ISSUES IN LONG-TERM CARE

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ISSUES

- Admission
- Home First Philosophy
- ALC Co-payment
- Regulated Documents
- Resident's Rights
- Reporting in LTC
- Complaints in LTC

Most Common Calls to ACE – Discharge from Hospital to Long-Term Care

- Relating to discharge from hospital into long-term care
  - Forcing to go into “wait at home” or “home first programs”
  - Requiring spouse/family to care for person pending admission to LTCH
  - Refusal to allow application to be made/ preventing contact with CCAC
  - Threats of charges
  - Requiring person to go to a RH pending placement into a long-term care home

Hospital Discharge Policies - Problems

- Hospitals may attempt to control admission process even though CCAC responsible for admission
- Hospital cannot have discharge policies that are contrary to the law
- For example:
  - Cannot require certain number of choices or number of choices from “short lists”
  - Cannot require patients to accept “available beds”
  - Cannot prevent patients from applying to LTCHs from hospital
  - Cannot require persons to go home or to a retirement home to “wait”
  - Cannot be threatened with “discharge” and charges of a “daily rate” which often run from $500 - $1500 per day
  - Cannot prohibit patients from making applications

Public Hospitals Act

- Physician can discharge patient pursuant to *Public Hospitals Act*
- If discharged, patient expected to leave within 24 hours
- However, if patient needs continued care, although not acute, cannot be “abandoned”
- If needs long term care and cannot return home with supports, then can remain at hospital pending transfer (alternative level of care)

Long-Term Care Homes Act, 2007

- Provides that the CCAC (Placement Coordinator) is responsible for applications to LTC homes NOT the hospital personnel
- CCAC must determine eligibility for LTC home admission
- CCAC must assist person to apply to LTC homes
- Confirms requirement for CHOICE of homes is that of the person
- Can choose maximum of 5 homes
- In crisis – may (but CANNOT be required to) – choose MORE than 5 homes
- Person cannot be required to go to LTC home unless he or she consents
- Consent must be INFORMED and voluntary and not based on misrepresentation

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Admission

- CCAC to control process
- Can choose **maximum** of 5 homes – there is no **requirement** to choose 5 homes
- If in crisis – may choose more homes – not **required** to choose more
- Hospitals and CCACs have no authority to make person choose specific homes
- “Invite” yes, “require” no

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Applications

- Can be made from hospital or community
- CCAC cannot refuse to take an application
- Important for application to be taken even if CCAC says person not eligible - as finding of ineligibility is appealable to HSARB
- Cannot require person to go to “Wait at Home” or “Home First” programs (some may say, will get bed faster from home)
- Cannot force family to care for person

Applications

- People cannot be told that can only apply for LTC after being discharged from hospital when out of hospital
- CAN encourage people to return home with home care **if** person's care needs could be managed at home with sufficient home care
- Can talk with people about alternatives to long term care placement – but it they are eligible for long-term care cannot REQUIRE them to go to an alternative

Choice

- While retirement homes may be considered – they are not the equivalent of LTCHs and cannot be used as such (see Nineteenth Annual Report of the Geriatric and Long-term Care Review Committee to the Chief Coroner for the Province of Ontario – September 2009, page 35)
- Cannot set arbitrary “rules” about where and when applications can be made that takes away right of choice of when to apply

Information to be Provided by Placement Coordinator

- Information about alternative services
- Responsibility to pay and maximum amounts that may be charged
- Rate reductions that are available and application requirements
- Approximate length of waiting lists
- Vacancies
- How to obtain information, including compliance reports, from the Ministry of Health and Long-Term Care
- If person is incapable, how SDM is to make decision (*Benes* case)

Choice of LTCHs
LTCHA s. 44

- Where the person/SDM wishes the CCAC shall assist the applicant in selecting homes
- Shall consider the applicant's preferences relating to admission, based on ethnic, religious, spiritual, linguistic, familial and cultural factors
- Application can only be made with the consent of the applicant – therefore homes that have not been applied to cannot be "offered"
- Applicants may choose any home in the province of Ontario and the CCAC shall work with the CCAC in that area regarding the application

Information Issues

- Some CCACs/Hospitals advise clients to apply for preferred accommodation as it has shorter wait lists – and then can transfer after 1 year. UNTRUE.
- Applications for transfer can be made on the DAY OF ADMISSION to the long-term care home; HOWEVER, actual transfer may take years due to alternate waiting list regulation
- Homes CANNOT “income test” or request income information and CANNOT refuse based on issues of income

Waiting Lists

- Applicant can only apply for a maximum of 5 LTCHs (except for crisis)
- Can apply to interim short stay, which are not included in the 5 maximum
- May, but is not required, to add homes if they are on crisis waiting list
- Can only be put on waiting list if there is valid consent unless it is crisis under HCCA

Can Choice List be Shared with Hospital?

- As with other types of consent – consent to release personal health information must be voluntary, knowledgeable, relate to the information, and not obtained through deception or coercion (PHIPA s. 18)
- Can choice of home be released without specific consent to CCAC to do so?
- PHIPA allows information to be released if it for the provision of health care
- Arguably the choice of facilities is not
- Additionally – person/SDM can prohibit this information being released to the hospital

Home First/ Wait at Home "Philosophy"

- Cannot do through the back-door what you cannot do through the front door – ie require person to choose short list, specific choices, homes that will place within a specified period of time
- In certain circumsntaces when awaiting LTC – no maximum amount of homemaking/personal support services
- CCAC may provide UNLIMITED amounts of care (both hours and time periods)

Expectations of CCAC in Home First "Philosophy"

- Provide information about type of service, amount of service, time periods, etc.
- The stated services will be provided
- In general, services will not be changed unless there is a change in the needs of the person

ALC Designation vs. ALC Copayment

- As of July 1, 2009, all acute and post-acute hospitals were required to use a standardized Provincial ALC Definition
- Designation as ALC does not mean person can be charged
- Can only be charged copayment if meet requirements set out in regulation to the *Health Insurance Act*

ALC Co-payment

- Attending physician must designate patient as requiring chronic care and being more or less permanently resident in a hospital or other institution
- Only applies to patients who are presently in certain types of public hospitals as set out in the regulations
- Cannot ever charge a patient who received services under the *Mental Health Act*- ie at any time was a mental health patient – even if are now ALC (s. 46 of the *Health Insurance Act*)

Maximum Allowable Rate for ALC Patients Under Health Insurance Act

- Maximum amount can be charged pursuant to regulations under Health Insurance Act is $56.14.
- Rate reductions are available – for both low income as well as spouses still in community.

Long-Term Care Regulated Documents - Certification

- No regulated document can be presented to the resident or their SDM for signature unless it
  - Complies with all regulations and
  - Is **certified by** a lawyer
- Not every regulated document is compliant

Regulated Documents - General

- A regulated document is a document that is
  - Required by the regulations to meet certain requirements and
  - Described as a regulated document in the regulations

- Requires that everyone who signs a document is provided with a copy of the document

Regulated Documents - Types of Documents

- Two types of regulated documents:
  - Any agreement between the licensee and a resident or a person authorized to enter into such an agreement on the resident's behalf for any of the charges referred to in subsection 91 (1) of the Act.
  - Any document containing a consent or directive with respect to "treatment" as defined in the *Health Care Consent Act, 1996*, including a document containing a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act.

Regulated Documents - Accommodation

- Regulations require that agreements relating to basic or preferred accommodation be
  - Separate from other agreements
  - Contain only certain provisions as set out in the regulations

Regulated Documents - Health

- Any document containing a consent or directive – which would include “level of care” documents
  - Must meet the requirements of the *HCCA*
  - Must not include any financial matters
  - Must contain a statement that consent may be withdrawn or revoked at any time

Refusal To Sign Documents, Consent, Etc.

- No (prospective) resident can be told or led to believe that they will be refused admission or discharged from the home because:
  - They have not signed a document;
  - An agreement has been voided;
  - Consent to treatment or care has been given, not given, withdrawn or revoked; or
  - A directive regarding treatment or care has been given, not given, withdrawn or revoked.
- This does not apply with respect to consent required by law for admission to a long-term care home or transfer to a secure unit.

Accommodation Rates

- Three types of rates
- 40% of rooms have to be offered at the basic rate
- Basic – not tied to physical structure
- Preferred – broken down into semi-and private
- As of July 1, 2012 – higher rates for semi and private accommodation in new admissions to “Class A” beds
- Ministry of Health and Long-term Care set rates annually
- Can transfer between accommodation levels – home MUST put you on transfer list on request – but waiting times vary

Accommodation Rates

- Rate reduction only available in basic accommodation
- New scheme for rate reduction – more complicated – includes reduction for dependents (under age 65)
- Came into effect on January 1, 2011

Resident's Bill of Rights

- Twenty-seven (27) rights
- Specifically states that it is enforceable as a contract
- Guides interpretation of:
  - The Act and regulations
  - Agreements between the licensee and Crown/agent
  - Agreements between the licensee and resident/SDM

Right to Visitors

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
  - Not uncommon for homes to attempt to “bar” family under *Trespass to Property Act*
  - Legality questionable – as person has a right to visits without interference (query, though, if the visitor creates a risk)
  - SDMS – may also attempt to restrict – where is the authority unless it’s a safety issue and are Attorney or Guardian

Prevention of Abuse and Neglect

- Licensee has duty to protect residents from abuse from anyone and neglect by licensee or staff.
- Ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.
- Communicate policy to all staff, residents and residents' SDMs.

Notification re Incidents

- Licensee must ensure that the resident's SDM, if any, and any other person specified by the resident,
  - are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
  - are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident.
- Licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under the Act, immediately upon the completion of the investigation.

NOTE: Where the SDM/person to be notified is the alleged abuser, the Ministry of Health and Long-Term Care have confirmed that no notification is required and there will be no finding of non-compliance, but that this must be documented with both the Ministry as well as in the home's records.

Police Notification

- Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Police Notification

- Must put mind to whether it meets the definition of abuse/neglect in the Act
- AND
- May constitute a criminal offence
- ex. Physical Abuse
- Resident on resident – must have caused physical injury
- Staff on resident– use of force that causes physical injury OR pain
- ex. Sexual Abuse
- All sexual acts between staff/resident UNLESS relationship pre-dates admission
- All non-consensual acts between resident and resident/non-staff

Reporting and Complaints

Licensee required to:

- Have written procedures for initiating complaints to the licensee and for how the licensee deals with complaints.
- Forward all written complaints concerning the care of a resident or the operation of the long-term care home to the Director.

Dealing with Complaints

- Licensee must ensure that all written or verbal complaints made to the licensee or staff are dealt with, as follows:
  - The complaint must be investigated and resolved where possible, and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Dealing with Complaints

- If the complaint cannot be investigated and resolved within 10 business days, an acknowledgement, they have to provide within those 10 days:
  - The date when they can reasonably expected to have a resolution
  - Provide a follow-up response as soon as possible

Dealing with Complaints

- The response must be made to the person who made the complaint, indicating,
  - what the licensee has done to resolve the complaint, or
  - that the licensee believes the complaint to be unfounded and the reasons for the belief

Reporting Certain Matters to the Director

- **Everyone** who believes that **any** of the following have occurred or may occur must **immediately** report to the Director
  - Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
  - Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
  - Unlawful conduct that resulted in harm or a risk of harm to a resident.
  - Misuse or misappropriation of a resident's money.
  - Misuse or misappropriation of funding provided to a licensee under this Act.

Reporting Certain Matters To The Director (cont'd.)

- Knowingly providing false information is an offence, except in the case of incapable residents
- Residents **may**, but are not required, to make reports

Duty On Practitioners and Others

- Reports may be made by health practitioners and social workers even if the information is based upon confidential or privileged information, as long as it is not malicious or without reasonable grounds for the suspicion.
- This includes health practitioners and social workers OUTSIDE the home

No Retaliation Against Residents

- No retaliation against residents, and specifically:
  - Discharge or threat of discharge
  - Subjected to any discriminatory treatment – including any change or discontinuation of service to or care of a resident or the threat of any such change or discontinuation.
- No threats against family members with the possibility of the above.
- No retaliation **even** where the resident or other person acted maliciously or in bad faith.

Critical Incidents

The following critical incidents must be reported to the Director **immediately**:

- An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
- An unexpected or sudden death, including a death resulting from an accident or suicide.
- A resident who is missing for three hours or more.
- Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
- An outbreak of a reportable disease or communicable disease as defined in the *Health Protection and Promotion Act*.
- Contamination of the drinking water supply.

Critical Incidents

The following incidents must be reported to the Director within **1 business day** after occurrence:

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

Part IX - Compliance and Enforcement

- Different types of inspections
  - Resident Quality Inspections (RQI)
  - Complaint Inspection, Critical Incident
  - Follow up
- RQI is complete inspection – was to be completed annually
- Now Ministry saying that any type of inspection meets the “annual inspection” requirement

RQI

- RQI
- Most unannounced (except where allowed by regulation)
- All findings of non-compliance to be documented
- Ministry backing away from completing annual RQIs despite previous statements it would do so
- due to overwhelming number of complaint and critical incident inspections – do not have resources to complete
- No indication from Ministry what the timeline is for RQIs, how they will choose which homes will be inspected

Other Inspections

- Are issue specific – ie triggered by complaint, critical incident, etc.
- If inspector sees other issues, should trigger further

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Resources

- Discharge from Hospital to Long-Term Care: Issues in Ontario, February 2014, Jane E. Meadus
- Tips & Traps When Dealing with Long-Term Care, Jane E. Meadus
- Provincial ALC Definition, Cancer Care Ontario
- Hospital Complex Continuing Care (CCC) Payment: Questions & Answers, Updated June 4008, Ministry of Health and Long-Term Care
- Issues with Long-Term Care Rate Reductions, Jane E. Meadus
- A Brand New World: Ontario's New *Long-Term Care Homes Act,* Jane E. Meadus
- Every Resident: Bill of Rights for People Who Live in Long-Term Care Facilities – December 2011 – ACE/CLEO

Ministry of Health and Long-Term Care - Memos

- Crisis Designation and First Available Bed Policy, February 23, 2011, Ruth Hawkins ADM(A)
- ALC patients who refuse an offer of admission to a prior-chosen LTC home bed, May 23, 2012, Rachel Kampus, A/ADM
- The Home First Philosophy, January 9, 2013, Catherine Brown (ADM)

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