strike the right balance between openness and accountability on one hand, and the protection of residents' rights and privacy on the other.

Subject to these overarching principles, we respectfully submit the following recommendations for the Committee's consideration.

## C. RECOMMENDATIONS

In what follows, we identify areas of the Bill [hereinafter “LTCHA, 2006”] that could benefit from greater clarity or detail. We also identify procedural components relating to hearings, licenses, inspections, and other matters. Where appropriate, we propose language that could be adopted as amendments to the First Reading version of the LTCHA, 2006. In each instance, we identify the issue, comment on the rationale for proposing changes to strengthen the LTCHA, 2006, and set out our recommendation.

Although we have no expertise in legislative drafting, our suggestions and recommendations are put forward with the intent of assisting to improve the safety, quality of life, and protection of the rights of long-term care home residents. In each instance, our perspective is informed by our years of legal representation of seniors, including many in long-term care homes across Ontario.

### 1. Definitions

**1.1 ISSUE:** Additional definitions are required to bring clarity to the legislation.

**COMMENT:** There are a number of key terms that are not defined in the legislation. This will lead to confusion and disparity in the way the terms are interpreted and applied. Such differences could cause widely fluctuating practices and procedures across Ontario, despite the fact that the legislation is intended to apply uniformly across the province. Residents will not be well-served, nor served equally, unless the terms are readily understood by all.

“Restorative services” is an undefined term, found in Resident Right 12 and in subsection 6(4) concerning care plans and section 8 concerning restorative care. It is not clear what “restorative services” are, as this is not a term which can be defined with reference to other sources. As the LTCHA, 2006 gives residents the right to receive these services, and requires the homes to provide them, a definition is required for clarity. We submit that restorative services should include any and all services that promote or return health to an individual, including but not limited to physical therapy, occupational therapy, rehabilitation, mobility therapy, and speech/language therapy.

“Interventions” is an undefined term, found in subsection 6(2) concerning care plans. Again, long-term care homes are required to provide “interventions”, but it is unclear what is meant by this term.

“Personal Assistance Services Device (PASD)” is defined in section 31, but should be moved to subsection 2(1).

“Restraining” is found in Resident Right 13, and is the subject of sections 27 through 34, yet is not adequately defined. The draft “Least Restraints” policy standard dated November 2004, a copy of which is attached to this submission as **Appendix A**, contains definitions for “Restraints”, “Restrain”, “Physical Restraints”, “Chemical Restraints” and “Environmental Restraints” which should be incorporated into the Act.

**RECOMMENDATION:** Definitions should be added for the following terms:

- “restorative services”: any and all services that promote or return health to an individual, including but not limited to physical therapy, occupational therapy, rehabilitation, mobility therapy, and speech/language therapy.
- “interventions”: definition required.
- “restrain”: definition required per Draft “Least Restraints” Policy dated November 2004.
- “restraints”: definition required per Draft “Least Restraints” Policy dated November 2004.
- “physical restraints”: definition required per Draft “Least Restraints” Policy dated November 2004.
- “chemical restraints”: definition required per Draft “Least Restraints” Policy dated November 2004.
- “environmental restraints”: definition required per Draft “Least Restraints” Policy dated November 2004.
- “personal assistance services device” (PASD): move definition from section 31 to subsection 2(1).

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**1.2 ISSUE:** The current definition of “abuse” is overly narrow and technical, and does not cover all areas necessary to protect residents.

**COMMENT:** The definition of “abuse” in section 2(1) currently reads:

“abuse”, in relation to a resident, means physical, sexual, emotional, verbal or financial abuse, as defined in the regulations in each case; (“mauvais traitement”)



While it is understood that the definition as currently drafted contemplates that the regulations may expand on any one or more of the named types of abuse, the current definition is insufficient to address the concept of “abuse” in the context of the safety, health and well-being of long-term care home residents. The multiplicity of definitions from different sources could also create confusion.

The prevention of abuse and neglect figures prominently in the goals of this legislation. The legislation creates a mandatory duty to protect residents “from abuse by anyone” (per section 17), and a mandatory duty to report the suspicion of “abuse of a resident by anyone” (per section 22(1)2). Persons subject to these mandatory duties must understand the scope of their responsibilities. It is therefore imperative that these terms be defined and understood in the most comprehensive manner possible.

The Ministry of Health and Long-Term Care’s Policy on the *Prevention, Reporting and Elimination of Abuse of Residents of Long-Term Care Homes* (Document #0808-01, November 2004) goes into significant detail on the definition of abuse, types of abuse, appropriate responses to suspected abuse, and other strategies to combat abuse. The policy defines “abuse” as follows:

“Abuse” of a resident means any action or inaction, misuse of power and/or betrayal of trust or respect by a person against a resident, that the person knew or ought to have known would cause (or could reasonably be expected to cause) harm to the resident’s health, safety or well-being.

The policy goes on to provide examples of categories of abuse (physical, sexual, emotional, verbal, financial, neglect, prohibited use of restraints, etc.) and sets out definitions within each of those categories.

This policy should be maintained, and its core definition of abuse should be elevated into the legislation. This would strengthen the definition and would ensure definitional consistency as among the legislation, regulations and policies governing long-term care homes.

**RECOMMENDATION:** The definition of “abuse” in section 2(1) should be replaced by the definition of abuse in the Ministry of Health and Long-Term Care’s Policy on the *Prevention, Reporting and Elimination of Abuse of Residents of Long-Term Care Homes* (Document #0808-01, November 2004).

## 2. Applicability of legislation to substitute decision-makers

**2.1 ISSUE:** The legislation is not clear about its applicability to substitute decision-makers.

**COMMENT:** It is not well understood when and how a substitute decision-maker will make a decision on behalf of a mentally incapable person. This requires clarification to ensure that appropriate decision-making processes are respected when residents are mentally incapable of making particular decisions. These processes are already well-defined in legislation such as the *Substitute Decisions Act*, S.O. 1992, c. 30, the *Mental Health Act*, R.S.O 1990, C. M.7, and the *Health Care Consent Act, 1996*, S.O. 1996, c.2.

**RECOMMENDATION:** A general section should be added to state that where appropriate, “resident” should be read as “resident or substitute decision-maker of a mentally incapable resident”.

### 3. Consent, capacity, and substitute decision-makers: applicable legislative requirements

**3.1 ISSUE:** The right to consent to treatment must be strengthened in the legislation, including the right to consent to admission, restraints, and secure units.

**COMMENT:** Despite being in the existing Bill of Rights as well as being governed by the *Health Care Consent Act* and other legislation, the right to consent to treatment, or to have treatment consented to by a substitute decision-maker, continues to be ignored in long-term care homes and is one of the issues about which ACE receives a great number of complaints. The right in the legislation to consent to treatment must be strong as it may be the only information about this right that residents, their families and substitute decision-makers have. It also serves as a reminder to professional staff.

Very often, we are contacted when substitute decision-makers discover that the mentally incapable person has been receiving treatment with medication, about which the substitute decision-maker knew nothing. Usually, but not always, the complaints are about antipsychotic drugs, which have the potential for serious side effects. It is often not until the substitute decision-maker calls us that they learn of the health practitioner's legal obligation to obtain consent prior to commencing treatment.

In fact, many homes routinely fail to obtain consent at all. Other homes attempt to obtain "blanket" consents at the time of admission to apply to all treatments that might be prescribed during the course of their stay. This in no way can meet the definition of "informed" consent required by law.

Finally, some homes commence treatment and some time thereafter a staff member will contact the substitute decision-maker to "advise" them that the resident is not taking the medication, leaving no option open for "consent".

Where these concepts are mentioned in the LTCHA, 2006, there are two options:

1. Refer directly to the provisions of the *Health Care Consent Act* or the *Substitute Decisions Act* as applicable; or
2. Include the legal requirements of consent, capacity and substitute decision-making within the LTCHA, 2006 itself.

In our view, the best method to achieve this would be by referring to the *Health Care Consent Act* each time a consent issue arises in the LTCHA, 2006.

**RECOMMENDATION:** Resident Right 11(ii) should be amended as follows:

11. Every resident has the right to,

(ii) give or refuse consent to any treatment or care for which his or her consent is required by law, either for himself or herself or, if mentally incapable, by the resident's substitute decision-maker, in accordance with the requirements of the *Health Care Consent Act, Substitute Decisions Act*, other legislation or the common law.

Further, reference to the *Health Care Consent Act* should be imported into the LTCHA, 2006, in each instance where issues of consent, capacity and substitute decision-making arise.

## 4. Residents' Bill of Rights

The Residents' Bill of Rights is a crucial element of this legislation. It enshrines many of the rights that are essential to the day-to-day quality of life of long-term care home residents. However, as currently drafted, the Bill of Rights neglects certain key rights and offers insufficient protection to others. For the Bill of Rights to achieve its purpose, the following rights must be added, amended or strengthened.

**4.1 ISSUE:** The right to advocacy must be enshrined in the legislation.

**COMMENT:** Care plan meetings, and other meetings, can be difficult for residents, especially where the resident has complaints. Care meetings may be attended by numerous staff members such as physicians, nurses, social workers, dietitians, physiotherapists, administrative representatives, and others. This can be overwhelming and especially intimidating where residents or their substitute decision-makers question, oppose or criticize the care received by the resident. In the past, residents have been refused the right to be accompanied by an advocate, such as a friend or lawyer, to attend such meetings. Given the importance of these meetings to the day-to-day well-being of the resident, a right to have the assistance or representation of an advocate is crucial.

**RECOMMENDATION:** A new right should be added as follows:

Every resident has the right to have any friend or advocate of their own choosing attend any meeting with home staff.

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**4.2 ISSUE:** The right to access personal health information should be strengthened and clarified.

**COMMENT:** Despite being in the existing Bill of Rights as well as being governed by the *Personal Health Information Protection Act, 2004*, the resident's right to access information, either personally or by their substitute decision-maker, continues to be refused by staff and administration at long-term care homes. ACE has had numerous cases since 2004 where simple access to records requests have become complex due to confusion on the part of the long-term care home between the requirements of the *Personal Health Information Protection Act, 2004*, on one hand, and the governing long-term care legislation, on the other.

**RECOMMENDATION:** Resident Right 11(iv) should be amended as follows:

11. Every resident has the right to,

(iv) have his or her personal health information with the meaning of *Personal Health Information Protection Act, 2004* kept confidential in accordance with that Act, and to have access to that personal health information including, but not limited to, the health care chart and plan of care, either personally or by the resident's substitute decision-maker, including, but not limited to, reviewing the personal health information or receiving copies thereof.

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**4.3 ISSUE:** Residents should have a right to access advocates and legal counsel, including when they participate in the life of the long-term care home by raising concerns and recommending changes in policies and services.

**COMMENT:** In our experience, residents have been discouraged or prevented from seeking advocates or legal counsel to assist them. This is an inappropriate incursion on freedom of association. It also serves to dissuade residents from raising concerns on their own behalf or on behalf of others.

**RECOMMENDATION:** Resident Right 17 should be amended by adding a new clause (vi) and adjusting the numbering as follows:

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

- i. the Residents' Council,
  - ii. the Family Council,
  - iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 130 or of the board of management for the home under section 123 or 127,
  - iv. staff members,
  - v. government officials,
  - vi. advocate or lawyer;**
  - vii. any other person inside or outside the long-term care home.
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**4.4 ISSUE:** The right to private meetings is crucial in a long-term care facility, where rooms may be shared with other residents and where privacy and

personal space are at a premium. The right as currently drafted does not cover the situations it appears to be intended to cover.

**COMMENT:** The right needs to be clarified that the resident has the right to meet privately with any person(s) of their choosing.

**RECOMMENDATION:** Resident Right 21 should be amended as follows:

Every resident has the right to meet privately with his or her spouse or any other person or persons in a room that assures privacy.

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**4.5 ISSUE:** All residents should have the right to programming that is appropriate to their age, their physical and cognitive abilities, and their interests.

**COMMENT:** While Resident Right 23 gives the resident the right to pursue a variety of interests and to be given reasonable assistance by the licensee in these pursuits, there is nothing that requires the licensee to offer alternative programming. This is a problem for certain ethnic and religious communities, as well as for younger residents. For example, while younger residents are admitted to long-term care homes, programming is still geared for the elderly residents with cognitive deficits, and it is often not appropriate for these younger residents. In other cases, private rooms are not available to Muslim residents for their daily prayers. Long-term care homes must provide programming of interest to all residents, not just the majority.

**RECOMMENDATION:** Resident Right 23 should be amended to read as follows:

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential, and to be provided by the licensee with appropriate programs and assistance for the purpose of pursuing his or her interests and developing his or her potential.

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**4.6 ISSUE:** An important right has been narrowed from predecessor legislation. In predecessor legislation, residents had the right to be informed of laws, rules and policies affecting the home, whether or not they are with respect to services.

**COMMENT:** The long-term care home is the home of the residents. Residents should be informed of all rules, laws and policies affecting the home, not only with respect to services. ACE has dealt with many situations where homes have

refused to provide residents with copies of policies, despite this right. If the LTCHA, 2006 narrows the right in this way, some homes will attempt to restrict access as much as possible, which is not in the best interest of the residents. Examples of such policies are fire safety protocols, food safety rules, evacuation procedures, etc.

**RECOMMENDATION:** Resident Right 24 should be restored to the wording of Resident Right 16 in predecessor legislation as follows:

24. Every resident has the right to be informed in writing of any law, rule or policy affecting the operation of the home and of the procedures for initiating complaints.



## 5. Plans of Care

**5.1 ISSUE:** It is not a requirement in the current version of subsection 6(1) that plans of care be in writing. This requirement should be inserted into the legislation.

**COMMENT:** It is very positive that the legislation sets out the requirements of the plan of care. However, one of the most critical requirements is missing – namely, that the plan of care be in writing. Other subsections of section 6 set out important aspects of the development and communication of the plan of care for each resident. Subsection 6(8) stipulates that licensees “shall” provide the care set out in the plan of care. For the protection of the resident, the licensee and the staff, it is essential that the plan of care be in writing.

**RECOMMENDATION:** Subsection 6(1) should be amended as follows:

- 6. (1)** Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
- (a) the planned care for the resident;
  - (b) the goals the care is intended to achieve; and
  - (c) clear directions to staff and others who provide direct care to the resident as to how and when to provide the care.

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**5.2 ISSUE:** It is not a requirement in the current version of section 6 that plans of care be consented to by the resident or by the resident’s substitute decision-maker.

**COMMENT:** It must be clear that the plan of care must be consented to by either a competent resident or the substitute decision-maker prior to being implemented. Plans of care necessarily implicate health care and treatment decisions, and therefore must be subject to the requirement of consent.

**RECOMMENDATION:** Subsections 6(4), (6) and (13) should be amended to include the requirement of consent to the plan of care pursuant to the *Health Care Consent Act*.

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**5.3 ISSUE:** There is currently no obligation to consult appropriate medical specialists when creating the plan of care.

**COMMENT:** In some situations, the medical and nursing staff at a long-term care home may not possess the specialized expertise to deal with certain aspects of a residents’ health care or behaviour. The licensee should be required to ensure

that the care team consult appropriate medical or nursing specialists, even if those specialists are located outside the long-term care home, in order to make sure that the resident's plan of care covers all aspects of the resident's care with the appropriate level of expertise.

For example, if a resident has a rare blood disorder, the care team should be required to consult the resident's haematologist in the preparation of the care plan. Similarly, if a resident has unusual behavioural issues related to dementia, the care team should be required to consult specialists on this aspect of the resident's care. If a resident is taking several types of medication, the care team should be required to consult a pharmacist for expertise concerning the avoidance of potential adverse reactions from drug interactions. Further, there are many associations, such as the Parkinson Society Canada, that could provide staff training regarding issues specific to certain types of diseases.

**RECOMMENDATION:** Section 6 should be amended to require the licensee to ensure that medical specialists are consulted, as necessary and appropriate, in the creation of the plan of care and in the reassessment and revision of the plan of care.

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**5.4 ISSUE:** Reassessments and reviews/revisions of the plan of care are required under subsection 6(11) of the legislation, but there is not enough specificity about who is required to conduct these reassessments/reviews/revisions.

**COMMENT:** It is very positive that the legislation mandates that residents are to be reassessed every three months and at other specified times. However, the subsection does not indicate who is to conduct the reassessment or what areas are to be reassessed. The reassessment must cover the same areas as are listed in subsection 6(4). The legislation should also specify that at a minimum, reassessments must be conducted by the attending physician and the registered nurse in charge of the resident's care. The reassessments, which are key to the ongoing provision of appropriate care to residents, may not be appropriately done if they are conducted by a person without the necessary nursing expertise or understanding of a resident's scope of needs.

**RECOMMENDATION:** The subsection should be amended as follows:

6. (11) The licensee shall ensure that the resident is reassessed and the plan of care revised:
  - (a) at least every three months and at any other time when,
    - (i) a goal in the plan is met;
    - (ii) the resident's care needs change or care set out in the plan is no longer necessary; or

- (iii) care set out in the plan has not been effective;
  - (b) in such a way that ensures that the plan of care continues to cover all aspects of care as set out in subsection (4); and
  - (c) by, at minimum, the attending physician and registered nurse responsible for the resident's care.
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**5.5 ISSUE:** Subsections 6(14) and (15) concern access to plans of care under the *Personal Health Information Protection Act, 2004*, S.O. 2004, c. 3, and set out questionable limitations on the disclosure of information in plans of care.

**COMMENT:** It is not clear why subsection 6(14) limits access to the plan of care by a resident or substitute decision-maker. We cannot conceive of a reason where such disclosure would not be required under the *Personal Health Information Protection Act, 2004*. We would suggest that this subsection be removed entirely.

In the alternative, if the limitation on access to the plan of care is found to be absolutely necessary, the order of subsections (14) and (15) should be reversed, such that the legislation sets out the right of access *before* setting out any limitations on this right.

**RECOMMENDATION:** Subsections 6(14) and (15) should be deleted and replaced with the following:

**6. (14)** The resident and their substitute decision-maker have a right of access to the plan of care under the *Personal Health Information Protection Act, 2004*.

In the alternative, we submit that the order of subsections 6(14) and 6(15) should be reversed.

## 6. Care and Services

**6.1 ISSUE:** Section 9 requires licensees to ensure the presence of recreational and social programs to meet the interests and needs of the residents. However, this section does not adequately reflect the diversity of the long-term care home population, and in particular does not reflect diversity of residents' ethnicity, age, or cognitive abilities. This is particularly true given the possibility of younger persons with developmental disabilities being placed in long-term care following the closure of Regional facilities, and the increasing number of younger residents with mental illnesses.

**COMMENT:** The section as currently drafted is not strong enough to ensure that programs are offered to all residents, including, for example, those from ethnic communities, those who are younger than the average age in long-term care, and those with special needs. For example, while younger residents are being admitted to the homes, programming is still geared for the elderly residents with cognitive deficits, and the programs are often not appropriate for these younger residents. Homes must provide programming of interest to all residents, not just the majority.

**RECOMMENDATIONS:** Section 9 should be amended as follows:

### **Recreational and social activities**

**9. (1)** Every licensee of a long-term care home shall ensure that there are organized programs of recreational and social activities for the home to meet the interests and assessed needs of all of the residents.

### **Certain cases**

**(2)** Without restricting the generality of subsection (1), the programs shall include activities for residents with cognitive impairments, residents with special needs, and residents who are unable to leave their rooms.

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**6.2 ISSUE:** Section 11 guarantees an "organized program of medical services" in each home. It is not sufficiently clear that this organized program must be available to every resident on a 24-hour basis.

**COMMENT:** Access to medical services continues to be a problem in a number of ways. ACE has had cases where all physicians in a home refuse to provide medical services to certain residents, despite their mandate to provide care to residents. As well, our clients tell us that residents and their families are advised that physicians are not available until the following week and that physicians cannot be contacted outside of their regular hours. While we understand that

physicians cannot be available on-site 24 hours a day, residents are placed in long-term care so that they can have appropriate access to medical care on a 24-hour basis. It is necessary that medical services be available on a 24-hour basis.

**RECOMMENDATION:** Section 11 should be amended as follows:

**Medical services**

**11.** Every licensee of a long-term care home shall ensure:

(a) that there is an organized program of medical services for the home to meet the medical needs of the residents and that all residents have access to those services, and

(b) that those services are available as needed on a 24-hour basis.

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**6.3 ISSUE:** Section 12 seems intended to require homes to provide information, assistance and referral services to residents wishing to obtain goods, services and equipment that the licensee does not provide. The drafting is not sufficiently precise for the section to achieve its ostensible goal. Further, the section should not imply that residents must obtain goods, services, or equipment that are not provided by the licensee.

**COMMENT:** Subsection 12(2) seems to imply that the licensee is not required to help the resident *apply for* financial assistance. We assume the subsection is intended to indicate that the licensee does not have to *provide* financial assistance to the resident for unfunded services. The subsection should be redrafted to reflect this intent.

As well, we continue to have problems with licensees “requiring” residents to have certain types of unfunded services, sometimes at considerable expense to the resident. Examples of this are as follows:

- “valet services” (mending and ironing), which are generally not provided as promised and are simply a way of getting extra money;
- “chiroprody”, where the resident does not have a condition that would require him or her to have specialized foot care, but which service relieves the home from having to provide adequate foot care;
- “sitters”, who end up providing care or feeding assistance that is supposed to be performed by the licensee; and
- “preferred accommodation”, where families of residents who are disruptive due to their disability are told they will be discharged unless the family pays for private accommodation.

**RECOMMENDATION:** We recommend that section 12 be amended as follows:

**Information and referral assistance**

**12.** (1) Every licensee of a long-term care home shall ensure that residents are provided with information and assistance in obtaining goods, services and equipment that are relevant to the residents' health care needs but are not provided by the licensee.

**Clarification of extent of assistance**

(2) The licensee is required to assist the resident or their substitute decision-maker in completing any paperwork required in obtaining available financial assistance for services not provided by the licensee, but the licensee is not required to provide any financial assistance.

**No requirement to purchase unfunded items**

(3) The licensee shall not require the resident to purchase goods, services or equipment that are not funded by the licensee.

## 7. Prevention of Abuse and Neglect

**7.1 ISSUE:** Section 18 requires licensees to ensure the home has a written policy regarding abuse and neglect. It should be amended to require that these policies be approved by the Ministry.

**COMMENT:** While we agree that every licensee should have a written policy to promote zero tolerance of abuse and neglect, it is our position that these policies should be approved by the Ministry of Health and Long-Term Care. While this might appear to be a cumbersome task given the number of homes in Ontario, we expect that homes will likely either follow corporate policy where they are part of a large municipality or chain, or adopt policies written by their industry organizations, the Ontario Association of Non-Profit Homes and Services for Seniors, and the Ontario Long-Term Care Association.

**RECOMMENDATION:** A subsection should be added to section 18 as follows:

**18. (3)** The policy to promote zero tolerance of abuse and neglect of residents must be approved by the Director.

## 8. Inspections based on information received by the Director

**8.1 ISSUE:** Subsection 23(3) requires the Director to have an inspector conduct an inspection or make inquiries if the Director receives information other than what is covered under subsection 23(1), but only if that information causes the Director to believe there may be “risk of harm to a resident”. The threshold for this subsection should not be to require a “risk of harm” in order for the Director to inspect or make inquiries.

**COMMENT:** Many complaints are made about issues that would not come under the auspices of subsection 23(1), and may not meet the threshold of “risk of harm” but would nonetheless be of importance to residents. Examples of this could include: homes overcharging or charging illegally for uninsured items; homes requiring residents to purchase extra care; homes refusing to allow family members to visit; staff searching residents’ bodies for items such as cigarettes or alcohol; staff going through residents’ personal belonging and confiscating items; failing to return items from the laundry; failing to provide proper food (i.e. not providing choice of items on menu, or not providing food for special dietary requirements. All of these examples may not implicate a “risk of harm” but all are actions that could violate rights, violate the legislation, or cause serious distress. The threshold “risk of harm” is too high.

**RECOMMENDATION:** Section 23 should be amended to require inspectors to conduct an inspection or make inquiries of all complaints in a long-term care home.

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**8.2 ISSUE:** Subsection 23(5) permits the disclosure of complaints that the Director does not investigate to the licensee, Residents’ Council, Family Council, or “another person”. This could cause a breach of privacy.

**COMMENT:** Residents and others involved will already be aware of the possibility of bringing issues to the attention of the Residents’ Councils and/or Family Councils, and to the licensee through a complaints process. Should they have chosen to make complaints to those entities, they would have done so. They may have particular reasons for choosing not to pursue these routes. To disclose the complaint to these entities, and also to “another person” per the language of the subsection, is to breach the person’s privacy and could lead to the ostracism of the resident, to retaliation by residents or others, and to other



problems. People may then refrain from making complaints of any type to the Ministry for fear that the information will be disclosed.

**RECOMMENDATION:** Subsection 23(5) should be deleted.

In the alternative, which we do not believe to be appropriate, subsection 23(5) should be amended to state that no such information should be disclosed without the consent of both the complainant and any resident and/or substitute decision-maker who may be involved, and that where such consent is refused, the inspector shall conduct the investigation.

## 9. Whistle-blowing protection

**9.1 ISSUE:** Section 24(1)(c) prohibits retaliation against anyone who gives or may give evidence in a proceeding, including under the LTCHA, 2006 or in an inquest under the *Coroners Act*. This protection should be clarified and broadened.

**COMMENT:** This section specifies that there be no retaliation where evidence is given in a proceeding concerning the enforcement of the LTCHA, 2006 as well as in a proceeding under the *Coroners Act*. We understand that the list is not exhaustive, but we submit that the subsection should be clarified to specify that it includes protection for those who provide information and/or evidence in Regulated College discipline matters, employment/union matters, civil litigation, human rights complaints, occupational health and safety, etc. (This is not an exhaustive list.) Staff should feel free to speak up at these types of proceedings where a fellow staff member may be accused of abuse and the person may be involved as a witness.

**RECOMMENDATION:** Section 24(1)(c) should be amended to include various types of proceedings in which a whistleblower might be required to give evidence or otherwise be involved.

## 10. Restraints and Detention

All sections which authorize restraint or detention by a substitute decision-maker must also include the right to a review in accordance with the law.

In Canada, no one may be detained or restrained against their will except by process of law. Under the common law, persons can only be restrained in an emergency where immediate action is required to prevent serious bodily harm to the person or to others, and only for so long as the emergency continues. The common law duty to restrain does not apply in situations where it might be “reasonably foreseeable” that a person might harm themselves or others; it only applies in emergency situations. Where restraint is required in a non-emergency situation, it can only be done where legislation allows, and only then in accordance with the *Charter*.

There is no common law duty to detain. Detention goes beyond an emergency situation. Legislation must specifically authorize detention within certain specifically defined circumstances. Legislation must also set out the right of a person to counsel, the right to have the detention reviewed, etc.

All persons have the following rights pursuant to the *Canadian Charter of Rights and Freedoms*:

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
9. Everyone has the right not to be arbitrarily detained or imprisoned.
10. Everyone has the right on arrest or detention
  - a) to be informed promptly of the reasons therefor;
  - b) to retain and instruct counsel without delay and to be informed of that right; and
  - c) to have the validity of the detention determined by way of *habeas corpus* and to be released if the detention is not lawful.
12. Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.
15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination

and, in particular, without discrimination based on ... age or mental or physical disability.

Persons entering long-term care homes do not give up these rights. In the context of long-term care, in fact, where it is more likely that a person will find themselves in a situation where staff either restrain or detain them, it is important that legislation specifically set out how such restraint or detention is to be done, and the rules which must apply. This not only protects the person who may be restrained or detained, but also assists the home both in determining when such actions are appropriate, and in protecting itself from legal actions for unlawful imprisonment, battery, etc.

These rights do not apply only to persons in a secure unit, but to any resident who is prevented from leaving a facility by the use of barriers, locks or other devices, such as wanderguard bracelets. Therefore, the sections should be expanded to reflect these rights.

If a resident is not allowed to leave a long-term care home, he or she is entitled to all the protection of the law. This does *not* mean that every person in a facility with a lock on the front door is being detained: if when they request to leave they are allowed to do so, they are not detained. However, if the person asks to leave and is not allowed to do so, this is detention and the person must be entitled to due process.

At the present time, there is no authority for homes to restrain or detain, except under very narrow circumstances. However, most residents are presently detained or restrained illegally, or by inappropriate means, due to the lack of appropriate legislative framework. Further, since there is no appropriate legislative framework in this area, the only persons who may have authority to consent to a person being detained or restrained are guardians of the person, or attorneys for personal care where the power of attorney contains a special “Ulysses” clause.

ACE has had numerous clients who have been prevented from leaving a long-term care home. This can occur when they are locked on a secure unit or prevented from leaving the building by the use of environmental restraints. ACE has heard a variety of purported rationales for this, including:

- the home has a “policy” preventing all residents from leaving without an escort;
- a family member or attorney for personal care directs the home not to allow the person to leave despite the fact that the health practitioners

in the home believe the person to be capable and, even if the person were mentally incapable, the family member or attorney has no legal authority to do so;

- the home prevents the person from leaving because they might fall, get hurt, get into trouble, drink alcohol, etc., even though the person is mentally capable of making such decisions.

Despite the fact that homes have no legal authority to detain their residents, these types of issues continually arise. While some matters can be resolved by legal counsel pointing out to the home that its actions are illegal, at other times it can be quite difficult where the home believes it is in the person's "best interest" for them to be prevented from leaving. Because there is no process other than court application to address this (a step which residents usually do not want to take), it can be a very difficult issue to resolve, particularly given that the resident usually has no other option but to stay in that home. It is often very difficult for the resident to move to another long-term care home or alternative accommodation, due to limited availability of long-term care home beds in most communities, and limited home care and resources to provide care in accommodation other than a long-term care home. The resident seeking to move would also be in the lowest priority category for placement in an alternate home. The resident may also find it too difficult to move simply because of his or her state of health.

It is important to have a quick and easy approach to resolving these matters while also upholding and respecting residents' rights. Setting out the requirements in the legislation would make the staff of long-term care homes put their mind to whether or not such refusals are legal, thereby reducing the number of illegal detentions.

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**10.1 ISSUE:** Section 27 requires licensees to ensure the home has a written policy regarding the minimizing of restraints. It should be amended to require that these policies be approved by the Ministry.

**COMMENT:** While we agree that every licensee must have a written policy to regarding the minimizing of restraints, it is our position that these policies should be approved by the Ministry of Health and Long-Term Care. While this might appear to be a cumbersome task given the number of homes in Ontario, we expect that homes will likely either follow corporate policy where they are part of a large municipality or chain, or adopt policies written by their industry organizations, the Ontario Association of Non-Profit Homes and Services for Seniors, and the Ontario Long-Term Care Association.

**RECOMMENDATION:** A subsection should be added to section 27 as follows:

**27. (3)** The policy to minimize the restraining of residents must be approved by the Director.

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**10.2 ISSUE:** The sections concerning minimizing of restraining must clearly state that there is no ability to restrain a competent resident against their will. This is a matter of fundamental rights.

**COMMENT:** No capable person can be restrained against their will, except where the common law allows. A statement similar to section 14 of the *Mental Health Act*, which states that “[n]othing in this Act authorizes a psychiatric facility to detain or to restrain an informal or voluntary patient” should be included in the legislation. In the case of the LTCHA, 2006, the statement should refer to “capable persons” rather than “informal or voluntary patients”.

**RECOMMENDATION:** A section should be added to the legislation stating that “Nothing in this Act authorizes a long-term care home to detain or restrain a mentally capable resident, except in accordance with the common law”.

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**10.3 ISSUE:** Section 29(2)5 provides that a resident can be restrained on their own consent or that of their substitute decision-maker. The section does not identify who makes the finding of incapacity, what it is the person is incapable of, and if there is an appeal process to that finding (see discussion above, under Restraints and Detention – general comments).

**COMMENT:** Persons can be capable of making decisions in respect to certain matters at the same time as they are mentally incapable of making other kinds of decisions. For example, a person can be mentally incapable of managing their property but can at the same time be capable of choosing a substitute decision-maker and signing a Power of Attorney for Property. In each instance where legislation contemplates someone being found mentally incapable, the legislation must specify in respect of what decision. “Incapacity” does not exist in a vacuum. This section should specify that the person must be found mentally incapable with respect to consenting to restraints.

Part II of the *Health Care Consent Act* should be specifically referenced in the LTCHA, 2006, wherever the context demands, with respect to obtaining consent from the substitute decision-maker.

The LTCHA, 2006 must refer specifically to those persons who are appropriate to assess capacity, namely the health practitioner proposing the restraint (please see the requirement under section 10 of the *Health Care Consent Act* that a health practitioner determine capacity to consent to treatment, and obtain consent, prior to treating). Further, when a person is found to be mentally incapable, it is crucial that due process be in place to allow the person to challenge the finding of incapacity by appealing the finding to the Consent and Capacity Board.

Section 29(2)5 should be amended to acknowledge that where restraining is required immediately and can be applied pursuant to the common law duty to restrain, such restraint can only continue for so long as the emergency situation persists, at which time consent must be obtained forthwith from the appropriate substitute decision-maker. Where a person found to be mentally incapable of consenting to restraints wishes to challenge that finding to the Consent and Capacity Board, the restraint could still be applied pending the Board hearing if the common law duty to restrain continued to apply. If the duty to restrain no longer applied (i.e. the emergency situation no longer persisted) either during the Board hearing or during any further appeals of the Board's decision, a special order of the Board would have to be made to authorize further restraint pending the final outcome of the dispute over the resident's capacity.

Persons found mentally incapable in this context should also have the right to request a hearing to the Consent and Capacity Board to determine whether their substitute decision-maker was complying with the requirements of section 21 of the *Health Care Consent Act*, as it pertains to consenting to restraints on behalf of the mentally incapable person.

**RECOMMENDATION:** The LTCHA, 2006, should be amended to confirm that Part II of the *Health Care Consent Act* applies with respect to findings of incapacity to consent to restraints.

Further, the *Health Care Consent Act* should be amended to add the following sections:

**18.1(1) Restraint may begin** – This section applies if

1. the person is a resident of a long-term care home as defined in the *Long-Term Care Homes Act, 2006*;
2. a health practitioner proposes a restraint for the person, the health practitioner is of the opinion that the person is mentally incapable with respect to the application of restraint, and the person's substitute decision-

maker has given consent on the person's behalf in accordance with this Act and the *Long-Term Care Homes Act, 2006*;

3. the requirements regarding restraints found in the *Long-Term Care Homes Act, 2006*, its regulations and policies have been met; and

4. restraint is required to prevent imminent and serious physical harm to the person or to another person.

**18.1(2) Restraint pending review** – If all the requirements set out in section 18.1 have been met, and

(a) the mentally incapable person applies to the Board for:

(i) a review of the finding; or

(ii) the appointment of a representative to give or refuse consent to the restraint on his or her behalf; or

(b) another person has applied to the Board to be appointed as the representative of the mentally incapable person to give or refuse consent to the restraint on his or her behalf,

the person can be restrained until the commencement of the hearing or for seven days, whichever is less.

**18.1(3) Restraint pending review** – Where section 18.1(2) applies, but either the hearing commences or the time to the hearing will be more than seven days, restraint may not continue without an order of the Board, which may order:

(a) no restraint pending the decision of the Board;

(b) restraint for a specified period of time; or

(c) restraint until the decision of the Board.

Further, section 19 of the *Health Care Consent Act* should apply to restraint pending appeal.

Consequential amendments would be required to amend section 37 of the *Health Care Consent Act* to reflect the principles described above. For example, a new section, s. 37.2 should be added to the *Health Care Consent Act* to provide:

**37.2** If a person is a resident of a long-term care home as defined in the *Long-Term Care Homes Act, 2006*, and if consent to restraint is given or refused on an mentally incapable person's behalf by his or her substitute decision-maker, and if the mentally incapable person is of the opinion that the substitute decision-maker did not comply with section 21, the mentally



incapable person may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21.

Subsections 37(2) through (7) would apply, *mutatis mutandis*, and section 37.1 would have to be amended to include section 37.2.

## 11. Admission or transfer to a secure unit

**11.1 ISSUE:** Subsections 30(4)-(7) of the LTCHA, 2006, deal with transfer to a secure unit from within a long-term care home. Section 200(9) of the LTCHA, 2006, which is a consequential amendment to the *Health Care Consent Act*, deals with admission to a secure unit from outside the home. Having two sections which deal with the same issue in two different pieces of legislation is illogical and confusing. Admission and transfer to a secure unit should appear in one piece of legislation, namely the *Health Care Consent Act*. The legislative scheme for transfers to a secure unit should mirror the requirements of the legislative scheme for admissions to a secure unit, found as Part III of the *Health Care Consent Act*.

**COMMENTS:** Admission to a secure unit is a very similar issue to admission to a long-term care home. It is therefore logical that all admissions, be they transfer within a home or admission from outside the home, be dealt with in the same manner and within the same legislation.

It is also important that both admissions to secure units and transfers into secure units come under as much scrutiny and review as possible, as residents on the units are detained in every sense of the word, and must be afforded the rights necessary to ensure appropriate detention. Without these rights, we submit that any detention would be contrary to the *Charter*.

ACE has dealt with residents who have been illegally detained on locked units. Residents on locked units rarely leave the units. They eat their meals, have their programming, and see their doctors within that unit. Most residents on locked units do not have access to telephones, and typically may only use the telephone at the nurses' station. At present, it is therefore very difficult, if not impossible, for these residents to seek outside assistance. Visitors to the unit are admonished not to allow residents to leave the unit. It is not uncommon for persons on that unit to ask for help to get out. Most people assume that the person has dementia, and therefore they ignore their pleas for assistance. However, this is not always the case, and there are those in the system who are on these units because of the wishes of their family or disagreements with the home administration, and for other reasons.

In our submission, most of these detentions are illegal; unfortunately, they are tacitly allowed, and there are presently no safeguards in place at all. This means that it is very difficult for these residents and others who might assist them to

know that they have legal rights and that they might exercise these rights to get off these units.

The most egregious case of illegal detention that ACE has been involved with was that of a 58 year old woman, S.S., who was admitted to a secure unit at the age of 51. She had a bipolar disorder as well as a number of physical illnesses, and did require some level of assistance at that time.

In 1997 she was found mentally incapable of making property decisions and had a Guardian of Property appointed by the Court. It would appear that thereafter, the assumption was made that she was mentally incapable for most if not all aspects of her life. The guardian himself assumed he was guardian for both property and the person, although this was not, in fact, the case.

In 1997 she was also admitted to the secure unit at a long-term care facility. Her mental health issues were brought under control. By 2002, she was requesting to get out, but the Guardian of Property refused to allow it. She was transferred to a secure unit in a second long-term care facility in 2004. She continued to be unhappy with being in a long-term care facility, but no one advised her that she could do anything about it. Her guardian of property authorized detention and limited outings. However, if she “used up” all her outings, she was not allowed out. On occasion when she was allowed to go out on her own, she was followed by the staff of the long-term care home. The Guardian’s wife also entered the picture, “authorizing” stricter detention, even though she had no authority whatsoever.

At one point, S.S. was allowed to leave the unit if she stayed within the facility. This “privilege” was eventually withdrawn as she was making it “difficult” for staff who had to “prevent” her from walking out the door. When she complained about not being able to go out to an art show (her guardian of property had said she had “used up” her once a week optional outing), she was detained by three staff members and seen as “noncompliant” and “difficult” when she complained about being illegally incarcerated.

Given that she was mentally competent, she was able to learn the codes to get off the unit and when she did, was brought back under duress. It was not until ACE intervened on her behalf that we were able to stop the illegal detention. This unfortunate woman eventually discharged herself – not only out of the locked unit, but out of the facility. She is now living successfully on her own, enjoying her outings and taking cruises.

This illegal detention could have been prevented if there had been legislation which clearly outlined when and how detention could take place.

**RECOMMENDATION:** The *Health Care Consent Act* should be amended by the addition of Part III.1 dealing with admissions to secure units of long-term care homes. The proposed Part III.1 is attached as **Appendix B** to this submission.

## 12. Sections more appropriately included in *Health Care Consent Act*

**12.1 ISSUE:** Certain provisions that currently appear in the first reading version of Bill 140 would more logically and appropriately be included in the *Health Care Consent Act*.

**COMMENT:** In our submission, provisions regarding consent and reviews of incapacity, etc., should be removed from this legislation and should instead become consequential amendments to the *Health Care Consent Act*.

The *Health Care Consent Act* deals with many aspects of the law relating to consent and the procedure for seeking review of findings of incapacity to consent. That legislation is the logical place for a complete legal scheme concerning consent to detention and secure units, because the requirements for consent to detention and consent to placement in a secure unit should mirror the requirements for consent to admission. The present sections are confusing, given the cross-application of the two pieces of legislation. Under the current drafting, neither piece of legislation provides a comprehensive code for consent to treatment in a long-term care facility. The risk is that residents and long-term care home operators will not have a full understanding of the rules governing consent and capacity, and the avenues of review that are available.

**RECOMMENDATION:** Provisions regarding consent to detention and placement in a secure unit should be removed from the LTCHA, 2006, and should be redrafted as consequential amendments to the *Health Care Consent Act*. The *Health Care Consent Act* should be amended by creating a new “Part III.1” that would govern admission to a secure unit of a long-term care home. The proposed Part III.1 is attached as **Appendix B** to this submission.

### 13. Incapacity to consent to personal assistance services device (“PASD”)

**13.1 ISSUE:** Section 31(4)4 states that if a person is “incapable”, the substitute decision-maker may consent to the use of the PASD. There is no reference as to who makes the finding of mental incapacity, and to what the incapacity refers.

**COMMENT:** This section should clarify that the finding of mental incapacity must be made by an evaluator, as that term is defined and understood in the *Health Care Consent Act*. Further, the section must state that the relevant incapacity relates to the ability to understand and appreciate the use of the PASD. It is submitted that reference to the *Health Care Consent Act* should be made in this section, so that it is clear that the list of substitute decision-makers set out therein applies to this decision.

**RECOMMENDATION:** Section 31(4)4 should be amended to reflect that in this context, “capacity” means “capacity to consent to the use of a personal assistance services device”. It should further be amended to confirm that the finding of mental incapacity can only be made by an evaluator as defined in s. 2(1) of the *Health Care Consent Act*. It should further be amended to reflect that section 20 of the *Health Care Consent Act* applies, with necessary modifications, for the purpose of determining who is authorized to give or refuse consent to the use of personal assistance services devices on behalf of a person who is mentally incapable with respect to the use of a personal assistance services device.

## 14. Persons ineligible to become placement co-ordinators

**14.1 ISSUE:** Section 38 states that the Minister shall designate “persons, classes of persons or other entities as placement co-ordinators” and shall not so designate persons, classes of persons and other entities “described in the regulations as ineligible for designation”. It is fundamental that persons designated as placement co-ordinators be directly accountable to the Community Care Access Centres and not be staff or contract employees of hospitals or long-term care homes, as the latter have a conflict of interest in respect to placement issues.

**COMMENT:** Some hospital staff and employees have the task of moving people out of hospital, as their mandate is to manage access to acute care beds and to the care services available in the hospital setting. Hospitals are places where people receive care, but they are not places in which people should live long-term except in situations where they need complex continuing care.

The role of hospital discharge personnel is complementary to that of placement co-ordinators. Hospital staff identify and prepare those persons who are (or will be) appropriate for transfer out of the hospital to their own home or to alternative accommodation where ongoing care needs may be met.

It is the responsibility of CCAC placement co-ordinators to assess eligibility for admission to long-term care homes as well as to assist people in the application process for admission to appropriate homes. Their role is to assist people not only to find the appropriate care to meet their needs, but to find the appropriate accommodation in which this care may be provided.

This role is distinct and must remain at arm’s length from that of the hospital discharge staff and from long-term care home staff, in order for the assessment and placement process to be credible, transparent, and without conflict of interest. The danger of hospital or long-term care home staff being given the responsibility to act as placement co-ordinators is that assessments and placements will be driven by hospital or long-term care home criteria and needs rather than the assessments of care and accommodation requirements of the potential residents.

For example, one of ACE’s clients was assessed by hospital personnel as being “ambulatory” when in fact he was a double amputee who had no prosthesis. This

clearly made a great deal of difference to his placement and requirements for care.

Long-term care home staff should also be ineligible to act as placement co-ordinators. On applications to transfer residents from one long-term care home to another, we have seen reports where long-term care home staff underplay residents' care needs or behaviours because they wish to make the resident more attractive for a transfer. Other reports may over-exaggerate residents' care needs or behaviours so that a transfer becomes less likely. In either case, these assessments are not independent and free from bias.

**RECOMMENDATION:** The regulations must specify that staff and employees of hospitals and staff and employees of long-term care homes are ineligible to be designated as placement co-ordinators.



## 15. Compliance by placement co-ordinators

**15.1 ISSUE:** Section 39 confirms that placement co-ordinators must act in accordance with the LTCHA, 2006 and regulations. However, there is no penalty section or sanction if placement co-ordinators fail to comply.

**COMMENT:** Our experience is that placement co-ordinators and Community Care Access Centres do not always follow the present law in respect to the placement process. Other than complaining to the Community Care Access Centre, there is no remedy available to complainants. Considering that the placement co-ordinators control access to long-term care homes, a section providing for sanctioning placement co-ordinators for failure to comply is necessary.

**RECOMMENDATION:** A subsection should be added to section 39 to make failure of the placement co-ordinators to act in accordance with the LTCHA, 2006 and the regulations an offence, such that the penalties in section 177 will apply to any failure to comply.

## 16. Eligibility for long-term care admission

**16.1 ISSUE:** The term “agent” in section 41(5)3 should be defined as prohibiting hospital staff or employees, or long-term care home staff or employees, from acting as “agents” of the placement co-ordinators for the purpose of the LTCHA, 2006. The same potential for conflict of interest applies in this situation as described above in relation to section 38.

**COMMENT:** Section 41 details the process for determining eligibility for admission to a long-term care home. The assessment described in section 41(4)2 includes an assessment of the applicant’s (i) functional capacity, (ii) requirements for personal care, (iii) current behaviour, (iv) behaviour during the preceding year, and (v) any other assessment or information provided for in the regulations. The assessment must be made by an employee or “agent” of the placement co-ordinator who meets certain professional criteria as outlined in section 41(5)3.

While we appreciate the need for “agents” of the placement co-ordinator, especially in small or remote communities, it is crucial that the person performing these assessments not be a staff member or employee of a hospital or long-term care home, as such persons are in a clear conflict of interest.

The responsibility of hospital discharge staff is to process patients for discharge from the hospital, and they are accountable to the hospital. The risk is that the assessment process may be unduly influenced by pressures within the hospital to discharge patients. Similarly, long-term care home staff are accountable to the home, and may be subject to pressures that would render their assessment biased.

To be fair both to persons seeking admission and to the licensees who will be using the assessments to determine if they have the physical facilities and staff with the nursing expertise to meet the applicant’s care requirements, these assessments should not be influenced by other external issues, such as pressures on hospitals to discharge.

**RECOMMENDATION:** The term “agent” in s. 41 should be defined so as to prohibit staff and employees of hospitals or long-term care homes from being retained as agents for the purpose of these assessments.

**16.2 ISSUE:** The requirement in subsection 41(7) to “give information” and to “explain” the process for admitting persons into long-term care homes must specify that the placement co-ordinator will do this in person, in a face-to-face discussion with the applicant. This cannot be a paper process.

**COMMENT:** After the placement co-ordinator determines that the applicant is eligible for long-term care home admission, the placement co-ordinator is required to give information to the applicant about the process of admission, as well as to “explain” the process, the choices that the applicant has in the process and the implications of those choices. This must be done at a face-to-face meeting between the applicant and the placement co-ordinator and not by simply providing a written information package.

The move to a long-term care home is a major event in a person’s life. This is why consent is required to admission to long-term care home. The person is moving to new accommodation in which she will also receive care services. The long-term care home will become her home.

Few people know how long-term care homes operate or are knowledgeable about the services and resources available (or not available) at long-term care homes. As well, not every long-term care home is identical, although all are subject to the same degree of regulation. Applicants often have many questions about how long-term care homes operate, and such questions will be particular to their own level of need and level of understanding. It is only through a face-to-face meeting that placement co-ordinators are able to determine what individual applicants require and can therefore be responsive to questions that arise in the course of the meeting.

If an evaluator has found the applicant not capable of consenting to admission to long-term care, the placement co-ordinator must provide information and explain the process to the appropriate substitute decision-maker for the applicant. In this situation, the placement co-ordinator should meet with the substitute decision-maker in a face-to-face meeting if possible, unless the substitute decision-maker is out of the jurisdiction or it is not physically possible for the placement co-ordinator to meet with the substitute decision-maker. In this case, the discussion should be by telephone.

**RECOMMENDATION:** The word “explain” should be clarified in this section to require that the explanation be provided in a face-to-face meeting with the applicant. The meeting with the substitute decision-maker (if the applicant is not

capable to consent to admission) may be by telephone if the substitute decision-maker is out of the jurisdiction or if it is not physically possible to meet with the substitute decision-maker because of distance.

## 17. Licensee withholding approval for admission

**17.1 ISSUE:** A person applying to a long-term care home should have a right of review and/or appeal when a licensee withholds approval for admission.

**COMMENT:** Subsections 42(9) and (10) deal with situations where a licensee withholds approval for admission to a long-term care home. The bill currently states that if the licensee withholds approval for admission on certain named grounds, the licensee must give a written notice of this decision to the applicant, the Director and the appropriate placement co-ordinator. The licensee must provide the applicant with the information about the refusal, and must include contact information for the Director. However, there is no right of review for the applicant of this decision of the licensee, nor is there an obligation on the part of the Director to review situations where approvals are withheld.

To ensure fairness and accountability in the process of withholding approval for admission, the applicant should have a right of review of the licensee's decision. This right of review is essential because access to care in a long-term care home is fundamental to our health care system. Without the right of review, there is a risk that licensees will "cherry pick" from waiting lists, and approve applicants who may require less care, or who are considered more "compliant" than other applicants with more challenging care needs.

No single home can meet the needs of all high-needs residents. However, no home should be able to exclude applicants because of challenging behaviours and care needs. The only way the system will meet the needs of all persons in Ontario who need long-term care is to ensure a balance in the system and effort on the part of all homes to accommodate a range of care needs of applicants. By providing the opportunity to have refusals reviewed, applicants are provided with fairness in the process. Homes equally have an opportunity to withhold acceptance of admission when the licensee determines fairly that it cannot accommodate persons with particular care needs at a specific point in time.

The first level of review should be by the Director at the request of the applicant who has received a written notice of the withholding of approval for admission. Applicants, licensees and placement co-ordinators should all have the right to make written submissions to the Director. The Director should have the authority either to affirm the withholding of approval, or to rescind the withholding of approval and refer the matter back to the licensee for redetermination in accordance with such directions as the Director considers proper. The review application to the Director should be made within one week of receipt of the

notice, and the Director should be required to render a decision within one week of receiving the notice requesting a review.

All parties should have a right to review the Director's decision to the Health Services Appeal and Review Board, with a similar process and scope of review as described above in respect to the review by the Director.

**RECOMMENDATION:** The LTCHA, 2006 should provide for a long-term care home applicant's right to apply to the Director for a review if the licensee withholds approval for admission. All parties should have a further right of review from the Director's decision to HSARB.

## 18. Residents' Councils and Family Councils

**18.1 ISSUE:** Substitute decision-makers of mentally incapable residents should not be entitled to be members of the Residents' Council unless there is no Family Council in the long-term care home.

**COMMENT:** Given that there is provision in the LTCHA, 2006 for the formal recognition of a Family Council and for the Family Council to have a formal role, it is appropriate for substitute decision-makers of mentally incapable residents to use the Family Council forum to raise issues with the licensee, rather than being members of the Residents' Council. If there is no Family Council in a home, it would be appropriate for substitute decision-makers of mentally incapable residents to have the right to be members of the Residents' Council in order to ensure that residents who lack capacity still have a voice in the operation and life of the home.

**RECOMMENDATION:** A paragraph should be added to subsection 54(3) as follows:

### **Who may not be a member**

(3) The following persons may not be members of the Residents' Council:

6. If a Family Council is organized in a home, the substitute decision-maker of a mentally incapable resident.

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**18.2 ISSUE:** The LTCHA, 2006 does not confirm that the Residents' Council assistant has a duty of confidentiality to the Residents' Council.

**COMMENT:** The LTCHA, 2006 does provide that the licensee must make available a Residents' Council Assistant who is acceptable to the Residents' Council. The LTCHA, 2006 further provides that in carrying out his or her duties, the Residents' Council assistant shall take instructions from and report to the Residents' Council.

However, the LTCHA, 2006 does not confirm that the Residents' Council assistant has a duty of confidentiality to the Residents' Council. Most of the work of the Residents' Council will be conducted in a public forum and will not be kept confidential by the Council. Nonetheless, circumstances may arise where the

Council wishes to meet in private, or to have some or all of their deliberations on an issue be kept confidential even though they may decide to make their decisions or conclusions public. Placing an obligation of confidentiality on the Residents' Council Assistant will enable the Assistant to fulfil his or her accountability to the Residents' Council, and will maintain a separation from the licensee or any employee or management of the licensee.

**RECOMMENDATION:** Section 56 of the LTCHA, 2006 should be amended to confirm that the Residents' Council assistant owes a duty of confidentiality to the Residents' Council.

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**18.3 ISSUE:** The LTCHA, 2006 does not confirm that the Family Council assistant has a duty of confidentiality to the Family Council.

**COMMENT:** For the same reasons described in relation to the Residents' Council assistant, the Family Council assistant should be subject to a duty of confidentiality.

**RECOMMENDATION:** Section 59 of the LTCHA, 2006 should be amended to confirm that the Family Council assistant owes a duty of confidentiality to the Family Council.

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**18.4 ISSUE:** The LTCHA, 2006 provides that a Residents' Council must be organized in a home, and that a Family Council may be organized in a home, and that there is an obligation on the licensee not to interfere with meetings or operation of either. However, there is no specific requirement that the licensee provide appropriate and private meeting space for the Residents' Council and Family Council (if any).

**COMMENT:** Although the LTCHA, 2006 does confirm that licensees must ensure that a Residents' Council exist in a home and must cooperate with the Residents' Council, there is no specific requirement that the licensee must make appropriate meeting space available for the Residents' Council. There is no requirement that any such meeting space be a private space. The same problem exists for Family Council: there is no specific requirement that the licensee must make appropriate and private meeting space available for the Family Council. To ensure that there are no barriers for the Residents' Council and Family Council to meet and have privacy, the LTCHA, 2006 should be amended to place an obligation on the licensee in this respect. While this is one aspect of the co-operation between



licensees and the Residents' or Family Councils, it is a crucial one that should be specifically provided for.

**RECOMMENDATION:** Section 63 should be amended to obligate the licensee to make appropriate and private meeting space available for meetings of the Residents' Council and the Family Council, if any.

## 19. Training for persons who provide direct service to residents

**19.1 ISSUE:** The term “direct service to residents on a periodic visitation basis” in section 74 needs to be defined so that the section is not overly broad in application.

**COMMENT:** The intent of this section appears to be that an obligation be placed on the licensee to ensure that basic training and knowledge be provided to all staff involved in direct care of residents, as well as to all persons, whether staff of the home or private staff (paid companions or supplemental private pay care staff) or any persons (staff, volunteers, others coming from outside the home on some “periodic” basis) who interact with the residents. The subjects on which training is to be provided break down into three broad categories:

- the “culture” of the home – i.e. the mission statement, the Residents’ Bill of Rights, zero tolerance of abuse, the minimization of restraints;
- the specific obligations of a person (staff, volunteer, other person) arising from legislation, regulations, or policies – i.e. the duty to report abuse, the legislative, regulatory or policy matters relevant to the person’s specific responsibilities;
- emergency procedures and infection control – i.e. fire prevention and safety, emergency and evacuation procedures, and infection control procedures.

This obligation would go far to ensure that all persons involved in the life and the care of the residents know their obligations and appreciate the culture of the home. This makes sense when applied to direct care staff, regular volunteers assisting with activities of daily living and activities in the home, and residents’ private pay companions and supplemental private pay care staff, as all of these person are directly involved in the life of the home and the care and support of the residents.

However, it is not clear who else would be captured in the definition of a person providing “direct service to residents on a periodic visitation basis”. This broad term could include residents’ family members and friends who visit regularly, since these persons may help residents with activities such as dressing, bathing, or eating. Information is already posted in the home and made available to family and friends about these issues. It would seem overly intrusive and onerous, both on the licensee and on these family members, friends and other visitors, to impose an additional requirement for “training”.

Further, residents' privacy would be compromised under the current drafting of this section. Would this obligation require licensees to ask all visitors to declare whether they were "providing direct services to a resident on a periodic visitation basis" before being allowed into the home to meet with the resident without undertaking a training program? This could inappropriately control access by residents to persons from outside the home.

Lawyers whose clients are long-term care residents could be captured in this definition. This would be inappropriate, as residents may not want the licensee to know that they are seeking or receiving legal advice. Residents have the right to expect privacy in their relationships with others, particularly with lawyers, financial advisors, spiritual advisors, and others with whom they have a private relationship. Indeed, this is a protected right under Residents' Right 14. This type of service provider should not be required to disclose to the licensee their relationship with the resident. This is an inappropriate invasion of the residents' privacy.

**RECOMMENDATION:** The term "direct service to residents on a periodic visitation basis" should be defined to clarify the obligation of the licensee to provide training to staff (full time, part time, agency etc.), volunteers, any persons retained by residents as supplemental private pay care staff and companions. Other persons that visit with residents (family, friends, other visitors, other service providers, clergy, etc.) should be excluded from this definition.

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**19.2 ISSUE:** Licensees should be required to ensure that training of direct care staff in the matters outlined in paragraphs 1-6 is not only offered but is actually received by the intended direct care staff, as provided in the current wording of subsection 74(6).

**COMMENT:** This requirement is a very positive development. Currently, training in some of the areas listed in paragraphs 1-6 of subsection 74(6) may be offered to staff of long-term care homes but, paradoxically, staff are not required to attend the training. For example, in one staff education session in which ACE participated, all staff members in attendance were wearing pagers and were required to respond to residents' care needs throughout the session, with the result that few if any staff members were able to attend the full session. This makes the training of little value to staff and defeats the intent of the licensee in providing the training.

ACE encourages the government to make adequate funding available to permit appropriate education of staff to take place. Staff should be able to participate in training programs without the need to provide care services to residents at the same time unless, of course, the training component involves training at the bedside.

The requirement for training of staff on caring for persons with dementia, behaviour management, abuse recognition and prevention, and minimization of restraints are fundamental considering the high proportion of residents with dementia now residing in long-term care homes.

**RECOMMENDATION:** This section should be retained as currently drafted to ensure staff members have the skills and training to provide for the needs of a growing population of residents with dementia. Although it is understood that the LTCHA, 2006 does not address funding, ACE encourages the government to provide appropriate funding to ensure that this training can take place in a comprehensive manner.

## 20. Regulated documents for resident

**20.1 ISSUE:** In order for the intent of section 78 to be fulfilled, the section should be amended to require licensees to use standard form documents provided for in the regulations. The intent of the section, which appears to be to improve the quality and legality of documents used in long-term care, should be maintained.

**COMMENT:** In ACE's experience, there are many problems with documents presented to long-term care home residents, substitute decision-makers and families. Specifically, many of these documents include clauses that, in our opinion, do not comply with the existing legislation, regulations, and policies. This non-compliance crosses a variety of areas of law including but not restricted to long-term care, health care consent, and substitute decisions.

For example, ACE has seen admission contracts that contain clauses purporting to exempt the licensee from all liability in respect to the provision of care to residents. This type of exemption would not likely be upheld if tested in a court action, but the inclusion of such a clause may make the resident and their family assume that they have no right of action in the event of negligence on the part of the licensee.

We have also seen admission contracts that require the resident to "preconsent" to any treatment ordered by a physician or other health provider. Such a clause is likely unenforceable and contrary to the legal requirement for informed consent prior to treatment. The *Health Care Consent Act* requires that consent be specific, that it relate to the particular treatment, and that it be obtained after specific information is provided to the person who is making the treatment decision (the resident or his or her substitute decision-maker, if the resident is mentally incapable). A 2004 research study of advance directive policies in long-term care homes in Ontario found that "policies regarding advance directives in long-term care centres in Ontario generally do not comply with the spirit or the letter of the applicable laws".<sup>1</sup>

By including section 78 in the LTCHA, 2006, it would appear that the government seeks to address these types of deficiencies in documents provided to residents.

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<sup>1</sup> Dr. Heather Lambert et al., "Advance Directive Use in Ontario Long-Term Care Facilities: A Policy Study" (Health Services and Policy Research Day, Queen's University, Kingston, ON, poster, 2004). A copy of the summary of this study is attached as **Appendix C** to this Submission.

However, the approach set out in the current version of section 78 will not be likely to result in improved documents. This section puts an onus on long-term care homes to have a lawyer “certify compliance” of the documents with the regulations. It is likely that lawyers were involved in the drafting of most documents currently used in long-term care homes. Any new documents required by this legislation, and old documents currently in use, will likely be redrafted by lawyers. Certification by a lawyer, as contemplated by the current version of section 78, will only be a “legal opinion” by a lawyer or law firm that the document so drafted complies with the requirements of the regulations. Another lawyer or law firm may have a different opinion as to the degree of compliance. Until the matter is brought to court, the question of compliance would not be finally determined.

One way to ensure that there is a common understanding of “compliance” is for the regulations to include standard form documents for those regulated documents determined to be fundamental to the relationship between the licensee and the residents. These could include a standard form admission agreement, standard form financial agreements, health care consent documents, standardized statements to record health wishes, and so forth. It would be appropriate that some of these documents be mandatory, such as the financial documents required under s. 89 of the LTCHA, 2006. Others should not be mandatory, such as health wishes documents, since the *Health Care Consent Act* permits persons to express wishes about future health care in any format, whether written, oral or communicated by alternative means. If the licensee wants to provide an opportunity for persons to execute optional documents, these documents should be in the regulated format. Standardization would prevent the use of questionable documents, and would save costs for both homes and the government.

An alternative approach would be for the legislation to require that all regulated documents be approved by the Ministry of Health and Long-Term Care. Licensees would submit the documents to the Ministry for review, and the Ministry would confirm compliance or require changes to be made to the documents until approval is given. This would be a less onerous undertaking than it might appear, since many homes are parts of chains and most homes are members of one of the two associations (OAHNSS and OLTCA) that might take on the task of creating standardized documents for use by individual homes or chains.

**RECOMMENDATION:** Section 78(1) should be amended by replacing clauses (a) and (b) with a requirement that regulated documents must be in the form prescribed in the regulations.

In the alternative, section 78(1) should be amended by replacing clause (b) with a requirement that the documents must be approved by the Ministry of Health and Long-Term Care.

## 21. “Directives” with respect to treatment

**21.1 ISSUE:** The term “directive” in section 80 and subsection 81(1) should be changed to “wishes” for consistency with the wording in the *Health Care Consent Act*.

**COMMENT:** It appears that this section is an effort to confirm and make clear that residents (and their substitute decision-maker if the resident is mentally incapable) have the right under the *Health Care Consent Act* to withdraw or revoke consent to treatment. As well, the section is intended to confirm that competent residents have the right under the *Health Care Consent Act* to revoke any expression of wishes about future health care. This is commonly referred to as a “directive” or “advance directive”.

However, the term “directive” is not used in the *Health Care Consent Act* or in any other legislation in respect to treatment and care. The word “wishes” is used in section 5 of the *Health Care Consent Act* to describe what is in a “directive”. Section 5 of the *Health Care Consent Act* provides:

5.(1) A person may, while capable, express wishes with respect to treatment, admission to a care facility or a personal assistance service.

### **Manner of expression**

(2) Wishes may be expressed in a power of attorney, in a form prescribed by the regulations, in any other written form, orally or in any other manner.

(3) Later wishes expressed while capable prevail over earlier wishes.

The word “wishes” is used instead of “directive” in the *Health Care Consent Act* because wishes can be expressed in any form – oral, in writing, or communicated by alternative means. The word “directive” usually infers a written format such as a Power of Attorney for Personal Care or an “advance health care directive” or “level of care” form. To avoid confusion and to be consistent with the *Health Care Consent Act*, the word “directive” should be replaced with the word “wishes”. This would capture directions expressed by any means and is not limited to a written format.

**RECOMMENDATION:** The word “directive” in section 80 and in subsection 81(1) should be replaced by the word “wishes” to be consistent with the language and intent of the *Health Care Consent Act*.



## 22. Recovery of overpayment to residents

**22.1 ISSUE:** The proposed LTCHA, 2006, is silent on recovery of excessive charges or overpayment by residents other than saying that a court could order restitution if a case were litigated (s. 177(4)).

**COMMENT:** It is a positive development that section 89 of the LTCHA, 2006, states that for anything other than accommodation the resident can only be charged for something consented to under a written agreement, and only at the amount provided for in Regulations or at a reasonable amount determined in the agreement. However, the legislation as currently drafted does not provide a mechanism for residents to recover payments that may have been made for accommodation, care, services, programs or goods that the resident did not receive. Further, there is no mechanism for residents to recover payments for items that were inadequately provided or not provided at all. The LTCHA, 2006, moves a step backward from the status quo on this issue.

Currently, section 22 of the *Nursing Homes Act* states that if a resident pays for “accommodation, care, services, programs or goods” that were either not provided or were inadequately provided, the Minister may deduct the amount of that payment from the payment it would otherwise make to the licensee and may pay that amount to the resident, or the Ministry may simply pay that money directly to the resident.

We are not attempting to have the Ministry resolve financial disputes between the licensee and the resident or substitute decision-maker. We are dealing here with money that is clearly owed, but is not forthcoming from the home. In one of our client’s cases, a home refused to complete a rate reduction / exceptional circumstances application although she was entitled to the reduction. After this was determined, it was up to the home to pay the resident back for her prior overpayment. Without being able to rely on the Ministry’s authority under section 22 of the *Nursing Homes Act*, the client would not have been able to recover the money without litigation.

In the case of another set of clients, the long-term care home chain refused to reimburse residents for days after they had left the home. This chain, like many others, required prepayment of accommodation fees at the beginning of the month. If the resident left partway through the month to go to another home, or if the resident died, the remainder should have been reimbursed. However, the chain refused to reimburse the clients. Without the Ministry’s authority, these clients would never have received the money clearly owed to them. In many cases, the sums were small and probably not worth litigation, so the home would otherwise have benefited from its illegal actions.

**RECOMMENDATION:** The right to recover overpayment should not be extinguished. A provision equivalent to section 22 of the *Nursing Homes Act* should be added to the LTCHA, 2006, to enable residents to recover overpayments.

## 23. Definition of long-term care home

**23.1 ISSUE:** Subsection 93(1) restricts the operation of “residential premises for persons requiring nursing care or in which nursing care is provided to two or more unrelated persons” unless the person has been granted a licence or is exempted from the LTCHA, 2006 under clause (b) of subsection 93(2).

**COMMENT:** ACE supports the inclusion of this section. This definition is arguably more broad than definitions under the predecessor legislation, and could potentially cover many more types of residential accommodation, including supportive housing and “care homes” currently subject to the *Tenant Protection Act, 1997*, S.O. 1997, c. 24 (and subject to the *Residential Tenancies Act* as of January 31, 2007). These “care homes” are sometimes referred to as “retirement homes” or “seniors’ residences”.

Long-term care homes are currently, and will continue to be, subject to government regulation. This is not only understandable (given the fact that long-term care homes are publicly funded), but is also desirable (given the fact that long-term care home residents are highly vulnerable). However, it must be recognized that “care homes” are also “residential premises ... in which nursing care is provided” for a segment of the senior population, many of whom also have high care needs, without being subject to long-term care legislation. It is to be noted that “nursing care” is not a defined term under this legislation, nor under the *Nursing Act, 1991*, S.O. 1991, c.32.

It is crucial that the government recognize the need to provide protection to seniors living in what might be called “bootleg” long-term care homes – that is to say, residential premises in which nursing care is provided but without the same level of regulation, oversight and financial contribution as in licensed long-term care homes. It is, of course, important that such “care homes” remain an option for seniors who do not require the level of care that would make them eligible for admission into long-term care. In some situations, however, the same level of care is being provided in a “care home” as in a “long-term care home”, but the latter is subject to many important safeguards while the former is subject to none. It cannot be the case that Ontarians support a two-tiered system of residential care for our seniors who require care, a system in which some are left out of the key protections of this legislation.

Therefore, the definition of long-term care homes currently found in section 93 of the LTCHA, 2006 should be retained as-is. Pursuant to s. 93(1)(b), residential premises that are “care homes” under landlord-tenant legislation should be excluded from the requirement for a licence under the LTCHA, 2006. However, such care homes should be excluded only on the understanding that they must be defined and their operation must be regulated under other legislation. Such

regulation must be more comprehensive than currently provided for under landlord-tenant legislation.

**RECOMMENDATION:** “Care homes” currently subject to the *Tenant Protection Act, 1997* (and subject to the *Residential Tenancies Act* as of January 31, 2007) should be exempted by Regulation from the licensing requirement in s. 93 of the LTCHA, 2006. These homes must then be defined and regulated separately, on the understanding that such homes are a tenancy in which some level of nursing care may be provided. Such tenancies and care must be subject to standards and regulation.

## 24. Public interest test

**24.1 ISSUE:** Predecessor legislation specifically required the Minister to take into account “the health facilities other than facilities for nursing care that are available” when considering whether a new long-term care home (or new beds) would be in the public interest. The public interest test in the LTCHA, 2006, requires the Minister to consider “the other facilities or services that are available”.

**COMMENT:** While long-term care homes are considered “homes” under the new legislation, it must also be recognized that long-term care homes are health facilities to their residents. It is crucial that when applying the public interest test to determine whether there should be one or more long-term care homes in an area, the Minister specifically turn his or her mind to an assessment of the health facilities and services that are available in the community. The public interest test should be comprehensive and should include an assessment of home care and of social, recreational, rehabilitative, and other kinds of facilities and services, but health services should be specifically enumerated as a factor to be taken into account.

**RECOMMENDATION:** Section 94 of the LTCHA, 2006, should be amended to include a specific reference to “health facilities other than facilities for nursing care” as a factor in the public interest test for determining whether there should be one or more long-term care homes in an area.

## 25. Commitment to promotion of delivery of not-for-profit long-term care

**25.1 ISSUE:** The LTCHA, 2006, does not include a commitment to not-for-profit operation of long-term care homes, whereas other recent pieces of health care legislation have included such a commitment. Long-term care should not be treated differently from other aspects of the health care system in this respect.

**COMMENT:** ACE submits that the stated commitment to not-for-profit delivery of health care found elsewhere should be included in the LTCHA, 2006. For example, the preamble to the *Local Health System Integration Act, 2006*, S.O. 2006 c.4, states that the people of Ontario and their government “are committed to the promotion of the delivery of public health services by not-for-profit organizations”.

Further, the *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c. 5, notes that the people of Ontario and their government:

- Recognize that Medicare – our system of publicly funded health services – reflects fundamental Canadian values and that its preservation is essential for the health of Ontarians now and in the future;
- Confirm their enduring commitment to the principles of public administration, comprehensiveness, universality, portability and accessibility as provided in the *Canada Health Act*;
- Continue to support the prohibition of two-tier medicine, extra billing and user fees in accordance with the *Canada Health Act*...

Long-term care homes occupy a significant position in the health care delivery framework in Ontario. The same stated commitments to public administration, comprehensiveness, universality, portability and accessibility that appear in the above-noted health care legislation should also apply in the context of long-term care home regulation.

**RECOMMENDATION:** In order to recognize that health care legislation impacting primarily on seniors is treated in the same way as general health care legislation, the LTCHA, 2006 should be amended to include a commitment to the promotion of the delivery of not-for-profit long-term care in Ontario.

## 26. Hearing concerning taking control of municipal or joint home

**26.1 ISSUE:** Section 135(3) provides that the Minister shall appoint a person who is not an employee of the Ministry to conduct a hearing if a municipality does not consent to the Director taking control of a municipal home or joint home (on specified grounds in subsection (1)). There is no requirement that the person conducting the hearing be a lawyer.

**COMMENT:** Clause (c) of subsection 135(4) requires the person conducting the hearing to report to the Minister concerning recommendations, findings of fact, and “conclusions of law arrived at” during the hearing. If the person conducting the hearing is required to set out conclusions of law, the person conducting the hearing should, at the least, be a trained lawyer.

**RECOMMENDATION:** Subsection 135(3) should be amended to indicate the minimum requirements for the person conducting the hearing, including that the person must be a trained lawyer.

## 27. Rules governing approvals

**27.1 ISSUE:** Clause 138(2)(b) provides that the Lieutenant Governor in Council may make regulations “providing additional or alternate rules governing approvals” under Part VIII. Regulations should not be used to create “alternate” rules.

**COMMENT:** While regulations are appropriately used to expand on or clarify requirements contained in legislation, it is inappropriate for regulations to create “alternate” rules that could oust the application of rules set out in the legislation to govern approvals.

**RECOMMENDATION:** The words “or alternate” should be deleted from clause 138(2)(b).



## 28. Inspectors and inspections

**28.1 ISSUE:** The language in sections 139 and 140 concerning the appointment of inspectors and the carrying out of inspections should be mandatory, not permissive.

**COMMENT:** As currently drafted, sections 139 and 140 contain the permissive language “may appoint inspectors” and “may conduct inspections” rather than the mandatory “shall appoint inspectors” and “shall conduct inspections”. This legislation stands and falls on a framework of inspections and compliance with the rules set out elsewhere in the legislation, regulations and policies. Therefore, these two sections must place a mandatory obligation on the government to appoint inspectors who will conduct inspections of long-term care homes.

**RECOMMENDATION:** The word “may” should be replaced with the word “shall” in sections 139 and 140.

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**28.2 ISSUE:** The legislation currently contains no specific provision for training of inspectors. Training for inspectors is a crucial element of the compliance, inspection and enforcement framework of this legislation.

**COMMENT:** While the legislation provides for the appointment of inspectors in section 139, there is no requirement that the inspectors be trained in the specific compliance issues that may emerge in the long-term care home sector. Further, while staff of homes and such other persons as may be covered in sections 74 and 75 are required to receive training – particularly in matters such as the Residents’ Bill of Rights, legislative and regulatory frameworks, and in certain cases matters such as dementia care, minimizing of restraints, and abuse prevention – there is no parallel requirement for inspectors to receive training.

In order for the compliance, inspection and enforcement framework of this legislation to be meaningful and comprehensive, inspectors must receive training on all matters relevant to their responsibilities. This includes, of course, information relating to their powers of inspection and the procedures they must follow, but must also include training relating to investigative techniques, residents’ rights, care and services, admissions, Residents’ and Family Councils, and the operation of homes. This training must be required in legislation.

**RECOMMENDATION:** A section should be added to Part XI, Compliance and Enforcement, providing for mandatory training for inspectors appointed under section 139.

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**28.3 ISSUE:** Subsection 141(2) is a regulation-making power to create “classes” of long-term care homes that may be exempted from the requirement of unannounced inspections at least annually. The power to exempt homes should be removed.

**COMMENT:** It is ACE’s position that all long-term care homes should be subject to the requirement of unannounced inspections at least annually. It is not in residents’ interests to exempt any home from this requirement. Allowing for the possibility of exempting long-term care homes, even those “recognized as having good records of compliance”, creates the very real possibility that violations of the LTCHA, 2006 and of residents’ rights will go unnoticed and unremedied.

There is an infinite number of variables in a long-term care home’s operation, including changes in personnel, changes in administration, changes in the population of residents, changes in resident behaviour, or any number of other situations that could range in significance from minor to crisis level. Exempting a long-term care home from the requirement of inspections under sections 141 and 142 could lead to an unacceptable risk to resident care and safety, even among long-term care homes “recognized as having good records of compliance”. Without the uniform application of this requirement, the compliance framework set out in the legislation is rendered ineffectual in protecting the rights of all long-term care residents in Ontario in a consistent manner.

It is certainly true that the annual inspections of long-term care homes “recognized as having good records of compliance” may take much less time than the inspections of other homes. This will be the case when long-term care homes are meeting the requirements of the legislation, regulations, and related policies. Regulations can be developed pursuant to s. 178(2)(r) of the LTCHA, 2006 to find methods to recognize homes with good records of compliance.

**RECOMMENDATION:** The LTCHA, 2006, should not allow for any long-term care homes to be exempted from the requirement of unannounced inspections at least once a year. At a minimum, all long-term care homes should be inspected at least once a year in order to ensure that the legislation’s consumer protection, compliance, inspection and enforcement framework is meaningful and effective for all residents of long-term care homes.

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**28.4 ISSUE:** Inspectors should be able to enter long-term care homes without a warrant in emergency situations.

**COMMENT:** Section 145 deals with warrants authorizing inspectors to enter premises and carry out their powers of inspection under section 144. Inspectors must have the ability to enter long-term care homes without a warrant in emergencies, including urgent issues of resident safety or care. Section 143 deals with the power of an inspector to “at any reasonable time enter a long-term care home” but is not explicit about the power to enter without a warrant at any time in an emergency.

Other legislation, such as the *Substitute Decisions Act, 1992*, provides for entry without a warrant in specific situations: see s. 82(2) and (8), where the Public Guardian and Trustee is permitted to enter certain premises under certain circumstances “without a warrant and at any time that is reasonable in the circumstances”.

**RECOMMENDATION:** The LTCHA, 2006 should be amended to provide for inspectors to enter a long-term care home, or place operated in connection with the home and providing services to it, “without a warrant and at any time that is reasonable in the circumstances”, in emergency situations and, in particular, when conducting inspections under s. 23(2).

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**28.5 ISSUE:** Section 146 of the LTCHA, 2006 governs the inspector preparing an inspection report after completing an inspection. However, the LTCHA, 2006 is silent on the timeline according to which an inspector must release his/her report following an inspection.

**COMMENT:** Some inspections will be conducted upon receipt of complaints, and others will be done in accordance with the annual inspection requirement under s. 141. Different timelines may apply in these different situations. However, it is crucial that the legislation prescribe timelines within which the reports must be delivered to appropriate parties. Where there is an allegation of serious harm or immediate threat to resident safety, this timeline must be very short.

**RECOMMENDATION:** Section 146 of the LTCHA, 2006, should be amended to provide that reports of inspections must be released to all appropriate parties within 30 days of the inspection, or forthwith if one or more resident is at risk of harm.

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**28.6 ISSUE:** Section 146(1) provides that inspectors shall prepare inspection reports and shall “give a copy of the report to the licensee and to the Residents’ Council and the Family Council, if any.” The failure to differentiate between two different types of inspection reports could result in breaches of residents’ privacy, or could inappropriately curtail public access to information about long-term care homes and their records of compliance.

**COMMENT:** There are two streams of inspections under this legislation. The “first stream” is Ministry-initiated inspections that may be based on the requirement for annual unannounced inspections pursuant to section 141, follow-up to those annual inspections, or examination of systemic issues at a particular home or chain of homes. The “second stream” is inspections conducted as a result of complaints under section 23.

ACE submits that reports of inspections from the “first stream” should be made public pursuant to subsection 146(1). This public reporting ensures accountability of homes, assists long-term care home applicants and their families in their selection of homes to which they wish to apply, and reassures the public that there is adherence to the compliance and enforcement framework of the legislation.

However, inspection reports from the “second stream” should not be made public. Rather, they should be provided only to the complainant(s) and/or resident(s) to which the complaint or inspection pertains (see our recommendation below under “Release of inspection report – copies to complainant”).

Residents’ privacy must be paramount in long-term care home operation as well as in the compliance and enforcement regime. Personal information, including about physical and mental health, finances, and family matters, must be treated with the utmost respect and, in particular, must be dealt with according to all applicable legislation.

Notwithstanding the regulation-making power set out in s. 178(2)(k) to limit the publication, posting or distribution of inspection reports for the purpose of protecting the privacy of a resident, the release of the “second stream” of inspection reports to Residents’ Councils and Family Councils and the posting of such reports pursuant to section 77 raise serious concerns about the protection of residents’ privacy. Even in larger long-term care homes, it is at least possible (indeed it is likely) that persons reading inspection reports would be able to identify residents whose situations are the subject of comment in the reports. Residents may be identified in the reports as having certain health care

requirements, personal care requirements, capacity concerns, family concerns, or security concerns. It is not appropriate for these concerns to be known by Residents' or Family Councils, and certainly not appropriate for inspectors to be the people providing the information to the Councils.

While ACE values the role of Residents' Councils and Family Councils in participating in and overseeing the communities of which they are a part, individual residents' privacy and security must be paramount. Despite efforts which may be taken to anonymize the information in the "second stream" of inspection reports, residents (and others named in the inspection reports) could still be identifiable from a description of their situation.

**RECOMMENDATION:** Subsection 146(1) should be amended to provide that reports of inspections triggered by complaints under section 23 of the legislation should not be disclosed to Residents' Councils or Family Councils. Further, reports of inspections must anonymize complainants to protect their identity, unless the complainant and/or the resident who is the subject of the complaint consents to the release of this information (if the resident is competent to consent to this release).

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**28.7 ISSUE:** The legislation as drafted does not include a requirement to provide a copy of the inspection report to a resident who made a complaint, to a person who made a complaint on behalf of a resident, or to a resident who was the subject of a complaint made on his or her behalf.

**COMMENT:** It is crucial that persons who make complaints which trigger inspections under section 23 (or persons making complaints on behalf of residents) be provided with a copy of any report created as a result of the inspection. Without a copy of the report, persons making complaints cannot be assured that their complaint was properly investigated and addressed by the inspector. Absent this essential communication with complainants, the compliance process is not transparent.

**RECOMMENDATION:** Section 146 of the LTCHA, 2006, should be amended to provide that reports of inspections following complaints under section 23 must be released to the complainant(s), the resident on behalf of whom the complaint was made, or their substitute decision-maker.

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**28.8 ISSUE:** While sections 160 and 161 contemplate reviews and appeals of orders made by inspectors against licensees, the legislation contains no provision for a review of an inspector's report created pursuant to section 146. The ability for the Director to review these reports is crucial.

**COMMENT:** In ACE's experience, inspection reports can be deficient. There is currently no recourse or route of review of either the process of an inspection or its outcomes and conclusions. These deficiencies may relate to the thoroughness of the investigation or of the report itself. There may also be deficiencies in the investigator's findings, namely that the conclusions reached in the report do not match or reflect the facts on which they are based.

The LTCHA, 2006 must provide an avenue by which a resident, or someone on behalf of a resident, can request that the Director review inspection reports. If the Director is of the view that the inspection either was not conducted properly, or that the inspector's conclusions are erroneous or baseless, the Director must have the ability to direct a re-inspection by a different inspector in accordance with such directions as the Director considers proper. A copy of the Director's decision must also be provided to the same parties as those who have the right to receive a copy of inspection reports.

**RECOMMENDATION:** A section should be added to the LTCHA, 2006 providing for the ability to request in writing that the Director review inspection reports, and that the Director may direct a re-inspection where necessary and appropriate. This section should provide that a copy of the Director's decision must be given to any party that had a right to receive the inspection report.

## 29. Participation on reviews and appeals of orders

**29.1 ISSUE:** Sections 160 and 161 govern reviews and appeals by licensees against whom an order has been made. Section 164 states that the parties to an appeal are the licensee and the Director. There is no avenue by which a resident, family member, resident group, employee or employee group can seek a review of an inspector's order, or participate in a review or appeal thereof.

Further, there is no provision for anyone other than the licensee and the Director to have party status, nor to make any form of submissions, when a licence may be revoked under s. 154.

**COMMENT:** Residents and their representatives should have the ability to review and/or appeal inspectors' orders. While the orders will be directed to licensees pursuant to sections 149 and 150, such orders will also have a direct or indirect impact on residents. Residents, Residents' Councils, and their representatives should have the ability to request the Director to review inspectors' orders and to make submissions thereon.

Further, under predecessor legislation, residents, resident groups, employees and employee groups were permitted to seek party status at a hearing regarding revoking or refusing to renew a licence. Residents (particularly those who have made complaints), resident groups, employees, and employee groups should have the opportunity to be heard at any review or appeal of an inspector's order. At the very least, the Board should have the discretion to grant status to the appropriate participants according to the dictates of the situation.

### **RECOMMENDATIONS:**

- a. Section 160 of the LTCHA, 2006, should be amended to provide that residents, Residents' Councils, and their representatives may request the Director to review inspectors' orders. Subsections 160(2) and (3) should govern the process for any party requesting the Director to review inspectors' orders.
- b. Section 164 of the LTCHA, 2006, should be amended to include a provision that residents, resident groups, employees and employee groups may seek party status on an appeal to the Appeal Board. Alternatively, section 164 of the LTCHA, 2006, should be amended to include a provision granting the Appeal Board discretion to allow party status to any person or group of persons at the hearing of a licensee's appeal.

- c. The language in subsections (5) and (6) of section 160 should be amended to ensure consistency regarding the Director's power to "confirm or *alter*" an order [ss. 160(5)] versus the Director's power to confirm or *amend* an order [ss. 160(6)].



### **30. Proposed amendment to the *Mental Health Act* concerning findings of incapacity to manage property**

**30.1 ISSUE:** Section 60(3) of the *Mental Health Act* should be amended to correct an inequity that presently exists between a finding of incapacity to manage property under that legislation, and a finding of incapacity to manage property by a capacity assessor under section 16 of the *Substitute Decisions Act*. This inequity is a problem for elderly persons and others being admitted to long-term care homes from psychiatric facilities.

**COMMENT:** Pursuant to the *Mental Health Act*, all psychiatric patients, except those with a guardian or attorney managing property, must be assessed upon admission to a psychiatric facility for capacity to make property decisions. If the patient is found mentally incapable of making property decisions after admission, their capacity to manage property must be reassessed before being discharged (see s. 57 of the *Mental Health Act*).

If the patient continues to be mentally incapable at the time of discharge, a “Notice of Continuance” is issued, which authorizes the statutory guardian or attorney to continue to manage the person’s property after the patient is discharged from hospital.

The patient must receive rights advice and may challenge the finding of incapacity by applying to the Consent and Capacity Board. However, in the case of the Notice of Continuance, this application must occur before the patient is discharged from hospital; otherwise, he or she loses the right to apply to the Board. The person then must wait six months before they can retain a capacity assessor, at their own cost, to reassess their capacity. Only then, if they are again found mentally incapable, can they apply to the Consent and Capacity Board to review the finding.

In contrast, under the *Substitute Decisions Act*, a person who is found mentally incapable may apply to the Consent and Capacity Board for a review at any time during the six months following the finding of incapacity by a capacity assessor.

This leads to an unfair situation for patients being discharged from a psychiatric facility, vis-à-vis all others who are found mentally incapable of managing property, as they may lose their right to apply to the Board on the same day as the finding, if the person is assessed and discharged on the same day.

This is especially an issue for the elderly and others who are being admitted to long-term care homes from psychiatric facilities, as these persons may be required to take a bed in the long-term care home immediately upon the offer of a bed being made. This leaves little time for the person to make the decision to apply to the Consent and Capacity Board, as they are preparing for their move to their new home, and often they do not make the decision to apply until after they are settled there. By that point, according to the *Mental Health Act* as it presently stands, it is too late.

It is our understanding from the Consent and Capacity Board that these cases are presently decided by way of orders for dismissals without hearings and rarely get to the hearing stage. In the case of *Re A.*, (2002 CanLII 6475 (ON C.C.B.) 2002-06-25 Docket: *TO-020721;TO-020722*), Michael Bay, then Chair of the Consent and Capacity Board, made the following comments regarding this issue of appeals to the Board regarding Notices of Continuance:

Under the *Mental Health Act*

The right to apply under the *Mental Health Act* flows from the following clause of Section 20.2 of the Act. The relevant portions of that section read as follows:

**60.** (1) A patient in respect of whom a certificate of incapacity or a notice of continuance has been issued may apply in the approved form to have the Board review the issue of his or her capacity to manage property.

...

(3) If an application is commenced under this section by a patient in respect of whom a notice of continuance has been issued, the application may continue to be dealt with by the Board even after the patient is discharged from the psychiatric facility.

It is clear from the above wording of sub-section 60(1) that the right to apply to the Board under this section is restricted to persons who are “patients” for the purposes of the Act. The term “patient” is defined in Section 1 of the Act as, “a person who is under observation, care and treatment in a psychiatric facility.” It is clear, therefore, that the right of application to the Board for a review of capacity to manage property under the *Mental Health Act* is only available to persons who are in-patients for the purpose of the Act. If there was any doubt as to the correctness of this interpretation, it is disposed of by subsection 60(3) since that subsection would be redundant were the meaning of “patient” for the purpose of the section to include individuals who were, but are not longer, in-patients.

**This analysis leads to the inevitable, but regrettable, conclusion that a patient who does not appeal his or her Notice of Continuance prior to discharge from a psychiatric facility may not do so until his or her capacity to manage property has been the subject of a further assessment sometime after being discharged from the facility. As unreasonable as this interpretation may seem, it is inevitable as the result of the clear language of the statutes. If this matter is to be rectified it will require action on the part of either the legislature or the court. [emphasis added]**

We respectfully draw your attention to the comments in bold, and submit that the *Mental Health Act* should be amended to allow those who have been found mentally incapable of managing property, and in respect of whom a Notice of Continuance has been issued, to apply to the Consent and Capacity Board for a review during the six months following the issuance of the Notice of Continuance.

**RECOMMENDATION:** Subsection 60(4) of the *Mental Health Act* should be amended as follows:

**(4) Patient discharged** – If a patient in respect of whom a notice of continuance has been issued is discharged from the psychiatric facility, the patient may apply for a review of that finding within the first six months after the notice of continuance is issued.