Submission to the Ministry of Health and Long-Term Care:

Part 2 of the Proposed Initial Draft Regulation made under the *Long Term Care Homes Act, 2007*

October 15, 2009

ADVOCACY CENTRE FOR THE ELDERLY

2 Carlton Street, Suite 701
Toronto, ON M5B 1J3
T: (416) 598-2656
www.acelaw.ca

Contact: Jane Meadus, Institutional Advocate
meadusj@lao.on.ca

INTRODUCTION

The Advocacy Centre for the Elderly (ACE) is a community legal clinic, funded by Legal Aid Ontario, to provide legal services to low income seniors on elder law issues. ACE has been in operation since 1984. A primary area of practice of ACE has been advocacy and representation of residents in the long-term care system. One of the lawyers at ACE is a full-time Institutional Advocate, who provides advice to seniors living in various forms of facilities in the health system, as well as people considering moving into such places and families of seniors who may become or are residents in long-term care homes, hospitals, and other group living environments. ACE not only represents and advises individual clients, but also engages in public legal education and law reform activities on long-term care and health institution issues. ACE has also produced a text in excess of 600 pages that is now in its third edition entitled *Long Term Care Facilities in Ontario: The Advocate's Manual*.

We would like to thank the Ministry of Health and Long-Term Care for allowing us to participate in the process under which the draft regulations were initially created. We believe that the consultations which have taken place over the past year with various stakeholders have proven invaluable in the creation of these regulations. Of critical importance was the Ministry's outreach to residents, family councils and staff working in the homes, whose input was critical. We would like to specifically commend Colleen Sonnenberg and her team for their hard work, listening to stakeholders and endeavouring to draft regulations which meet the needs of residents of long-term care homes.

GENERAL COMMENTS

The Ministry of Health and Long-Term Care has given the public one month to comment on Part 2 of the initial draft regulations pursuant to the *Long-Term Care Homes Act, 2007 (LTCHA* or the *Act)*. One of the difficulties with this process is that the regulations do not yet appear to be complete. We therefore request that the following provision be added:

> ***Part 1 and 2 of the draft regulations will be open to further amendments upon receipt of the final part of the draft regulations to ensure completeness and permit the public an opportunity to respond to the draft regulations in its entirety.***

We would also like to note that throughout most of our submission, we have provided suggestions as to what the amendments to the regulations should look like. In other instances, while we have indicated that a regulation is required, the contents and drafting are left to the Ministry to determine. These areas have been shaded in grey.

REGULATION-MAKING AUTHORITY

The *Long-Term Care Homes Act* leaves many issues to be explained in the regulations and allows the Lieutenant Governor in Council to make regulations in numerous areas. Our review of the statute revealed that several important topics were not addressed in either the first or second set of draft regulations.

Secure Units and Rights Advice

Some of the most important provisions in the *LTCHA* pertain to the new legal protections afforded to residents where admission or transfer to a secure unit is being proposed. Residents are now required to receive rights advice before being moved to a secure unit and the right to apply to the Consent and Capacity Board for a determination as to whether the substitute decision-maker has complied with their statutory duties. Without these rights, ACE believes that any detention is contrary to the *Charter of Rights and Freedoms.*

Despite explicit statutory authority to make regulations regarding secure units and rights advice (please refer to sections. 2(1), 32(4), 45(2), 183(2)(i)), the draft regulations fail to provide any meaningful guidance or details on these noteworthy issues.

> ***Draft sections pertaining to secure units and the provision of rights advice***

Residents' Bill of Rights

Section 3(4) of the *LTCHA* states that "the Lieutenant Governor in Council may make regulations governing how rights set out in the Residents' Bill of Rights shall be respected and promoted by the licensee". Unfortunately, besides the provisions referring to complaints and enforcement both sets of draft regulations are silent about "how" residents can enforce their rights.

ACE recently completed a research project for the Law Commission of Ontario about the law as it affects older adults, namely access to justice for older adults residing in congregate settings.[1] After conducting research and consulting with residents of long-term care homes and industry stakeholders, we concluded that while there are many legal protections in place for residents of long-term care homes (most of which are found outside the statute), there are no concrete enforcement mechanisms available to the resident in the *LTCHA*.

ACE was advised that many administrators and operators are supportive of the Bill of Rights but they express concerns about its interpretation in a collective environment where many residents living together. How are the rights of an individual to be

[1] A copy of our report, entitled *Congregate Living and the Law as it Affects Older Adults*, can be found at the website for both ACE (www.acelaw.ca) and the Law Commission of Ontario (http://www.lco-cdo.org/en/olderadultsresearchpapers.html).

interpreted in relation to the collective when individual actions may impact on the group and vice versa? Homes have a legal duty to respond to the care needs of all residents but are challenged to do so by funding and staff limitations. When complaints are made to homes about the lack of appropriate care, they are told that is "just the way things are," or that they do not receive enough funding to provide appropriate care.

Some of the rights involve a degree of subjectivity, such as the right to be treated with dignity and respect. Residents may interpret the rights in a manner different from staff as they are interpreting these rights through the lens of the long-term care home being their "home." Meanwhile, staff may have a different view as the long-term care home is their workplace. For instance, one of the rights of residents is to know who is providing them with care but it is not unusual for this request to be refused, especially where there is concern about the quality of care. Another manifestation of the subjectivity of the interpretation of the Bill of Rights is when residents encounter difficulties regarding their right to have visitors without interference. As noted earlier in this paper, homes will, on occasion, issue trespass notices against residents' visitors without lawful authority, usually because the visitor is considered to be too demanding or a "complainer." ACE lawyers have also frequently had difficulty meeting in private with residents or are questioned about the purpose of their visit by staff members.

Although meant to protect and create a culture within a long-term care home, many of the rights are challenging to enforce in practice. Thus, it is integral that the regulations provide guidance to residents to ensure that justice is actually done.

Draft sections pertaining to "how" residents and their substitute Decision-makers can meaningfully enforce the rights contained in the Residents' Bill of Rights

Office of the Long-Term Care Homes Resident and Family Adviser

According to section 37(c) of the *LTCHA*, "the Minister may establish an Office of the Long-Term Care Homes Resident and Family Adviser to perform any other functions provided for in the regulations or assigned by the Minister". We note that there is no reference to this Office in either set of draft regulations.

Even if the Ministry did establish this Office, ACE is of the opinion that the mandate of the Office is inadequate to assist residents. Further, the Office is not independent as it exists at the pleasure of the Minister, who could cease its operations if he or she felt threatened by the Office. Again, we refer you to our submission for the Law Commission of Ontario for further discussion on what we believe would be an adequate system.

Temporary and Casual Staff

Section 74 of the *LTCHA* says: "In order to provide a stable and consistent workforce and to improve continuity of care to residents, every licensee of a long-term care home

shall ensure that the use of temporary, casual or agency staff is limited in accordance with the regulations." Section 89(2)(i) then goes on to permits regulations to define temporary or casual: there are no limitations or definitions in the draft regulations. This is a significant oversight as it is important to ensure the highest quality of care for residents.

Draft definitions of "temporary" and "casual" staff

PART I – INTERPRETATION

Section 1 – Definitions

Section 1 of both the first and second set of draft regulations includes an identical definition for a dietitian. However, the first set of regulations uses the phrase "registered dietitian" while the second set uses the word "dietitian". Both regulations should use the same language in order to be consistent.

Ensure consistency in the regulations by using the same title for persons currently referred to as "dietitians" and "registered dietitians"

PART II – RESIDENTS: RIGHTS, CARE AND SERVICES

PLAN OF CARE

Section 4 - Changes in plan of care, regulated document

This section will need to be amended per our comments on section 128 below.

SAFE AND SECURE HOMES

Section 5 – Doors in a home

The issue of door safety is one which has arisen in a number of coroner's inquests and reviews. It is important that the door alarm be sufficiently loud and distinctive to alert staff that a door is being opened in order to be able to prioritize response times to an alarm. For example, in a case which was reviewed in the *Fourteenth Annual Report of the Geriatric and Long Term Care Committee to the Chief Coroner for the Province of Ontario*, a gentleman in a long-term care home maneuvered his wheelchair through a fire door into a stairwell and died. The evidence to the Committee was that "this fire exit

had an alarm that sounded when the door was opened but stopped as soon as the door closed. None of the staff on duty heard the alarm…"[2]

We therefore recommend that section 5.1.iii be amended so that the door alarms are identifiable as such, as follows:

> ***Every licensee of a long-term care home shall ensure that the following rules are complied with:***
>
> ***(a) All doors leading to stairways and the outside of the home must be,***
>
> ***iii. equipped with an audible door alarm that,***
>
> ***A. is connected to the resident-staff communication and response system;***
> ***B. allows calls to be cancelled only at the point of activation; and***
> ***C. the sound of the alarm be separate and distinct from other types of alarms and easily identifiable as such.***

Section 9 – Bed-rails

Bed-rails constitute a form of restraint and therefore should be used sparingly. We have seen many injuries attributable to bedrails. Between January 1, 1985 and January 1, 2008, the US Food and Drug Administration received 722 reports of incidents where patients were caught, trapped, entangled or strangled in hospital beds, resulting in 460 deaths.[3] Today, there are many alternatives to bed-rails, including, to name a few, low beds, floor pads, and monitoring systems. It is therefore important that the use of bed rails only occur when absolutely necessary and with informed consent from either the resident on their substitute decision-maker. These requirements are absolutely essential, as it is often the substitute decision-maker who requests the use of bed-rails, believing them to be safe, without understanding the true ramifications.

ACE also supports the recommendations made by the Psychiatric Patient Advocate Office in its submissions to the Ministry with respect to section 9 of the draft regulation.[4]

We therefore recommend that the following amendments be made to section 9:

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[2] March 2004 at page 78.
[3] *A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts*, http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/MedicalToolsandSupplies/HospitalBeds/ucm123676.htm.
[4] Letter to Colleen Sonnenberg, Ministry of Health and Long-Term Care from Vahe Keyayan, Psychiatric Patient Advocate Office, *Part 2 of the Draft Regulations to the Long-Term Care Homes Act, 2007* (October 15, 2009).

(1) Every licensee of a long-term care home shall ensure that where bed-rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with appropriate evidence-based practices to minimize risk to the resident;
(b) all alternatives to bed-rails have been considered;
(c) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment;
(d) other safety issues related to the use of bed-rails are addressed, including height and latch reliability;
(e) that informed consent is obtained from either the patient or their substitute decision-maker, including advising them of all of the risks, benefits and alternatives to the use of bed-rails; and
(f) there are adequate safeguards respecting such issues as monitoring intervals, the review of bed-rail use for individual residents, least restraint policies, annual reporting requirements and annual training for staff.

Section 14 – Cooling Requirements

This section is silent regarding when designated cooling areas should be utilized. We receive many complaints in the summer months about the heat in rooms which are not air conditioned.

While we do not have the expertise to specify the temperature at which cooling areas should be utilized, we believe that the regulations should be amended to specify, as follows:

14(2) The licensee shall ensure that,

(c) Residents must be taken to the cooling area when the temperature/humidex reaches xxxx, unless medically impossible.
(d) Where for medical reasons, the resident cannot be taken to a cooling area, the resident must be kept cool by means of portable air, conditioning, fans, sponge baths, etc.

GENERAL REQUIREMENTS - ORGANIZED PROGRAMS

Section 17 – General Requirements

We believe it is imperative that these programs be reviewed by the Ministry of Health and Long-Term Care on at least an annual basis. We therefore recommend that the following be added:

17. Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act:

4. The Ministry of Health and Long-Term Care shall review the program descriptions and annual evaluations at minimum on an annual basis, and more frequently where necessary.

NURSING AND PERSONAL SUPPORT SERVICES

In general, we fond that sections 18 through 34 were vague as to how it would be determined by the Ministry of Health and Long-Term Care whether or not the services were sufficient to meet the needs of residents. While there are required programs and plans, the actual criteria to measure whether or not the residents' were being cared for appropriately are unclear.

Sections 18-34 should be amended to include more specific requirements based upon outcome requirements to ensure that residents' needs are being met

Section 18(3)(a)

This section is not strong enough in its requirements for nursing levels. The staffing level should not merely be "consistent" with needs, it must meet those needs. We therefore recommend the following:

(3) The staffing plan must

(a) provide for a staffing mix that is able to meet the resident's assessed care and safety needs;

Section 18(3)(d)

It is unclear how this section would be enforced. There is no timeframe or standards to be met. The section should be amended to clarify the expectations. For example:

(d) be evaluated, in writing, at least quarterly or when otherwise necessary, to identify changes, if any, required to improve the plan, to ensure that residents care and safety needs continue to be met.

Provision of Care Services

At present, the standards in the Long-*Term Care Homes Program Manual (Program Manual)* require that care services be provided in accordance with the person's assessed needs and mutually determined goals.[5] ACE recommends that a new section be added to the regulations to read as follows:

> ***Every licensee of a long-term care home shall ensure care and services are provided according to each resident's assessed needs and mutually determined goals as identified in his/her individual plan of care.***

Section 20 – Bathing

The section requires that a resident have two baths per week. There are some residents who would not be amenable to two baths per week and this section should not be used to force residents to bathe. We recommend that the section be amended as follows:

> ***(1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless refused by the resident or contraindicated by a medical condition.***

Section 21 – Oral Care

Dentures are required in this section either when the resident requests them or during meals. There are many residents who would be unable to request the use of dentures but whose previous lifestyle was such that they would never have wanted to be seen without dentures. The section should be amended as follows:

> ***(2) The licensee shall ensure that each resident receives assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the care plan, unless the resident refuses.***

Section 22 – Foot Care

The regulations should be explicit about what foot care is required to be provided by the long-term care home and that it is to be provided without cost to the resident. We have dealt with many cases where basic foot care is not provided unless purchased from a chiropodist or other foot care specialist. As well, we believe that a section should be added regarding regular nail care, as this is another area which is often not provided

[5] Ministry of Health and Long-Term Care, *Long-Term Care Homes Program Manual*, "Provision of Care and Services," 0903-01, page 2.

unless additional services are paid for by the resident. Nail care is presently a standard in the *Program Manual*.[6] We therefore recommend the following be added:

> ***22. Every licensee of a long-term care home shall ensure that each resident of the home receives preventative and basic foot care at no additional cost to ensure comfort and prevent infection. The foot care should include at a minimum the following:***
>
> ***(a) Every licensee of a long-term care home shall ensure that each resident of the shall have their fingernails and toenails shall be cleaned and trimmed in accordance with his or her stated preferences and documented on the resident's plan of care.***

Section 23 – Transferring and positioning techniques

Another area in which we receive complaints is lift use. Lifts are often not used when required, or, if they are used, they are not employed properly or without sufficient staff. This section of the draft regulation needs to clarify that lifts must be used when identified. We recommend that the section be amended as follows:

> ***Every licensee of a long-term care home shall ensure:***
>
> ***(a) that staff use safe transferring and positioning techniques when assisting residents and that the resident has his or her weight bearing capability, endurance and range of motion maintained or improved whenever possible; and***
> ***(b) that lifts are used for every transfer and change in position when identified as being required in the care plan.***

Section 25 – Mobility devices

This section requires that a home provide mobility devices to residents who require them on a short-term basis. It is not clear what will occur if the resident requires mobility devices for long-term use but cannot afford them. For example, while the Assistive Devices Program will pay for 75% of a wheelchair in many cases, the person may not qualify or not be able to pay the remaining 25% (especially if it is an expensive device and they are only in receipt of the comfort allowance). We therefore recommend that the following amendment be made:

> ***(a) Every licensee of a long-term care home shall ensure that mobility devices are available to all times without charge to residents who require them on a short-term basis.***
> ***(b) Where a resident requires a mobility device, the licensee shall assist the resident in obtaining the device.***

[6] *Long-Term Care Homes Program Manual,* 0903-01, page 2, 3B.38.

(c) Where a resident is unable to purchase a mobility device, the licensee shall make the mobility device available to them until such time as the resident is able to obtain the device.

Section 28 – End-of-life care

This section requires end-of-life care to be provided in a "holistic" manner without defining same. There is also no requirement to meet religious or cultural requirements. The section should be amended as follows:

(1) Every licensee of a long-term care home shall ensure that that every resident receives end-of-life care in a holistic manner when required.

(2) Holistic is defined as ….

(3) The licensee shall ensure that it provides the support and resources necessary to meet the religious and cultural requirements of the resident, both before and after death; and

(4) The licensee shall ensure that the end-of-life care responds to the immediate needs of other residents, family members and staff following the death of a resident.

Section 29 – Notification re personal belongings, etc.

This section assumes that individuals either have family members or a substitute decision-maker to assist them in ensuring that they have personal belongings and that these items are repaired. Some competent residents do not have family and, therefore, no substitute decision-maker to assist them. In those cases, the home should be required to assist them in making arrangements. The following section should be added:

(3) Where the resident requests, the home shall provide assistance to the resident in arranging to obtain or repair personal aids or equipment, or in obtaining personal belongings.

Section 30 – Communication methods

There are many residents who do not speak English and who reside in homes where the primary mode of communication is English. This section should be amended to include a requirement that the home must also include communication in the language of the person's choice, especially with respect to obtaining consents. We recommend that the regulation amended as follows:

Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication skills, verbalization skills, or who do not communicate in the dominant language of the home.

Section 31 – Availability of supplies

In ACE's experience, if there is not a specific requirement for homes to provide items, some homes will not do so. At the present time, the guidelines in the *Program Manual* contain specific requirements as to what must be provided.[7] As the *Program Manual* will no longer exist after the implementation of the regulations, these requirements must be incorporated into the regulations. We recommend the following:

Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available as required to meet the nursing and personal care needs of residents, which must include, but are not limited to the following:

- ***Medical supplies and nursing equipment necessary for the care of residents, including the prevention or care of skin disorders, continence care, infection control, and sterile procedures.***
- ***Medical devices, such as catheters and colostomy and ileostomy devices.***
- ***Supplies and equipment for personal hygiene and grooming, including skin care lotions and powders, shampoos, soap, deodorant, toothpaste, toothbrushes, denture cups and cleansers, toilet tissue, facial tissue, hair brushes, combs, razors/shavers, shaving cream, feminine hygiene products.***

Section 32 – 24-hour nursing care – exceptions

This section allows smaller homes to utilize contract or agency nurses to fulfill the requirement that there be a registered nurse at the home at all times. This is in direct contravention of section 74 of the *Act* which limits the use of regulations.

The reason that the use of agency staff has been limited in the *Act* is to ensure continuity of care and knowledgeable staff who are able to meet the residents' needs. Residents of smaller homes are no less vulnerable to these issues, nor are they deserving of lower standards. We therefore recommend that section 32 be deleted:

Delete entire section.

[7] *Long-Term Care Homes Program Manual*, 0902-01, page 13, A2.9. Only part of the list has been included as the rest of the items are dealt with in other places in the regulations.

Section 34 – Qualifications of personal support workers

Personal support workers are not defined in the legislation or the regulations. We believe that there should be more than training requirements but a specific definition indicating the parameters of their duties. At the present time, there are no standards established by any of the three groups noted which meet the legislative requirements as drafted.

We believe that there should be only one standard for a personal support worker program which should be established by the Ministry of Training, Colleges and Universities. This will lead to consistency and government control over the industry, which is extremely important given that this is an unregulated profession that provides the bulk of care in long-term care homes.

We are also concerned about the ramifications of this section with respect to homes which may close down or be bought and replaced by new entities. While we fully support the requirement that personal support workers be appropriately trained, we can also see that there might be problems if a home closes due to redevelopment and is replaced by another. If the personal support workers in the closing home had worked there for years and did not meet the requirements as set out in the *Act*, would this mean that they would all have to retrain? This may have implications on the new home/owner's ability to staff their facility. There must be a way for "replacement" homes to staff using existing home's staffing without too much difficulty. We recommend that an exception be made but we leave it to the Ministry to determine exactly what that exception would be.

We recommend that the section be amended as follows:

(1) Every licensee of a long-term care home shall ensure that every person hired as a personal support worker after March 31, 2011 has successfully completed a personal support worker program that meets the requirements in subsection (2).

(2) The personal support worker program,

(a) must meet the vocational standards established by the Ministry of Training, Colleges and Universities, and
(b) must be a minimum of 600 hours in duration, counting both class time and practical experience time.

(3) Despite subsection (1), a licensee may hire as a personal support worker,

(a) a registered nurse or registered practical nurse;

(b) a student who is enrolled in an educational program for registered nurses or registered practical nurses and who is hired on a seasonal basis; or

(c) a person enrolled in a program described in subsection (2) and who is completing the practical experience requirements of the program, but such a person must work under the supervision of a member of the registered nursing staff and an instructor from the program.

Exception

(4) Where ownership of a long-term care home changes, or where a long-term care home is closed due to redevelopment and replaced by another home, ….

RESTORATIVE CARE

In general, we found that sections 35-42 were vague as to how the Ministry of Health and Long-Term Care would determine whether or not the services were sufficient to meet the needs of residents. While there are required programs and plans, the actual criteria to measure whether or not the residents' were being cared for appropriately is unclear. Therefore, we recommend the following:

Sections 35-42 be amended to include more specific requirements based upon outcome requirements to ensure that residents' needs are being met.

Section 35 - Restorative Care

The section needs to be amended to include a definition of what is meant by "restorative care".

Define "restorative care.

Section 37 – Therapy services

The section does indicate that the services have to **meet** the needs of the residents. Thus, we recommend the following changes:

Every licensee of a long-term care home shall ensure that there are therapy services for the home that include,

(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting to meet residents' assessed care needs;

(b) occupational therapy and speech-language therapy; and
(c) other therapies.

RECREATIONAL AND SOCIAL ACTIVITIES

In general, we found that sections 43-45 were vague as to how the Ministry of Health and Long-Term Care would determine whether or not the services were sufficient to meet the needs of residents. While there are required programs and plans, the actual criteria to measure whether or not the residents' were being cared for appropriately is unclear. Therefore, we recommend the following:

Sections 43-45 be amended to include more specific requirements based upon outcome requirements to ensure that residents' needs are being met.

Section 43 – Recreational and Social Activities Program

Certain key elements found in the *Program Manual* have not been included in the regulations.[8] We recommend that the section be amended as follows:

(1) This section applies to the organized recreational and social activities program for the home required under subsection 10(1) of the Act.

(2) Every licensee of a long-term care home shall ensure that the program includes,

(a) the provision of supplies and appropriate equipment for the program without charge to the residents;
(b) the development of the program with input from residents/ representatives;
(c) implementation and communication to all residents and families of a schedule of recreation and activity programs that are offered during days, evenings and weekends;
(d) a range of indoor and outdoor recreation, leisure, outings and social activities that are of a frequency and type to benefit all residents of the home;
(e) opportunities for resident and family input into the development and scheduling of recreation programs and activities;
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently; and

[8] *Long-Term Care Homes Program Manual*, 1003-01, page 1, E1.

(g) ***opportunities and assistance to participate in social and community programs, which are compatible with their interests and abilities, both within the facility and in the community***.

NUTRITION CARE AND HYDRATION PROGRAMS

Section 49 – Menu

The section should be amended to add that menus should be developed in consultation with residents, in addition to the requirement that menus be approved by the Resident's Council.[9] All residents, not just those who choose to participate in the Resident's Council, should have the opportunity to participate in menu development. We recommend changes as follows:

(1) Every licensee of a long-term care home shall ensure that all menu cycles,

(a) are developed in consultation with the residents;
(b) are a minimum of three weeks in duration;
(c) include menus for regular, therapeutic and texture modified diets;
(d) include alternate food and beverage choices and snacks;
(e) are approved by a dietitian for the home;
(f) are approved by the Resident's Council for the home, along with times of meal and snack services; and
(g) are reviewed and updated at least annually.

Section 51 – Dining Services

Receiving appropriate meals suitable for a resident's individual needs is a constant issue. We receive many complaints about residents who are to be on a minced diet being fed sandwiches, diabetic residents receiving regular meals, and so forth. It is therefore important that the requirements ensure that residents receive the meal specified by their meal plan. There are also often issues with respect to pureed foods, where the meals are mixed together inappropriately (i.e., all the main course is mixed together, or the desert and main course are mixed together). It must be made clear that each food item should be fed separately unless the care plan specifies otherwise. We recommend the following be added to section 51(2):

(c) when a resident is being fed, that each part of the meal be fed to the resident separately unless otherwise specified in the plan of care or requested by the resident; and
(d) the resident receive the meal as set out in the plan of care.

[9] *Long-Term Care Homes Program Manual*, 1014-01, page 1, P1.1.

ATTENDING PHYSICIANS AND RNs (EC)

Certification of Physicians and RNs (EC)

There is no requirement that the home ensure that the physician or registered nurse in the extended class is a member of the appropriate college. We recommend that an additional section be added similar to section 33 of these regulations and the *Program Manual*.[10] We recommend the following section be added:

> ***Every licensee of a long-term care home shall ensure that:***
>
> ***(a) every member of the of the medical staff of the home has a current certificate of registration with the College of Physicians and Surgeons of Ontario and***
> ***(b) the RN(EC) holds a current certificate of registration in the Extended Class with the College of Nurses of Ontario.***

Section 58 – Attending physician or RN (EC)

It must be made clear that not only is the attending physician/RN(EC) to provide services but that they also must meet the assessed needs of the resident. We therefore recommend that the following amendment be made:

> ***(1) Every licensee of a long-term care home shall ensure that either a physician or a registered nurse in the extended class,***
>
> ***(a) conducts a physical examination of each resident upon admission and an annual physical examination annually thereafter, and produces a written report of the findings of the examination;***
> ***(b) attends regularly at the home to provide services required to meet the assessed needs of the residents;***

One of the ongoing problems in long-term care is the ability of a resident to retain their own physician. Most homes require that the physician not only agree to provide care to the resident, but that they provide care on 24-hour, 7 days a week basis. No physicians will agree to such a requirement, making a resident's ability to retain a physician theoretical only. The draft regulation indicates that the physician must "participate" in the after hour and on-call coverage of the home. This section should be redrafted to encourage physicians in the community to provide care in the home without being discouraged by the after-hours coverage. This would alleviate pressure on the system given the shortage of physicians who are willing to enter into agreements to provide care in long-term care homes. We recommend the following change:

[10] *Long-Term Care Homes Program Manual*, 1012-01, pages 2-3, N1.1 and N1.9.

(c) participates in the provision of after-hours coverage and on-call coverage.

The present *Program Manual* contains criteria for attending physicians with respect to providing care in long-term care homes. The poor provision of care or failing to provide necessary care is a common complaint against physicians in homes. We believe there must be standards set to ensure that physicians are aware of their roles in long-term care and ask that the criteria set out in the *Program Manual* be added back into the regulations.[11] Thus, the following additions should be made to the regulations:

Attending physicians shall assess, plan, implement and evaluate their residents' medical care and participate in the interdisciplinary approach to care.

Attending physicians shall document on the resident health record on each visit, to maintain continuity and ongoing evaluation.

RELIGIOUS AND SPIRITUAL PRACTICES

Section 62 – Religious and spiritual practices

The *Long-Term Care Homes Program Manual* contains added criteria regarding religious and spiritual practices which we believe should be added into the regulation as follows:[12]

Efforts shall be made to arrange for spiritual counseling and one-to-one visitation, according to the resident's wishes.

Mechanisms shall be in place to support and facilitate residents' participation in the facility's spiritual and/or religious programs.

Arrangements shall be made to facilitate spiritual and religious care for the hearing and visually impaired, where resources are available.

ACCOMMODATION SERVICES

Accommodation services programs

The regulations need to spell out that if a service is contracted out to a third party, the home is responsible for ensuring that the third party complies with the Act as required:

[11] *Long-Term Care Homes Program Manual,* 1012-01, N1.14 and N1.15.
[12] *Long-Term Care Homes Program Manual*, 1005-01, page 1, G1.3-5.

(2) Where services under any of the programs are provided by a contractor who is not an employee of the licensee, the licensee shall ensure that there is in place a written agreement with the service provider that sets out the service expectations, including compliance with the Act and its regulations as appropriate.

Section 64 – Housekeeping

This section does not include cleaning personal items as was required in the *Program Manual*.[13] We therefore recommend the following amendment:

(a) cleaning of the home including,

(i) resident bedrooms including floors, carpets, furnishings, privacy curtains and screens and wall surfaces;
(ii) resident personal furnishings and mementos; and
(iii) common areas and staff areas including floors, carpets, furnishings and wall surfaces;

While section 64 clearly states that cleaning equipment and supplies be available, it remains silent about the storage of same in residential areas. We recommend that the section be amended as follows:

(3) The licensee shall ensure that a sufficient supply of housekeeping equipment and cleaning supplies is readily available to all staff at all times.

(4) When the housekeeping equipment and cleaning supplies are stored in a housekeeping cart, the cart shall be equipped with a locked compartment for storage of hazardous substances and be locked at all times when not attended.

Section 66 – Laundry services

It must be made clear that laundry services are to be provided to the resident at no additional charge. This is often misunderstood or mis-communicated, resulting in the purchase of unnecessary services by the resident. We recommend that section 66 be amended as follows:

(f) these services are provided at no additional charge to the resident.

[13] *Long-Term Care Homes Program Manual*, 1013-01, page 6, 03.3.

Section 67 – Maintenance services

The requirement for 24-hour emergency coverage has not been included in the regulation.[14] We recommend that the following be added to the requirements of this section:

> ***Maintenance services shall provide 24-hour emergency coverage***

REPORTING AND COMPLAINTS

Section 72 – Dealing with complaints

The legislation sets out a procedure for dealing with complaints. We believe that the written record required under section 72(3)(c) should also be submitted to the Ministry of Health and Long-Term Care for assessment, review and action where necessary. We therefore recommend the following be added:

> ***(3) The licensee shall ensure that,***
>
> ***(a) the documented record is reviewed and analyzed for trends at least quarterly;***
> ***(b) the results of the review and analysis are taken into account in determining what improvements are required in the home;***
> ***(c) a written record is kept of each review and of the improvements made in response; and***
> ***(d) a copy of the written record is submitted to the Director upon completion.***

Section 77 – Reports re critical incidents

An issue which often arises is the resident who is injured but who may not, for a variety of reasons, be taken to the hospital, but is instead treated at the home. This information should be submitted to the Ministry. We also submit that all medication incidents or adverse drug reactions should be reported.

Therefore, we recommend that section 77(3) be amended as follows:

> ***(3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):***

[14] *Long-Term Care Homes Program Manual*, 1013-01, page 4, 02.2.

1. ***A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition.***
2. ***An environmental hazard, including a breakdown or failure of the security system or a breakdown of major equipment or a system in the home that affects the provision of care or safety, security or well-being of residents for a period greater than six hours.***
3. ***A missing or unaccounted for controlled substance.***
4. ***An injury in respect of which a person is taken to hospital or receives treatment at the home.***
5. ***Any medication incident or adverse drug reaction.***

Reporting to Authorities

ACE has found that homes dealing with serious issues often want to handle them "internally" rather than contact the appropriate authorities. Often, this involves a failure to call the police respecting incidents of, for instance, physical or sexual assault or theft. We believe that the regulations must mandate such reporting, otherwise homes will not do so. We believe that "Reporting of Unusual Occurrences" section in the *Program Manual* can be used as a guide for such reporting.[15] However, it must be transformed into a requirement instead of a list of reports to the Ministry, as follows:

(a) Police for occurrences of:

- ***abuse and/or assault involving a resident, including willful direct infliction of physical pain or injury, as well as sexual assault***
- ***alleged fraud, theft***
- ***bomb threats, evacuations***
- ***missing person, according to the home's own disaster/search plan definition of when a person is "missing"***
- ***unusual/accidental death including suicide***
- ***missing/misappropriated drugs***

b) Fire Department for occurrences of:

- ***fire emergency within the facility requiring partial evacuation of an area or disruption of service***

c) Medical Officer of Health for occurrences of:

- ***infectious disease at the outbreak level***
- ***communicable diseases as per Health Protection and Promotion Act***
- ***problems with drinking water supply (i.e., contamination) residents at risk***

[15] *Long-Term Care Homes Program Manual*, 0806-01, page 2.

(d) Health Canada for occurrences of:

- ***adverse effects of medication***
- ***medical device malfunctions***

ABSENCES

Sections 79-82 – Absences

While the majority of the regulations about absences are contained within the above-notes sections, section 26 of the first set of draft regulations also refers to absences. For ease of reference, we believe all of the sections about absences should be consolidated.

> ***Transfer section 26 from the first draft regulation to the section in the second draft regulation pertaining to absences***

Section 79 – Absent Residents

This section is silent as to how long records respecting absences are to be kept. We recommend that records be kept for a minimum of two years, as per section 47.4 of the current regulations to the *Nursing Homes Act*, as follows:

> ***The licensee shall ensure that each medical absence, psychiatric absence, casual absence and vacation absence of a resident of the home is recorded and that the record is kept for a period of at least two years after the date the absence begins.***

DISCHARGE

Section 84 – When licensee may discharge

We recommend that section 84(3)(c) include an obligation for the licensee to take steps to locate the resident, as is now required in section 48(2)(d) of the regulations to the *Nursing Homes Act*, as follows:

> ***The resident is absent from the home for a period exceeding seven days and has not informed the administrator of the home of his or her whereabouts, and the administrator has taken reasonable steps to locate the resident but has not been able to do so.***

Section 85 – When licensee shall discharge

Section 85(3) is discriminatory as it treats those with psychiatric illnesses differently from residents who have medical issues. A short-stay resident is entitled to be on a medical absence for 14 days, although they must be discharged if they are on a psychiatric absence. We recommend that the section be amended as follows:

> ***(3) A licensee shall discharge a short-stay resident if,***
>
> **(a)** ***the resident is on a medical or psychiatric absence that exceeds 14 days; or***
> **(b)** ***the resident is on a vacation absence.***

Section 86 – Requirements on licensee before discharging a resident

This section must be amended to ensure that consent is obtained and the person is discharged to a safe place. We often see residents being discharged for inappropriate reasons and by inappropriate methods, such as being "discharged" to hospital on a Form 1 or being refused re-entry to a home after completing a psychiatric or medical absence despite being cleared for return by the medical team at the hospital within the required timeframe. It is important to clarify that a person cannot be admitted to an alternate setting without legal consent and that the alternate setting must be both willing and able to accept the person, as well as being a safe and appropriate place for the person to have their needs met. The section indicates that the resident and substitute decision-maker are to be "kept informed" and "given an opportunity to participate in discharge planning". This does not go far enough. The home must get consent and have the participation of the person before a discharge can be completed.

Alternatively, there must be a an appeal mechanism if a person is being discharged without their consent or that of their substitute decision-maker, which would allow a neutral third party, such as the Health Services Appeal and Review Board, to determine if the person's needs can be met in that long-term care home.

We therefore recommend the following be included in amendments to this section:

> ***That the resident not be discharged without obtaining informed consent from the resident or their substitute decision-maker;***
>
> ***That the resident cannot be admitted to another type of accommodation without obtaining informed consent from the resident or their substitute decision-maker;***
>
> ***That the alternate accommodation be one which is safe and appropriate, and which can provide the health care that the resident requires with no cost to the resident;***

In the alternative:

Where a resident is being discharged against his or her wishes or that of their substitute decision-maker, that they have a right of appeal to the Health Services Appeal and Review Board in the same manner as would be available after a finding of ineligibility pursuant to section 43(8) of the Long Term Care Homes Act.

PART III – ADMISSION OF RESIDENTS

INTERIM BED SHORT-STAY PROGRAM

Sections 91 through 100 of the draft regulations permit certain individuals to apply to an interim bed in a short-stay program in a long-term care home while awaiting placement as a long-stay resident in a long-term care home. The intent of these sections appears to be to move "alternate level of care" or "ALC" patients out of hospital pending placement in long-term care. While the applicant or their substitute decision-maker must consent to admission to one of these interim beds, it does not explicitly state that someone can refuse such a bed, nor is there incentive for someone to choose an interim bed in a home that is not one of their five choices. There does not appear to be a time limit as to how long a person can participate in the interim bed short-stay program.

An increasingly large number of older persons or their substitute decision-makers contact ACE with respect to first available bed policies. Essentially, these policies attempt to force hospital patients or their substitute decision-makers to accept placement at a long-term care home they would not have chosen had it not been forced upon them, contrary to the *Health Care Consent Act* and the long-term care legislation. We do not believe such policies comply with the current legislation.[16]

ACE is concerned that applicants and their families will be pressured to accept interim beds to help hospitals deal with bed shortage issues and hospitals will develop similar first available bed policies for interim beds.

Section 91 – Criteria for eligibility, interim bed short-stay program

Section 91 of the second set of regulations refers to the criteria for eligibility under section 30 of the first draft regulation. Section 30(1)(e) states that an applicant can only be found eligible for admission if their care requirements can be met in a long-term care home. However, there is no definition or explanation as to what this means in the draft regulations or the legislation. The lack of clarity causes difficulties, as applicants whose needs are too complex or who require additional care are often either admitted to

[16] ACE has written two papers entitled *Ethical Issues Paper Respecting First Available Beds* and *Discharge to a LTC Home from Hospital* that explains these issues in detail. These documents are available on our website at www.acelaw.ca.

homes when they should not be, or they are made eligible and are subsequently unable to find a home which will admit them. In such situations, we believe the Ministry of Health and Long-Term Care must make a decision regarding the use of High Intensity Needs Funds (for preferred accommodation, for example), prior to admission so that the additional funding and resources can be considered, in addition to the applicant's individual circumstances.

Please refer to ACE's recommended changes to section 30 in our "Submission to the Ministry of Health and Long-Term Care: Proposed Initial Draft Regulation made under the Long-Term Care Homes Act, 2007"

Section 95 – Ranking on waiting list, interim beds

If individuals choose to participate in the interim bed short-stay program, it should be recognized that they are agreeing to temporarily move into a home that they would not have otherwise chosen. Accordingly, ACE recommends that they be moved to a higher level of priority on the waiting lists for the long-stay program.

An additional category should be added immediately after crisis admissions to for those who have agreed to go to an interim or lower choice home from hospital.

Section 96 – Authorization of admission, interim beds

The regulations have never been clear as to how long a person may take to make their decision regarding accepting an offer of admission and how long they have to move in to the home after accepting the offer before being charged. We recommend that applicants have 24-hours to accept or reject an offer, as well as 24-hours from the time they accept an offer to move into the home before payment is required.

Please refer to ACE's recommended changes to section 59 in our "Submission to the Ministry of Health and Long-Term Care: Proposed Initial Draft Regulation made under the Long-Term Care Homes Act, 2007"

Section 97 – Removal from waiting list, interim beds

Exceptions should be made to the general rule that persons be removed from the waiting list if they refuse to consent to admission to a short-stay in an interim bed. Situations may arise where the person arrives at the home and turns down the room due to problems with the room for justifiable reasons. For example, in the context of long-stay beds, ACE had an anxiety ridden client who arrived at a home to discover that her roommate was a very demented woman who continuously screamed. She refused to have this roommate and was taken off of the list for 24 weeks at which time she had to reapply and went to the bottom of all of her lists. In another case, a client refused to

stay at a home after learning that the previous resident had repeatedly urinated on the floor and despite attempts to clean the room, it still smelled of urine. Finally, offers have been turned down because persons were misinformed about the homes or their choices. We know of people who are told to put a home on their list and then go to see it later. Admission is offered almost immediately, before the person is able to visit, and when they see the home they are unhappy and refuse to go. As there are many extenuating circumstances to this rigid rule, the Director should be able to make exceptions where necessary.

Please refer to ACE's recommended changes to section 42 in our "Submission to the Ministry of Health and Long-Term Care: Proposed Initial Draft Regulation made under the Long-Term Care Homes Act, 2007"

SPECIALIZED UNITS

Section 101 – Specialized Units

This section requires the Local Health Integration Network (LHIN) to designate specialized units in long-term care homes. We submit that the Community Care Access Centres have expertise in the type of care which is required in their area and, as such, should be involved in this process. We therefore submit that the following subsection be added:

The local health integration network shall:

(i) consult with the Community Care Access Centre for that geographic area to determine the needs of the community with respect to specialized units,
(ii) consult with the Community Care Access Centre for the geographic area where a long-term care home is located to determine the viability of placing the specialized unit in that home.

Section 103 – Waiting list criteria for admissions to specialized unit

Subsection (c) indicates that it is up to the placement coordinator to determine whether or not the person is eligible for the specialized unit, but gives no appeal mechanism.

Subsection (d) indicates that a home must approve a person's admission to the specialized unit, but does not require the home to justify the reason for declining admission or to provide written notice.

We submit that requirements similar to that of regular admission are necessary, as follows:

Determination of ineligibility – assistance and notice

If the placement co-ordinator determines that the applicant is not eligible for admission to the specialized unit,
(a) the placement co-ordinator shall suggest alternative placement options and make appropriate referrals on behalf of the applicant; and
(b) the placement co-ordinator shall ensure that the applicant is notified in writing of,

> ***(i) the determination of ineligibility,***
> ***(ii) the reasons for the determination, and***
> ***(iii) the applicant's right to apply to the Appeal Board for a review of the determination. Review of determination of ineligibility***

Review of determination of ineligibility

The applicant may apply to the Appeal Board for a review of the determination of ineligibility made by the placement co-ordinator, and the Appeal Board shall deal with the appeal in accordance with section XX.

Licensee consideration and approval

Where the appropriate placement co-ordinator has determined that the person requires and is likely to benefit from the specialized unit and has provided the licensee copies of the assessments and information that are required to be taken into account, the licensee shall review the assessments and information and shall approve the applicant's admission to the specialized unit unless,

(a) the specialized unit lacks the physical facilities necessary to meet the applicant's care requirements; or
(b) the staff of the specialized unit lack the nursing expertise necessary to meet the applicant's care requirements.

Section 104 – Waiting list categories and ranking

This section states that certain waiting list categories do not apply to specialized units. We are unsure as to the underlying rationale for this section. One would hope that if a person required a specialized unit (e.g., a behavioural unit, dialysis unit, young person's unit) and had a spouse living in that home, that the spousal reunification category be utilized to reunite them. We therefore submit that the section be amended to include, at a minimum, the spousal reunification category:

Include the spousal reunification category in the waiting list for specialized units.

Section 105 – Authorization of admission: specialized unit

This section allows only those who meet the requirements for specialized units to be admitted to a specialized unit. There should be a provision allowing admission to the unit in very specialized circumstances, as permitted by the Director (e.g., outbreak situations, such as SARS, where persons might have to be placed in specialized units for safety reasons). We therefore recommend that the Director be able to authorize placement in rare situations, as follows:

(c) As authorized by the Director in emergency situations.

Section 107 – Transfer, specialized units

It is assumed that some specialized units, such as behavioural units, will have a higher staff to resident ratio than regular units. One can therefore foresee that even after the specialized care is provided in that unit, residents may not wish to transfer to another unit. While we believe that consent is generally required for transfers, there may be some circumstances where it is not appropriate for the resident to remain on the specialized unit if the transfer can be supported within the facility. We therefore recommend that there be a transfer mechanism and a corresponding appeal process which would allow transfers in some circumstances. Depending on the drafting of the regulations, the appeal may be to the Health Services Appeal and Review Board respecting eligibility issues or the Consent and Capacity Board concerning substitute consent issues.

Where a resident no longer requires placement in the specialized unit, but the resident or their substitute decision-maker refuses to consent to a transfer within the facility, there be a mechanism to transfer the resident which includes a right of appeal.

SPECIAL CIRCUMSTANCES

Section 109 – Special Circumstances

Where a licensee withholds approval of a person's admission under section 109(4)5, the same written notice should be required to be provided to the placement coordinator and the resident or their substitute decision-maker as is required under section 44(9) of the *Act.* ACE recommends the following changes to the draft regulation:

Written notice if licensee withholds approval

If the licensee withholds approval for admission, the licensee shall give to persons described in subsection xx a written notice setting out,

(a) the ground or grounds on which the licensee is withholding approval;
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care;
(c) an explanation of how the supporting facts justify the decision to withhold approval; and
(d) contact information for the Director.

Persons to whom notice given

The persons referred to in subsection xx are the following:

1. The applicant.
2. The Director.
3. The appropriate placement co-ordinator.

TRAINING

Section 118 – Additional training – direct care staff

A persistent problem in long-term care is the lack of understanding of the requirements for consent to treatment by physicians, staff and management. For example:

- Staff either fail to get consent from the capable resident or the substitute decision-maker of residents who are incapable for treatment. Or, staff merely informs the substitute decision-maker, after the fact, of the treatment ordered by the physician.

- Staff may seek consent but from a person that is not the proper substitute decision-maker of pursuant to the *Health Care Consent Act.*

- Consent is not obtained from capable residents. Instead, they are ignored and the consent, if obtained, is from the person who would be the resident's substitute decision-maker if they became incapable to consent for treatment in the future. However, the consent is invalid as consent may only be obtained from a substitute decision-maker **after** a person has been found incapable: here, the resident still has capacity for this purpose.

- Advance directives or level of care forms are used as consents in place of informed consent. We frequently see situations when these documents are used in place of informed consent from either a resident or the incapable resident's substitute decision-maker. We have identified that there is confusion between a "plan of treatment" and an "advance care plan". Long- term care homes justify requiring advance care planning forms as if they were part of the plan of treatment. This same confusion is reflected in these draft regulations in the section on regulated documents, which will be discussed later in this submission.

- Level of care forms are not explained to the resident or substitute decision-maker. We often see level of care forms given to residents or their substitute decision-makers upon admission to be signed immediately. The document is signed without anyone from the long-term care home explaining the document, how it would be used and without any discussion of the resident's own care needs. Incoming residents and their families have been told that signing such an advance directive is "required' as a condition of admission or continued residency. In one such case, after having been told by the administrator that such a document would need to be signed, we asked to speak to the Director of Care, assuming that she, as a registered nurse, would be more knowledgeable about the requirements of the *Health Care Consent Act*. The Director of Care also told us that this advance directive, as well as a blanket "preconsent" in the admission agreement, was necessary because the staff had no time to get consents form individuals. She further advised us that the Ministry of Health and Long-Term Care compliance advisor had "approved" their forms and practice. We were then advised by the compliance advisor that this practice was acceptable. Clearly, this is not correct and does not reflect the requirements of the *Health Care Consent Act*.

There should be a requirement in the regulations for training of direct care staff on health care consent and advance care planning. This training must include such topics as: what is and is not informed consent; when informed consent is required; capacity; substitute decision-makers; the differences between consent and advance care planning; the differences between a plan of care and an advance care planning, who can and cannot advance care plans.

We recommend that section 118 of the regulations be amended to add the following requirement:

> ***(1) For the purposes of paragraph 6 of subsection 76(7) of the Act, every licensee of a long-term care home shall ensure that all staff who provide direct care to residents receive training in the following additional areas:***
>
> ***8. Health Care Consent and Advance Care Planning***

Section 119 - Orientation for volunteers

The draft regulations state that the orientation of volunteers is to apply only to volunteers that begin volunteering at the home after the coming into force of this section. This is not acceptable as the turnover of volunteers is likely fairly small, meaning that many volunteers would never receive the orientation.

In order to allow for the orientation of all volunteers, we recommend that the timing for compliance with this requirement be delayed to a year after the coming into force of the section. This should not pose a burden to the licensee as the licensee must organize this orientation program for all new volunteers, even if there is only one new volunteer. Presentation of such an orientation can be done just as easily to a small group of new volunteers as it is to a larger group that includes existing volunteers. We would assume that licensees may use experienced volunteers to deliver parts of the orientation program therefore making it manageable for all volunteers to receive this orientation over an extended period of time.

Additionally, volunteers by their nature are eager; otherwise they would not be volunteering. Training is generally not just welcomed, but is often perceived by volunteers as a supportive effort on the part of the home not to take their volunteerism for granted.

We recommend that section 119(3) be amended as follows:

> ***A licensee is not required to comply with this section until one year after the section comes into force.***

INFORMATION

Section 120 – Information for Residents

Section 78 of the statute and section 120 of the second draft regulation set out what information must be given by the long-term care home to residents and their substitute decision-maker, if any, upon admission. Taken together, these requirements are still less detailed than the current Program Manual.

We recommend that the following be added to section 120:

> ***For the purposes of clause 78(2)(r) of the Act, every licensee of a long-term care home shall ensure that the package of information provided in section 78 includes information about the following:***
>
> ***5. The home's organizational structure and internal accountability mechanisms.***

6. ***How a resident or substitute decision-maker can recommend changes to the home.***

7. ***The process for resident or substitute decision-maker to participate in the assessment, planning and evaluation of the resident's care and the home's program and services.***

8. ***The fact that the choice of attending physician is available to the resident, including the resident's own physician.***

9. ***Financial information about comfort allowances, financial assistance from government programs for those over 60 years of age and the availability of trust accounts.***

Section 121 – Posting of Information

The current regulations require specific information to be posted in a "prominent place" that is "easily accessible" to staff, residents and substitute decision-makers. Certain information also has to be in large print. Section 121, however, removes the prominence and accessibility requirements.

Information is power. ACE has heard from residents and their substitute decision-makers that although an array of information is provided upon admission, the documents about such important issues as residents' rights and complaint procedures are often buried amongst the administrative paperwork. This, plus the fact that the day of admission is a difficult one for the resident and their family and friends, means that the information is often not digested. If older adults, their substitute decision-makers and family members do not have information about residents' rights, their independence, security and dignity are jeopardized. Thus, it is essential that the specified information be posted in a prominent place where residents and substitute decision-makers are constantly reminded about their rights.

We therefore recommend that section 121 be amended as follows:

> ***(2) The licensee shall ensure that the information referred to in clauses 79(3)(a), (e), (f), (h), (i) and (j) of the Act, as well as the telephone number referred to in paragraph 3 of subsection (1), is posted in a prominent place that is easily accessible to the staff of the home, the residents of the home and the substitute decision-makers of residents with a font size of at least 16.***

Communication of Information

Although section 79(2) of the *LTCHA* requires every licensee to ensure that the required information is communicated in a manner that complies with any requirements that may be provided for in the regulations to residents who cannot read the information, the draft regulations do not contain any such details.

We recommend that a new section be added to specify how information can be communicated, as determined appropriate by the Ministry of Health and Long-Term Care, taking into account the following principles:

> ***The information must be communicated in a manner appropriate for the individual resident, including but not limited to:***
>
> ***1. Reading the materials to residents on a regular basis.***
>
> ***2. Translating materials into different languages.***

EMERGENCY PLANS

Section 124 – Emergency Plans

The emergency plan states that they shall test plans on an annual basis. The *Program Manual* requires monthly fire drills.[17] This should be included in this section, as follows:

> ***Monthly fire drills shall be held on all shifts and staff attendance documented.***

AIR TEMPERATURE

Section 127 – Air Temperature

There should be a maximum temperature/humidex level at which the home is required to take action to ensure the safety of residents (see section 16 above). An amendment should be made as follows:

> ***When the temperature reaches xx degrees or xx humidex level, the home shall take such steps as necessary under subsection 16 as is necessary for the safety of the residents.***

[17] *Long-Term Care Homes Program Manual,* 1011-01, page 8, M3.14.

REGULATED DOCUMENTS

Section 128 – Regulated documents

Section 80 of the *LTCHA* states that every licensee "shall ensure that no regulated document is presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident" (hereinafter referred to as the "resident or substitute decision-maker") "unless that document complies with all requirements of the regulations and that compliance has been certified by a lawyer." Section 128 of the draft regulations is intended to define a regulated document and the requirements applicable to those documents.

There are a number of problems with this section, particularly the reference in section 128(1)2 to "any document containing a consent or directive with respect to 'treatment' as defined in the *Health Care Consent Act,* including a document containing a consent or directive with respect to a 'course of treatment' or a 'plan of treatment' under that Act. We submit that this subsection needs to be completely redrafted.

Elements of section 128 conflict with the *Health Care Consent Act*. It also uses terms, such as "directive", that are not defined in the *LTCHA,* the draft regulations or the *Health Care Consent Act*. Moreover, the term "directive" has a specific meaning already used in health care, which differs from the meaning employed in this section.

The draft regulation makes it appear that substitute decision-makers may execute directives (we assume this refers to what is commonly known as "advance directives" or "level of care forms"). However, this is in direct conflict with the *Health Care Consent Act* which says only capable people may execute such documents as a means of expressing their "wishes" in respect to future care.

The draft regulation also confuses a "plan of treatment" with an "advance care plan", which will be discussed in detail below. Simply stated, an advance care plan is **NOT** part of a plan of treatment. These are two separate concepts.

At a minimum, the regulation elevates level of care forms into a form of advance care plan or directive. Worse, the regulation may include the level of care form in a document that is part of a plan of care for which consent is obtained. Please see the discussion below for additional details. Level of care forms are **tools** – they are not directives or consents and should not be made into such via regulation. This also conflicts with the *Health Care Consent Act*.

While we are providing comments below with regards to the draft regulation, we would appreciate the opportunity to meet with Ministry staff, including legal counsel, to discuss this particular section. Leaving the draft as is, or making minor amendments, will lead to more confusion than already exists in long-term care homes, to the detriment of both residents and licensees.

Definition – "Certified"

A definition of "certified" should be added to the regulations to explain what a lawyer is expected to do to certify the documents. The word "certify" does not have any particular meaning to lawyers, other than to certify something as a "true copy". If the intent is that the licensees lawyers are to confirm that the regulated documents are legally correct and comply with the *LTCHA*, its regulations, and with other applicable legislation such as the *Health Care Consent Act* and the common law (for example regarding contracts), then the regulation should be amended as follows:

> ***For the purposes of section 80(1) (b) the term "certified" means that the a lawyer must provide a legal opinion to the licensee that a regulated document is in compliance with the Act, its regulations, and with any other applicable legislation and regulations, including but not limited to, the Health Care Consent Act and the common law on contract.***

Definition – "Directive"

The word "directive" appears both in the *Act* and in the draft regulations. The directive referred to in sections 4 and 128 of the regulation appear to be a different type of directive than that in section 143.

The word "directive" has a specific meaning to health professionals and an explanation of that appears below. These terms need to be defined in the regulation to avoid confusion.

It would be preferable to redraft this section and to amend the sections in the *LTCHA* referring to directives (sections 183, 182 and 183) by changing the terminology. However, if it is not possible to amend the *LTCHA*, specific definitions must be included in the regulations to limit any confusion.

Sections 4 and 128 refer to directives regarding treatment or care for individuals. If this is intended to refer to directives (commonly known as advance directives or advance care plans) that are the **wishes** about future care and treatment expressed by a capable person (as referred to in section 5 of the *Health Care Consent Act*), "directives" should be given the same meaning as "wishes" in the *Health Care Consent Act*. For ease of reference, section 5 of the *Health Care Consent Act* states as follows:

> **Wishes**
> 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.

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

Defining "directive" in these sections the same as "wishes" in the *Health Care Consent Act* would provide consistency in interpretation and also serve as a reminder that the law requires health providers to obtain informed consent to treatment, not merely an advance directive (statement of wishes) from residents.

Another benefit of including a definition is to ensure that directives are not given by residents' substitute decision-makers but only by residents who are mentally capable for this purpose. Substitute decision-makers can only provide consent to treatment – they cannot give a directive about residents' care and treatment as this conflicts with the requirements of the *Health Care Consent Act*.

Finally, it is necessary to have a definition as the legislation and draft regulations otherwise will leave licensees with the impression that "advance directives" are required documents and may be used as consents.

Therefore, we recommend the following addition to section 1 of the regulation:

> ***In this regulation, "directive" has the same meaning as the word "wishes" in section 5 of the Health Care Consent Act and may only be given by a capable resident.***

Directives in section 143 refer to a different kind of directive, namely "medical directives or orders for the administration of a drug". This term is also not defined in the legislation or draft regulations. We assume it means the same as the term "medical directive" as explained by the policies of the various regulated health colleges. We understand that the Colleges of Physicians and Surgeons of Ontario, Pharmacists and Nurses all understand the term "medical directive" the same way.

The College of Physicians and Surgeons of Ontario defines medical directive in their *Policy on Delegated Acts* as follows:[18]

> Medical directives are blanket instructions by physicians (often more than one) to other health care providers. They pertain to any patient who meets the criteria set out in the medical directive. The medical directive contains the delegation and provides the authority to carry out the treatments, interventions or procedures that are specified in the directive, providing that certain conditions and health care can be delivered without a physician's direct assessment of the patient or direct supervision. Their use is especially frequent in institutional settings.

[18] College of Physicians and Surgeons of Ontario, *Policy on Delegated Acts* (Updated February 2007), http://www.cpso.on.ca/policies/policies/default.aspx?id=1554&terms=medical+directive.

> A medical directive must always be written and must comply with the principles set out in this policy. …
>
> A more comprehensive guide and toolkit is posted on the Federation of Health Regulatory College of Ontario's (FHRCO) website. This guide was developed by a working group of FHRCO in 2006.
>
> The toolkit provides templates for construction of Medical Directives, as well as explanations of how to establish the prerequisites. The templates will have the most direct application for large institutional settings, but anyone who wishes to establish a Directive (or to learn more about delegation) will find them helpful. Their use is not mandatory, but any physician who delegates a controlled act pursuant to a Medical Directive developed using these templates will be in compliance with the legislation and College policy and will be providing the very best quality of care to patients.

The College of Nurses of Ontario's practice guideline entitled *Directives* describes both "orders" and "directives". An order is: [19]

> A prescription for a procedure, treatment, drug or intervention. It can apply to an individual client by means of a direct order or to more than one individual by means of a directive from a physician or Nurse Practitioner (NP). A direct order is client specific. It is an order for a procedure, treatment, drug or intervention for an individual client. It is written by an individual practitioner (for example, physician, midwife, dentist, chiropodist, NP or Registered Nurse [RN] initiating a controlled act) for a specific intervention to be administered at a specific time(s). A direct order may be written or oral (for example, by telephone). A directive may be implemented for a number of clients when specific conditions are met and when specific circumstances exist. A directive is always written.

The practice guideline then goes on to explain what information must be included in a directive.

As section 128 of the draft regulation is in the section on medication management it is assumed that the medical directives in section 143 are restricted to directives about drugs.

> ***Define "medical directive" in section 1, similar to the definition contained within the policies and practice guidelines of both the College of Physicians and Surgeons of Ontario and the College of Nurses of Ontario.***

[19] College of Nurses of Ontario, *Practice Guideline – Directives* (2009), http://www.cno.org/docs/prac/41019_MedicalDirectives.pdf.

Section 128(1) – Draft regulations are too limited

The draft regulations limit regulated documents to only written agreements for any of the charges listed in subsection 91(1) of the *Act* and to any document containing a consent or directive with respect to "treatment" as defined in the *Health Care Consent Act,* including a document containing a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that *Act*. This is too narrow.

Regulated documents should include any documents presented by the licensee for signature by a resident or substitute decision-maker, such as admission agreements.

Although a primary purpose of admission agreements is to clarify charges, ACE has the inclusion of other provisions, such as: limitations on the licensee's liability; requirements for personal guarantees of payment by substitute decision-makers; and the requirement that a substitute decision-maker relocate a resident if it is the licensee's opinion that they cannot provide the care services that the resident or substitute decision-maker expect.

In our opinion, these kinds of agreements represent efforts to circumvent the legislation and regulations. Although there may not presently be a specific prohibition against the licensee from asking the substitute decision-maker or another family member to act as a guarantor, there is no requirement that there be a guarantor in order for a resident to be admitted. Charges for accommodation are to be based on the income of the resident and it is the obligation of the resident to pay, even if the resident is not mentally capable and their finances are managed by a substitute decision-maker. Most agreements leave the impression that a substitute decision-maker or family member must sign the document as is or the resident will not be admitted. Further, it may not be made clear to the person that they are a guarantor and personally responsible, or that they can decline to sign as a guarantor and the resident must still be admitted. In fact, in a recent court case, a staff member of a home specifically indicated that they would not admit a resident if there was no guarantor. Substitute decision-makers and family members are being held personally responsible for payments which they had no intention of entering into personally.[20]

Licensees do not need to create admission agreements, other than the agreements with respect to costs and charges as described as regulated documents in this regulation. However if they do, the document should be one that has been certified by their lawyers as being in compliance with the *Act* and regulations and other relevant legislation and law.

ACE recommends the following amendments to the draft regulation:

[20] See *Hellenic Home for the Aged v. Tsirakis et al*, TO 74083/08, Toronto Small Claims Court, Justice Godfrey (6 October 2009) and *Hellenic Home for the Aged v. Beis et al*¸ TO 68831/08, Toronto Small Claims Court, Justice Godfrey (6 October 2009). Copies of these cases are attached to our submission.

To include a section that requires that any agreements between licensee and residents and their substitute decision-makers that describes the legal relationship (rights and responsibilities) between the parties be defined as a regulated document.

OR

To prohibit any written agreements between the licensee and residents and their substitute decision-makers that describe the legal relationship (rights and responsibilities) between the licensees and residents and their substitute decision-makers other than those described in the regulations.

Although it may be argued that the description of the regulated document in respect to charges requires that it only reference the obligation of the resident to pay, and that any separate agreement between the licensee and the substitute decision-maker as guarantor would still be a regulated document in that it falls into section 128(1)1, we are concerned that this matter is not addressed adequately by this section. Thus, we recommend the following addition to section 128:

Licensees are explicitly prohibited from requiring that there be a guarantor who is personally responsible for fees in long-term care.

Section 128(3) – Substitute decision-makers cannot give directives & Expression of directives (wishes)

Section 128(3) states that a copy of any document containing a consent or a directive with respect to treatment is to be provided to the resident or the substitute decision-maker authorized to give a consent or directive. However, substitute decision-makers cannot give directives as directives are simply statements of the capable wishes of a resident respecting health care and treatment. Substitute decision-makers can only give or refuse consent to treatment. They are required to follow the residents' wishes expressed while capable; but, the *Health Care Consent Act* does not confer authority to them to express wishes. Substitute decision-makers must always give or refuse consent in the context of the person's present health condition.

The current drafting of the regulation makes it appear that substitute decision-makers are authorized to give advance directives on behalf of residents, contrary to the *Health Care Consent Act*. This has been a critical misunderstanding in many long-term care homes, where licensees routinely demand that substitute decision-makers sign generalized level of care forms and other directives in place of informed consents.

Many homes also assume that a consent or directive must be a written document, although section 5 of the *Health Care Consent Act* states that wishes may be expressed orally or in any other manner. Section 128(3) requires amendment to reflect that the

directives or wishes may be given orally or in other ways and recorded in a chart or other format in the resident's record.

The substitute decision-maker should be able to obtain a copy of any directive that the resident has made, whether it is oral and recorded in the chart or put into writing in some other form. Substitute decision-makers pursuant to the *Health Care Consent Act* also have the right under the *Personal Health Information and Protection Act* to have access to the resident's records of personal health information.

Further comments about copies will follow which will explain our recommendation to change the word "or" to "and".

Based on the foregoing information, we recommend that the section be amended as follows:

> ***(3) The licensee shall provide the resident and the substitute decision-maker authorized to give a consent with a copy of any document referred to in paragraph 2 of subsection (1) when it is signed or recorded in a document or record.***

Section 128(2) and (3) – Copies

The regulation requires the licensee to provide a copy of the agreement in respect to charges to the resident OR the person authorized to enter into such agreement on the resident's behalf. However, a resident that is mentally capable in respect to property may have given a continuing power of attorney of property and also be capable with respect to finances. **Both** the attorney and the resident are entitled to get a copy of this agreement for charges as both have an interest in the agreement. Likewise, the regulation provides that the licensee provide the resident OR the substitute decision-maker with respect to treatment with a copy of any document containing a consent or directive. Comments have been made above about the fact that a substitute decision-maker cannot make a directive. Both residents (whether capable or incapable) and their substitute decision-makers that are authorized to give consent should be able to receive copies of any consents or directives.

We recommend that section 128 be amended as follows:

> ***(2) Every licensee of a long-term care home shall provide the resident and the person authorized to enter into the agreement on the resident's behalf with a copy of any agreement referred to in paragraph 1 of subsection (1) when it is signed.***
>
> ***(3) The licensee shall provide the resident and the substitute decision-maker authorized to give a consent with a copy of any document referred to in paragraph 2 of subsection (1) when it is signed or recorded in a document or record.***

Section 128(5)1 – A description of goods and services, including quantity

This section allows the home to define quantity of products. Questions arise as to when this provision can be used. For example, can the home limit the number of incontinence products provided to a resident?

Up until now, the standard for incontinence care has been that the licensee was required to ensure that residents were kept clean and dry at all times and there was a prohibition against charging for incontinence products or limiting the supply of such products. The licensees were required to provide these products as needed to the individual residents. However, it has been widely reported, and we have been told many times by our clients, that licensees already restrict the number of incontinence products that a resident may use on a daily or weekly basis. We have also been advised by residents' families that they were informed by the licensee that they would have to supply their own incontinence products if the resident used more than the allowed quantity. While this is not legal, this habitual problem has been well documented.

We are concerned that the section as drafted opens the door to allow the licensee to limit the quantity of incontinence or other products which are supposed to be supplied by the licensee. We submit that these products must continue to be supplied by the licensees in any quantity necessary to meet the residents' needs, such as being clean and dry at all times. Otherwise, the door is opened to restrictions, which would lead to significant health problems for low income residents and residents without family and friends who might be able to supplement these costs. This will only increase the costs of health care as residents will run the risk of many health problems related to incontinence and skin breakdown. We therefore recommend the following amendment:

> ***A description of all goods and services to which the agreement applies.***

If the intent of the section is not to restrict or limit access to supplies, then a section must be included to clarify this fact. As well, a specific regulation explicitly stating that it is the obligation of the licensee to supply incontinence products in any number necessary to keep residents clean and dry at all times, or explicitly prohibiting licensees from charging residents for incontinence products, should be added.

> ***A description of all goods and services to which the agreement applies, including any quantity, if applicable***
>
> ***A quantity can only be specified if it is an item which is not to be provided free of charge under the Act or regulations;***
>
> ***For more certainty, a licensee may not charge for incontinent products for each resident.***

Section 128(7) – Education

As this section confirms that any documents containing a consent or directive with respect to treatment must comply with the requirements of the *Health Care Consent Act*, this should help address the inappropriate practice of homes requiring or asking substitute decision-makers to sign advance care planning documents. However, we recommend that this issue be addressed in any education program that the Ministry may offer on the *Act* and regulations to licensees and their staff. Education must also be provided to compliance advisors and any other Ministry staff involved in inspection, compliance and enforcement. Thus, ACE recommends the following addition to the regulations:

> ***Education on advance care planning and the requirements of the Health Care Consent Act should be provided to licensees, their staff, and Ministry staff involved in inspection, compliance and enforcement.***

Section 128(8) – Level of care directives

This section does not address the fundamental problems regarding level of care directives. Although it may have been intended to address issues raised regarding "level of care forms" (specifically, the right of residents to change any expression of wishes that they may make), this section, unfortunately, only serves to reinforce the use of level of care forms as consents or as advance care plans.

This subsection should be removed entirely from the regulations as section 128(7) already states that the consent or directive must comply with the *Health Care Consent Act.* The challenge will be to train long-term care home licensees, staff, management and Ministry personnel (compliance, etc.) that levels of care forms cannot be signed by substitute decision-makers and cannot be used in place of informed consents. Homes should be encouraged to stop using level of care documents as consents or advance care plans as they are meaningless and only cause confusion. Homes and registered staff should also be made aware that reliance on these documents as legal consents could lead to lawsuits and professional discipline for failure to obtain informed consent. Although level of care forms may be used as tools to guide and direct discussion about both plans of treatment and wishes for future care, they cannot be used as a consent.

ACE has identified several problems identified with subsection 128(8):

- This section conflicts with the *Health Care Consent Act* and gives the impression that substitute decision-makers may give directives for residents. Substitute decision-makers cannot sign level of care directives. Substitute decision-makers may only give or refuse consent to treatment; they cannot express "wishes" on behalf of incapable residents. They can only give informed consent or refusal of consent in context of the incapable resident's present health condition.

- It confuses a plan of treatment with an advance care plan. A plan of treatment cannot contain a level of care directive or any other advance care plan. A plan of treatment requires informed consent. A plan for treatment may be created for "one or more of the health problems that the person is likely to have in the future given the persons present health condition" and it may "provide(s) for the administration to the person of various treatments or course of treatment".[21] However, that can only be provided in the context of the person's **present health condition**. This phrase is very significant because the plan of treatment is developed in the **context** of the person's present health condition. The health provider is then able to give the person the information necessary to provide an informed consent because the context for the plan is the person's health condition. The future health problems are directly related to the person's present health condition. The health provider can then administer the treatments discussed in the plan of treatment without getting an additional consent if the person develops the conditions that were expected in light of their present health condition at the time the plan of treatment was developed.

    - In contrast**,** an advance care plan or advance directive is a statement of wishes about future care that is not necessarily based on the person's present health condition. It is speculative. The person does not necessarily have all the facts on which to determine whether they would likely develop a particular health condition. The person may have no particular health concerns, yet they may express their wishes about future care if they should develop such a concern. The health provider would **NOT** take direction from the advance care plan except in an emergency, even if the person developed the health problem about which they had speculated. The health provider would need to get an informed consent to any treatment in the non emergency situation from either the capable person or their substitute decision-maker.

      In a non-emergency situation, if a substitute decision-maker must make a treatment decision for an incapable person and that person had prepared an advance care plan (either written, oral or expressed by other means), the substitute decision-maker must consider that advance care plan and comply with the wishes in the plan that are applicable to the specific decisions that the substitute decision-maker must now make. It is up to the substitute decision-maker to interpret any wishes an incapable person may have made and to decide how they are to be applied to the proposed treatment.

    - An advance care plan (a statement of wishes) is NOT part of a plan of treatment (informed consent to a group of treatments based upon the present health condition). These are two separate things.

[21] *Health Care Consent Act,* s. 2.

- Level of care forms are not tailored to the individuals needs but are overly-generalized statements that substitute decision-makers and residents are often asked to execute without a discussion. They are not part of a plan of care, as they do not meet the requirement that they deal with one or more of the health problems **that the person** may have in the future in context of their **present** health condition.

  Signing the documents does not fulfill the requirements of informed consent. To be part of a plan of care, any statements about "health problems that the person is likely to have in the future" need to be related to the persons' present health condition and must be discussed with the person or the substitute decision-maker, providing the person or the substitute decision-maker with information about the possible future health problems and the possible specific treatments for those problems. We have not seen any level of care forms that presently meet that standard. Even detailed level of care forms are purely speculative, as they are simply a list of everything from possible heart attacks to situations which may require dialysis, whether or not that individual's present health condition would lead one to believe that they may need such future health care.

- Level of care forms are treated as consents in place of obtaining proper informed consent. This practice will continue if this section is contained in the regulations as this section appears to authorize the use of level of care directives as part of a consent, despite the fact that level of care forms do not meet the criteria required to be informed consent. Informed consent must relate to the treatment, be informed, be voluntary, and must not be obtained through misrepresentation or fraud.[22] To be informed, the person giving consent must receive information about the nature of the treatment, the expected benefits of the treatment, the material risks of the treatment, the material side effects of the treatment, the alternatives course of action and the likely consequences of not having the treatment.[23] Informed consent is not obtained when a person is asked to tick off boxes on this general form.

- The levels of care (number and content) in levels of care forms differ from home to home. The section as drafted would infer that a resident could "vary the levels of care" – we assume this means that they can add or subtract something from a particular level or restate the level of care and that they could change the level of care. It would be preferable to have licensees spend the time preparing proper consents to treatment that reflect the care options in light of the person's present health condition and to help people express their own wishes in an individualized and meaningful way relative to their own needs rather than working on redrafting a broad and generalized level of care form.

[22] *Health Care Consent Act*, s. 11(1).
[23] *Health Care Consent Act*, s. 11(3).

- Level of care forms may be useful as a **tool** to guide decision-making in response to a resident's current health condition. This is an approach that a number of health providers have used successfully as part of a discussion that leads to a plan of treatment that is individualized and may lead to getting an informed consent from the resident or their substitute decision-maker. The tool is useful, if and only if, it is used as part of a process for acquiring consent to treatment to a specific plan that is relative to one of the four levels on the form and for which the resident is not restricted to the options provided in these levels on the forms. Licensees and their staff need to understand how to use them. These tools can help residents and substitute decision-makers process issues and to conceptualize their options. They can assist health providers define the treatment options for the residents and/or their substitute decision-maker.

The problem of the misuse of level of care forms will continue unless efforts are made to address this now. Education could be developed as to how these tools could be used, which may then help health providers shift from improperly using these forms as consents or advance directives to using them as part of the process of developing plans of treatment which can then be consented to or in helping residents express wishes about future care in an advance care planning process.

This has been a matter of discussion with in the Alzheimer's Knowledge Exchange (AKE). Recent education programs put on by the AKE on this exact topic were very well attended with an estimated 1500 attendees at two sessions. A group of health providers and ACE have been discussing these issues in an effort to design programs to influence change in practice on maters related to consent, advance care planning and level of care tools. This recommendation is based on what has been learned from both our practice as well as discussion with health providers who work in long-term care and other health facilities.

Consequently, we recommend that:

Section 128(8) be deleted from the regulations.

CRIMINAL REFERENCE CHECKS

Section 137(6) – Criminal Reference Checks

Generally, all long-term care home staff and volunteers will be required to undergo a criminal reference check. Section 137(6), however, exempts medical directors, physicians and nurses in the extended class from this requirement. As these individuals provide direct care to residents and potentially wield great power over residents, ACE believes they should not be exempt from this provision.

Accordingly, ACE recommends the following:

Delete section 137(6).

MEDICATION MANAGEMENT

Section 141 – Quarterly evaluation

It must be made clear that the use of medication for restraint can only be done under the common law where immediate action is required. One of the most common complaints is that antipsychotic medication is administered on an ongoing basis without consent of the resident or, where they are incapable, their substitute decision-maker. The regulations must explicitly state that the common law duty to restrain is different than the ongoing use of psychotropic medications.

Further, this section indicates that changes should be made based upon "prevailing practices". This is also problematic, as it has been argued that, while contrary to the *Health Care Consent Act*, treating without obtaining informed substitute consent is the "standard" within the long-term care industry. As well, despite warnings from the Food and Drug Administration in the United States and Health Canada of the risks associated with these medications and the lack of evidence of benefits, the widespread use of atypical antipsychotics in long-term care homes in Ontario continues.[24] It is submitted that "prevailing practices" are not an appropriate goal to strive for.

Finally, we submit that this issue is of such importance that the results must be submitted to the Ministry of Health and Long-Term Care as well as to the Residents' Council and Family Council.

We recommend, therefore, that the section be amended as follows:

(2) The quarterly evaluation of the medication management system must include at least,

(a) reviewing drug utilization trends and drug utilization patterns in the home, including the use of any drug or combination of drugs, including psychotropic drugs, that could potentially place residents at risk;

(b) reviewing reports of any medication incidents and adverse drug reactions referred to in subsections 161 (2) and (3) and all instances of the restraining of residents by the administration of a drug when immediate action is necessary to prevent serious bodily harm pursuant to the common law duty referred to in section 36 of the Act; and

[24] Paula Rochon, *Healthcare Quarterly*, Vol. 10, No. 4, 2007, page 20.

(c) identifying changes to improve the system, in keeping with evidence-based practices.

(3) The licensee shall ensure that the changes identified in the quarterly evaluation are implemented.

(4) The licensee shall ensure that a written record is kept of the results of the quarterly evaluation and of any changes that were implemented.

(5) The licensee shall ensure that a copy of the written record is provided to the following:

(a) The Director
(b) The resident's council of the home; and
(c) ***The family council of the home.***

PHARMACY SERVICE PROVIDER

Section 146 – Responsibilities of pharmacy service provider

In the community, a pharmacy provides a person receiving medication with information about the medication, including its risks, benefits and side-effects. This information is not provided by the pharmacy in long-term care homes to the resident or their substitute decision-maker. Under the requirements set out in the *Program Manual,* the pharmacist is required to be involved in the preparation of the care plan[25] and to report prescribing irregularities. We recommend that these requirements be added to the services to be provided by the pharmacy, as follows:

Provide written information the resident or their substitute decision-maker about the risks, benefits, side-effects, contraindications or other pertinent information regarding each medication.

Provide clinical consultation within a mutually agreed upon time on residents' pharmacotherapy and other drug-related matters, including participating when requested in the development, implementation, and review of residents' individual care plans (either in person or through a written report to the interdisciplinary care team) and in response to identified resident needs.

Reporting any irregularities or concerns about drug ordering or administration to the administrator, physician, or the director of nursing.

[25] *Long-Term Care Homes Program Manual,* 1016-01, page 3, R1.4.

Section 148 – Purchasing and handling of drugs

This section states that the home may not use a medication that is not obtained from either the pharmacy service provider or the Government of Ontario. While we understand that section 145 requires the provision of drugs on a 24 hour basis, 7 days a week, this has always been the requirement in the *Program Manual* although this has not always been the case in practice.[26] Residents have been sent to hospital and prescribed medication or medication has been prescribed by their physician on a weekend or holiday, only to be told that the pharmacy services are unavailable and that they cannot obtain the medication from the local pharmacy, thereby delaying necessary treatment.

The section should therefore be amended to include allowance to obtain medications on an emergency basis from an alternate pharmacy, as follows:

> ***Exception:***
>
> ***(c) Where a drug is prescribed and required on a holiday, weekend, or evening where immediate treatment is required and obtaining the drug from the pharmacy service provider or Government of Ontario is not practicable, the drug may be obtained from a local pharmacist.***

Sections 151 and 152 – Monitored dosage system and Packaging of drugs

These sections are a departure from the requirements presently in the *Program Manual*, which require as follows:

> All drugs and biologicals for individual residents shall be labelled with a prescription number, the resident's name, date, medication's name, strength, form, manufacturer, quantity, directions for use, a valid expiration date (if for PRN use), the prescriber's name, the name, owner, address, and telephone number of the dispensing pharmacy and with appropriate accessory and cautionary instructions.[27]

In light of this, we recommend that the sections be reviewed to ensure that all of the appropriate labeling requirements are met.

> ***Review of section required***

[26] *Long-Term Care Homes Program Manual,* 1016-01, page 4, R1.5.
[27] *Long-Term Care Homes Program Manual*, 1016-01 R.4.2.

Section 156 – Security of drug supply

The requirements regarding the storage of narcotics and controlled substances have been left out of the new regulations. We submit that sections 65(6) and (7) of the regulations to the *Nursing Homes Act* be included in these regulations, as follows:

> ***Every narcotic and every controlled drug shall be stored in a locked box or cabinet to be known as the narcotic cabinet.***
>
> ***The narcotic cabinet shall be inside the general drug cabinet or storeroom and no other drug or other article shall be kept in the narcotic cabinet.***

Section 157 – Administration of drugs

The right to consent to treatment by individuals who are capable, or to have treatment consented to by a substitute decision-maker if incapable, continues to be ignored and is one of the issues about which ACE receives the greatest number of complaints. A section should be added that clarifies the requirements of consent and findings of incapacity pursuant to the *Health Care Consent Act*. We recommend the following changes to the draft regulation:

> ***No drug is to be administered without obtaining informed consent pursuant to the Health Care Consent Act.***
>
> ***If a resident is found to be incapable of consenting to drug, they are to be informed of the finding and of their right to apply to the Consent and Capacity Board for the review of that finding or for an appointment of a representative, pursuant to section 33 of the Health Care Consent Act.***

Section 158 – Natural health products

There is no definition of "natural health products". As well, alternative medicine should be included in this policy.

> ***Definition required for "natural health products"***
>
> ***Similar section required for "alternative medicine"***

Section 161 – Medication incidents and adverse drug reactions

We submit that the record of all medication incidents and adverse drug reactions should be submitted to the Director.

We also submit that all adverse drug reactions should be reported to Health Canada.

> ***(1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,***
>
> ***(a) documented in the resident's health records, together with a record of the immediate actions taken to assess and maintain the resident's health; and***
> ***(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the resident's attending physician and the pharmacy service provider.***
> ***(c) In addition, every adverse drug reaction shall be reported to Health Canada.***
>
> ***(2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,***
>
> ***(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed;***
> ***(b) corrective action is taken as necessary; and***
> ***(c) a written record is kept of everything required under clauses (a) and (b).***
>
> ***(3) Every licensee shall ensure,***
>
> ***(a) that a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions;***
> ***(b) that any changes and improvements identified in the review are implemented; and***
> ***(c) that a written record is kept of everything provided for in clauses (a) and (b).***
>
> ***(4) A copy of the written records required under (2)(c) and (3)(c) shall be given to the Director.***

Section 163 – Restraining by administration of drug, etc., under common law duty

As stated in section 141 above, it must be made clear that the administration of a drug can only be done without consent if it is required to prevent serious bodily harm.

ACE also supports the recommendations made by the Psychiatric Patient Advocate Office in its submissions to the Ministry with respect to section 163 of the draft regulation.

We recommend the following amendments:

> ***(1) Any prescriber may order the administration of a drug for the purposes of subsection 36(3) of the Act.***
>
> ***(2) Every licensee shall ensure that every administration of a drug to restrain a resident when immediate action is necessary to prevent serious bodily harm pursuant to the common law duty described in section 36 of the Act is documented in the resident's record, and without limiting the generality of this requirement, the licensee shall ensure that the following are documented:***
>
> 1. ***Circumstances precipitating the administration of the drug.***
> 2. ***Who made the order, what drug was administered, the dosage given, by what means the drug was administered, the time or times when the drug was administered and who administered the drug.***
> 3. ***The resident's response to the drug.***
> 4. ***All assessments, reassessments and monitoring of the resident.***
> 5. ***Discussions with the resident or where the resident is incapable, the resident's substitute decision-maker, following the administration of the drug to explain the reasons for the use of the drug.***
> 6. ***The development and implementation of adequate safeguards respecting issues such as regular monitoring intervals, the review of individual restraint use, least restraint policies, annual reporting requirements and annual training for staff.***

Prescription Ordering, Transmission

Standard 3 of 1016-01 in the *Program Manual* has been omitted from the draft regulations. We believe it should be reinstated as follows:

> 1. ***All prescriptions shall be written and shall be signed by the physician.***
> 2. ***Prescriptions shall specify at least the resident's name, date, medication name, strength, form, quantity, frequency and route of administration (application area if topical), and be signed by the physician.***
> 3. ***There shall be a system in place for safe, accurate and timely transmission of all prescription orders.***

4. ***All telephone prescription orders shall be given by the prescriber and shall be received and documented in the facility by registered nursing staff or the pharmacist.***
5. ***The prescriber or the attending physician shall sign the documented telephone order in accordance with established facility policy.***
6. ***A written copy of all prescriptions or duplicate prescription order sheets signed by the prescriber shall be sent to the pharmacist.***
7. ***All medication orders telephoned to the pharmacy shall be given only to the pharmacist.***
8. ***There shall be a quarterly, or more frequent as needed, documented review of each resident's medications, signed by the physician.***
9. ***Following the quarterly medication review, the quarterly medication review record shall be included in the resident's health record and a copy shall be returned to the pharmacy.***

PART VI – FUNDING

NON-ARMS LENGTH TRANSACTIONS

Section 166 – Non-arms length transactions

We submit that all non-arms length transactions should require approval of the Director. If, for example, the licensee is also the owner of a temporary nursing agency, an appropriate bid can always be made. This does not make the transaction acceptable. One impetus for these transactions is to add to the profit margin of the agency, which charges a premium for nurses. By utilizing the agency, the licensee is indirectly adding to their profit. This was the subject of recommendations at the 2003 Wilson Inquest.

We recommend the following amendments to section 166:

(1) For the purposes of section 93 of the Act and this Regulation, "non-arm's length transaction" means a transaction between two parties where one party is an associate of the other party within the meaning of subsection 2 (4) of the Act.

(2) Subject to subsection (3), no licensee of a long-term care home shall enter into a non-arm's length transaction, unless,

- ***(a) in the case of services, that the licensee cannot hire staff to provide the service;***
- ***(b) in the case of services or goods, the supplier is the successful bidder in a competitive bidding process where the licensee obtains at least three unrelated bids;***

(c) the licensee has created a record documenting the transaction, including, in cases where a competitive bidding process is required, the particulars of the competitive bidding process;

(d) the transaction will provide value for the money spent, in that money will be spent with due regard for economy, efficiency, and effectiveness; and

(e) the transaction is approved in writing by the Director.

(3) If a licensee is unable to meet the requirement under clause (2) (a) because of insufficient resources in the area where the long-term care home is located, the licensee may enter into the transaction with the prior written approval of the Director.

(4) A licensee may apply to the Director for the written approval under subsection (3) in the form and manner acceptable to the Director.

(5) Every licensee shall submit to the Director by March 31, or at any other time required by the Director, a report that sets out for the previous calendar year or a time stipulated by the Director, the following:

1. ***Every non-arm's length transaction entered into by the licensee, including a description of the services or goods purchased and the money spent for the goods and services.***
2. ***Confirmation, unless an approval was received by the Director under subsection (3), of compliance with clause (2)(a), or if clause (2)(a) was not complied with, the fact of non-compliance.***

Private Care Workers

The use of private care workers is related to non-arms length transactions, although it may be more appropriate to place it in a different section of the regulations. We also recommend that homes should be barred from recommending private care agencies, requiring that private care be purchased through specific agencies, or from allowing the recruitment of agency staff from private care workers employed by individual residents and their families. We have become aware of instances where homes have highly recommended private care staff be hired by a specific agency and then contracted by the family. This places control in the hands of the agency, doubles the fees for the family and generates a profit to a company related to the home. We strongly believe that this is inappropriate and should be prohibited. Finally, we have had many cases where homes have attempted to "require" the purchase of private care services as a stipulation for continued residence in the home. In some instances, but not all, it involves a non-arms length agency. It must be made clear that there can be no

requirement that a person purchase private care in order to live in a long-term care home. Thus, ACE recommends the following changes to the regulations:

Private Care Staffing

(1) The licensee is prohibited from:
(a) recommending purchasing private care services from specific agencies;
(b) requiring that private care services be purchased from specific agencies; or
(b) promoting the recruitment of private care workers from staff privately contracted by residents or family members; and
(c) requiring the use of private care services as a basis for continued residence in the home.

RECONCILIATION AND RECOVERY

Section 167 – Reconciliation and Recovery

The regulations do not include the semi-annual reports that were required under section 112 of the regulations to the *Nursing Homes Act*. Instead, it requires an annual report and at times specified by the Minister. We believe that semi-annual reporting should be continued, with the addition of times as specified by the Minister, as follows:

Every licensee of a long-term care home shall provide reconciliation reports to the Minister on June 30 and December 31, annually, and at times specified by the Minister.

NON-ALLOWABLE RESIDENT CHARGES

Section 173 – Non-allowable resident charges

The regulations must be unambiguous that residents cannot be forced to pay for preferred accommodation in order to receive appropriate care. For instance, ACE is aware of situations where residents and substitute decision-makers are advised that a resident's care needs can only be met in a specialized unit, locked unit or other area of the home due to increased care requirements. However, they are advised that only preferred accommodation beds are available and there is a wait list for basic accommodation. The person's needs are not being met and transfer is needed immediately. In this instance, the home cannot require a resident or substitute decision-maker to take a preferred accommodation bed and pay the premium in order for the person to access care. We therefore recommend the following amendment be added to section 173:

Charges for preferred accommodation where an internal transfer is required to be able to meet the resident's care needs.

It also needs to be made clear that the agreement for extra charges for goods and services must be in writing. We therefore recommend the following amendment to section 173.5:

Charges for goods and services provided without the resident's written consent.

Section 174 – Statements

The requirement to provide a statement for charges made to the resident is not broad enough. In some cases, trustees appointed under government benefit programs but they are not captured under this section. We therefore recommend the following amendment:

Every licensee of a long-term care home shall, within 15 days after the end of each month, provide each resident or the resident's attorney under the Powers of Attorney Act, or person exercising a continuing power of attorney for property or a guardian of property under Part I of the Substitute Decisions Act, 1992, or person managing the resident's income pursuant to the Ontario Disability Support Program Act, 1997, Ontario Works Act, 1997, Canada Pension Plan Act or Old Age Security Act, with an itemized statement of the charges made to the resident.

PREFERRED ACCOMMODATION

Section 175 – Preferred accommodation maximum

It must be made clear that a home can offer preferred accommodation at a lower rate, including the basic rate. As well, when a person is being offered preferred accommodation at the basic rate, they should also be made aware that they are also entitled to apply for a reduction in basic accommodation charge. Accordingly, ACE recommends the following changes:

A home may offer preferred accommodation at a lower rate than the maximum set out in the regulations.

Where preferred accommodation is offered at the basic accommodation rate, the resident is entitled to be treated as a resident in basic accommodation, including the right to apply for a rate reduction.

CHARGES FOR ACCOMMODATION

In general, all references to the $125 comfort allowance should be changed to $128, as this is the new allowance as of November 1, 2009, which will be well before the implementation of any new regulations.

Section 180 – Reduction in basic accommodation charge

There must be an obligation on the home to explain all possible rate reductions to the resident, including the exceptional circumstances reductions.

The licensee must provide the resident or person with authority to manage their finances with information regarding applying for the rate reduction and exceptional circumstances reduction.

Section 180(7) includes benefits which were not previously included when calculating the rate reduction. To date, it is only taxable income upon which the rate reduction was calculated. The draft regulation includes numerous other non-table private insurance benefits which were previously not included. We recommend that this be removed from the regulations:

Remove references to non-taxable private insurance benefits.

Section 181 – Further reduction in exceptional circumstances

Section 181(1)2 states that if the previous year's notice of assessment is not representative of income available to the resident in the current year, an exceptional circumstances application can be made. We wish to stress the importance of this section and ensure that this will include people who may have cashed their RRSPs the previous year. Many of our clients have cashed out RRSPs to do such things as pay for medical treatment or to take trips when they were well. In all cases, they were not, of course, aware that the following year they would become so ill as to require admission to long-term care and that the cashing of the RRSPs would create financial burdens. ACE wants to ensure that people are not penalized for their pre-admission lifestyle since admission is often unplanned.

Ensure that section 181 takes into account the unexpected change that admission may have on a person's lifestyle and that prior monetary decisions have no bearing on the current monetary situation.

We also believe that a resident should not have to pay where the maximum amount is calculated at being higher and the miscalculation was not the fault of the resident. We have had instances where miscalculations by homes have caused difficulties for resident and their families. If a person is residing in basic accommodation and has been paying too little, it is often the case that any remaining money has been spent on

necessities. The resident is then asked to pay money back which has already been spent. We submit that if the miscalculation was the fault of the home, then the resident should not have to pay the amount. However, if the miscalculation was the result of the resident knowingly deceiving or failing to provide requested documentation, then they should have to pay the fees owing.

We therefore recommend the following amendment:

> ***If the Director determines that the resident should have paid a higher maximum amount in the prior years, then the resident shall repay the difference only if the miscalculation was due to the resident knowingly failing to provide requested income information or providing false information to the licensee. Such repayment must be made before obtaining a reduction under the current application. Where the miscalculation was due to an error made by the licensee or Ministry of Health and Long-Term Care, the resident will not be required to repay the difference.***

We submit that our comments made regarding section 180(7) should also apply to section 181(9), as follows:

> ***Remove references to non-taxable private insurance benefits.***

Section 182 – Reduction in charge, resident with dependents

It would appear that this section has two purposes:

1. To take the place of the exceptional circumstances reduction presently available to spouses of residents who continue to reside in the community; and
2. To take into account that some residents have other dependents in the community.

We do not believe this section is sufficient.

In the case where both spouses are over 65 and one remains in the community, we do not believe that income alone is sufficient to determine whether or not the rate should be decreased. While we are pleased that the deduction appears to provide more for a resident's spouse living in the community than the present amount of $152.08, we believe that there should also be recognition of debts or liabilities. As indicated previously, many people undergo catastrophic accidents or illness and end up in a long-term care home, often with devastating effects on the family. Consideration should be given to provide a deduction even when the income levels are higher than those assessed.

In the case where one or both of the spouses are under the age of 65, we believe that the scheme as set out in section 10 of the *Health Insurance Act* regulations should apply. This is a more generous scheme and takes into account family income. This appears to acknowledge the increased monetary difficulties for those under the age of 65. As more and more younger persons with a disability are now being admitted into long-term care instead of complex continuing care, we believe that the long-term care system must treat them the same. The present allowance for the amounts of $1404.55 for a spouse and $330.74 for a child in no way can meet the needs of those families. If the amounts are not changed, we will see families who have already been hit with personal catastrophes such as a father having early Parkinson's, or a mother suffering from MS, we will now see them loose their homes, be unable to provide for their children, and spiraling downward due to the weight of the long-term care home fees.

We have taken the following amounts Table 2 of the regulations to the *Health Insurance Act*[28] and ask that it be amended as necessary for the purpose of these regulations:

Person with no dependants – maximum estimated income $1,742.21
1. Monthly - Estimated income less $128.00
2. Daily - Estimated income less $128.00, divided by 30.4167

Person with one dependant – maximum aggregate estimated incomes $8,411.00
1. Monthly - Aggregate estimated incomes less $3,567.00, divided by 3
2. Daily - Aggregate estimated incomes less $3,567.00, divided by 91.2

Person with two dependants – maximum aggregate estimated incomes $8,921.00
1. Monthly - Aggregate estimated incomes less $4,078.00, divided by 3
2. Daily - Aggregate estimated incomes less $4,078.00, divided by 91.2

Person with three dependants – maximum aggregate estimated incomes $9,387.00
1. Monthly - Aggregate estimated incomes less $4,543.00, divided by 3
2. Daily - Aggregate estimated incomes less $4,543.00, divided by 91.2

Person with four or more dependants – maximum aggregate estimated incomes $9,802.00
1. Monthly - Aggregate estimated incomes less $4,958.00, divided by 3
2. Daily - Aggregate estimated incomes less $4,958.00, divided by 91.2

Person not referred to elsewhere in this item
1. Monthly - $1,614.21
2. Daily - $53.07

[28] R.R.O. 1990, Reg. 552.

Section 183 – Restriction, interest charges

This section implies that a home may charge interest for non-payment of long-term care fees. Under the present legislation, it was arguable that interest could not be charged as it would be requesting more than the maximum fees allowed under the legislation. We recommend that a prohibition on charging interest be included in the regulations by deleting section 183 and replacing as follows:

> ***Residents may not be charged interest for missed, incomplete or late payments.***

Section 184 – Restriction on charges

Section 184(1)(d) states that a resident cannot have their accommodation reduced if they are a sponsored immigrant if they have not exhausted financial support from their sponsor. This compounds the present issue, included now in section 184(1)(a), that a resident is not eligible for a reduction if they do not apply for government entitlements, which would include ODSP benefits.

Many people sponsor their parents to come live with them in their old age. These sponsored immigrants often come from countries from which they do not receive any retirement benefits or where those benefits are minimal. When they come to Canada, they are sponsored for ten years. While the sponsors understand that they must support their parent, they are unaware that if their parent gets ill that there will be such a high cost for long-term care.

While we understand the Ministry of Health and Long-Term Care's reluctance to subsidize these fees, there is a greater issue. These immigrants are in Canada legally and many are in fact citizens. They all are entitled to care under our health insurance plan. When the sponsor learns that they will have to pay the fees (either the fees themselves or to pay back ODSP payments), they may withdraw their parent's application to long-term care if they are the substitute decision-maker or the parent will withdraw the application themselves if they believe it will have a negative effect on their children. The result is that the person does not get the health care to which they are entitled and they may suffer declining health or be put in harms way. For example, if a person has dementia and the family works during the day, they may be locked in a home to prevent them from wandering or they may start a fire trying to cook on their own.

This section has taken the matter even further, requiring that sponsored immigrants have exhausted the financial support of their sponsor. It is not clear whether this includes bringing a court action to enforce the agreement or to seek support. This would be an additional barrier to the person obtaining necessary health care, as it is unlikely that many of these persons would be willing or able to bring such an application.

While income is not supposed to be a barrier to entry, in this case it is. Applications will not be made or will be withdrawn when information regarding fees is provided. Moreover, if persons are admitted to homes and do not pay because they are not entitled to appropriate rate reductions, under this legislation the home will bear the burden of the debt. This is unfair to the other residents of the home and to the home itself as it is providing care but not being paid.

The ramifications of this section regarding sponsored immigrants are profound and the section must be reworked so that those entitled to access care can receive it.

Amendments are required to remove financial barriers for sponsored immigrants to be admitted to long-term care and receiving the care to which they are entitled.

PART VII – LICENSING

Section 192(d) – Premises that do not require licence

The effect of this section is that "retirement homes" will be able to provide nursing care for two or more unrelated persons without a license. In other words, even if a retirement home offers the same level of care as a long-term care home that requires a licence, they will be able to do so. There are a number of problems with this section:

- The term "retirement home" is not a defined term in this or any other legislation in Ontario. What is commonly referred to as a retirement home is defined as a "care home" under the regulations to the *Residential Tenancies Act.*[29] If this section is intended to exempt care homes from the application of the *LTCHA*, then care homes as defined by the regulations to the *Residential Tenancies Act* should be specifically exempted. If the meaning is something other than care homes, the term "retirement home" should be defined in this regulation for clarity.

- Whether a retirement home or a care home is exempted, the same major problem exists if this regulation is not deleted or amended. This regulation will result in retirement homes being allowed to offer the same level of care and services (or even more care services) as a licensed long-term care home without public oversight or inspection, leaving the residents of those homes without effective remedies to address problems with care services.

The *LTCHA* and its predecessor legislation exist not only to provide accountability for the use of public health dollars, but also because it was determined that vulnerable populations residing in such accommodation need protections and that this type of industry requires public oversight. Report after report on long term-care, including those done by this government, such as the report by Monique Smith, focused on this

[29] O.Reg. 516/06, s. 1.

vulnerability and the need for effective regulation to ensure that vulnerable adults get the quality or care that they need and are entitled to in this public health system.

Exempting residential accommodation with care services, such as retirement homes, would mean that a large sector of vulnerable adults would not have these protections. Although the accommodation portion of care homes are regulated under the *Residential Tenancies Act* so that these residents, properly known as tenants, have the protections of landlord and tenant law, the care services are not regulated in any way (other than a requirement for the provision of a Care Home information Package). For example, there are no inspections, no requirements for care standards and no effective oversight of care services. Likewise there are no effective remedies that these tenants can pursue to address problems that arise in these settings.

Section 192(d) would affect both wealthy individuals, as well as the poor elderly and people with physical disabilities residing in care homes across the province. This latter group is even more vulnerable in light of their limited economic options.

Retaining section 192(d) would be a statement by this government that they are not interested in the protection of vulnerable adults who live anywhere besides licsensed facilities. This exemption would authorize retirement homes that operate as bootleg nursing homes to continue operating without any oversight. It would be a confirmation that this government supports two-tier medicine.

Obviously, this would be a major shift in public policy in Ontario. We think it important to obtain feedback from the broader public on whether they would support a two-tier system in long term care – a provincially regulated and publicly funded system for some people, and a separately regulated private pay system (whether regulated by a third-party regulator or by the industry itself). We made this statement in 2007 at the time of the Public Consultation on Regulating the Retirement Home Industry. We attach to this submission both our brief on that consultation as well as a letter we wrote to the Ministers of the day with respect to this issue.

Therefore, we recommend the following change to the draft regulation:

Section 192(d) should be deleted.

PART IX – COMPLIANCE AND ENFORCEMENT

Sections 211-215 – Compliance and Enforcement

The *LTCHA* establishes a comprehensive regime for long-term care homes to review and challenge compliance orders. Residents and their substitute decision-makers, however, do not have a similar opportunity. Currently, the only recourse for a resident or their substitute decision-maker is to make a complaint to the Ombudsman of Ontario,

who has jurisdiction over government services and the actions of government employees.

Using the statutory authority found in section 3(4) of the *LTCHA,* for example, which permits the Lieutenant Governor in Council to make regulations governing how rights set out in the Residents' Bill of Rights are respected and promoted by the licensee, ACE recommends that regulations should be made to create and implement an appeals process for residents and their substitute decision-makers to review compliance reports, as the Ministry of Health and Long-Term Care determines is appropriate:

Develop an appeals regime for residents and substitute decision-makers to review compliance reports, analogous to the scheme already established for long-term care homes.

PART X – ADMINISTRATION, MISCELLANEOUS AND TRANSITION

TRUST ACCOUNTS

Section 217 – Trust accounts

It must be made clear that a licensee cannot be named as a trustee or person to manage a resident's money under the *Old Age Security Act, Canada Pension Plant, Ontario Disability Support Program Act, Ontario Works Act*, *Substitute Decisions Act, or Powers of Attorney Act*. What has happened in the past is that homes have applied to be named the person managing the money on behalf of allegedly incapable residents of their home. Homes should NEVER be the decision-maker regarding their client's money, as it is too easy to lead to abuses. We therefore recommend that the following be added to this section or elsewhere as is deemed appropriate:

A licensee is prohibited from being named as a trustee or person to manage a resident's money under the Old Age Security Act, Canada Pension Plant, Ontario Disability Support Program Act, Ontario Works Act or Substitute Decisions Act, or Powers of Attorney Act.

In section 217(12) the word "trustee" is not defined. This should include those who are acting as a person managing a person's money under legislative authority, and may also include someone who is managing the money where the money is held jointly in a bank account. Thus, ACE recommends the following addition to section 217:

Definition of "trustee".

EXEMPTIONS

Section 245 – Exemptions, alternative settings

It is not clear what the “alternative settings” that are being authorized include. We are concerned that there are lengthy exemptions being made to any long-term care home beds, including short-stay or interim beds. We believe that there should be no exemptions to the *Act* or regulations for any beds where long-term care is provided.