Submission to the Standing Committee on the Legislative Assembly

Bill 37
Providing More Care, Protecting Seniors, and Building More Beds Act, 2021

November 25, 2021

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A. INTRODUCTION TO ACE

The Advocacy Centre for the Elderly (ACE) is a specialty legal clinic under the *Legal Aid Services Act* that was established to provide a range of legal services to low-income seniors in Ontario. Its mission is to uphold the rights of low-income seniors, and its purpose is to improve the quality of life of seniors by providing legal services which include direct client assistance, public legal education, law reform, community development and community organizing. ACE has been operating since 1984 and was the first legal clinic in Canada with a specific mandate to serve older adults and with expertise in elder-law issues.

ACE currently employs six lawyers, three paralegals, and an administrative coordinator. On average, ACE annually receives over 4,000 calls from older adults, families of older adults, health and social service providers and other callers. More than 65% of the intakes and client cases that ACE assists with are in the area of health law. Most of the telephone inquiries come from the Greater Toronto Area with approximately 20% originating from other areas of the province. From time to time, ACE also receives inquiries from outside of Ontario.

Clients regularly seek our advice on issues relating to long-term care. Specifically, ACE has received numerous calls regarding:

- Callers being unable to access long-term care due to waiting lists;
- Callers advising that they do not receive sufficient care and attention to meet their health care needs;
- Callers concerned about the poor quality of long-term care home services;

ACE also has a high number of calls regarding unregulated care facilities that are used by hospitals and Local Health Integration Networks (LHINs) to house "alternate level of care" (ALC) patients while waiting for placement into long-term care homes.

ACE lawyers are in high demand as speakers on all issues relating to older adults including home care, long-term care homes, retirement homes, consent and capacity law, and elder abuse. ACE lawyers have made many presentations on these issues at the local, provincial national, and international levels.

Given ACE's experience in legal issues affecting the rights and interests of older adults in Ontario and throughout Canada, we trust that our submissions concerning the proposed changes to the Ontario home care system will be of some assistance.

a. Demand for Services during COVID Pandemic

The COVID pandemic affected the practice at ACE on behalf of the residents of both long-term care homes and retirement homes.

During that time, our work on behalf of these vulnerable residents changed the other chronic issues that we had long seen to issues of detention due to COVID, lack of visitation, and hospital admissions and discharges, to name a few. We also spent a great deal of time collecting and disseminating directives, policies and regulations related to COVID-19 and care in long-term care, retirement homes and other sectors.

b. Impact on Seniors of COVID-19

As of November 22, 2021, approximately 4,000 long-term care home residents have died from COVID-19. Thirteen long-term care home staff members also succumbed to the disease.[1] Over 15,000 long-term care residents and over 7,000 long-term care home healthcare workers were reported to have had COVID-19. Retirement home residents also had considerable losses, with 619 resident deaths, and four staff deaths, with cumulative COVID-19 cases of 4,031 residents and 2,270 staff.[2] The effect of COVID-19 on the long-term care home system as a whole was devastating, and put an already fragile system into a tailspin.

On March 28, 2020, as the first directives were created for long-term care homes and changes were being made to "protect" long-term care home's residents, based upon 26 years of experience advocating for residents in the long-term care sector, ACE's Jane Meadus was quoted in the *Toronto Star* stating that changes being made were "going to be a disaster".[3] Unfortunately, this proved till be all too true.

During the pandemic, along with the deaths, the civil liberties of the over 150,000 residents of Ontario's long-term care homes and retirement homes were ignored when they were illegally detained in their homes via the Chief Medical Officer of Health's directives. These populations plus those in group homes (who were not even subject to a directive) were the only persons in Ontario so detained, while all other members of society who were detained were subject to s. 22 orders under the *Health Protection and Promotion Act,* which were required to meet

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[1] Government of Ontario. (November 23, 2021). How Ontario is Responding to Covid-19. ontario.ca. Retrieved November 24, 2021, from https://www.ontario.ca/page/how-ontario-is-responding-covid-19. The Ontario Government maintained website contains inconsistent data, with deaths reported for residents both at 4,023 and 3,824, and of long-term care home healthcare workers at 10 and 13.

[2] Retirement Home Regulatory Authority. (November 23, 2021). RHRA COVID-19 Dashboard. Covid-19 Dashboard – retirement homes regulatory authority. Retrieved November 24, 2021, from https://www.rhra.ca/en/covid19dashboard/

[3] Welsh, M. (March 29, 2020). Province suspends rules protecting vulnerable, long-term care residents. *Toronto Star.*. Retrieved November 24, 2021, from https://www.thestar.com/news/canada/2020/03/28/province-suspends-rules-protecting-vulnerable-long-term-care-residents.html.

specific legal criteria and were subject to review, as required under Canada's *Charter of Rights and Freedoms*.

At the same time, all visitors, including essential caregivers, were banned from homes. Many physicians stopped attending homes in person. Issues which predated the pandemic grew exponentially, such as staffing, care service, and cleanliness. One only has to review reports such as the Canadian Armed Forces reports,[4][5][6] the Report of the Office of the Auditor General of Ontario,[7] Special Report of the Patient Ombudsman of Ontario,[8] Report of Ontario's Long-Term Care COVID-19 Commission[9] to see the devastating effect that COVID had on long-term care homes across Ontario.

However, as we and many other long-term care home advocates pointed out, these issues were not new, but in fact, were problems which had existed in long-term care homes for years, but had been allowed to continue and grow. When the issues were just those of long-term care home residents which did not affect the outside world, they were ignored. Death from disease outbreaks, staffing shortages, overcrowding, poor quality of care, old deficient homes, and failure to enforce the *Long-Term Care Homes* Act, all existed prior to March 2020. It was only when residents started dying, not in the hundreds, but in the thousands, that attention began to be paid to the conditions in which they were living.

Legislative changes can only do so much. If this and subsequent governments want to provide quality care to long-term care home residents, they must ensure that the resident's rights are upheld, and that the homes are and care are properly funded, regulated and inspected, and that consequences for non-compliance are meaningful.

Without true culture change, we will only continue to perpetuate the problems we have seen in long-term care during this pandemic.

B. TIMING OF BILL 37

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[4] Mialkowski, C.J.J., Brigadier General, (May 14, 2020) Canadian Armed Forces. OP Laser - JTFC Observations in Long-Term Care Facilities in Ontario.

[5] CAF Team Downsview. (June 4, 2020) 61 CIMIC Meeting Briefing Notes.

[6] CAF Team Hawthorne (May 18, 2020) 61-2020-05-16).

[7] Office of the Auditor General of Ontario. (April 2021) *COVID-19 Preparedness and Management: Special Report on Pandemic readiness and response in Long-Term Care.*

[8] Patient Ombudsman of Ontario. (October 2020) *Special Report – Honouring the voices and experiences of Long-Term Care Home residents, caregivers and staff during the first wave of COVID-19 in Ontario).*

[9] Marrocco, F. N. et al, (April 2021). *Ontario's Long-Term Care COVID-19 Commission Final Report.* Queen's Printer for Ontario.

a. Timing and Haste of Bill 37

Bill 37 proposes numerous changes to Ontario's long-term care home legislation. If passed it will affect thousands of current and future residents of Ontario who may require the services of the long-term care home system. The lack of consultation and discussion, and the swift processing through the legislature, including committee, does a disservice to the long-term care home residents and others affected by this legislation.

Discussion

Bill 37 was introduced in the legislature on October 28. Prior to that, there had been a very limited public consultation, which was targeted to some very specific areas. In many cases, the consultation was limited to individualized completion of questionnaires and perhaps some discussion with Ministry of Long-Term Care staff. Some groups may have had more fulsome participation, but this was not universal. Further, this consultation did not include provision of any draft legislation or information about what the Government was suggesting as changes. This made it impossible to discuss beforehand what issues these changes might suggest.

The quick turn-around time from referral to the Standing Committee on the Legislative Assembly (November 23), to the oral presentations on November 23-25, which written submissions on November 25, gave little time for preparation. Many people and groups who wish to present or submit do not have the resources available for such a quick turn around, despite having a wealth of hands-on knowledge. Further, the limitation to two days of public testimony (as the first was for the Ministers only) likely means that many groups and individuals ls were not able to present.

The Minister of Long-Term Care has expressed his intent to make meaningful changes for long-term care homes; however, with such a compressed time frame in all aspects changes to this legislation we have a missed opportunity to properly ensure that the necessary changes are being made.

C. REVIEW OF SPECIFIC SECTIONS OF BILL 37

a. Bill 37, Title

Providing More Care, Protecting Seniors, and Building More Beds Act, 2021

Discussion

The above-noted title does not reflect the fact that long-term care homes are not only homes for seniors, but also for many persons with disabilities ages 18 and above who cannot find appropriate supportive housing elsewhere.

The title also indicates that it is for “Protecting Seniors”. This is extremely paternalistic and embeds the position that we must “protect” those living in long-term care, rather than allowing them to live their lives. The title should reflect a more appropriate goal, which is to protect the residents’ rights.

There is nothing in this legislation that either regulates or the building of more beds. While this is an important goal, it is not part of this legislation.

Recommendation

ACE recommends that the Act be renamed as follows:

> ***Providing More Care and Protecting Long-Term Care Home Residents’ Rights Act, 2021***

b. *Fixing Long-Term Care Act, 2021,* preamble

> **Preamble**
>
> Are committed to providing and promoting high quality accommodation in a safe, comfortable, home-like environment where every long-term care resident has an ability to enjoy life, and pursue the relationships, activities and interests that are meaningful to them;
>
> …
>
> Are committed to the promotion of the delivery of long-term care home services by not-for-profit and mission-driven organizations; …

Discussion:

The first section of the preamble noted above indicates that there is a commitment to providing high quality accommodation, which is laudable. However, nowhere in the preamble is it clear that there is a commitment to provide high quality health care. This must be remedied.

The second section of the preamble noted above indicates that there is a commitment to promote both not-for-profit as well as “mission-driven”

organizations. “Mission driven” is an undefined term that applies to for-profit facilities that have a “mission” to provide care for the residents of their homes.

We do not believe that there should be a commitment to any type of for-profit entity in the long-term care sector. While their continued existence as part of the system may at this point be inevitable, providing them with a special status in the preamble is not. Studies have shown that not-for-profit facilities provide superior care in general and did better than for-profit facilities during the COVID-19 pandemic. Ultimately, no matter what type of “for-profit” facility it is, they are, by definition, removing a profit from the money collected by the home, which would otherwise go to assisting the residents. For this reason, we do not believe that the special recognition of these undefined for-profit facilities should have specific support in the Act.

Recommendation:

Amend the preamble as follows:

> **Adding:**
>
> **Are committed to providing and promoting high quality health care with access to long-term care home staff, including nursing professionals, physicians, allied health professionals and others within the home, as well as access to outside professionals as required by the individual;**
>
> **Amending by removing “mission-driven”:**
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> **Are committed to the promotion of the delivery of long-term care home services by not-for-profit organizations**

c. *Fixing Long-Term Care Act, 2021,* section 3 – Residents’ Bill of Rights

> 8. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
>
> 19. Every resident has the right to,
>
> …
>
> iii. participate fully in making any decision concerning any aspect of their care, including any decision concerning their admission, discharge or transfer to or from a long-term care home and to obtain an independent opinion with regard to any of those matters, and

24. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

25. Every resident has the right to be provided with care and services based on a palliative care philosophy.

Discussion

Residents' Right #8 entitles the resident to share a room with another resident "if appropriate accommodation is available". Unfortunately, many of the new builds do not have multi-resident rooms, and because of the Act and regulations, long-term home operators believe that they cannot put two people in a private room. The result is that couples, many of whom have been together for decades, are forced to live apart within the home. We want the rights to include that partners have the absolute right to live together in every home. Design standards or exceptions to regulations to allow two residents to sleep together in a private room (with the second room potentially used as a sitting room) must be amended in conjunction with this right.

Resident right #19 does not give the resident the right to participate in decisions regarding internal transfers. While we agree that there is no "security of tenure" within the long-term care home that would give a resident the absolute right to stay in a specific room, we firmly believe that such transfers should only be done in conjunction with meaningful discussions with residents. Room transfers that are not requested by residents should only occur when there are no other options, and in conjunction with residents' input. In our experience, transfers are often forced on residents where the residents and the home disagree on the reason for the transfer, such as requiring a different unit, moving away from specific people, and staffing issues, to name a few. Residents must always be included in the discussions to ensure that if the transfer must occur, the reason for the transfer is understood by the resident, and sufficient accommodations are made to ensure a safe transfer.

Resident right #24 indicates that residents have the right not to be restrained except as permitted by the Act. We would like to add a section that makes it very clear that residents cannot be confined except under due process of the law. This would be done in conjunction with the inclusion of what is now section 203 into the main body of the legislation, amendments to that section, and enacting it at the same time as the rest of the legislation.

Resident right #25 indicates that residents have the right to receive care and services based on a "palliative care philosophy". We believe that this puts too much of an emphasis on "palliative care", which most people believe to be the provision of specific services at end of life. Instead, we believe that access to

quality palliative care when needed as consented to by the resident or their substitute decision-maker is a better alternative, and has less of a focus on a long-term care home being a place where one comes to die.

Recommendations

Amend the rights as follows:

> **8a. Every home must provide accommodation for residents who are partners and who wish to reside in the same room.**
>
> **19. Every resident has the right to,**
> **…**
>
> **iii.1. participate fully in making any decision concerning a transfer within a long-term care home and to obtain an independent opinion with regard to the transfer**
>
> **24.1. Every resident has the right not to be confined except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.**
>
> **25. Every resident has the right to be provided with quality palliative care when needed and consented to in accordance with the law.**

d. *Fixing Long-Term Care Act, 2021,* section 3(3) – Residents' Bill of Rights - Enforcement

> **Enforcement by the resident**
> (3) A resident may enforce the Residents' Bill of Rights against the licensee as though the resident and the licensee had entered into a contract under which the licensee had agreed to fully respect and promote all of the rights set out in the Residents' Bill of Rights.

Discussion

While every resident has the right to enforce the Residents' Bill of Rights as a contract, this has not occurred. Bringing a case through the courts, including Small Claims Court, is cumbersome, time-consuming, and largely inaccessible to residents for practical reasons.

While we recommend the continuation of the right to enforce the Act as a contract, we recommend that a new tribunal for long-term care home residents

be established to assist. This tribunal would hear cases regarding breaches of the entire Act, including the Residents' Bill of Rights and whistle-blowing protection which could be brought by a resident or substitute decision-maker. The tribunal would be based upon the Consent and Capacity Board model with respect to simplification of process, ease of access, quick turn-around, and being user-friendly, which would allow residents to bring such cases quickly and see more immediate results. This tribunal would have the authority to make orders to the home, as well as order monetary compensation for breaches or damages.

Recommendations

Create the following:

Creation of a new tribunal to hear complaints by residents of breaches of the entire Fixing Long-Term Care Act, 2021 and have the ability to make orders for homes to comply and orders for damages

e. *Fixing Long-Term Care Act, 2021,* section 8 and 9 – Direct Hours of Care – Target

> **Direct hours of care target — personal support workers, nurses**
>
> Target date
>
> 8(3) The target set in subsection (2) must be achieved no later than March 31, 2025, and once achieved, shall continue at that level, subject to subsection (5).
>
> How average calculated
>
> 8(7) The average is to be determined by taking the total number of hours of direct care actually worked by registered nurses, registered practical nurses and personal support workers in all long-term care homes, and dividing that number by the total number of resident days in all long-term care homes for the applicable calculation period provided for in the regulations.
>
> **Direct hours of care target — allied health care professionals**
>
> When to be achieved
>
> 9(3) The target set in subsection (2) must be achieved no later than March 31, 2023, and, once achieved, shall continue at that level, subject to subsection (5).
>
> How average calculated

(7) The average is to be determined by taking the total number of hours of direct care actually worked by allied health care professionals in all long-term care homes, and dividing that number by the total number of resident days in all long-term care homes for the applicable calculation period provided for in the regulations.

Discussion

Increasing direct hours of care to four hours per resident is a laudable goal. However, we believe that this should occur sooner. Four hours of care was recommended in 2008 in the "Sharkey" report[10], over 13 years ago. Residents need these hours now, not in four years.

Given the age of this report and the documented increase in acuity in long-term care home residents since that time, we believe that a scientific study be conducted forthwith to determine the actual time required to provide good, resident-centered quality of care in today's long-term care setting, and that the results be implemented by 2023.

The legislation indicates that the calculation of the four hours is across the system, not per home. While we agree that there are differences in resident requirements, where some residents may require less than four hour and some more, calculating across the system will perpetuate the inequities that exist today. The Honourable Rod Phillips, when making submissions on November 23, 2021 before the Standing Committee on the Legislative Assembly regarding this Bill, stated that there were some homes that were already providing five hours of care, and that he did not want them penalized for doing so.

However, calculating the hours across the system will perpetuate inequities as homes that have not been providing high levels of care will be able to continue to do so. This means that some homes can provide more than four hours of care (which are likely run by municipalities and not-for-profits that use the "other" funding envelope plus other source funds to supplement care), while other homes (which are likely for-profit) can continue to provide low levels of care as the "average" will result in four hours.

All long-term care home residents should be entitled to the same level of care, which here includes the four hours. To allow some homes to have lower than average hours of care per resident, just because the home down the road provides higher hours of care, is unfair, does a disservice to those residents, and

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[10] Sharkey, Shirlee. (May 2008) *People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes.* Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario. Queen's Printer of Ontario at page 10.

does not fulfill the promises made to long-term care home residents by this government and pursuant to this Bill.

Recommendations

Amend the Act as follows:

Direct hours of care target — personal support workers, nurses

Target date

8(3) The target set in subsection (2) must be achieved no later than March 31, 2023, and once achieved, shall continue at that level, subject to subsection (5).

How average calculated

8(7) The average is an average per home to be determined by taking the total number of hours of direct care actually worked by registered nurses, registered practical nurses and personal support workers in each long-term care homes, and dividing that number by the total number of resident days in each long-term care homes for the applicable calculation period provided for in the regulations.

Direct hours of care target — allied health care professionals

How average calculated

(7) The average is an average per home to be determined by taking the total number of hours of direct care actually worked by allied health care professionals in all long-term care homes, and dividing that number by the total number of resident days in all long-term care homes for the applicable calculation period provided for in the regulations.

Study of Direct Hours of Care

10.1 (a) The Ministry of Long-Term Care commits to the completion of a study into the actual amount of care required by residents in long-term care homes by the March 31, 2023, and fund and implement that level of care by 2025.

(b) The Ministry of Long-Term Care completes annual reviews starting in 2026 to review the amount of care

required by residents in long-term care homes and fund and implement increased levels of care as necessary.

f. *Fixing Long-Term Care Act, 2021,* section 12 – Palliative Care

Palliative care

12 (1) Every licensee of a long-term care home shall ensure that, subject to section 7, residents are provided with care or services that integrate a palliative care philosophy.

Matters in regulations

(2) Without restricting the generality of subsection (1), every licensee shall comply with the regulations respecting palliative care and the palliative care philosophy.

Discussion

It appears from the Act as well as the oral submissions heard on Tuesday, November 23, 2021 before this Committee, that the intent is that this "palliative care philosophy" be included in all care plans.

Residents of long-term care homes do not come to the home to die; they come to live, as was evident by the submissions of long-term care home residents Devorah Greenspon and Carolynn Snow before this Committee on November 24, 2021.

These residents expressed very clearly that the mandatory requirements to include "palliative care" in every resident's care plan is inappropriate. This perpetuates the idea that long-term care homes are places where people come to die.

As noted above, the admission age for long-term care is 18. Many younger, disabled persons end up in long-term care, not because they want to, but because it is a last resort. These residents often have lengthy lives ahead of them, and to be told at the beginning of their journey that they are going to be

treated "palliatively" is entirely inappropriate. The same applies for the older residents. While many of them may require palliative care at some point, this does not mean that they require it upon admission.

While some in the medical profession will say that "palliative care" is a philosophy and does not equate to end-of-life care, that is not what will be interpreted by the residents, families, and staff. Words matter. By indicating that the "palliative care philosophy" should be applied to every resident, it will be interpreted as long-term care being a journey towards death, instead of a path towards living life to its fullest. This does a huge disservice to the residents.

We agree that quality palliative and end-of-life care has not been provided in many long-term care homes. This has been seen very clearly during the COVID-19 pandemic. Long-term care homes, as health care facilities, should be able to provide in-home quality care to the residents at the end of their lives, if the resident or their substitute decision-maker so chooses. The Act should be amended to require all residents to have access to such care.

We are concerned, however, that "Level of Care" or "Advance Directives" will be made a mandatory part of the palliative care program. We strongly urge that the legislation make clear that these documents are never mandatory, and that instead of such documents, residents are encouraged to have discussions with the health professionals as well as any substitute decision-maker or family member that they wish to include. Discussions around end-of-life wishes are more important than the creation of documents.

ACE has dealt with these documents over many years. We refer to "Level of Care" or "LOC" documents, but they have many names. Usually, LOCs are provided to residents with the admission documents. The LOCs have a number of "levels" that are set out, such as "No CPR, No Ventilations, No Hospital Care, Comfort Measures Only" being one level, with "Full CPR, All Interventions" at the other end.[11]

LOCS, Advance Directives, and living wills are <u>not legal documents</u> in Ontario. Even if signed by the resident, they only express a competent person's "wishes" with respect to future care. Pursuant to s. 10 of the *Health Care Consent Act*, as long as a resident is mentally capable, they make all of their own treatment decisions. It is only when the person is no longer capable that "wishes" become important. Section 21 of the *Health Care Consent Act* provides that when making a decision regarding a proposed treatment, substitute decision-makers must consent or refuse a treatment in accordance with a known competent wish of the

[11] For a full analysis of the problems related to the use of these documents, see Wahl, J., Dykeman, MJ, and Walton, T. (December 2016) *Health Care Consent, Advance Care Planning, and Goals of Care Practice Tools: The Challenge to Get it Right: Improving the Last Stages of Life*. Commissioned by the Law Commission of Ontario.

person. If none is known, then the substitute decision-maker makes their decision in accordance with the best interest test, as set out in section 21(2).

While some people <u>choose</u> to record their wishes in documents, including in powers of attorney for personal care, this is not required. Wishes can be expressed in any manner, and the most recent wish applies, no matter how it is made. Therefore, verbal wishes made later will override any previous wishes, even if they appeared in a document such as an LOC or power of attorney for personal care.

Further, substitute decision-makers cannot make “wishes” on behalf of an incapable person. This means that they <u>cannot</u> sign an LOC on behalf of a resident. If a resident is incapable, no such document can be signed. Substitute decision-makers can only make decisions at the time that a treatment is being offered.

The difference is context. Substitute decisions can only make healthcare decisions on behalf of an incapable person when the person is in the situation requiring the treatment and they are provided with the actual information about the treatment.

When an incapable person has made a wish, this wish does not “speak” to the health practitioner; it is not a “consent” that provides instructions. Instead, the health practitioner must turn to the person's substitute decision-maker for informed consent, pursuant to section 10 of the *Health Care Consent Act* and it is up to that substitute decision-maker under s. 21 of the *Health Care Consent Act* to interpret any wish and determine if it applies to the situation.

LOCs and other documents used in long-term care and other settings are very often misused as “consents”. Instead of speaking to the resident or their substitute decision maker, the health practitioner simply relies upon the documents. Because these documents are wishes and have no context, this often has negative results. During COVID, many residents were not sent to hospital because they or their substitute decision-maker completed an LOC and ticked off “no hospital”. Frequently what was understood at the time of signing the document (which usually is not done with assistance of a health professional), is that if the person is dying, they do not wish to be hospitalized. When the document is taken at face value, this statement denies residents care that could assist them in recovery. Residents died from COVID because they were not sent to hospital to seek treatment, without even being given the opportunity to decide whether that was something they wanted to do. These documents were not signed with any knowledge of COVID, therefore any “wish” not to be sent to hospital could not have applied, and yet that is what homes did.

ACE has also had many cases where residents with serious injuries, including broken hips, were left in their beds because this box was ticked off, without being

given the opportunity to go to hospital. In one case, an administrator called ACE to ask if she could send a resident who required emergency treatment to hospital because the resident had ticked off the "no hospital" box years earlier. When asked, the administrator admitted that the resident was mentally capable of making the decision, and was sitting before them asking to go to hospital! It would seem to defy logic that this could happen, but sadly it happens all of the time.

Such documents are often also seen as "do not treat" documents. Emergency personnel as well as hospital staff have been known to refuse to administer care, transfer residents, or admit or treat in hospital, due to the overall misunderstanding of these documents.

Residents themselves may have some very clear ideas about what they want, and they of course may indicate these wishes at any time. If the resident is incapable, and there is a known wish they made when they were capable, it should be documented, however, the use of these documents as mandatory or as of rote, should be discontinued, due to the actual harm they cause to residents. Further, staff, including medical directors and physicians providing care, should receive training on Health Care Consent and Advance Care Planning to understand the residents' rights and their responsibilities in this area.[12]

<u>Recommendations</u>

Amend the Act as follows:

Palliative care

12 (1) Every licensee of a long-term care home shall ensure that, subject to section 7, residents who could benefit from palliative care are offered and provided with care or services that integrate a palliative care philosophy.

Matters in regulations

(2) Without restricting the generality of subsection (1), every licensee shall comply with the regulations respecting palliative care and the palliative care philosophy.

[12] Hospice Palliative Care Ontario provides resources and training on Health Care Consent and Advance Care Planning and has trained many health professionals, including long-term care home staff. For further information see: www.hpco.ca.

g. *Fixing Long-Term Care Act, 2021,* section 23 – Infection Prevention and Control Program

Infection prevention and control program 23 (1) Every licensee of a long-term care home shall ensure that there is an infection prevention and control program for the home. Requirements of program (2) The infection prevention and control program must include, (a) evidence-based policies and procedures; (b) an educational component in respect of infection prevention and control for staff, residents, volunteers and caregivers; (c) daily monitoring to detect the presence of infection in residents of the long-term care home; (d) measures to prevent the transmission of infections; (e) a hand hygiene program; and (f) any additional matters provided for in the regulations.

Discussion

The COVID-19 pandemic has highlighted the issues that have been present in long-term care for many years with respect to the lack of infection control. Outbreaks of flu, respiratory illness, gastrointestinal illnesses were common-place prior to COVID-19, and many residents suffered from these illness, and many died. It was only the COVID-19 pandemic that brought this to the forefront of the public's mind.

One of the serious issues during COVID-19 was the lack of access to personal protective equipment (PPE) for both staff and residents. Staff were seen wearing make-shift gowns using garbage bags, unions had to sue for the right of their staff to have access to N95 masks,[13] and overall issues related to PPE was an issue.

[13] For example see *Ontario Nurses Association v. Eatonville/Henley Place*, 2020 ONSC 2467 (CanLII), <https://canlii.ca/t/j6mbp>, retrieved on 2021-11-25

We believe that the right to have access to proper PPE by both staff and residents should be enshrined in the Act as a requirement of any infection control program.

Recommendation

Amend the Act as follows:

Add: **(e.1) Access to adequate and appropriate personal protective equipment for staff, residents and visitors when required to prevent the transmission of infectious diseases.**

h. *Fixing Long-Term Care Act, 2021,* section 25(3) – Policy to Promote Zero Tolerance – Communication of Policy

Communication of policy 25(3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is communicated to all staff, residents and residents' substitute decision-makers.

Discussion

The legislation requires that the policy shall be "communicated" to staff, residents, and residents' substitute decision-makers.

As was seen during the Gillese Inquiry, this is not sufficient. Staff may have been given the policy, but they did not understand it. Physicians were not required to even have it communicated to them, as they are not "staff". Volunteers are also not included.

We recommend that all staff and contractors working in a home should be required to be trained on these policies. All residents and substitute decision-makers should receive copies of these policies, and homes should provide educational sessions to those who wish to take part in them, including residents, substitute decision-makers, families, essential caregivers, and any others who may wish to attend.

Recommendation

Amend the Act as follows:

Communication and training of policy

25(3) Every licensee shall ensure that the policy to promote zero tolerance of abuse and neglect of residents is

(a) **communicated to all staff, contractors and volunteers, and that training is provided with respect to this policy; and**

(b) **communicated to all residents, residents' substitute decision-makers, family members and essential caregivers, and education sessions regarding the policy be made available for them to attend**

i. ***Fixing Long-Term Care Act, 2021,* section 30 – Whistle-Blowing Protection**

Discussion

A motion entitled "Voula's Law" passed by the house on March 4, 2021, regarding the misuses of the *Trespass to Property Act* to bar visitors to residents from long-term care homes and other congregate care facilities. The *Trespass to Property Act* is often used by long-term care homes to bar visitors who are seen as difficult, including those who have made complaints against a long-term care home.

The *Trespass to Property Act* states as follows:

> 2(1) Every person who is not acting under a right or authority conferred by law…
>
> is guilty of an offence and on conviction is liable to a fine of not more than $10,000.

When a person is confronted with being "trespassed" and potentially arrested and fined, they will often stop attending at the home. However, visitors cannot be barred by the home, as they have a right to be there as a visitor, conferred by the Residents' Rights under the *Fixing Long-Term Care*. Despite this, homes and police will often use these sections to prevent visitors from attending. If visitors are doing something that is endangering people, homes are still entitled to call the police and the police may lay charges and use the criminal system if that is required.

The *Fixing Long-Term Care Act* must make it clear that the *Trespass to Property Act* and the use of trespass notices against visitors is not allowed.

Recommendation

Amend the Act as follows:

No retaliation against visitors **30(4.1) The *Trespass to Property Act* cannot be used to exclude substitute decision-makers and visitors of the resident.**

j. *Fixing Long-Term Care Act, 2021,* section 35 – Restraining by Physical Devices

Restraining by physical devices 35 (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 34 (1) if the restraining of the resident is included in the resident's plan of care. Provision in plan of care (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied: 5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Discussion

The above-noted sections contemplate that capable residents can consent to their own restraint.

We recommend that this be removed, and the Act make clear that capable residents cannot be restrained except pursuant to the common law.

While Personal Assistance Services Devices (PASDs) can be used by a capable resident, it is impossible to "restrain" someone who is capable. While they may consent to something that could be identified as a restraint to be used, they can immediately request it be removed, thus nullifying the consent. It makes no sense that residents will be restrained, because this implies having something done to them against their will.

The only time that such restraint would be allowed would be under the common law, where restraint may be permitted for a short time in an emergency situation. Once that emergency passes, restraint cannot be used.

Another issue is that "restraint" is not covered by the *Health Care Consent Act*, and therefore there is no "substitute decision-maker" in law to make that decision, unless that person has either a Guardian of Property with that authority, or has a "Ulysses Contract"-type power of attorney.

Further, consent to restraints is a limitation on liberty, and as such, should be subject to the same restrictions as set out in the section on confinement, currently set out in section 203 of this Act. We recommend that the due process sections that are set out in the confinement sections discussed later be applied to restraints as well.

Recommendation

Amend the Act as follows:

Restraining by physical devices

35 (1) An incapable resident may be restrained by a physical device as described in paragraph 3 of subsection 34 (1) if the restraining of the resident is included in the resident's plan of care.

1.1 No capable resident may be restrained except in accordance with the common law.

Provision in plan of care

(2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:

5. The restraining of the resident has been consented to by the incapable resident's substitute decision-maker with authority to give that consent.

No resident shall be confined except pursuant to the rules set out under s. 34.1

k. *Fixing Long-Term Care Act, 2021,* section 36 – PASDs that limit or inhibit movement - Consent

PASDs that limit or inhibit movement

Inclusion in plan of care

36(4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

Discussion

This section indicates that substitute consent can be obtained for the use PASDs for residents. However, PASDs are not covered by the *Health Care Consent Act*, and therefore there is no "substitute decision-maker" in law to make those decision, unless that person has either a Guardian of Property with that authority, or a power of attorney for personal care that gives such authority.

We recommend that this requires a change to the Act as well as the *Health Care Consent Act* to include "PASDs" in the "personal assistance services" definition to which Part IV of that Act applies.

Recommendation

Amend the Acts as follows:

PASDs that limit or inhibit movement

Inclusion in plan of care

36(4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:

4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent pursuant to the *Health Care Consent Act*.

Health Care Consent Act

Interpretation
2 (1) In this Act,

“personal assistance service” means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning, personal assistance services device (PASD) or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service; (“service d’aide personnelle”)

I. ***Fixing Long-Term Care Act, 2021,*** section 43(4) – Resident and Family/Caregiver Experience Survey

Resident and Family/Caregiver Experience Survey

Advice

(4) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in carrying out the survey and in acting on its results.

Discussion

The section has removed the word “developing” from the previous legislation. We believe it is vital for residents to have a say in the development of any surveys and believe that this wording should remain in the section.

Recommendation

Amend the Act as follows:

Advice

(4) The licensee shall seek the advice of the Residents’ Council and the Family Council, if any, in developing, carrying out the survey and acting on its results.

m. *Fixing Long-Term Care Act, 2021,* section 44 – Long-Term Care Quality Centre

Long-Term Care Quality Centre 44 (1) The Minister may establish a Long-Term Care Quality Centre.

Discussion

While we believe that it is important for long-term care homes to have access to supports that will assist them in providing the best care possible, we are concerned about the establishment of such a Centre. Currently, there exists the "Centre for Learning, Research and Innovation in Long-Term Care (CLRI), which consists of Baycrest, Bruyere, and the Research Institute for Aging, provide some support to the sector.

Baycrest and Bruyere both operate charitable long-term care homes and the Research Institute for Aging is associated with the Schlegel company, which operates for-profit long-term care homes throughout Ontario.

We have no knowledge as to how these facilities were chosen as being "centres of excellence", nor what criteria may have been used. Further, all of these centres are all related to facilities that currently provide care to residents.

We believe that a quality centre should be available but should have no affiliation with any long-term care home operators. Criteria for being such a centre should be set out in the regulations, and should include the requirement that it not have any affiliation with long-term care home operators.

Recommendation

Amend the Act as follows:

Long-Term Care Quality Centre **44 (1) The Minister may establish a Long-Term Care Quality Centre.** **(2) The Long-Term Care Quality Centre shall be fully independent of any long-term care home providers.**

n. *Fixing Long-Term Care Act, 2021,* section 88 – Coercion Prohibited

Coercion prohibited

89 (1) Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

(a) a document has not been signed;

(b) an agreement has been voided; or

(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.

Saving

(2) Subsection (1) does not apply with respect to a consent that is required by law for admission to a long-term care home.

Discussion

As discussed in Section F above regarding palliative care, we do not believe that any documents should be provided to residents or their substitute decision-makers such as "Level of Care" forms, "Advance Directives" etc. Instead, residents are entitled to express wishes in any format they wish and substitute decision-makers can advise on such wishes made when the resident was capable.

Recommendation

Amend the Act as follows:

Coercion prohibited

89 (1) Every licensee of a long-term care home shall ensure that no person is told or led to believe that a prospective resident will be refused admission or that a resident will be discharged from the home because,

(a) a document has not been signed;

(b) an agreement has been voided; or

(c) **a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked.**

(1.1) No resident shall be asked or required to sign a document purporting to be a consent for future treatment or care, including but not limited to Level of Care forms, Advance Care Directives, or other similar documents. Discussions about wishes for future care are part of the care-planning process and should be documented.

(1.2) No substitute shall be asked or required to sign a document purporting to be a consent for future treatment or care for an incapable resident, including but not limited to Level of Care forms, Advance Care Directives, or other similar documents. Should substitute decision-makers or other persons know of any wishes that the incapable resident may have expressed while capable, they should advise the home and these should be documented.

Saving

(2) Subsection (1) and (1.1) does not apply with respect to a consent that is required by law for admission to a long-term care home.

o. *Fixing Long-Term Care Act, 2021,* section 144 – Appointment of Inspectors

Appointment of inspectors

144 (1) The Minister may appoint inspectors for the purposes of this Act.

Director is an inspector

(2) The Director is, by virtue of office, an inspector.

Certificate of appointment

(3) The Minister shall issue to every inspector a certificate of appointment which the inspector shall produce, upon request, when acting in the performance of their duties.

Discussion

While the *Long-Term Care Homes Act* contained provincial offences, inspectors were not provincial offences officers allowed to lay charges pursuant to the *Provincial Offences Act.* For this reason, this avenue of enforcement has not been utilized.

Minister of Long-Term Care Phillips has indicated that inspectors will be provincial offences officers with the ability to charge homes under the *Provincial Offences Act*. While not strictly necessary, we believe it is important to enshrine that within the *Fixing Long-Term Care Act*.

Recommendation

Amend the Act as follows:

Appointment of inspectors

144 (1) The Minister may appoint inspectors for the purposes of this Act.

Director is an inspector

(2) The Director is, by virtue of office, an inspector.

Certificate of appointment

(3) The Minister shall issue to every inspector a certificate of appointment which the inspector shall produce, upon request, when acting in the performance of their duties.

(4) All inspectors under this Act shall be provincial offences officers for the purpose of the *Provincial Offences Act.*

p. *Fixing Long-Term Care Act, 2021,* section 146 – Annual Inspection

Annual inspection

146 Every long-term care home shall be inspected at least once a year.

Discussion

Since the *Long-Term Care Homes Act* came into force on July 1, 2010, every home was required to have an “annual inspection”. When the Act was originally passed, it was promised that these inspections would be full, proactive inspections, currently referred to as Resident Quality Inspections, or RQIs. However, because “annual inspections” are not defined, there have been continued attempts to curtail proactive, full home inspections as being required to meet the annual inspection requirement.

This occurred in 2013, when the Ministry of Health curtailed RQI inspections from all homes, indicating that as long as the homes had any inspection during a year, that would qualify as an annual inspection. Due to promises made to the public prior to the enactment of the *Long-Term Care Homes Act*, that these would be the RQIs, these were reinstated. However, the Ministry of Health and Long-Term Care later introduced a less rigorous type of RQI, which did not meet the standards that had been set by researchers and experts when setting up the RQI program.

Upon the change of government in 2018, the Ministry of Long-Term Care again curtailed the RQIs, with only a handful of RQIs done in subsequent years. During the pandemic when long-term care homes were ravaged by COVID-19, then Minister Merrilee Fullerton repeated that demands for annual proactive RQI inspections were a red-herring, and that the fact that the Ministry had been doing some type of inspection during a year was sufficient to ensure care.

We are encouraged by the fact that the new Minister of Long-Term Care, Rod Phillips, has recognized the value of proactive inspections and that they are a vital part of ensuring quality care in long-term care. We point out that the Ministry’s own statistics show that proactive inspections look at very different things and make very different findings than occur in either complaint or critical incident inspections.

However, we are discouraged by the fact that the section requiring annual inspections has not been amended to ensure that the annual inspection is a whole-home proactive inspection. Unless this is changed, we fear that subsequent Ministers or governments will again change the interpretation of this section and remove this vitally important tool in ensuring quality long-term care.

Recommendation

Amend the Act as follows:

Annual Proactive Inspection

146. Every long-term care home shall have a proactive, whole home inspection at least once a year.

q. *Fixing Long-Term Care Act, 2021,* section 147 – Inspections Unannounced

Inspections unannounced

147 No notice shall be given of,

(a) any inspection required under section 146; or

(b) any other inspection of a long-term care home, subject to any exceptions provided for in the regulations.

Discussion

While all except pre-opening inspections are supposed to be unannounced, we continue to hear that homes are given advance notice of inspections. The Honourable Mr. Justice Frank Marrocco has publicly stated[14] that in testimony before Ontario's Long-Term Care COVID-19 Commission, staff members indicated that they often knew when inspections were coming, and homes subsequently increased staffing, cleaned up, and made other changes in order to seem to comply with the requirements.

For this reason, we believe that it must be an offence to give notice to a home of an inspection that is to be unannounced.

Recommendation

Amend the Act as follows:

Inspections unannounced

147 (1) No notice shall be given of,

(a) any inspection required under section 146; or

[14] Comments made at the Advocacy Centre for the Elderly Special Lecture, November 9, 2021.

(b) any other inspection of a long-term care home, subject to any exceptions provided for in the regulations.

(2) Anyone who gives notice to a licensee, staff member or contractor of an inspection of a long-term care home in contravention of subsection (1) is guilty of an offence.

r. *Fixing Long-Term Care Home Act,* – Proposed addition concerning Mandatory Reports on Threats to Life and Safety:

Issue

On occasion, Ministry Inspectors will receive information concerning immediate threats to life and safety of long-term care home residents. In some cases, this information will be outside the knowledge of police, fire, and public health agencies that should know of the immediate threat in order to respond.

Discussion

The Ministry should be under a legal duty to immediately share information concerning threats to the life and safety of long-term care home residents with police, fire and public health authorities. Otherwise, continuing threats might not otherwise be reported, thereby jeopardizing the life and safety of long-term care home residents.

Furthermore, the retention of such information in "silos" without the sharing of such information with other agencies that have public safety mandates is not in the public interest.

Recommendation

Amend the Act as follows:

159.1 Reports on Threats to Life and Safety

The Authority shall promptly report any immediate threats to the life and safety of long-term care home residents of which the Authority is aware that has not already been reported to any relevant police, fire, and a public health agencies.

s. *Fixing Long-Term Care Act, 2021* – Proposed addition concerning Mandatory Reports to Professional Colleges:

Issue

On occasion, the Ministry Inspectors will receive information concerning misconduct by regulated health professionals that may jeopardize the well-being, life and safety of long-term care home residents. In some cases, this information will be outside the knowledge of the professional colleges that should know of such misconduct in order to respond.

Discussion

The Ministry and its Inspectors should be under a legal duty to immediately share misconduct by regulated health professionals that may jeopardize the well-being, life and safety of long-term care home residents with their relevant professional colleges. Otherwise, such misconduct may go undetected by the relevant professional colleges who would be unreliable to respond.

Furthermore, the retention of such information in "silos" without the sharing of such information with other agencies that have public safety mandates is not in the public interest. The retention of such information by long-term care homes in similar situations led to the continuing opportunity for the serial murder of long-term care home residents in the Elizabeth Wetlaufer matter.

The failure to report such information may jeopardize the well-being, health and safety of all Ontarians, including long-term care home residents.

Recommendation

Amend the Act as follows:

159.2 Reports on Professional Misconduct to Professional Colleges **The Authority shall promptly report misconduct by regulated health professionals that may jeopardize the well-being, life and safety of long-term care home residents to their relevant professional colleges.**

t. *Fixing Long-Term Care Act, 2021,* section 203 – Amendments to this Act

RESTRAINT AND CONFINEMENT

Confining of resident

34.1 (1) A resident may be confined as described in paragraph 5 of subsection 34 (1) if the confining of the resident is included in the resident's plan of care.

5. The confining of the resident has been consented to by the resident or, if the resident is incapable, by a substitute decision-maker of the resident with authority to give that consent.

Notice and advice if substitute consent to confining

(4) The following apply if the substitute decision-maker of a resident has given consent on the resident's behalf to the confining of the resident:

2. The rights adviser notified under subparagraph 1 iii shall promptly meet with the resident and explain,

i. the right of the resident or any person acting on their behalf to apply to the Consent and Capacity Board, under section 54.18 of the Health Care Consent Act, 1996, for a determination as to whether the substitute decision-maker complied with section 54.7 of that Act, and

ii. any other matters that may be provided for in the regulations.

Contents of notice to resident

(6) The written notice given to the resident under subparagraph 1 i of subsection (4) shall be in accordance with the requirements, if any, provided for in the regulations and shall inform the resident,

(c) that the resident, or any person acting on their behalf, is entitled to apply to the Consent and Capacity Board, under section 54.18 of the Health Care Consent Act, 1996, for a determination as to whether the substitute decision-maker complied with section 54.7 of that Act;

Discussion

Date to Come Into Force

This section currently is set out in an amendment to Bill 37. It is unclear why a bill would already have an amendment, and we can only presume that this is

because the intent is for it not to come into force at the same time as the rest of the legislation.

We strongly urge you to enact these sections at the same time as the rest of the Act.

At the moment, any resident of a long-term care home who is prevented from leaving a unit, a floor, or the building, is illegally detained. In law, people can only be detained or restrained in accordance with legislation, which must be compliant with Canada's *Charter of Rights and Freedoms*. Currently, we would submit that the detention of residents in long-term care homes breach sections 2(d), 7, 9, 10, 12, and 15 of the *Charter* as follows:

> Fundamental freedoms
>
> 2 Everyone has the following fundamental freedoms:
>
> …
>
> (d) freedom of association.
>
> Legal Rights
>
> Life, liberty and security of person
>
> 7 Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.
>
> Detention or imprisonment
>
> 9 Everyone has the right not to be arbitrarily detained or imprisoned.
>
> Arrest or detention
>
> 10 Everyone has the right on arrest or detention
>
> (a) to be informed promptly of the reasons therefor;
>
> (b) to retain and instruct counsel without delay and to be informed of that right; and
>
> (c) to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful.

> Treatment or punishment
>
> 12 Everyone has the right not to be subjected to any cruel and unusual treatment or punishment.
>
> 15 (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

At present, long-term care home residents who are being restrained or detained do not enjoy the rights set out above.

Many homes have policies that require all residents to be confined unless accompanied by a responsible third party. Even then, homes may refuse residents the right to leave if the home or a third party (such as a substitute decision-maker) decides that they do not wish to allow it. We have had many clients who are prevented from leaving a long-term care home without accompaniment simply because they live in a long-term care home. It must be made clear that restrictions on liberty can only take place in accordance with the due process guarantees of the *Charter* and recommend the amendments below.

We recognize that many residents of long-term care homes could be in danger should they attempt to leave the home unaccompanied. Currently, homes are restricting liberty according to what they see as the “best interest” of the person, or in conjunction with demands of family or substitute decision-makers. None of these parties have any legal authority to detain long-term care residents as the law currently stands except in emergency situations or where is a guardian of person with legal authority, or an attorney for personal care which is a “Ulysses Contract”.

Courts have been very clear that the confinement of patients is illegal without the correct authority and compliance with the law. A vast history of cases exists relating to the detention of psychiatric patients and access to rights.

A recent case in British Columbia entitled *AH v. Fraser Health Authority*[15] reviewed the involuntary detention of a woman in a hospital who was not being detained under legislation, and for which they were seeking remedies pursuant to a *habeas corpus* application. The detention was being done for the purpose of “protecting” the woman. The case commenced with the following statement:

> [1] As expressed by then Chief Justice McLachlin in *United States of America v. Ferras*, 2006 SCC 33 at para. 19, it is "an ancient and

[15] *A.H. v. Fraser Health Authority*, 2019 BCSC 227.

> venerable principle … as old as the *Magna Carta*" that no person shall lose her liberty "without due process according to the law". This is among the most fundamental aspects of the rule of law, and one that must be protected and fostered, perhaps most keenly in the context of the non-punitive detention of vulnerable people who, because of some incapacitating condition, find themselves subject to well-meaning but non-consensual state interventions that deprive them of their autonomy.[16]

We can think of no better expression of the problem that has continually plagued long-term care home residents, who have no access to due process when it comes to confinement, save expensive court proceedings.

The Court in *AH v. Fraser Health Authority* concluded that despite having "good reasons" for its concerns that she could be at risk of serious harm if she left, the failure to provide her with appropriate due process violated her constitutional rights.[17]

Similar findings were made by the European Court of Human Rights in the case of *H.L. v. The United Kingdom*, which found that the conditions for lawful detention were not found as there was no access to due process.[18]

The sections contained in the *Fixing Long-Term Care Act* go partway to ensuring these rights, but require further amendments.

1. Include restraints in section 34.1

   Any restriction of liberty, including by use of restraints, requires the same due process. Being restricted physically versus environmentally makes no difference to the individual.

2. Section 34.1(2)5. Removal of any reference to confinement of a competent resident.

   In law, competent residents cannot be confined or restrained, except in emergency situations under the common law. While they may be residing in a unit or building that has controlled access, they must be allowed out when requested. Restraint or confinement imply that it is being done against the will of the person. As soon as a capable person says they want out, then consent is withdrawn. With respect to physical "restraints", only PASDs should be used on competent residents, and only with consent pursuant to

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16 *A.H. v. Fraser Health Authority*, para. 1, page 1.

17 *A.H. v. Fraser Health Authority*, paras. 179-185 pgs. 55-56.

18 *H.L. v. The United Kingdom* - 45508/99 Judgment 5.10.2004 [Section IV]

those sections of the legislation.

3. The proposed Act only allows incapable residents the ability to challenge the decision to confine made by their substitute-decision maker pursuant to section 54.18 of the *Health Care Consent Act.*

   This section is flawed as follows:

   (a) It does not provide any guidance as to who is to "evaluate" capacity and under what circumstances or authority.

   (b) The section does not provide any criteria for a finding of incapacity to consent to confinement.

   (c) The section does not allow the incapable person to access the full complement of Consent and Capacity Board applications as would be available should the decision to confine have been made prior to admission. This not only presupposes that the person is incapable, but denies them the due process that should be afforded them. The Act should be amended to include all Consent and Capacity Board applications under s. III.1 of the *Health Care Consent Act* found in sections 54.14 to 54.20

4. Rights advice continues to be vitally important and those sections would be required to be amended to include rights on the entire suite of Consent and Capacity Board applications, indicated above.

Recommendation

Amend the Act as follows:

Note: Sections referencing confinement should be amended to include restraint. Some of these sections are set out below.

Confining or restraining of resident

34.1 Part III.1 of the *Health Care Consent Act* applies with respect to confinement or restraint of a resident in a long-term care home.

34.1 (1) A resident may be confined as described in paragraph 5 of subsection 34 (1) if the confining of the resident is included in the resident's plan of care.

34.1 (1.1) A resident may be regulations as described in [insert sections] and pursuant to the regulations if the

restraining of the resident is included in the resident's plan of care.

5. The confining of the resident has been consented to by a substitute decision-maker of the resident with authority to give that consent.

Notice and advice if substitute consent to confining

(4) The following apply if the substitute decision-maker of a resident has given consent on the resident's behalf to the confining or restraining of the resident:

2. The rights adviser notified under subparagraph 1 iii shall promptly meet with the resident and explain,

i. the right of the resident or any person acting on their behalf to apply to the Consent and Capacity Board, under sections 54.14 to 54.20 of the *Health Care Consent Act, 1996*,

ii. any other matters that may be provided for in the regulations.

Contents of notice to resident

(6) The written notice given to the resident under subparagraph 1 i of subsection (4) shall be in accordance with the requirements, if any, provided for in the regulations and shall inform the resident,

(c) that the resident, or any person acting on their behalf, is entitled to apply to the Consent and Capacity Board, under section 54.14 to 54.20 of the *Health Care Consent Act, 1996*;

u. *Fixing Long-Term Care Act, 2021* – Additional Regulation Making Authority

The following additions to the regulation-making authority in the Act:

1. Requiring inspectors and the Director of the Ministry of Long-Term Care to report potential wrongdoing to various agencies and professional colleges;

2. Provide an upper limit to the care that can be provided by long-term care homes; and

3. Restrict services that a long-term care home can provide.

D. Commentary on proposed amendments to the Retirement Homes Act, 2010:

a. *Retirement Home Act, section 24.1*– Proposed addition concerning Mandatory Reports on Threats to Life and Safety:

Issue

On occasion, the RHRA will receive information concerning immediate threats to life and safety of retirement home residents. In some cases, this information will be outside the knowledge of police, fire, and public health agencies that should know of the immediate threat in order to respond.

Discussion

The RHRA should be under a legal duty to immediately share information concerning threats to the life and safety of retirement home residents with police, fire and public health authorities. Otherwise, continuing threats might not otherwise be reported, thereby jeopardizing the life and safety of retirement home residents.

Furthermore, the retention of such information in "silos" without the sharing of such information with other agencies that have public safety mandates is not in the public interest.

Recommendation

Amend the Act as follows:

The [Retirement Homes] Act is amended by adding the following section:

24.1 Reports on Threats to Life and Safety

The Authority shall promptly report any immediate threats to the life and safety of retirement home residents of which the Authority is aware that has not already been reported to any relevant police, fire, and a public health agencies.

b. *Retirement Homes Act,* Schedule 3 – Proposed addition concerning Mandatory Reports to Professional Colleges:

Issue

On occasion, the RHRA will receive information concerning misconduct by regulated health professionals that may jeopardize the well-being, life and safety of retirement home residents. In some cases, this information will be outside the knowledge of the professional colleges that should know of such misconduct in order to respond.

Discussion

The RHRA should be under a legal duty to immediately share misconduct by regulated health professionals that may jeopardize the well-being, life and safety of retirement home residents with their relevant professional colleges. Otherwise, such misconduct may go undetected by the relevant professional colleges who would be unreliable to respond.

Furthermore, the retention of such information in "silos" without the sharing of such information with other agencies that have public safety mandates is not in the public interest. The retention of such information by long-term care homes in similar situations led to the continuing opportunity for the serial murder of long-term care home residents in the Elizabeth Wetlaufer matter.

The failure to report such information may jeopardize the well-being, health and safety of all Ontarians, including retirement home residents.

Recommendation

Amend the Act as follows:

> The [Retirement Homes] Act is amended by adding the following section:
>
> 24.2 Reports on Professional Misconduct to Professional Colleges
>
> The Authority shall promptly report misconduct by regulated health professionals that may jeopardize the well-being, life and safety of retirement home residents to their relevant professional colleges.

c. *Retirement Homes Act, 2021,* s. 2 (3) – Accommodation and care services, prices

Section 55 of the Act is amended by adding the following subsection:

Accommodation and care services, prices

(3) Every licensee of a retirement home shall ensure that the information set out in clause 54 (2) (k) is made available in print or electronic form, or both, to any person on request, in accordance with the regulations, if any.

Discussion

This amendment requires that retirement homes must provide an itemized list of the different types of accommodation and care services provided in the retirement home and their prices in print or alternative formats to any person on request.

The provision of such information is an important consumer protection measure that would help to inform and empower consumers, and is consistent with the purposes of the Act.

Recommendation

ACE supports this amendment.

d. *Retirement Homes Act,* section 92.1 – Orders in extraordinary circumstances

The Act is amended by adding the following section:

Orders in extraordinary circumstances

92.1 (1) The Registrar may serve an order on a licensee of a retirement home in accordance with this section if,

(a) there are extraordinary circumstances, as set out in the regulations, that require immediate action to be taken with respect to the retirement home; and

(b) the Registrar believes on reasonable grounds that the extraordinary circumstances have resulted or may result in harm or a risk of harm to one or more residents.

Management order

(2) The Registrar may serve an order on the licensee of a retirement home ordering the licensee to employ or retain, at the licensee's expense, one or more persons acceptable to the Registrar to manage or assist in managing all or some of the operations of the retirement home.

Contents of management order

(3) The order may specify the period of time during which the order is in effect and may name a person or persons selected by the Registrar who are to

manage or assist in managing all or some of the operations of the retirement home.

Other order
(4) The Registrar may serve an order on the licensee of a retirement home ordering the licensee to refrain from doing something, or to do something, for the purpose of responding to the extraordinary circumstances, preventing or alleviating the corresponding harm or risk of harm to one or more residents, or both.

Examples
(5) Without limiting the generality of subsection (4), the order may require the licensee to comply with the advice, recommendations and instructions of,
(a) a local medical officer of health or designate;
(b) a person or persons with expertise in dealing with the extraordinary circumstances giving rise to the order; or
(c) a person or persons employed or retained under subsection (2) or section 91.

Same, limitation
(6) An order under subsection (4) shall not require the licensee to contravene any requirement under this Act.

Contents of other order
(7) An order under subsection (4) may specify the date or dates by which the licensee shall comply with its requirements.

No stay
(8) An order under this section is not subject to an application for a stay under subsection 101 (2) of the Act.

Discussion

This amendment provides legal jurisdiction for the Registrar to make orders in extraordinary, urgent and emergent circumstances, such as threats to life and safety that were connected with the 2020–21 Covid-19 pandemic, outside the usual process of making such orders. ACE supports the broad purpose of this amendment is a necessary measure in the public interest to protect the life and safety of retirement home residents.

The Act would further provide an additional regulatory power to define the circumstances under which extraordinary orders may be made. The definition of such circumstances by regulation is essential to safeguard the integrity of the Act.

Extraordinary orders without resort to the usual legal process raise the possibility that such orders may compromise the *Charter* rights of retirement home

residents. For example, a Registrar's order should not authorize the confinement or detention of retirement home residents. The infringement of *Charter* rights should be prohibited by statute.

Recommendation

Amend the Act as follows:

> **Add subsection (6.1) as follows:**
>
> An order under subsection (4) shall not entail the infringement of any residents' rights under the *Canadian Charter of Rights and Freedoms,* and shall be inoperative and of no force and effect to the extent of any such infringement.

e. *Retirement Homes Act,* s. 12 – Communication on behalf of Authority

> **The Act is amended by adding the following section:**
>
> **Communication on behalf of Authority**
> **108.1** The Authority may require a licensee to deliver a written communication, on behalf of the Authority, to a resident or their substitute decision-maker in the time and manner the Authority may specify.

Discussion

This amendment allows the Registrar to communicate directly with retirement home residents through the licensee.

This is a reasonable requirement that supports the ability of the Authority to inform and communicate with retirement home residents, and is in keeping with the purposes of the Act.

Recommendation

ACE supports this amendment.

f. *Retirement Homes Act,* s. 113 – Contact Information

> **Section 113 of the Act is amended by adding the following subsections:**
>
> **Contact information**
> (2.1) The Authority and its officers, directors, employees, appointees and agents may collect a resident's or their substitute decision-maker's contact

information from either of them or from the licensee of the retirement home.

Same, disclosure
(2.2) If the Authority seeks to collect the contact information from a licensee, the licensee shall disclose the information to the Authority.

Purpose for collection
(2.3) The Authority may use the contact information collected under subsection (2.1) for the purpose of administering this Act and the regulations.

Discussion

This amendment allows the Authority to ascertain the identity and contact information of retirement home residents.

The possession of such information may be critical to the Authority in fulfilling its mandate to conduct investigations and other matters that are consistent with the purposes of the Act.

Recommendation

ACE supports this amendment.

g. *Retirement Homes Act,* s.15 (2) – Borrowing money or property

Subsection 121 (1) of the Act is amended by adding the following paragraph:

28.1 governing or prohibiting borrowing money or other property from a resident;

Discussion

This amendment permits the Authority to regulate the borrowing of money or other property from the resident, which might otherwise form the substance of financial abuse.

Recommendation

ACE supports this amendment.

h. *Retirement Homes Act, s. 121(1)*

Subsection 121 (1) of the Act is amended by adding the following paragraph:

45.1 specifying extraordinary circumstances for the purpose of subsection 92.1 (1);

Discussion

This amendment provides a regulation making power to specify the circumstances under which an extraordinary Registrar's order could be made under proposed Section 92.1 of the Act.

The definition of extraordinary circumstances is necessary to guard against the arbitrary imposition of such orders.

Recommendation

ACE supports this amendment.

E. CONCLUSION

We thank the Government for allowing us the opportunity to comment on Bill 37, *Providing More Care, Protecting Seniors and Building More Beds Act, 2021,* and ask that the Government amend the legislation as we have outlined above.

We urge the Committee to consider our submission and welcome the opportunity for any further discussion.

Yours very truly,

ADVOCACY CENTRE FOR THE ELDERLY

Per:

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