# Submission to the Standing Committee on General Government

# Bill 160, Strengthening Quality and Accountability for Patients Act, 2017

November 23, 2017


ADVOCACY CENTRE FOR THE ELDERLY

2 Carlton Street, Suite 701
Toronto, ON M5B 1J3
T: (416) 598-2656
F: (416) 598-7924
www.acelaw.ca

Jane E. Meadus, B.A., LL.B.
Barrister and Solicitor
Institutional Advocate

Christine Morano, M.A., J.D.
Staff Research and Policy Lawyer

Graham Webb, LL.B, LL.M
Lawyer and Executive Director

## A. Introduction to ACE

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

ACE currently employs six lawyers, two paralegals and an office manager. Since ACE's inception, the legal issues of residents in long-term care homes have been a primary focus of ACE's work. Annually, ACE receives over 3600 new client contacts. Of these, approximately a third can be identified as directly involving issues in long-term care and other health facility settings.

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

Having a lawyer dedicated to working on long-term care and hospital issues has helped ACE develop a specific expertise in these legal problems, as well as an understanding of the long-term care system. In response to these issues, ACE has continued to advocate for legislative and policy changes in these institutional settings.

ACE staff produces a variety of written materials for both advocates and lay people, to help them understand the law and advocate for themselves. For example, in conjunction with CLEO, the publishing arm of community legal aid clinics, we have produced *Every Resident*, which explains the residents' rights in long-term care homes; as well as pamphlets on home care, power of attorney, etc. In 1988, ACE produced the 600+ page *Long-Term Care Facilities in Ontario: The Advocate's Manual*, which included chapters on institutional care, home care, retirement homes, substitute decision-making, powers of attorney, and advocacy. The manual was in its third edition prior to the enactment of the *Long-Term Care Homes Act* and *Retirement Homes Act*.

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

ACE brings this experience and expertise of advocating for residents and patients to the proposed amendments.

## B. Recommendations

### 1. Schedule 1: *Ambulance Act, 1990*

**General Concerns**

In reviewing the amendments being put forth regarding paramedics, we have reviewed numerous documents relating to the scope of paramedics' practice. In 2013, the Minister of Health and Long-Term Care denied the application of the Ontario Paramedic Association to be regulated under the *Regulated Health Professions Act*. This decision was based on the recommendation of the Health Professions Regulatory Advisory Council.[1] The council determined that "the risk of harm threshold had not been met and that self-regulation of paramedics is not in the public interest."[2]

The refusal to make paramedics a regulated health professional has created a situation in which health care provided by paramedics may not be in compliance with legislation, and specifically, with the *Health Care Consent Act*.[3] This problem would be compounded by the enactment of the increased responsibilities set out in Bill 160.

The *Health Care Consent Act* states that informed consent for medical treatment can only be obtained by a "health practitioner," which is defined in the *Act* as "a member of a College under the *Regulated Health Professions Act*, or a member of a category of persons described by the regulations as health practitioners.[4] Paramedics are not so designated and therefore cannot determine capacity or obtain consent for treatment. While the current standards, such as the *Basic Life Support Patient Care Standards*[5] seem to indicate that paramedics should be determining capacity and obtaining consent, they are not presently legally entitled to do so.

The amendments to the *Ambulance Act* propose to give increased authority to the paramedic, which would require them to assess capacity and obtain informed consent, which they cannot do, even under the supervision of a regulated health professional.

It is our position that in general, until such time as paramedics are designated as regulated health professionals, these actions are outside of their scope of practice and illegal under the *Health Care Consent Act*.

---

[1] Health Professions Regulatory Advisory Council, "Paramedicine in Ontario: Consideration of the Application for the Regulations of Paramedics under the *Regulated Health Professions Act*, 1991" online: (2013) Volume 1 http://www.hprac.org/en/resources/HPRAC_Paramedic_Report_Volume_1.pdf >.
[2] *Ibid* at 3.
[3] *Health Care Consent Act,* SO 1996, c2 Sched A.
[4] *Ibid* at ss 2(1), 10, 13.
[5] Emergency Health Services Branch Ministry of Health and Long-Term Care, "Basic Life Support Patient Care Standards" online: (2016) 3.0.1, < http://www.tbrhsc.net/wp-content/uploads/2017/06/BLS-PCS-v3.0.1-Implementation-date-Dec-112017.pdf>.

**Section 7.0.1(3)(a)**

**Issue**

It is outside paramedics' scope of practice and training to assess and determine the appropriate place of treatment of a patient.

**Discussion**

Section 7.0.1(3)(a) of the proposed amendments would allow the Minister to issue directives that would permit paramedics to transport a person to a destination other than hospital.

A decision about where a person can receive the necessary treatment will require an assessment and diagnosis of the person's condition. While we recognize that paramedics are integral to Ontario's health care system, they currently do not have the training and expertise to properly diagnose a patient's condition. An accurate diagnosis requires a physical assessment by the appropriate regulated health professional and a determination as to the tests and treatment required. Without appropriate training and regulation, the proposed "alternative destination model" will erode the health care system and result in poorer patient outcomes. It will lead to delays in treatment in cases where patients will require a second trip by ambulance from non-hospital sites to hospital.

If paramedics are allowed to practice outside the scope of their profession, this will substantially increase the risk of harm to the health and safety of the public. Currently, paramedics may only manage symptoms on route to hospital and perform controlled medical acts under the supervision of a physician in emergency situations. Under the amendments, the role of paramedics will go well beyond this practice.

If the Government proposes that paramedics be permitted to diagnose and treat medical conditions (this aspect is discussed later in our submissions), we submit that the profession must be regulated under the *Regulated Health Professions Act.* This would ensure that the profession has the proper knowledge and qualifications to perform these tasks, and be answerable to a regulatory body the same as other health professionals.

ACE is also concerned that seniors are the target of these proposed amendments, as they are perceived as taking up too many hospital resources. We are concerned that seniors will be the focus of redirection to alternative destinations despite having serious and life threatening physical conditions. We are concerned that delays in treatment due to misdiagnosis are more likely if seniors are redirected away from hospitals. For example, what appears to be a mental health condition in the case of a senior could actually be delirium; a symptom resulting from a serious physical condition.

**Recommendation**

We do not recommend that paramedics be entitled to transport patients anywhere except to a hospital.

In the alternative, the section should not be in force until such time as paramedics are made regulated health professionals.

**Issue**

There are no informed consent provisions in the Bill regarding transportation of persons to non-hospital sites.

**Discussion**

The Bill does not deal with the requirement to advise the person of the recommended site, the reason for transportation to that site, and to obtain consent regarding transportation to destinations other than hospital.

Presently, when an ambulance arrives, a person knows the paramedics will transport him or her to hospital, unless he or she refuses to go with them, as is their right. Under the amendments, people should be given sufficient information to make informed decisions about the place where they will receive their health care. For example, if paramedics intend to take someone to a "community health facility" rather than a hospital, he or she should be fully informed and have the opportunity to refuse. These requirements are important so that the person's right to decide what happens to him or her is respected.

**Transport to Designated Psychiatric Facilities**

The Bill does not address the specific requirements for transportation under the *Mental Health Act*.[6] Under the *Mental Health Act*, a person can only be forcibly transported to a psychiatric facility in the following circumstances: (1) by the police pursuant to the requirements set out in section 17; (2) by the police pursuant to a Form 2 issued by a justice of the peace; or (3) by any person acting on the authority pursuant to a Form 1 - Application by Physician for Psychiatric Assessment being completed.[7] Paramedics do not have the legal authority under the *Mental Health Act* to transport a patient against their wishes on their own authority.

Furthermore, there is also the practical problem that most psychiatric facilities will not admit a person directly, but instead require that a person be first taken to a general hospital for assessment.

---

[6] RSO 1990, c M7.
[7] *Ibid* at ss 15-17.

**Recommendation**

We do not recommend that paramedics be entitled to take patients anywhere except to a hospital.

In the alternative, the section be amended as follows:

(a) the *Ambulance Act* and the *Health Care Consent Act* are amended requiring informed consent for the transporting of a patient to any site other than hospital from the person or their substitute decision-maker in accordance with the principles of informed consent;
(b) that the section does not authorize transportation to a psychiatric facility except pursuant to the requirements of the *Mental Health Act*; and
(c) this section shall not be in force until such time as paramedics are designated as regulated health professionals.

**Issue**

The Bill does not address who will incur the cost of the ambulance when a patient is transported to a non-hospital site.

**Discussion**

Under section 15 of the Regulations to the *Health Insurance Act,*[8] ambulance services are insured if the person is transported to a hospital as defined in the *Public Hospitals Act* or *Private Hospitals Act.* In these cases, the insured pays a maximum $45.00 co-payment, provided that the service was medically necessary.

The Bill does not set out who will incur the cost of the ambulance when a person is taken to a non-hospital site. Ambulance fees are currently $240.00 when a person is transported to a non-hospital site. If patients are forced to incur the ambulance costs in these situations, this will be a significant barrier to health care.

**Recommendation**

If the legislation is amended to allow paramedics to transport patients to places other than public or private hospitals, a concurrent amendment to section 15 of Reg. 552 to the *Health Insurance Act* will be required as follows:

**15.** (1) Ambulance services are insured services if,

[8] RRO 1990, Reg 552, s 15.

(a) the ambulance services are provided to an insured person by an ambulance service operator that holds a certificate issued by the certifying authority in accordance with the *Ambulance Act*;

~~(b) the ambulance crew of the operator transports the insured person to or from a hospital as defined in the *Public Hospitals Act* or a private hospital as defined in the *Private Hospitals Act*;~~ and

(c) the insured person pays a co-payment of $45 to the hospital.

(2) Where ambulance services are provided by air or by rail, including where applicable any ambulance service required to connect with the air or rail facilities, an insured person shall pay as his or her share of the ambulance charges an amount of $45 a trip by way of co-payment.

~~(3) An ambulance service is not an insured service if it is not medically necessary.~~

**Section 7.0.1(3)(b)**

**Issue**

Paramedics do not have the authority under the *Health Care Consent Act* to treat patients in non-emergency situations, where informed consent is required.

**Discussion**

Under the proposed amendments the Minister may issue directives permitting paramedics to provide treatment to persons who do not require conveyance by ambulance or for patients with lower acuity conditions.

As previously discussed, in addition to the lack of expertise to definitively diagnose and treat patients, paramedics do not have legal authority to assess capacity and obtain informed consent to treat. Under the *Health Care Consent Act*, informed consent is required in order for any treatment to be administered.[9] Unregulated health practitioners, such as paramedics, have no authority to assess capacity and obtain informed consent to treatment either on their own or on behalf of a regulated health professional.[10]

**Recommendation**

We do not recommend that paramedics be entitled to treat patients except in an emergency and under the direct supervision of the appropriate regulated health professional.

---

[9] *Supra* note 3 at s 10.
[10] *Ibid* at ss 2(1), 10.

In the alternative, the section should not be in force until such time as paramedics are made regulated health professionals.

**Section 22(1)(f)**

**Issue**

There are many issues which will have to be addressed before a fire-medic pilot project can be rolled out. Amongst these are the following issues:

1) Fire-medics do not have the authority under the *Health Care Consent Act* to assess capacity and obtain informed consent; and
2) Fire-medics are not "health information custodians" under the *Personal Health Information Protection Act*[11] and therefore none of the protections set out with respect to the collection, use, and disclosure of personal health information apply.

**Discussion**

The proposed language in section 22(1)(f) would allow for the development of a fire-medic pilot project. There has been a great deal of debate and several submissions to the Committee on this topic.

ACE is specifically concerned about the impact that a fire-medic model will have on the quality of care for seniors. Presently, there is a lack physician oversight in fire departments as well as the lack of appropriate medical equipment.

In addition to these practical concerns, the fire-medic model as presently proposed would not be in compliance with the *Health Care Consent Act*. Under the *Act,* informed consent is required in order for any treatment to be administered, except in certain emergency situations. Firefighters have no legal authority to assess capacity and obtain informed consent to treatment either on their own or on behalf of a regulated health professional.

The *Personal Health Information Protection Act* establishes rules that health information custodians must follow when collecting, using, and disclosing personal health information. If the government were to adopt a fire-medic model, the *Act* would have to be amended to designate fire-medics as health information custodians to protect patients' rights to privacy and confidentiality. This will be complex, as it would only apply to specific information within the fire department.

[11] SO 2004, c 3 Sched A.

**Recommendation**

We do not recommend that the fire-medic model be adopted at this time pending further study and consultation.

## 2. Schedule 2: *The Excellent Care for All Act*, 2010

**Issue**

The Patient Ombudsman should be an impartial officer of the legislature and not under the auspices of Health Quality Ontario (HQO).

**Discussion**

The Patient Ombudsman's mission is to facilitate resolutions and investigate complaints involving health care sector organizations without taking sides.[12] However, the office of the Patient Ombudsman is presently under the auspices of Health Quality Ontario, an agency which reports to the Ministry of Health and Long-Term Care, thereby creating a perceived conflict of interest. In order to achieve real change and improve the patient experience, the Patient Ombudsman must be able to speak openly about problems in the health care system. It is also important that the institution be seen as independent to ensure the trust of the public.

**Recommendation**

A *Patient Ombudsman Act* should be passed, requiring the appointment of the Patient Ombudsman as an officer of the Legislature and to be independent from all government ministries and agencies.

**Section 13.6(1)**

**Issue**

The Ontario Health Quality Council should not have access to personal health information collected by the Patient Ombudsman.

**Discussion**

The possibility that HQO will have access to personal health information obtained by the Patient Ombudsman by way of public complaints or investigations will result in members of the

[12] "Patient Ombudsman's Message" online: Patient Ombudsman <https://patientombudsman.ca/About-Us/Patient-Ombudsmans-Message/Vision-Mission-and-Values>.

public avoiding the Patient Ombudsman process due to fear of their information being accessed.

**Recommendation**

The Patient Ombudsman must be an independent Ombudsman with her own legislation as stated above.

### 3. Schedule 3: *Health Protection and Promotion Act*, 1990

**Section 1(1)**

**Issue**

The definition of "personal service setting" in the Bill should be clarified to include any dwelling that provides meals and personal assistance services for a fee.

**Discussion**

People living in unlicensed group homes are some of the most vulnerable in Ontario. They are often elderly or suffering from mental illness and have nowhere else to live.

Recently, it was reported that the Ontario Provincial Police conducted a seven month investigation into several of these unlicensed homes and found unsafe conditions due to mattresses on the floor, mice feces and dead mice, inadequate food supply, and unlicensed support workers.[13] Despite the evidence of unsanitary and unsafe conditions, these homes were allowed to continue to operate. In fact, it was only after a fire that the province approved a request to shut down at least one of these homes.[14]

Many of the residents of these homes have health issues which make them specifically vulnerable to infection and disease. It is up to the government to step in and strengthen legislation to protect those living in these homes. For this reason, we request that the definition of "personal service setting" be clarified to include group homes.

Under Bill 160, premises at which services such as hairdressing, barbering, tattooing, body piercing, etc. are being conducted have been included in the definition of "personal service

[13] Jennifer Pagliaro & Betsy Powell, "Unlicensed group home operators face new health and safety violations", The Toronto Star (21 July 2017) online: The Star < https://www.thestar.com/news/city_hall/2017/07/21/unlicensed-group-home-operators-face-new-health-and-safety-violations.html>.

[14] Betsy Powell, "Unlicensed Toronto group home ordered shut after fire", The Toronto Star (31 October 2017) online: The Star < https://www.thestar.com/news/city_hall/2017/10/31/unlicensed-toronto-group-home-ordered-shut-after-fire.html>.

settings". Under section 96 (3)(j) of the proposed amendments to the *Act*, the Lieutenant Governor in Council may make regulations in respect of the health and safety of these settings, including establishing requirements and standards. If the government is willing to protect those who choose to get a tattoo from infection and disease, the same protections should be extended to the vulnerable population living in group homes, who face the same kinds of elevated risk but have nowhere else to go.

**Recommendation**

**Section 1(1) of the *Health Promotion and Protection Act* should be amended as follows:**

> "personal service setting" means a premises at which personal services are offered where there is a risk of exposure to blood or body fluids and includes premises at which hairdressing and barbering, tattooing, body piercing, nail services, electrolysis and other aesthetic services are offered and includes any dwelling where meals and personal services are included as part of a fee for service arrangement;

**Section 1(1)**

**Issue**

The proposed amendments to the definition of "food premise" in subsection 1(1) should include the kitchens of unlicensed group homes.

**Discussion**

We support the amendments to the definition of "food premise," which will include private residences with the exception of a room actually used as a dwelling. The definition appears to capture the kitchen of an unlicensed group home.

However, under section 2(1)(a) of the Regulations to the *Health Protection and Promotion Act*, boarding houses that provide meals for fewer than ten boarders are exempt. In order to avoid having to comply with the *Retirement Homes Act,* most group homes will have fewer than six occupants.[15] As a result, these homes may not be subject to the food premise regulations, given the ten boarder exception. However, "boarding house" is not currently defined and therefore it is not clear to which dwellings this exception would apply. Despite the lack of clarity, food standards must be in place to protect the health of all residents in unlicensed group homes, especially given the recent evidence of unsanitary conditions.

[15] *Retirement Homes Act*, 2010, SO 2010 c 11 (section 3(1) of the Regulations defines a "retirement home" as a residential complex or the part of a residential complex that is a retirement home must be occupied or be intended to be occupied by at least six persons who are not related to the operator of the home).

**Recommendation**

Any reference in the legislation or regulations to a home with less than ten boarders should be deleted.

**Section 21(1)**

**Issue**

The definition of "institution" in section 21(1) of the *Act* should be amended to include "retirement homes" within the meaning set out in section 3(1) the *Retirement Homes Act*.[16]

**Discussion**

Currently, retirement homes are not specifically included in the definition of "institution" in section 21(1) of the *Health Protection and Promotion Act*. Under section 27(2) of the *Act*, the superintendent of an institution has a legal obligation to report to the medical officer of health any case of a confirmed or suspected reportable disease as set out in the Regulations. As a result, it is currently not clear whether retirement homes have these reporting obligations.

However, retirement homes are similar to many of the places already included in the definition of "institution". More specifically, like long-term care homes, private hospitals, and psychiatric facilities, retirement homes have many people coming and going from in the community and residents are living in close proximity to each other. In addition, the elderly in retirement homes are particularly vulnerable to infection and disease. We request that the government amend section 21(1) to include "retirement homes" as defined in the *Retirement Homes Act*.

**Recommendation**

The definition of "institution" under s. 21(1) of the *Health Protection and Promotion Act* be amended to add the following section:

(o.1) "retirement home" within the meaning of the *Retirement Homes Act*, 2010.

The definition of "health facility" under s. 29.1(2) should be amended as follows:

"health facility" means a hospital to which the *Public Hospitals Act* applies, a long-term care facility regulated under a statute of Ontario, a psychiatric facility within the meaning of the *Mental Health Act*, a retirement home within the meaning of the *Retirement Homes Act*, or a person or entity prescribed as a health facility.

[16] *Ibid.*

## 4. Schedule 4: *Health Sector Payment Transparency Act*, 2017

**General Concerns**

Pharmacies in Ontario are being required to pay millions of dollars a year to long-term care homes to secure contracts in order to be able to supply drugs to residents at the homes. Residents in those homes are required by the *Long-Term Care Homes* Act to obtain all of their prescriptions from the home's pharmacy provider.[17] Presently, there are no rules regarding this practice, and therefore there is a lack of transparency in terms of the amounts of money changing hands and what is being done with that money. Consequently, pharmacy services are being retained by the licensee based on what the pharmacy is willing to pay to the licensee, rather than the services that the pharmacy will provide to the residents.

Presently, dispensing fees in long-term care homes are paid by the Ministry of Health and Long Term Care's ODB program, and residents are charged an additional $2.00 co-payment for each drug dispensed. Unlike in the community, these pharmacies rarely waive the $2 co-payment, and will only do so if pressure is placed on them by an individual resident or their family. Given that the pharmacies have a captive market, there is no impetus for them to waive these fees, unlike in the community. Furthermore, residents are required to purchase their prescriptions on a monthly basis, rather than for a longer period of time as they might do if they were residing in their home. Many long-term care home residents are on multiple medications, resulting in their paying large portions of their small disposable income, which is often only $146 per month, for their prescriptions, leaving them little left to pay for wheelchairs, dental bills, telephone, cable, clothes, or other sundry items.

We recommend the following:

(1) that pharmacy payments to long-term care homes be prohibited altogether,
(2) that the $2 copayment be eliminated for all long-term care home residents;
(3) that the dispensing fees for long-term care home residents be reviewed and amended as needed by the government, and that any savings from the reduction of dispensing fees be redistributed equitably among all long-term care homes in Ontario.

**Section 2**

**Issue**

The definition of "payor" should be clarified to include pharmacies.

[17] O Reg 79/10, s 122.

**Discussion**

It is not clear that pharmacies are included in the proposed interpretation of "payor." However, they could fall under item 3 in the interpretation of "payor" in section 2 of the *Act* which states as follows:

> 3. A wholesaler, distributor, importer or broker that promotes or facilitates the sale of a medical product

**Recommendation**

We recommend that the legislation be clarified so that pharmacies are specifically included in the definition of "payor" under item 3 as follows:

> 3. A wholesaler, distributor, importer, pharmacist or broker that promotes or facilitates the sale of a medical product.

In the alternative, we recommend that pharmacies be listed as their own category of payors.

**Section 2**

**Issue**

The definition of "recipient" should be clarified to include long-term care homes as defined in the *Long Term Care Homes Act*.

**Discussion**

The definition of "recipient" has been left to the regulations. As a result, legislation requiring disclosure of payments in the health care system is of no effect until such regulations are passed. If the government is serious about transparency in the health care sector such a crucial piece of the legislation should not be left to the regulations.

**Recommendation**

A list of persons and institutions, including long-term care homes, should be listed in section 2 of the *Act* under "recipient."

**Section 4(2)**

**Issue**

The prescribed threshold for reporting transfers of value should be low and should include cumulative transfers of value.

**Discussion**

Under section 4(2) a payor is not required to report a transaction that has a dollar value that is less than the prescribed threshold. In order to avoid reporting obligations under the proposed legislation, payors and recipients can make multiple transfers of value below the threshold.

**Recommendation**

The prescribed threshold should be set low and it should include all transfers of value within the same year from the same payor to the same recipient.

## 5. Schedule 5: *Long-Term Care Homes Act, 2007*

**Section 2(1)**

**Issue**

Definition of "confine" in s. 2(1) of the *Long-Term Care Homes Act* is left to regulations.

**Discussion**

One of the main issues addressed by the proposed amendments to the *Long-Term Care Homes Act* relates to the rules related to allowing the confinement of long-term care home residents in certain circumstances. Without a definition of confinement within the legislation, the sections are meaningless as there is no reference point as to what is actually being regulated.

**Recommendation**

Section 2(1) should be amended to define confinement, and should include the following concepts:

(a) any resident who is restricted or not permitted from entering or exiting a part of the living space in the home on their own, or who is prevented from leaving the home on their own, is confined;
(b) such confinement may be by locks, alarms, restriction by staff, or any other method;

(c) confinement does not include residents being prevented from entering stairwells or any area of the home which is not part of the living space.
(d) any additional authority shall be set out in the regulations.

**Issue**

Removal of "secure unit" in subsection 3(1)11.iii. and replacing it with "or confinement within a long-term care home."

**Discussion**

At present, when a resident is considered for a move to a secure unit within a home, they have the absolute right to participate in any such discussion. This has been removed from the Residents' Bill of Rights and not replaced. Even though the person has a right to challenge such a move, it is important for them to be involved in any discussions leading up to a decision being made about confinement.

**Recommendation**

Section 3(1)11.iii. should be amended to read as follows:

> participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or confinement within a long-term care home and to obtain an independent opinion with regard to any of these matters.

**Section 25(2)**

**Issue**

The amendments to s. 25(2) removing some of the present requirements to conduct immediate inspections should not be passed.

**Discussion**

There are two proposed amendments. The first is that s. 25(2)1. be amended to include only a significant risk of serious harm to a resident rather than simply a risk of serious harm. The use of the phrase "serious harm" is sufficient to ensure that the matter is serious enough to warrant immediate inspection. The addition of "significant" will further limit the required inspection in a way that we believe would increase the risk to resident safety.

The second change is to remove s. 25(2)2 altogether. The section presently requires an immediate inspection when there are allegations that there have been violations to the

"whistle-blowing" protections. It is imperative that these sections continue to be inspected on an immediate basis, as there is a high risk to the safety of residents and others within the home. The whistle-blowing protection is an important aspect of this legislation and inspection of such allegations are very serious and time-sensitive. The failure of the Ministry to inspect immediately in these situations, will likely increase fear in the home and discourage reporting of incidents in the future.

**Recommendation**

Section 25(2) should be left as it presently is written in the *Long-Term Care Homes Act* and the amendments should be rejected.

**Section 30.1**

**Issue**

The heading prior to section 30.1 should be amended to restrict confinement to incapable residents only.

**Discussion**

It is not possible to obtain consent from a competent person to confine him or her. While a competent persons may agree to stay and not leave, once they change their mind they withdraw consent to their confinement and must be allowed to leave. Therefore, the *Long-Term Care Homes Act* cannot be used to detain a person who is capable and otherwise cannot be detained.

The *Act* does, however, give the home the authority in section 36 to confine a person pursuant to the common law in an emergency situation. This would give the home the time to determine whether the person has become incapable or whether they are capable but require assessment and possible admission to a psychiatric facility under the *Mental Health Act*.

**Recommendation**

Amend the heading to read as follows:

> Confining of an incapable resident

**Issue**

Clarify that capable residents cannot be confined, by adding a section prior to section 30.1 specifically stating this. In addition, the entire section should be amended to ensure that it refers only to the confining of an "incapable" resident.

**Discussion**

As set out above, competent residents cannot be confined and this has to be explicitly set out in the *Long-Term Care Homes Act* to ensure that homes do not unlawfully detain capable people.

**Recommendation**

A section should be added which states as follows:

> Nothing in this section allows the confining of a capable resident except under the common-law duty pursuant to section 36.

The entire section should be amended to add the word "incapable" prior to the word "resident" when referring confining. For example, section 30.1(1) should read:

> An incapable resident may be confined as described in paragraph 5 of subsection 30 (1) if the confining of the incapable resident is included in the resident's plan of care.

**Section 30.1(2)1**

**Issue**

The recommendation that an incapable resident be confined is based upon the requirement that there is a significant risk to the resident or another person and that they would suffer serious bodily harm if not confined as set out in s. 30.1(2)1. This determination is outside the scope of what a long-term care home should be dealing with. Further, it is inconsistent with the substitute decision-maker's principles of decision-making, as set out in the proposed new section of the *Health Care Consent Act* s. 54.7(1).

**Discussion**

We disagree with the recommended use of the test as written, which is similar to that found in the *Mental Health Act*. The draft legislation states that a person should be recommended for confinement if there is a significant risk of serious bodily harm, and that this would be included in the person's plan of care. We submit that where the issue is the potential of serious bodily harm to self or others, the care is beyond the scope of a long-term care home. Where the

person has the potential to harm themselves or others because of a mental disorder, this should be dealt with under the auspices of the *Mental Health Act* in a psychiatric facility, not in a long-term care home.

The use of the test for the recommendation of confinement as being a "significant risk of serious bodily harm" to the resident or others also conflicts with the requirements of substitute decision-making, which are compliance with a known wish if applicable, and if not, regarding the person's best interests. The best interest test is set out in the proposed section 54.7(2) of the *Health Care Consent Act*, and is focused on the person's quality of life and being the least restrictive, and does not necessarily take require consideration of the more serious issue of risk of bodily harm to self or others.

**Recommendation**

Section 30.1(2)1. should be deleted and replaced with the following:

1. There is a significant risk to the safety of an incapable resident if not confined.

**Section 30.1(2)5.**

**Issue**

The detention of capable residents is contemplated by this legislation in section 30.1(2)5.

**Discussion**

As discussed above, one cannot detain a capable person, even with their consent, and references to this should be removed.

**Recommendation**

Section 30.1(2)5. be amended as follows:

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

**Section 30.1(4)**

**Issue**

The entirety of s. 30.1(4) regarding notice and advice must be amended to reflect that only incapable residents can be confined.

**Discussion**

Without amendment, this section would suggest that capable residents could be confined.

**Recommendation**

The following amendments to s. 30.1(4) be made:

> Notice and advice to incapable resident if substitute has given consent to confining
>
> (4) ~~The following apply if~~ Once the substitute decision-maker of an incapable resident has given consent ~~on the resident's behalf~~ to the confining of that resident:

**Section 30.1(4)7.**

**Issue**

The amendments set out in s. 30.1(4)7. are presently not clear that the licensee cannot start to confine an incapable resident until after the appeal process under the *Health Care Consent Act* have been exhausted.

**Discussion**

While the legislation refers to the section it not affecting "further restrictions on the licensee under Part III.1 of the *Health Care Consent Act, 1996,*" this would not be clearly understood by persons working in the field. The section referred to in the *Health Care Consent Act* prevents the person from being confined until such time as any review or appeals are dealt with in accordance with that section. The amendments should make that clear for ease of reference for lay persons who will be reviewing the legislation.

**Recommendation**

Section 30.1(4)7. should be amended as follows:

> For greater certainty, the licensee may not start to confine an incapable resident while the review or appeal process is underway ~~paragraph 6 does not affect any further~~

~~restrictions the licensee under~~ pursuant to Part III.1 of the *Health Care Consent Act*, 1996.

**Section 30.1(8), 30.2 and 46**

**Issue**

The elements for consent reference must be changed to make it clear that it is only relating to incapable residents, as capable residents cannot be asked to consent to confinement as previously discussed.

**Discussion**

As discussed previously, this has to be clarified for the purpose of confinement.

**Recommendations**

The heading for section 46 should be amended as follows:

**Elements of consent for admission to a long-term care home**

Section 30.1(8) should be deleted and replaced with section 30.2, as follows:

**Elements of consent for confinement of an incapable resident**

30.2(1) The following are the elements required for consent to confinement in a long-term care home:

1. The consent must relate to the admission.

2. The consent must be informed.

3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud.

**Informed consent**

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

(a) the substitute decision-maker for the incapable resident received the information about the matters set out in subsection (3) that a reasonable substitute decision-maker in the same circumstances would require in order to make a decision about the confinement; and

(b) the substitute decision-maker for the incapable resident received responses to his or her requests for additional information about those matters.

**Same**

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

1. What the confinement entails.

2. The expected advantages and disadvantages of the confinement.

3. Alternatives to the confinement.

4. The likely consequences of not being confined.

**Section 30.3**

**Issue**

The section contemplates a one-time only notice and rights advice and contains no limit to the length of that confinement.

**Discussion**

The amendments appear to be premised on the idea that confinement could be indefinite with no ongoing review process or rights advice. Residents may regain capacity after receiving proper medication, nutrition, and medical care, but they may continue to be detained. As there is no obligation for the licensee to provide any further rights advice, we would argue that this will not happen, and the resident will have great difficulty in accessing due process in these cases.

Under the *Mental Health Act*, certificates of involuntary admission and certificates of renewal are time limited,[18] with rights advice being given every time a new certificate is issued allowing the person to apply for a review,[19] and a mandatory review by the Consent and Capacity Board on every fourth certificate of detention.[20] There is no such ongoing review and rights advice under the *Long-Term Care Homes Act*, and it is our position that this will mean that residents in long-term care will not be able to access their rights because of this.

[18] *Mental Health Act, supra* note 6 at s 20(4).
[19] *Ibid at* s 38.
[20] *Ibid* at s 38(4).

Failure to provide periodic access to review of confinement is in contravention of section 7 of the *Charter of Rights and Freedoms*, which guarantees "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". This issue was discussed specifically in the case of *P.S. v. Ontario*,[21] where a mental health patient was denied due process when being detained for a lengthy period of time. In that case, the Ontario Court of Appeal declared portions of the *Mental Health Act* as invalid as being inconsistent with section 7 of the *Charter* and of no force and effect pursuant to s. 52(1) of the *Constitution Act*, and the Government of Ontario was required to amend the *Mental Health Act* to bring it into compliance.

**Recommendation**

A section be added as 30.3 which would require that the licensee provide notice and advice at a minimum of every 6 months or when the incapable resident indicates they wish to challenge their confinement status.

(1) The licensee shall provide notice and advice to every incapable resident who is confined at a minimum of every 6 months or when a resident indicates they wish to challenge their confinement status.
(2) Notice and rights advised are to be provided in this section as per the requirements of section 30.1(4) – (6).

**Section 36(1)**

**Issue**

The legislation continues to allow for the confinement or restraint of a resident pursuant to the common law; however, it is not clear in that section that the common law duty allows restraint for a limited period only.

**Discussion**

The understanding of licensees and their staff of the common law duty to confine or restrain is limited. It is not understood well that this is for an emergency only and that the confinement or restraint is only to be applied where immediate action is required and that such action is limited both to an individual incident, as well as to time, where the confinement or restraint can only be until the emergency situation is over.

[21] *PS v Ontario*, 2014 ONCA 900.

**Recommendation**

Section 36(1) be amended as follows:

> Nothing in this Act affects the common law duty of a caregiver to restrain or confine a person in an emergency when immediate action is necessary to prevent serious bodily harm to the person or to others, where such restraint or confinement must be removed once the emergency situation has ended.

**Sections 44(2.1) and (2.2)**

**Issue**

Where an applicant is being considered for confinement at the placement stage pursuant to section 44(2.1) and (2.2), the sections must be amended in accordance with the concerns expressed previously relating to the inability to legally confine capable residents.

**Discussion**

The same issues arise when an applicant is considered for placement as have been previously discussed related to confinement being possible where the resident is incapable

**Recommendation**

The sections with respect to the consideration of confinement during the placement process be amended as follows:

> Confinement of incapable applicant to be considered
>
> (2.1) The placement co-ordinator who determined that the applicant is eligible for long-term care home admission shall consider whether the applicant may be incapable and may need to be confined in the home and shall make a recommendation to the licensee after considering,
>
> (a) whether there would be a significant risk to the safety of the allegedly incapable that the applicant ~~or anyone else would suffer serious bodily harm if the applicant were~~ not confined;
>
> (b) whether confining the allegedly applicant would be reasonable in light of the applicant's physical and mental condition and personal history; and
>
> (c) whether a physician, registered nurse in the extended class or other person provided for in the regulations has recommended the confining.

Advising of confinement recommendation

(2.2) If the placement co-ordinator intends to recommend to the licensee that the allegedly incapable applicant be confined in the home, the placement co-ordinator shall advise the applicant~~, and if the applicant is incapable,~~ and their ~~a~~ substitute decision-maker ~~of the applicant,~~ of the recommendation and of anything else that may be provided for in the regulations, prior to authorization of the admission and at such other times as may be provided for in the regulations.

**Section 44(7)**

**Issue**

The restriction on a licensee withholding approval for admission to a long-term care home set out in section 44(7) does not specifically state that confinement cannot be the only basis for the refusal.

**Discussion**

Presently, licensees often withhold approval for admission to applicants on illegal grounds and further, do not comply with the requirements for notification of their refusals. Historically, these issues have not been pursued by the CCAC (now the LHIN) or by the Ministry of Health and Long-Term Care on a consistent basis.

This section must be clarified to ensure that residents are not refused on the sole basis that they require confinement.

**Recommendation**

The following be added to the section:

(d) An incapable resident requiring confinement may not be the sole reason for withholding approval for admission.

**Section 156.1**

**Issue**

Section 156.1 of the *Long-Term Care Homes Act* will be amended to allow for administrative penalties to be charged to long-term care homes in certain circumstances. These penalties should not go into the general account of the Government of Ontario but should be reinvested into the long-term care system.

**Discussion**

While the purpose of administrative penalties is to ensure compliance with the *Long-Term Care Homes Act*, there will be occasions when these penalties will be paid. Since long-term care homes derive the bulk of their funds from either the Ministry of Health and Long-Term Care or the residents themselves, it would not be appropriate to remove or redirect these funds away from the long-term care system. Instead, the money should be used for the benefit of the system, such as educational resources, extra services, etc.

**Recommendation**

Amendments be made to the appropriate legislation to ensure that administrative penalty fees be reinvested into the long-term care system and be used for the benefit of the long-term care system and its residents.

***Health Care Consent Act***

**Section 2(1)**

**Issue**

Confinement is not defined in the proposed amendments. As it is a central concept in the Act, it must be defined in the definition section, not only in regulation.

**Discussion**

The issues are the same as under the *Long-Term Care Homes Act* discussed above and should mirror those amendments.

**Recommendation**

Section 2(1) should be amended to define confinement, and should include the following concepts:

(a) any resident who is restricted or not permitted from entering or exiting a part of the living space in the home on their own, or who is prevented from leaving the home on their own, is confined
(b) such confinement may be by locks, alarms, restriction by staff, or any other method;
(c) confinement does not include residents being prevented from entering stairwells or an area of the home which is not part of the living space.
(d) Any additional authority shall be set out in regulations.

**Section 54.7(3)**

**Issue**

This section refers to the confining of a person based upon it being essential to prevent serious bodily harm to themselves or others, which we have recommended be changed to a significant risk of safety.

**Discussion**

Please see previous discussion regarding a similar amendment under the *Long-Term Care Homes Act*.

**Recommendation**

Section 54.7(3) should be amended as follows:

> Subject to paragraph 1 of subsection (1), the person shall not give consent on the incapable person's behalf to the incapable person's confining in a care facility, unless the confining is essential to ~~prevent serious bodily harm~~ ensure the safety of the incapable person ~~or to others~~, or allows the incapable person greater freedom or enjoyment.

Section 54.9(1)

**Issue**

The *Health Care Consent Act* s. 54.9(1) refers to decisions which are "necessary and ancillary" to the confining of the incapable person, however fails to define what these might be. This will cause increased confusion in the future relating to the authority of the substitute decision-makers.

**Discussion**

There are other issues which have not been dealt with but which will be important as they related to the authority of the substitute decision-maker making decisions on behalf of someone being confined, which will have to be included in regulations. These would include the parameters of the substitute decision-making authority, for example

(a) Would they be able to restrict who can take an incapable resident outside the area or the home, and what would be the requirements in making that decision?
(b) Would they be able to restrict the amount of time that an incapable resident could be outside the home?

(c) Would they be able to restrict where the incapable resident could go outside the home with another person?

Substitute decision-makers under this section have limited authority, no matter whether they gain their authority from the hierarchy set in the *Health Care Consent Act*, as an attorney for personal care whose under the *Substitute Decisions Act*, or as a guardian of the person given authority by the Court. When dealing with issues such as who will be able to take an incapable resident out of the home, issues other than those related to the resident are often in play, such as dysfunctional family relationships, paternalistic attitude of the substitute decision-maker, etc. The regulations will have to make clear exactly what authority the substitute decision-maker has when dealing with the "confinement" issue.

**Recommendation**

That the regulations are written to coincide with the enactment of this legislation which will specifically address what issues may be necessary and ancillary to the legislation, and which are specifically not included.

> Authority to consent on an incapable person's behalf to the incapable person's confining in a care facility includes authority to make decisions that are necessary and ancillary to the confining as defined in the regulations.

## 6. Schedule 9: *Oversight of Health Facilities and Devices Act*, 2017

**Issue**

This new act eliminates private hospitals and independent health facilities, creating a new entity called a "community health clinic."

**Discussion**

The *Oversight of Health Facilities and Devices Act, 2017*, will repeal and replace both the *Private Hospitals Act* and the *Independent Facilities Act*. Unfortunately, there has been little to no consultation with the sector or the public, which has led to a lack of knowledge and understanding of the implications of this legislation. The bulk of the legislation is left to regulation, making the overall regulatory scheme unclear.

The *Act* purports to eliminate private hospitals, which could have numerous unrecognized implications, such as eliminating ambulance transportation as an insured service to that facility. Further, despite the stated objective that private hospitals are being transformed into community health clinics; this is not in fact the case. When one reviews the consequential

amendments, many continue to include private hospitals as *de facto* hospitals. An example is the consequential amendment to the *Health Care Consent Act*, which states as follows:

> The definition of "hospital" in subsection 2 (1) of the Health Care Consent Act, 1996 is repealed and the following substituted:
>
> "hospital" means,
>
> (a) a hospital as defined in the Public Hospitals Act, or
>
> (b) a community health facility within the meaning of the Oversight of Health Facilities and Devices Act, 2017 that was formerly licensed under the Private Hospitals Act; ("hôpital")

Given that private hospitals continue to be given a special status, it is unclear what the purpose of renaming and recategorizing these facilities is, and will only lead to confusion and inconsistencies.

**Recommendations**

We recommend that Schedule 9 be deleted in its entirety. Should the government wish to propose a new piece of legislation, it should be done with full public and sector consultation, to understand their needs and views. Any new legislation should contain more detailed sections and leave less to regulations than is presently proposed.

## 7. Schedule 10: *Retirement Homes Act,* 2010

**Issue**

The amendments include the use of confinement in a retirement home, which we do not believe to be legal or constitutional. We do not support these amendments.

**Discussion**

Retirement homes are not long-term care homes, and are not regulated, funded nor inspected in the same manner.

Retirement homes are generally tenancies and the relationship is that of a landlord and tenant. Allowing a person's landlord to confine a person, even under the authority of a substitute decision-maker, we would suggest is both illegal and unconstitutional. The *Charter of Rights and Freedoms* restricts the use of detention, and we would suggest that this would be outside

of the authority of the provincial government to allow for on-going detention by a landlord of a tenant in this manner.

The proposal in the *Retirement Homes Act* would be for a "substitute decision-maker" to have the authority to make these decisions on behalf of an incapable person. There are no such "substitute decision-makers" in law who would have such authority.

We would reiterate that, similarly to our discussion relating to confinement under the *Long-Term Care Homes Act,* no one can confine a competent person except in an emergency under the common-law.

Retirement homes do not have the same requirements for staffing and oversight, nor do they have to meet the same standards as long-term care homes. Oversight of the homes is not by the Ministry of Health and Long-Term Care or other government body, it is by an independent, self-regulated body, funded by the sector and it is therefore inappropriate that they would be overseeing the confinement of tenants in retirement homes.

These recommendations imply that the government is treating retirement homes as quasi-long-term care homes. This is indicative of the continual privatization of the sector and the downloading of health care and fees for healthcare to seniors which appears to be an increasing trend in this sector.

If retirement home residents require confinement, then their care is beyond the scope of what should be provided in a retirement home and long-term care admission should be sought.

**Recommendation**

We vehemently oppose the use of confinement or secure units under the *Retirement Homes Act* and recommend that all references to confinement or secure units except under the common-law duty be removed from the Act.