Excerpts from the Long-Term Care Homes Act, 2007, S.O. 2007, Chapter 8 and Regulation O. Reg. 79/10: GENERAL

The following are excerpted sections from the Long Term Care Homes Act and Regulation related to health care decision making and consent that may be of interest to you. The Highlighted sections are particularly relevant to our discussions at the Health Care Consent and Advance Care Planning workshop.

DEFINITIONS- LTCH ACT

S2 (1)

"care" includes treatment and interventions;

"incapable" means unable to understand the information that is relevant to making a decision concerning the subject matter or unable to appreciate the reasonably foreseeable consequences of a decision or a lack of decision; ("incapable")

NOTE – this is the same definition of incapacity as in the Health Care Consent Act

"substitute decision-maker" means a person who is authorized under the *Health Care Consent Act, 1996* or the *Substitute Decisions Act, 1992* to give or refuse consent or make a decision, on behalf of another person.

RESIDENTS' BILL OF RIGHTS -LTCH ACT

3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

9. Every resident has the right to have his or her participation in decision-making respected.

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. 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 a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the *Personal Health Information Protection Act, 2004* kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

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

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home.

PLAN OF CARE- LTCH ACT

6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(a) the planned care for the resident b) the goals the care is intended to achieve; and

(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Based on assessment of resident

(2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

Plan to cover all aspects of care

(3) The licensee shall ensure that the plan of care covers all aspects of care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. 2007, c. 8, s. 6 (3).

Integration of assessments, care

(4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,

(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and

(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Involvement of resident, etc.

(5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

Development of initial plan of care

(6) When a resident is admitted to a long-term care home, the licensee shall, within the times provided for in the regulations, ensure that the resident is assessed and an initial plan of care developed based on that assessment and on the assessment, reassessments and information provided by the placement co-ordinator under section 44. 2007, c. 8, s. 6 (6).

Duty of licensee to comply with plan

(7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Staff and others to be kept aware

(8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Documentation

(9) The licensee shall ensure that the following are documented:

1. The provision of the care set out in the plan of care.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

When reassessment, revision is required

(10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,

(a) a goal in the plan is met;

(b) the resident's care needs change or care set out in the plan is no longer necessary; or

(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Reassessment, revision

(11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Explanation of plan

(12) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the plan of care. 2007, c. 8, s. 6 (12).

Limitation on disclosure

(13) Subsection (12) does not require the disclosure of information if access to a record of the information could be refused under the *Personal Health Information Protection Act, 2004*. 2007, c. 8, s. 6 (13).

Access to plan

(14) Nothing in this section limits a right of access to a plan of care under the *Personal Health Information Protection Act, 2004*. 2007, c. 8, s. 6 (14).

Consent

7. Nothing in this Act authorizes a licensee to assess a resident's requirements without the resident's consent or to provide care or services to a resident without the resident's consent. 2007, c. 8, s. 7.

O. Reg. 79/10: GENERAL
under *Long-Term Care Homes Act, 2007, S.O. 2007, c. 8*
CARE PLANS AND PLANS OF CARE

24-hour admission care plan

24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

(2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:

1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.

2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

3. The type and level of assistance required relating to activities of daily living.

4. Customary routines and comfort requirements.

5. Drugs and treatments required.

6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.

7. Skin condition, including interventions.

8. Diet orders, including food texture, fluid consistencies and food restrictions. O. Reg. 79/10, s. 24 (2).

(3) The licensee shall ensure that the care plan sets out,

(a) the planned care for the resident; and

(b) clear directions to staff and others who provide direct care to the resident. O. Reg. 79/10, s. 24 (3).

(4) The licensee shall ensure that the care set out in the care plan is based on an assessment of the resident and the needs and preferences of that resident and on the assessment, reassessments and information provided by the placement co-ordinator under section 44 of the Act. O. Reg. 79/10, s. 24 (4).

(5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate to the extent possible in the development and implementation of the resident's care plan, and in reviews and revisions of the care plan. O. Reg. 79/10, s. 24 (5).

(6) The licensee shall ensure that the care set out in the care plan is provided to the resident as specified in the plan. O. Reg. 79/10, s. 24 (6).

(7) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's care plan and have convenient and immediate access to it. O. Reg. 79/10, s. 24 (7).

(8) The licensee shall ensure that the provision and outcomes of the care set out in the care plan are documented. O. Reg. 79/10, s. 24 (8).

(9) The licensee shall ensure that the resident is reassessed and the care plan is reviewed and revised when,

(a) the resident's care needs change;

(b) the care set out in the plan is no longer necessary; or

(c) the care set out in the plan has not been effective. O. Reg. 79/10, s. 24 (9).

(10) When the care plan is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the care plan. O. Reg. 79/10, s. 24 (10).

(11) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an explanation of the care plan. O. Reg. 79/10, s. 24 (11).

Initial plan of care

25. (1) Every licensee of a long-term care home shall ensure that,

(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and

(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

(4) For greater clarity, an initial plan of care is a "plan of care" for the purposes of the Act and this Regulation. O. Reg. 79/10, s. 25 (4).

Plan of care

26. (1) Every licensee of a long-term care home shall ensure that the requirements of this section are met with respect to every plan of care. O. Reg. 79/10, s. 26 (1).

(2) A plan of care,

(a) must identify the resident and include the resident's demographic information; and

(b) must identify all the persons who participated in the development of the plan of care, and the dates on which they participated. O. Reg. 79/10, s. 26 (2).

(3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.

12. Dental and oral status, including oral hygiene.

13. Nutritional status, including height, weight and any risks relating to nutrition care.

14. Hydration status and any risks relating to hydration.

15. Skin condition, including altered skin integrity and foot conditions.

16. Activity patterns and pursuits.

17. Drugs and treatments.

18. Special treatments and interventions.

19. Safety risks.

20. Nausea and vomiting.

21. Sleep patterns and preferences.

22. Cultural, spiritual and religious preferences and age-related needs and preferences.

23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

(4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,

(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and

(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Care conference

27. (1) Every licensee of a long-term care home shall ensure that,

(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any;

(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and

(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Changes in plan of care, consent

29. Every licensee of a long-term care home shall ensure that when a resident is reassessed and the resident's plan of care is reviewed and revised under subsection 6 (10) of the Act, any consent or directive with respect to "treatment" as defined in the

Health Care Consent Act, 1996, including a consent or directive with respect to a "course of treatment" or a "plan of treatment" under that Act, that is relevant, including a regulated document under paragraph 2 of subsection 227 (1) of this Regulation, is

End-of-life care

42. Every licensee of a long-term care home shall ensure that every resident receives end-of-life care when required in a manner that meets their needs. O. Reg. 79/10, s. 42.

Communication methods

43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

INDIVIDUALIZED MEDICAL DIRECTIVES AND ORDERS – LTCH ACT

81. Every licensee of a long-term care home shall ensure that no medical directive or order is used with respect to a resident unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 81.

MEDICAL DIRECTIVES AND ORDERS — DRUGS REGULATION

117. Every licensee of a long-term care home shall ensure that,

(a) all medical directives or orders for the administration of a drug to a resident are reviewed at any time when the resident's condition is assessed or reassessed in developing or revising the resident's plan of care as required under section 6 of the Act; and

(b) no medical directive or order for the administration of a drug to a resident is used unless it is individualized to the resident's condition and needs. O. Reg. 79/10, s. 117.

MINIMIZING OF RESTRAINING – LTCH ACT

Policy to minimize restraining of residents, etc.

29. (1) Every licensee of a long-term care home,

(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and

(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Policy to comply with regulations

(2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Protection from certain restraining

30. (1) Every licensee of a long-term care home shall ensure that no resident of the home is:

1. Restrained, in any way, for the convenience of the licensee or staff.
2. Restrained, in any way, as a disciplinary measure.
3. Restrained by the use of a physical device, other than in accordance with section 31 or under the common law duty described in section 36.
4. Restrained by the administration of a drug to control the resident, other than under the common law duty described in section 36.
5. Restrained, by the use of barriers, locks or other devices or controls, from leaving a room or any part of a home, including the grounds of the home, or entering parts of the home generally accessible to other residents, other than in accordance with section 32 or under the common law duty described in section 36. 2007, c. 8, s. 30 (1).

Devices that resident can release

(2) The use of a physical device from which a resident is both physically and cognitively able to release themself is not a restraining of the resident. 2007, c. 8, s. 30 (2).

Use of PASD to assist resident

(3) The use of a personal assistance services device ("PASD"), within the meaning of subsection 33 (2), to assist a resident with a routine activity of living is not a restraining of the resident. 2007, c. 8, s. 30 (3).

Administration of drugs, etc., as treatment

(4) The administration of a drug to a resident as a treatment set out in the resident's plan of care is not a restraining of the resident. 2007, c. 8, s. 30 (4).

Perimeter barriers, etc., of home, grounds

(5) The use of barriers, locks or other devices or controls at entrances and exits to the home or the grounds of the home is not a restraining of a resident unless the resident is prevented from leaving. 2007, c. 8, s. 30 (5).

Safety measures at stairways

(6) The use of barriers, locks or other devices or controls at stairways as a safety measure is not a restraining of a resident. 2007, c. 8, s. 30 (6).

Restraining by physical devices

31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31 (1).

Provision in plan of care

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

1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1.
3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1.
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining.
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).

Requirement if resident is restrained

(3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,

(a) the device is used in accordance with any requirements provided for in the regulations;

(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations;

(c) the resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the regulations;

(d) the resident's condition is reassessed and the effectiveness of the restraining evaluated, in accordance with the requirements provided for in the regulations;

(e) the resident is restrained only for as long as is necessary to address the risk referred to in paragraph 1 of subsection (2);

(f) the method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, one of the following is identified that would address the risk referred to in paragraph 1 of subsection (2):

(i) an alternative to restraining, or

(ii) a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history; and

(g) any other requirements provided for in the regulations are satisfied.

Common law duty

36. (1) Nothing in this Act affects the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others. 2007, c. 8, s. 36 (1).

Restraining by physical device under common law duty

(2) If a resident is being restrained by a physical device pursuant to the common law duty described in subsection (1), the licensee shall ensure that the device is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 36 (2).

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

(3) A resident may not be restrained by the administration of a drug pursuant to the common law duty described in subsection (1) unless the administration of the drug is ordered by a physician or other person provided for in the regulations. 2007, c. 8, s. 36 (3).

Same

(4) If a resident is being restrained by the administration of a drug pursuant to the common law duty described in subsection (1), the licensee shall ensure that the drug is used in accordance with any requirements provided for in the regulations and that any other requirements provided for in the regulations are satisfied. 2007, c. 8, s. 36 (4).

MINIMIZING OF RESTRAINING- REGULATION

Policy to minimize restraining of residents, etc.

109. Every licensee of a long-term care home shall ensure that the home's written policy under section 29 of the Act deals with,

(a) use of physical devices;

(b) duties and responsibilities of staff, including,

(i) who has the authority to apply a physical device to restrain a resident or release a resident from a physical device,

(ii) ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device;

(c) restraining under the common law duty pursuant to subsection 36 (1) of the Act when immediate action is necessary to prevent serious bodily harm to the person or others;

(d) types of physical devices permitted to be used;

(e) how consent to the use of physical devices as set out in section 31 of the Act and the use of PASDs as set out in section 33 of the Act is to be obtained and documented;

(f) alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach; and

(g) how the use of restraining in the home will be evaluated to ensure minimizing of restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation. O. Reg. 79/10, s. 109.

Requirements relating to restraining by a physical device

110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:

1. Staff apply the physical device in accordance with any manufacturer's instructions.
2. The physical device is well maintained.
3. The physical device is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

(2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

(3) Where a resident is being restrained by a physical device when immediate action is necessary to prevent serious bodily harm to the resident or to others pursuant

to the common law duty described in section 36 of the Act, the licensee shall ensure that,

(a) the resident is monitored or supervised on an ongoing basis and released from the physical device and repositioned when necessary based on the resident's condition or circumstances;

(b) the resident's condition is reassessed only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every 15 minutes, and at any other time when reassessment is necessary based on the resident's condition or circumstances; and

(c) the provisions of section 31 of the Act are complied with before continuing to restrain a resident by a physical device when the immediate action is no longer necessary. O. Reg. 79/10, s. 110 (3).

(4) Following the application of a physical device pursuant to the common law duty referred to in section 36 of the Act, the licensee shall explain to the resident, or the resident's substitute decision-maker where the resident is incapable, the reason for the use of the physical device. O. Reg. 79/10, s. 110 (4).

(5) Where a resident has been restrained by a physical device under section 31 of the Act, or pursuant to the common law duty referred to in section 36 of the Act, and the resident is released from the physical device or the use of the physical device is being discontinued, the licensee shall ensure that appropriate post-restraining care is provided to ensure the safety and comfort of the resident. O. Reg. 79/10, s. 110 (5).

(6) Every licensee shall ensure that no physical device is applied under section 31 of the Act to restrain a resident who is in bed, except,

(a) to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary; or

(b) if the physical device is a bed rail used in accordance with section 15. O. Reg. 79/10, s. 110 (6); O. Reg. 363/11, s. 9.

(7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.

8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

(8) Every licensee shall ensure that every use of a physical device to restrain a resident pursuant to the common law duty referred to in section 36 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:

1. The circumstances precipitating the application of the physical device.
2. The person who made the order, what device was ordered, and any instructions relating to the order.
3. The person who applied the device and the time of application.
4. All assessment, reassessment and monitoring, including the resident's response.
5. Every release of the device and all repositioning.
6. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (8).
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

PASDs– LTCH ACT

PASDs that limit or inhibit movement

33. (1) This section applies to the use of a PASD if the PASD has the effect of limiting or inhibiting a resident's freedom of movement and the resident is not able, either physically or cognitively, to release themself from the PASD. 2007, c. 8, s. 33 (1).

Definition of PASD

(2) In this section,

"PASD" means personal assistance services device, being a device used to assist a person with a routine activity of living. 2007, c. 8, s. 33 (2).

When PASD may be used

(3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33 (3).

Inclusion in plan of care

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

1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living.
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living.
3. The use of the PASD has been approved by,
    i. a physician,
    ii. a registered nurse,
    iii. a registered practical nurse,
    iv. a member of the College of Occupational Therapists of Ontario,
    v. a member of the College of Physiotherapists of Ontario, or
    vi. any other person provided for in the regulations.
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Use of PASD

(5) If a PASD is used under subsection (3), the licensee shall ensure that the PASD is used in accordance with any requirements provided for in the regulations. 2007, c. 8, s. 33 (5).

PASD used to restrain

(6) For greater certainty, if a PASD is being used to restrain a resident rather than to assist the resident with a routine activity of living, section 31 applies with respect to that use instead of this section. 2007, c. 8, s. 33 (6).

Records on restraining of residents

34. Every licensee of a long-term care home shall keep records in the home, as provided for in the regulations, in relation to the following:

1. The restraining of a resident, other than a restraint permitted under section 32.

2. The use of a PASD, within the meaning of section 33. 2007, c. 8, s. 34.

Prohibited devices that limit movement

35. Every licensee of a long-term care home shall ensure that no device provided for in the regulations is used on a resident,

(a) to restrain the resident; or

(b) to assist a resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement. 2007, c. 8, s. 35.

Requirements relating to the use of a PASD- REGULATION

111. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111 (1).

(2) Every licensee shall ensure that a PASD used under section 33 of the Act,

(a) is well maintained;

(b) is applied by staff in accordance with any manufacturer's instructions; and

(c) is not altered except for routine adjustments in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 111 (2).

Prohibited devices that limit movement

112. For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:

1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

5. Every release of the device and all repositioning.
6. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (8).

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5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

REGULATED DOCUMENTS FOR RESIDENT– LTCH ACT

80. (1) Every licensee of a long-term care home shall ensure that no regulated document is presented for signature to a resident or prospective resident, a substitute decision-maker of a resident or prospective resident or a family member of a resident or prospective resident, unless,

(a) the regulated document complies with all the requirements of the regulations; and

(b) the compliance has been certified by a lawyer. 2007, c. 8, s. 80 (1).

Interpretation

(2) For the purposes of this section, a "regulated document" is a document,

(a) that is required by the regulations to meet certain requirements; and

(b) that is described as a regulated document in the regulations. 2007, c. 8, s. 80 (2).

Voidable agreements

81. (1) An agreement between a licensee and a resident or prospective resident, a substitute decision-maker of a resident or prospective resident, or a family member of a resident or prospective resident is voidable by the resident, prospective resident, substitute decision-maker or family member for 10 days after it is made. 2007, c. 8, s. 81 (1).

Obligations incurred before voiding

(2) The voiding of an agreement under subsection (1) does not relieve any person from liability for charges that were incurred before the voiding. 2007, c. 8, s. 81 (2).

Preferred accommodation

(3) Subsection (1) does not apply to an agreement under paragraph 2 of subsection 91 (1) except as provided for in the regulations. 2007, c. 8, s. 81 (3).

Agreement cannot prevent withdrawal of consent, etc.

82. An agreement with a licensee cannot prevent a consent or directive with respect to treatment or care from being withdrawn or revoked. 2007, c. 8, s. 82.

Coercion prohibited

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

(a) a document has not been signed;

(b) an agreement has been voided; or

(c) a consent or directive with respect to treatment or care has been given, not given, withdrawn or revoked. 2007, c. 8, s. 83 (1).

Saving

(2) Subsection (1) does not apply with respect to a consent that is required by law for admission to a long-term care home or transfer to a secure unit. 2007, c. 8, s. 83 (2).

REGULATED DOCUMENTS - REGULATION

Regulated documents

227. (1) For the purposes of section 80 of the Act, the following are regulated documents:

1. 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.
2. 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. O. Reg. 79/10, s. 227 (1).

(2) Where a licensee has presented for signature a document to which subsection (1) applies, the licensee shall ensure that every one who signs it is provided with a copy of the signed document. O. Reg. 79/10, s. 227 (2).

(6) A 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,

(a) must meet the requirements of that Act, including the requirement for informed consent to treatment under that Act;

(b) must not contain any provisions dealing with any of the charges referred to in subsection 91 (1) of the Act or other financial matters;

(c) must contain a statement indicating that the consent may be withdrawn or revoked at any time; and

(d) must set out the text of section 83 of the Act. O. Reg. 79/10, s. 227 (6).

It is the duty of HEALTH PRACTITIONER offering the treatment to determine if patient capable or not and whether its necessary to turn to the patient's SDM for consent.
This is **NOT** done by a "capacity assessor" as defined in the Substitute Decisions Act. Only the patient themselves can challenge the finding of incapacity by a health care practitioner.

Ontario Public Gardian and Trustee

No fees apply.
Role of the PGT - https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/overview.php

The Ontario Public Guardian and Trustee is the SDM if no one on the hierarchy is available or if there is a conflict between equally ranked SDMs.

Toronto Regional Office
595 Bay Street, Suite 800, Toronto, ON M5G 2M6
Tel: 416-314-2800
Toll Free: 1-800-366-0335
Fax: 416-314-2619
TTY: 416-314-2687

Guardianship Investigations Unit – Tel: 416-327-6348
Treatment Decisions Unit – Tel: 416-314-2788

Consent and Capacity Board

No fees apply. The hearing is usually held within one week after the Board receives an application.
Frequently asked questions - http://www.ccboard.on.ca/scripts/english/faq/index.asp

The Board has the authority to hold hearings to deal with the following matters:
Health Care Consent Act

- Review of capacity to consent to treatment, admission to a care facility or personal assistance service.
- Consideration of the appointment of a representative to make decisions for an incapable person with respect to treatment, admission to a care facility or a personal assistance service.
- Consideration of a request to amend or terminate the appointment of a representative.
- Review of a decision to admit an incapable person to a hospital, psychiatric facility, nursing home or home for the aged for the purpose of treatment.
- Consideration of a request from a substitute decision maker for directions regarding wishes.
- Consideration of a request from a substitute decision maker for authority to depart from prior capable wishes.

- Review of a substitute decision maker's compliance with the rules for substitute decision making.

Mental Health Act

- Review of involuntary status (civil committal).
- Review of a Community Treatment Order.
- Review as to whether a young person (aged 12 to 15) requires observation, care and treatment in a psychiatric facility.
- Review of a finding of incapacity to manage property.
- Personal Health Information Protection Act
- Review of a finding of incapacity to consent to the collection, use or disclosure of personal health information.
- Consideration of the appointment of a representative for a person incapable of consenting to the collection, use or disclosure of personal health information.
- Review of a substitute decision maker's compliance with the rules for substitute decision making.

Substitute Decisions Act

- Review of statutory guardianship for property.

Mandatory Blood Testing Act

- Order a person to provide a blood sample for analysis.

Greater Toronto Area *(CW & MH LHIN's included)*
Mailing Address: 151 Bloor Street West, 10th Floor, Toronto, Ontario, M5S 2T5
www.ccboard.on.ca
Phone: (416) 327-4142
TTY/TDD: (416) 326-7TTY or (416) 326-7889
Fax: (416) 327-4207

Outside Greater Toronto Area
Phone: 1-866-777-7391 (Toll Free)
TTY/TDD: 1-877-301-0TTY or 1-877-301-0889 (Toll Free)
Fax: 1-866-777-7273 (Toll Free)

Capacity Assessment Office

Fees- Capacity Assessors set their own hourly rates which can vary. Rates range between $100 and $250 per hour, as some assessors charge higher fees because of their expertise in a specialized field. Whoever requests the service pays for the service. They assess if the person is able to manage their finances.

Suite 800 - 595 Bay Street
Toronto ON M5G 2M6

You can also email CAO@ontario.ca, call 416-327-6766 or toll free 1-866-521-1033, fax 416-327-6724