

ACE NEWSLETTER

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HOMICIDE IN LONG-TERM CARE: A SEARCH FOR ANSWERS



by Jane E. Meadus, Barrister & Solicitor, Institutional Advocate

A Coroner's jury has made 85 recommendations aimed at improving both the admission process for long-term care and for dealing with difficult residents. A number of these recommendations are intended to ensure that residents are better protected from harm at the hands of newly admitted residents who may suffer from mental illness or cognitive impairment. It is imperative that these recommendations become a reality.

On the afternoon of June 9, 2001, Piara Singh Sandhu was admitted to Casa Verde Nursing Home ("Casa Verde") in Toronto. By 7:30 p.m. that night, he had bludgeoned to death Ezeldine El Roubi and Pedro Lopez, his two roommates, and attempted to kill a third resident of the home. Mr. Sandhu was charged with the murders and sent for psychiatric assessment at Penetanguishene Mental Health Centre, where he later died without the charges having been resolved.

The deaths horrified the long-term care community. What happened to make Mr. Sandhu kill his roommates? Were there missed signs of his violent nature? Why did it happen? Could it happen again? How could we prevent another such tragedy from occurring?

On September 27, 2004, Dr. Barry McLellan, Chief Coroner for Ontario announced that there would be an inquest into the two deaths to try to find answers to these questions.

Concerned Friends of Citizens in Ontario Care Facilities is a non-profit, grass roots

organization whose unwavering advocacy on behalf of residents in long-term care homes has resulted in many systemic changes. The Advocacy Centre for the Elderly was pleased to have the opportunity to represent Concerned Friends at the inquest.

The inquest commenced on January 31, 2005. On April 18, 2005, the jury returned with 85 recommendations aimed at reforming a long-term care system unable to meet the needs of difficult residents (the jury's recommendations may be found at the ACE website at www.advocacycentreelderly.org).

Inquest

Con't P. 2

Inside This Issue



- * Accessibility Bill Receives 3rd Reading P. 4
- * The LHINs are coming! (Editorial) P. 5
- * The Schiavo Case: What if Mrs. Schiavo had been living in Ontario? P. 7
- * Holograph Wills P. 10

An inquest is an inquiry into the death(s) of a person(s). The purpose of the inquest is twofold. First, an inquest is held to determine the answer to five questions: Who was the deceased? How did the deceased die? When and where did the deceased die? By what means did the deceased come to his or her death? Here, these questions were easily answered and were not the ultimate goal of the inquest. Of primary importance here was the second purpose, which is to make recommendations directed to avoiding future similar deaths.

FACTS

Mr. Sandhu was a 74 year old man of East-Indian origin who spoke little English. Prior to the incident, he was living with his wife, son and his family. On March 25, 2001, he suffered a stroke, was hospitalized briefly and returned home after only three days, as he was becoming increasingly disruptive and confused.

On May 30th, his wife was treated by the family physician, Dr. Rahl, for a black eye caused by Mr. Sandhu. The doctor advised the family to contact the police or take Mr. Sandhu to a hospital (although he could not indicate why). The son stated that this was a family matter and did not want to follow either of these suggestions.

On June 2, 2001, Mr. Sandhu was taken to see Dr. Rahl to complete an application for long-term care. Dr. Rahl found him incapable of consenting to admission to a care facility (nursing home), and completed the medical report. The report included no comment on behavioural issues other than confusion and agitation, and there was no mention of the fact that Mrs. Sandhu had suffered a black eye at the hands of her husband. At the inquest, Dr Rahl said that he believed that the application would be reviewed by another physician prior to admission, and that Mr. Sandhu would be found to be ineligible for admission.

The Etobicoke Community Care Access Centre (CCAC) processed the application for long-term care. The family told the CCAC that Mr. Sandhu was demanding, suspicious, paranoid, verbally and physically aggressive towards spouse and son, might use objects to hit when frustrated, and screamed and was disruptive at night. The family wished Mr. Sandhu to be placed immediately on an emergency basis. Mr. Sandhu was eligible for admission and a bed was found at Casa Verde. A detailed behavioural assessment was then completed. It is unclear who provided the information for this assessment, however, it contrasted with the information provided originally as it stated only that Mr. Sandhu could be verbally aggressive.

Mr. Sandhu was admitted to Casa Verde early on a Saturday afternoon. The admission note completed by the charge nurse stated that Mr. Sandhu could be "very aggressive and violent". However, the evidence was that this information was not communicated to other staff.

The **Advocacy Centre for the Elderly (ACE)** is a legal clinic for low income seniors 60 years of age and over, funded by Legal Aid Ontario. ACE is incorporated as a non-profit corporation under the name "Holly Street Advocacy Centre for the Elderly Inc."

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The afternoon was uneventful. Mr. Sandhu was noted to be polite and co-operative. However, about 7:30 p.m. he was apprehended by staff while attacking a resident. It was then discovered that two residents had already been killed. A police officer described the scene as one of the worst homicides he had ever seen.

RECOMMENDATIONS

Much of the evidence at the inquest was with respect to the assessment of and provision of care for potentially aggressive residents in long-term care homes.

Dr. Heather MacDonald, who had prepared the coroner's report, and Dr. Ken LeClair, a leading geriatric psychiatrist, both testified that Mr. Sandhu's potential for violent behaviour was predictable. Unfortunately, evidence showed that no proper assessment took place. Nevertheless, the jury heard that even if it had been identified, there were very few alternatives for Mr. Sandhu and his family with respect to providing him with care and treatment.

(1) PIECES Training

The jury heard a great deal of testimony about "PIECES" training. PIECES was part of the Government of Ontario's Alzheimer's Strategy, aimed at enabling long-term care staff to assess residents for behavioural and psychiatric issues, and to problem solve regarding these issues within the home. While training was heralded, the jury heard that the funding for the training had concluded. As well, many of the PIECES trained staff had left their jobs, leaving great gaps in the system. Finally, even where PIECES trained staff were available, there was often insufficient time and support to implement their knowledge.

The jury heard that Mr. Sandhu's potential for violence could have been assessed at admission, flagging his behaviours and allowing for monitoring pending further assessment and programming. However, this was not done.

The jury recommended that funding for PIECES training continue and that there be requirements for PIECES trained staff to be available in all long-term care homes. (Recommendations 40-49)

(2) Specialized Units and Services

Even if Mr. Sandhu had been clearly identified as being violent, it is unclear what services might have been available to assist the home in dealing with him.

The evidence was that there were few resources available for violent or aggressive residents. Special programmes were either extremely limited or not known to facility and CCAC staff. Over and over, we heard that specialized units or facilities were required for these residents, but they were generally non-existent. Tim Burns, Director of Long-Term Care at the Ministry of Health and Long-Term Care, stated that it was up to the individual long-term care homes to assess and determine proper spending on these types of residents. We heard about the need for high staff-to-resident ratios in specialized units/facilities in order to meet the needs of these residents. It was clear that specialized services required by these residents could not be provided under the present funding scheme. Increased funding must be made available for these difficult to care for residents (see jury Recommendations 22-25; 38-39).

(3) Funding

The present funding system for long-term care has been criticized. Monique Smith (MPP Nipissing), in her report to the Minister of

Health and Long-Term Care, stated that the system was problematic and recommended a review with goal to establish a new model (Commitment to Care: A Plan for Long-Term Care in Ontario, Spring, 2004, (Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care), <http://www.health.gov.on.ca>, pgs.7 & 26).

The jury recommended that the funding system be revised within the next fiscal year. It stated that any new funding model must "take into account the higher skill level of staff required for residents with dementia [sic] and other mental health problems and, in particular, giving sufficient weight to actual and potential aggressive behaviours to ensure adequate staffing, sufficient time and resources for LTC facilities if they are responsible to manage residents with such behaviours". (Recommendation 26.)

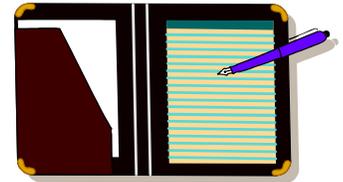
(4) Community Care Access Centres

The inquest heard a lot of testimony about the role of the CCAC in the placement of Mr. Sandhu. Mr. Sandhu had had no contact with the CCAC prior to his placement, and their knowledge of him was limited to that collected from the doctor and various family members. Further, the placement was done in a short-time period and there were questions about the process the CCAC followed.

The jury made a number of recommendations with respect to the completion of the application and placement of residents, to ensure that as much correct information as possible is obtained and that appropriate placements are made, so that the needs of all those requiring long-term care can be met. (Recommendations 53-60.)

CONCLUSION

The jury recommendations are far-reaching and will have a great impact on the lives of those living in long-term care if implemented. This is the opportune time for these recommendations to be considered, given the government's commitment to reform the system. However, these recommendations must be kept on the government's agenda by lobbying for their implementation. ♦



Accessibility Bill Receives Third Reading

Bill 118, the *Accessibility for Ontarians with Disabilities Act, 2005*, received unanimous approval on third reading in the Ontario Legislature on May 10, 2005. The Bill is expected to become law soon with royal assent.

Bill 118 provides a framework for achieving full accessibility for persons with disabilities within a 20 year time frame. Much hard work lies ahead in developing accessibility standards. The Bill is endorsed by the ODA Committee, an organization of volunteers who have worked tirelessly for accessibility legislation in Ontario. Persons wanting to contact the ODA Committee for further information about Bill 118 and the work ahead should visit their internet site at www.odacommittee.net.

June is Seniors' Month

The LHINs are coming! The LHINS are coming!

Editorial comment by George T. Monticone,
Barrister & Solicitor



Local Health Integration Networks (LHINs) will be 14 community-based organizations with a unique mandate to plan, coordinate, integrate, manage, and fund care at the local level within their defined geographic areas. So says Bulletin #1, dated October 6, 2004 posted on the Ontario Ministry of Health and Long-Term Care (MOHLTC) website for LHINs.

In Bulletin # 11 dated May 2, 2005 we learn that the government is considering funding each of the following health care providers through LHINs (in other words, each LHIN will be given a packet of money and authority to decide which of the following providers get what):

- Hospitals
- Divested psychiatric hospitals
- Community Care Access Centres
- Community Support Service Agencies
- Mental Health and Addictions Agencies
- Community Health Centres
- Long-Term Care Facilities

In other words, LHINs would control virtually all aspects of our health care system, with the important exception of physicians, drug programs, ambulance services, and laboratories. The MOHLTC is described in Bulletin #2 as “providing stewardship to the system” (October 20, 2004).

To date, the 14 LHIN districts have been established, meetings with stakeholders have been held, and each district has produced a report attempting to identify priorities. Hiring is in progress. Long-standing and valuable District Health Councils have been disbanded as

of March 31, 2005 on the theory that they would be redundant, since the planning and related functions carried out by the DHCs will now be done by LHINs. LHINs are expected to do so much more (see Bulletin #6, January 19, 2005).

Why this massive restructuring? The answer is harder to find in the government literature and press releases. One cannot find a succinct statement of why all this is necessary. But I have a theory that, if it is anywhere close to the mark, should alarm anyone who cares about our public healthcare system. But first a history lesson.

In the mid-1990’s the provincial government overhauled the home care system in Ontario. This was intended to provide one stop shopping for home care services and ensure that regardless of where one lives in Ontario, access to services would be more or less the same (equitable). Community Care Access Centres (CCACs) were created, one for each of some 40 districts in the province. Each CCAC was created to plan, coordinate, integrate, manage, and fund home care in its own district. Despite these best-laid plans, home care in Ontario is no better now than ever. Cutbacks in service rule the day. There is no consistency from one CCAC to another. Some CCACs have spent massive amounts on buying new buildings, money that could have been used to provide service to persons in need of home care. Well paid managers and service co-ordinators devote their expertise to rationalizing and implementing cutbacks in service while there is a shortage of workers to provide services. Seniors with chronic care needs have experienced a sharp decrease in availability of home care services in many areas of the province. When someone complains to the

LHINs

Con’t P. 6

MOHLTC about a reduction or cutback, CCACs are the scapegoats. The MOHLTC shrugs and blames individual CCACs for mismanagement. Despite serious systemic problems with CCACs that the MOHLTC is well-aware of, the problems remain. For example, home care legislation calls for eligibility criteria to be set out in regulations. After more than 10 years, there still are no eligibility criteria. A multi-million dollar system limps along with no one having a clear idea of who should get services and to what extent. This makes it difficult to complain about the inadequacy of the services you are receiving through a CCAC if you can't really say what you are entitled to. If you are responsible for management of MOHLTC this difficulty is not a cause for concern, it is a sure way to dodge responsibility when things go wrong.

If you substitute "LHIN" for "CCAC" in the above discussion, you will have an idea of what the future holds for health care in Ontario.

LHINs are being created to help the MOHLTC divest itself of managerial responsibility and accountability regarding the quality of health care in Ontario. That will now fall on the shoulders of the LHINs. And when something goes wrong, the MOHLTC finger will be pointed at the LHIN who will have "mis-managed". The MOHLTC as the benign steward of public funds will shrug and promise to investigate. At present there are significant pieces of legislation governing the various components of the health care system, setting limits on what they can and cannot do. LHINs are supposed to have flexibility in order to mold the health care system in each area to fit the resources and needs in the area. That sounds good until one realizes that existing legislation does not allow for that kind of flexibility from one district to another. There needs to be a very lengthy discussion about whether legislation

should allow that degree of discretion and flexibility. How does flexibility fit with guiding principles such as ensuring "equitable access based on patient need" (see Bulletin #1)? It didn't in the case of home care, and it likely does not here either. What needs to be asked is whether the provincial government will find it convenient, as it has with home care, to not pass appropriate legislation to ensure equitable access to health care across the province? Will this extra layer of bureaucracy make it even more difficult for someone to complain about inadequate health care? Likely it will. And critics of the health care system will be shunted back and forth between the MOHLTC and the LHINs, trying to figure out where the problem is and trying to figure out how to fix the problem.

Governments are capable of learning. The CCAC experiment since 1994 has taught the provincial government of Ontario a valuable lesson. Shunt off responsibility and accountability to someone else, keep a tight hold on the funding, and for heaven sake do not enact clear legislation governing the matter to let people know what they can expect and what they may be entitled to (and what they have a right to complain about). Actually, the lesson is that no legislation is even better than incomplete legislation in this regard. Make everything a matter of negotiation between the MOHLTC and the LHIN, negotiation that takes place away from the stern eye of public scrutiny.

If any of this scares you, talk to your local MPP and organize! ♦



THE SCHIAVO CASE: What if Mrs. Schiavo Had Been Living in Ontario? Are Living Wills the Answer?

By Judith A. Wahl, Barrister & Solicitor



The recent dispute in Florida over who had authority to make treatment decisions for Terry Schiavo and the accompanying frenzy in the press has created a demand in Ontario for “living wills”. Many people want to know whether they can do something to avoid disputes and court cases over their future health care treatment.

What would have happened if Terry Schiavo had been living in Ontario? What can a person do in advance to express their wishes about future health care and about who should make these decisions for them if they become incapable? Is a living will or an equivalent “legal” document in Ontario the answer?

Based on what appeared in the press, the basic facts concerning Terry Schiavo’s health issues were as follows:

1. Terry Schiavo was a married woman. Prior to having serious health problems, she prepared a Power of Attorney document naming her husband as her attorney responsible for making health decisions in the event that she was not mentally capable to make decisions for herself.
2. Mrs. Schiavo also had a close relationship with parents and other family members (brothers and sisters).
3. Mrs. Schiavo experienced a traumatic health event that left her with communication

limitations. Despite treatment, her condition deteriorated over the next 15 years. Her husband and a number of health care providers believed that Mrs. Schiavo lacked mental capacity to make health decisions and was not able to communicate. In fact, they believed that she was “brain dead” or close to that, not able to benefit from treatment, and would not recover. In contrast, her parents believed that Mrs. Schiavo could communicate although with limitations, had mental capacity, could benefit from treatment, and would one day recover with treatment.

4. There were many court applications regarding who was the appropriate decision maker for Mrs. Schiavo and what treatment was appropriate. The final outcome of these court proceedings was that Mr. Schiavo was confirmed to be the appropriate decision maker for his wife. Mr. Schiavo stated that he believed that his wife had advised him, when capable, that she would not want to be maintained on life supports, including a tube feed, if she found herself in the health condition that she eventually experienced.

Please note that this is only a brief summary of the issues reported by the press and may not be complete. However, this is the information which has caused people in Ontario to be concerned about preparing living wills to avoid or lessen the debate around their own care in similar circumstances.

What would have happened if Mrs. Schiavo had lived in Ontario? In Ontario a person can name someone else to be their substitute decision maker (“SDM”) for personal care decisions by executing a Power of Attorney for Personal Care (POAPC). Personal care decisions include decisions about health treatment. If Mrs. Schiavo had prepared a POAPC and named her husband as her attorney, then he would have been authorized to make treatment decisions for Schiavo

Con’t P. 8

her if she was mentally incapable to do so herself.

Could someone apply to court in Ontario to “trump” the attorney named in a POAPC? Yes. Someone else, like Mrs. Schiavo’s parents, could apply to court to be named as her guardian of the person. A court appointed guardian has priority over an attorney named in a POAPC.

To be appointed as a guardian, the parents or other applicant would have to provide evidence that the person was incapable of making personal care decisions and needed a guardian to make those decisions for her. They also have to prove that the attorney named in a POAPC is not making appropriate decisions in accordance with the law. Otherwise, the court is unlikely to appoint a guardian to replace the attorney chosen by the person.

What are the legal obligations of a SDM, such as an attorney named in a POAPC, when making health treatment decisions for a mentally incapable person in Ontario? The SDM must first determine if he knows of any wishes expressed by the person when capable in respect to treatment that would be relevant to the particular treatment decision that must now be made. The person could have expressed these wishes in writing in a POAPC. She also could have prepared an “advance directive”, also known as a living will, using a form or just writing out her wishes on a piece of paper. The term “advance directive” is not defined in Ontario law and no specific format is required in which to express written wishes. The term “living will” does not appear in Ontario legislation although that term, as well as “advance directive” is used commonly to describe any document in which a person expresses wishes about future health care.

Under Ontario law, wishes may be expressed orally or in any other form or by any other means of communication. For example, a person may express wishes in a video, by using a computer, or by using a bliss board.

The SDM must decide if the known wishes apply to the decision that needs to be made, and then must make a decision that follows and respects those wishes.

If no wishes are known that apply to the decision to be made, then the SDM must make a decision in the “best interests” of the patient. “Best interests” is a legal term defined in the *Health Care Consent Act*. There are six factors to consider when deciding what is in a person’s best interests. Briefly, these factors are (1) the person’s values and beliefs when capable, (2) wishes expressed after becoming incapable, (3) whether treating will result in improvement, prevent deterioration, or reduce the extent of deterioration, (4) what would happen without treatment, (5) whether the benefit outweighs the risk of harm, and (6) whether something less intrusive would be as beneficial.

The husband for the “Ontario” Mrs. Schiavo would likely not lose his authority to make decisions for his wife if he based his decisions about tube feeding on her expressed wishes. If there were no known relevant wishes, if he decided in her best interests as defined by the *Health Care Consent Act*, based on the known facts about her health condition as determined by the health professionals, it is unlikely the court would appoint a guardian. The court would likely respect the fact that his wife chose him when she was capable to make decisions for her should she become incapable.

Would things have been different if the “Ontario” Mrs. Schiavo had expressed her wishes in writing? If instead of orally expressed wishes, there were written wishes, the husband

could have used those written wishes as **evidence** of her wishes in the court proceeding to show that he was acting in accordance with her wishes. The existence of a document usually makes it easier to prove in court that the SDM made appropriate decisions. But otherwise, written wishes are no better than wishes expressed orally.

However, the existence of written wishes in a POAPC or other document would not have prevented a court application from being made in Ontario, but may have discouraged the application. The parents still might have claimed that the written wishes were not made voluntarily, or that they were expressed at a time when the person was mentally incapable, or that the wishes were not based on appropriate information. In other words, the applicants for guardianship could have challenged the validity of the written wishes or the SDM's application of the wishes to the decision to be made. In addition, just as in Florida, someone who believed that the SDM was mistaken about the person's situation could apply for guardianship in Ontario. If there was a dispute about the facts, such as whether the person was aware and able to communicate, someone could apply to have that dispute resolved in court.

Regardless of how careful one is, nothing can prevent the possibility of court cases over one's future health care, as there can always be disputes about what your wishes actually are, or whether you meant what you said. Furthermore, it is impossible to write everything down or anticipate every future situation. As medical science advances, treatments change in ways that cannot always be anticipated. As a result, one may not have expressed any wishes relevant to a decision that one's SDM must make. This leaves open the possibility of a dispute as to what is in your best interest. Finally, people can disagree about the facts, such as whether you can communicate

and are aware of your situation. All of these possible issues can end up before a court.

Despite this, it may be helpful to write things down as well as to communicate orally your concerns and wishes to your SDM and other persons who are important to you. The communication should extend beyond discussions of particular treatments, such as cardiac resuscitation and end of life care, and should include information about such things as how you define "quality of life". This type of information, along with statements of specific wishes, values, and beliefs helps your SDM feel confident about decision making if you should become incapable. If you decide to create a written document expressing specific wishes about health care, you should review this as your health changes or as life events occur that might change your wishes. You can do an oral override to any written document but its prudent to change the written documents as well if you change your wishes.

Since Ontario law also sets out a hierarchy of decision makers who can make health care decisions for you if you are incapable of making these decisions yourself, it is



important to understand how this affects you. This hierarchy is described in the Booklet "Advance Care Planning" that is available on the Ontario government website.

If the law says that someone you do not want would be making health care decisions for you, you can avoid this by appointing someone else you trust in a Power of Attorney for Personal Care. Legal advice may be helpful in this regard. ♦

June is Seniors' Month

HOLOGRAPH WILLS - Testators Beware!

By Rita Chrolavicius, Barrister & Solicitor

“A man who dies without a will has lawyers for his heirs”. (anonymous)



A will that is written completely in the hand of the testator and signed at its end by the testator is considered to be a valid will in Ontario. Such wills are known as “holograph wills”. They do not need to be witnessed. However, they do need to be drafted in a way that makes it clear that the document is meant to be a will or a “testamentary instrument”, intending to leave property after the death of the testator. It is also a good idea to date the will, although this is not mandatory to make it a valid will in Ontario.

An example of the holograph will that I learned as a law student was the case of Cecil Harris, a Saskatchewan farmer who was pinned under his tractor on June 8, 1948. On the tractor’s fender, he scratched out the words, “In case I die in this mess, I leave all to my wife – Cecil Harris”. The court considered this to be a valid holograph will, and the tractor fender was admitted into probate. The fender is now permanently on display at the University of Saskatchewan Law Library.

Holograph wills are useful in cases of emergency. I do not recommend that they be used by anyone who really cares about what happens to their property after death.

There are many cases involving holograph wills where the estate is worth hundreds of thousands or even millions of dollars. If the deceased relies on a holograph will to make bequests, litigation will likely result about the following types of disputes:

- a) whether the will is valid;
- b) ambiguous or contradictory language;
- c) partial intestacy, missing pages, location of signature;

- d) proof that the will is in the handwriting of the deceased;
- e) alterations to the will.

Another major problem with holograph wills is that they can easily go missing. I suspect that there are many cases where holograph wills have been kept in a secret place and are not found after death. I have heard of other cases where next of kin remove documentation and there is subsequently suspicion that a holograph will has been destroyed because the person removing the documentation did not like the contents of the will.

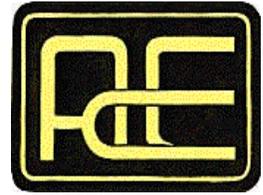
The same problems that arise with holograph wills also arise with attempts to make handwritten changes to wills. Any alteration on the face of the document will have no effect except to validate the words that can no longer be seen. There has been litigation about what kind of lights or devices can be used to try to see what words were written underneath a manually altered portion of the will. Altering an existing testamentary instrument will guarantee problems with proving the will.

Where problems arise with any will, the cost of hiring lawyers to fight about these problems will be born by the potential beneficiaries, relatives of the deceased or by the estate itself. There are cases where the whole estate has been consumed by legal fees, and potential beneficiaries receive nothing, or, even worse, are out-of-pocket for substantial sums of money.

There is a tendency to begrudge the cost of a lawyer to do something as straightforward as a simple will. This is false economy. In addition to preparing a will, a lawyer can keep the original will or a true copy of the will in a safe place, as well as retain a file that contains notes and information about the testator’s competence and intentions, next of kin, property and assets. Lawyers can also discuss estate planning issues with clients.

Individuals should pay as much care and attention to what happens to their property after they pass away as they do to what happens to their property while they are alive.◆

Long-Term Care Facilities In Ontario: The Advocate's Manual (3rd edition)



The Advocacy Centre for the Elderly (ACE) is proud to introduce the third edition of a comprehensive information resource for residents of long-term care facilities, their families and advocates, and for anyone working with residents of long-term care facilities in Ontario. An order form is available on the reverse.

Phone numbers, addresses, dollar amounts, and other information of this kind has been updated. The topics covered in the third edition remain much the same as in the second edition. However, in the last few years the body of case law related to mental capacity and substitute decision-making has grown rapidly. The third edition incorporates commentary on a number of these decisions, including the recent decision of the Supreme Court of Canada in *Starson*, the first case to reach that court with respect to Ontario's *Health Care Consent Act*.

In addition, in 2002 the Ontario Ministry of Health and Long-Term Care introduced a number of changes to the admission process for long-term care, including changes to how waiting lists are maintained. The third edition includes extensive commentary on these changes.

Over the years, lawyers and staff at ACE have learned much in dealing with clients who are residents of long-term care facilities. Efforts have been made to incorporate this collective wisdom into the third edition to enhance the information and, it is hoped, better serve residents and their advocates.

Included with the third edition is a Consent to Treatment Summary. This quick reference guide to the Health Care Consent Act has been laminated to preserve it. The Summary deals with consent to treatment and with the assessment of decisional capacity in the legal context.

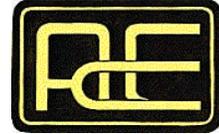
The following is a sampling of the many topics discussed in depth in *Long-Term Care Facilities in Ontario: The Advocate's Manual (3rd edition)*.

- ◆ The principles of advocacy
- ◆ Long-term care facilities (LTCFs) in Ontario: their nature and the legal structure that governs them
- ◆ Who is eligible for admission to a LTCF and how the admission process works
- ◆ The role of Community Care Access Centres in the admission process and in providing in-home services
- ◆ What it costs to live in a LTCF and how to apply for rate reductions
- ◆ The rights of LTCF residents: the Residents' Bill of Rights, the plan of care, the types of care, residents' councils, leaves of absence, visitors, etc.
- ◆ The use of restraints in LTCFs and the *Charter of Rights and Freedoms*
- ◆ How to make complaints and resolve problems that arise in a LTCF
- ◆ The *Substitute Decisions Act* and the *Health Care Consent Act* analyzed, with special emphasis on the relevance to residents of LTCFs, and reference to important recent decisions by the Courts and the Consent and Capacity Board
- ◆ Powers of Attorney for Property, Powers of Attorney for Personal Care, advance care planning
- ◆ Retirement homes (care homes) compared and contrasted with LTCFs
- ◆ The rights of tenants in retirement homes and other care homes
- ◆ Problems associated with transfers from hospitals to LTCFs
- ◆ The rights of recipients of in-home services from Community Care Access Centres

See Reverse for Ordering Information

The Advocacy Centre for the Elderly is a legal clinic funded by Legal Aid Ontario to provide a range of legal services to eligible low income seniors. Legal services include direct client assistance, public legal education, law reform, community development and referral.

Long-Term Care Facilities in Ontario: The Advocate's Manual (3rd edition)



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