

**A Guide to the *Long-Term Care Homes Act, 2007*  
and Regulation 79/10**

# Table of Contents

Introduction .....	1
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## Part I

Fundamental Principle and Interpretation.....	1-1
Policies and Records.....	1-2

## Part II

Residents' Bill of Rights.....	2-1
Mission Statement .....	2-6
Safe and Secure Homes .....	2-7
Care Plans and Plans of Care .....	2-12
General Requirements for Programs .....	2-20
Nursing and Personal Support Services .....	2-22
Required Programs .....	2-28
Responsive Behaviours .....	2-33
Altercations and Other Interactions .....	2-36
Behaviours and Altercations .....	2-37
Restorative Care .....	2-38
Recreational and Social Activities.....	2-41
Nutrition Care, Dietary Services and Hydration Programs.....	2-42
Medical Services .....	2-52
Religious and Spiritual Practices.....	2-54
Accommodation Services.....	2-55
Pets.....	2-59
Volunteers .....	2-60
Prevention of Abuse and Neglect .....	2-61
Reporting and Complaints (Complaints).....	2-67
Reporting and Complaints (Mandatory Reports).....	2-69
Reporting and Complaints (Critical Incidents).....	2-80
Minimizing of Restraining .....	2-84
Drugs .....	2-101
Absences.....	2-114
Discharge.....	2-118

**Part IV**

Councils – Residents’ Council.....4-1  
Councils – Family Council.....4-3  
Councils – General .....4-6

# Introduction

Ontario's *Long-Term Care Homes Act, 2007* (LTCHA) and Ontario Regulation 79/10 (Regulation) made under the LTCHA came into force on July 1, 2010. The new LTCHA and the Regulation replace the *Nursing Homes Act, Homes for the Aged and Rest Homes Act* and the *Charitable Institutions Act*, and the regulations under those Acts.

All long-term care homes in Ontario are now governed by one piece of legislation: the *Long-Term Care Homes Act, 2007*. The LTCHA is designed to help ensure that residents of long-term care homes receive safe, consistent, high-quality, resident-centred care.

The goal is to create long-term care home environments where residents feel at home, are treated with respect, and have the supports and services they need for health and well-being. The way to achieve this goal is through:

- An ongoing, province-wide commitment to the health and well-being of Ontarians living in long-term care homes; and
- Collaboration and mutual respect among residents, their families and friends, long-term care home licensees, service providers, caregivers, volunteers, the community and governments.

## About this Guide

This Guide provides a general overview of the LTCHA and the Regulation. The Guide does not address all aspects of the LTCHA and the Regulation and is made available for convenient reference only. It should be read in conjunction with the LTCHA and the Regulation and, in the case of any conflict, the provisions of the LTCHA and the Regulation are authoritative.

This Guide is designed to align with the Table of Contents of the LTCHA and the Regulation. This Guide is divided into ten Parts, reflecting the ten Parts of the LTCHA and the Regulation as set out in the Table of Contents.

Users should consult their own legal counsel for all purposes of interpretation.

## Who May Use this Guide?

This Guide is intended to provide a plain language reference and to be a useful resource for the following:

- Long-Term Care Home licensees;
- Long-Term Care Home staff;
- Residents;
- Substitute Decision-Makers;
- Residents' family members;

- Residents' Councils;
- Family Councils;
- Volunteers;
- Local Health Integration Networks (LHINs); and
- Community Care Access Centres (CCACs).

## Terminology

In this Guide, a “long-term care home” will be referred to as a “Home” for ease of reference. “Home” will also be used to refer to the “licensee”. The licensee is the person who is licensed or approved to operate the Home under the LTCHA and who is responsible for ensuring compliance with the requirements set out in the LTCHA and the Regulation.

For the purposes of this Guide, unless otherwise specified, “Director” refers to the Director, Performance Improvement and Compliance Branch, Health System Accountability and Performance Division, Ministry of Health and Long-Term Care.

To provide more context and help readers understand the LTCHA and the Regulation, this Guide includes the following additional information in some sections:

“**Definitions**” include definitions found in the LTCHA and the Regulation. In addition, there are other definitions taken from approved ministry policy sources.

“**Key Linkages**” cross-reference other sections of the LTCHA and the Regulation that should be considered when reading that part of the Guide.

“**Key Considerations**” provide additional information, resources or explanations.

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The LTCHA, the Regulation, and other Acts and Regulations referred to in this Guide are available at <http://www.e-laws.gov.on.ca/index.html>.

There is a Long-Term Care ACTION Line to register concerns or complaints about a Home's compliance with the LTCHA and the Regulation. The Long-Term Care ACTION Line is available at 1-866-434-0144 between the hours of 8:30 a.m. and 7:00 p.m. seven days a week.

# Part I Fundamental Principle and Interpretation

## A. Overview

Section 1 of the LTCHA sets out the fundamental principle to be applied in the interpretation of the LTCHA and the Regulation and section 2 of the LTCHA sets out the definitions for terms referred to in the LTCHA and the Regulation.

## B. LTCHA Requirements

### Section 1 – Home: the Fundamental Principle

The fundamental principle to be applied in the interpretation of the LTCHA and the Regulation is that a Home is primarily the home of its residents and is to be operated so that it is a place where its residents may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

### Section 2 – Interpretation

Section 2 of the LTCHA sets out the definitions for many of the terms referred to in the LTCHA and the Regulation.

Some of these definitions are referred to in this Guide in the “Definition” boxes. For a complete list of definitions, see the LTCHA and the Regulation.

## C. Regulatory Requirements

Sections 1 to 7 of the Regulation set out the definitions for terms referred to in the Regulation. Some of these definitions also apply to terms used in the LTCHA.

Some of these definitions are referred to in this Guide in the “Definition” boxes. For a complete list of definitions, see the LTCHA and the Regulation.

# Part I Policies and Records

## A. Overview

Section 8 of the Regulation sets out the requirements relating to the Home's policies and records.

## B. LTCHA Requirements

None.

## C. Regulatory Requirements

### Section 8 – Policies, etc. to be Followed, and Records.

Where the LTCHA or the Regulation requires the Home to have a plan, policy, protocol, procedure, strategy or system, the plan, policy, protocol, procedure, strategy or system must be:

- In compliance with and implemented in accordance with all applicable requirements under the LTCHA; and
- Complied with.

Where the LTCHA or the Regulation requires the Home to keep a record, the record must be kept in a readable and useable format that allows a complete copy of the record to be readily produced.

## Part II Residents' Bill of Rights

### A. Overview

Section 3 of the LTCHA sets out the Residents' Bill of Rights, which addresses residents' personal well-being and safety and includes the privileges, choices and protections available to all residents of a Home. Some of the rights set out in this section are supported by further requirements in the LTCHA and the Regulation.

### B. LTCHA Requirements

#### Section 3 – Residents' Bill of Rights

The Residents' Bill of Rights may be enforced as though the resident and the Home had entered into a contract in which the Home agreed to fully respect and promote all of the resident's rights. The LTCHA, the Regulation, and any agreements between the Home and the Crown or between the Home and the resident must be interpreted in a way that advances the respect of the resident's rights.

#### Key Consideration

The Residents' Bill of Rights expands on and strengthens the rights which existed in the legislation that governed Homes before the LTCHA.

#### Dignity and Respect

- 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 his or her dignity.
- Every resident has the right to exercise the rights of a citizen.
- Every resident has the right to be told who is responsible for and who is providing his or her direct care.
- Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
- Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room, subject to safety requirements and the rights of other residents.
- Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the Home to pursue these interests and develop his or her potential.

Key Linkage

See the Recreational and Social Activities and Religious and Spiritual Practices sections of the LTCHA, Regulation and Guide for more information.

### Prevention of Abuse and Neglect

- Every resident has the right to be protected from abuse.
- Every resident has the right not to be neglected by the Home or staff.

Definition

Abuse includes physical, sexual, emotional, verbal or financial abuse, as defined in section 2 of the Regulation.

Key Linkage

See the Prevention of Abuse and Neglect sections of the LTCHA, Regulation and Guide for more information.

### Care and Services

- Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
- Every resident has the right to live in a safe and clean environment.
- 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.

Key Linkages

See the Care and Services and Plans of Care sections of the LTCHA, Regulation and Guide for more information.

See the Accommodation Services and Safe and Secure Homes sections of the LTCHA, Regulation and Guide for more information.

See the Restorative Care sections of the LTCHA, Regulation and Guide for more information.

## Consent and Choices

- Every resident has the right to have his or her participation in decision-making respected.
- Every resident has the right to:
  - participate fully in the development, implementation, review and revision of his or her plan of care;
  - give or refuse consent to treatment, care or services for which consent is required by law and to be informed of the consequences of giving or refusing consent;
  - participate fully in making any decision about any aspect of his or her care, including admission, discharge or transfer to or from a Home, and to obtain an independent opinion about any of these things; and
  - have his or her personal health information kept confidential and have access to his or her records of personal health information, including the plan of care, in accordance with the *Personal Health Information Protection Act, 2004*.

### Key Linkage

See the Care Plans and Plans of Care sections in the LTCHA, Regulation and Guide for more information. In addition, see the *Health Care Consent Act, 1996*, *Substitute Decisions Act, 1992* and *Personal Health Information Protection Act, 2004*.

- Every resident who is dying or who is very ill has the right to have family and friends present 24 hours a day.
- Every resident has the right to form friendships and relationships and to participate in the life of the Home.
- Every resident has the right to have his or her lifestyle and choices respected.
- Every resident has the right to share a room with another resident based on their mutual wishes, if appropriate accommodation is available.
- Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

## Minimizing of Restraining

- Every resident has the right not to be restrained, except in the limited circumstances provided for under the LTCHA and in accordance with the LTCHA.

Key Linkage

See the Minimizing of Restraining sections of the LTCHA, Regulation and Guide for more information.

## Communications and Concerns or Complaints

- 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.
- Every resident has the right to designate a person to receive information about any transfer or hospitalization of the resident, and to have that person receive the information immediately.
- Every resident has the right to raise concerns or recommend changes in policies and services for himself or herself or others without interference and without fear of coercion, discrimination or reprisal against the resident or anyone else. This includes raising concerns or recommending changes to the Residents' Council, Family Council, the Home, staff members, government officials and any other person inside or outside the Home.

Key Linkage

See the Reporting and Complaints and Councils sections of the LTCHA, Regulation and Guide for more information.

- Every resident has the right to participate in the Residents' Council.

Key Linkage

See the Councils sections of the LTCHA, Regulation and Guide for more information.

- Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
- Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to him or her and of the procedures for making complaints.

Key Linkage

See the Reporting and Complaints, Information for Residents and Posting of Information sections of the LTCHA, Regulation and Guide for more information.

- Every resident has the right to have any friend, family member or other person of importance to the resident attend meetings with the Home or staff.

#### Key Consideration

This right includes the right to have a lawyer or other representative of the resident attend any meeting.

#### Other Rights

- Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

Key Linkage

See the *Substitute Decisions Act, 1992* for more information.

## Part II Mission Statement

### A. Overview

Section 4 of the LTCHA sets out requirements relating to the Home's mission statement.

### B. LTCHA Requirements

There must be a mission statement for each of the licensee's Homes that sets out the principles, purpose and philosophy of care of the Home. The principles, purpose and philosophy of care set out in the mission statement must be put into practice in the day-to-day operation of the Home.

The Home's mission statement must be consistent with the fundamental principle set out in section 1 of the LTCHA, and with the Residents' Bill of Rights.

The Home's mission statement must be developed and revised as necessary, in collaboration with the Residents' Council and the Family Council, if any. The Home's staff and volunteers must be invited to participate in the development and revision of the mission statement. At least once every five years after a mission statement is developed, the licensee must consult with the Residents' Council and the Family Council, if any, as to whether revisions are required, and must invite the Home's staff and volunteers to participate.

### C. Regulatory Requirements

None.

## Part II Safe and Secure Homes

### A. Overview

Section 5 of the LTCHA and sections 9 to 23 of the Regulation set out the requirements for providing a safe and secure environment for residents.

### B. LTCHA Requirements

#### Section 5 – Home to be Safe, Secure Environment

The Home must be a safe and secure environment for its residents.

### C. Regulatory Requirements

#### Section 9 – Doors in a Home

With the exception of doors leading to secure outside areas that preclude exit by a resident (including balconies and terraces) or doors to which residents do not have access, all doors in the Home leading to stairways and the outside of the Home must be kept closed and locked, and must be equipped with a door access control system that is kept on at all times. These doors must also be equipped with an audible door alarm that allows calls to be cancelled only at the point where they are activated and that is either:

- Connected to the resident-staff communication and response system; or
- Connected to an audiovisual enunciator connected to the nurses' station nearest to the door and has a manual reset switch at each door.

Doors leading to secure outside areas that preclude exit by a resident (including balconies and terraces) must be equipped with locks to restrict unsupervised access to those areas by residents. There must be a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access by residents.

Doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

All alarms for doors leading to the outside must be connected to a back-up power supply if the Home is served by a generator. If the Home is not served by a generator, doors leading to secure outside areas must be monitored by staff, in accordance with the procedures set out in the Home's emergency plans.

## Section 10 – Elevators

Any elevators in the Home must be equipped to restrict residents from entering areas that are not to be accessed by residents. Despite this requirement, Homes that are redeveloping under Phase 1 of the MOHLTC’s Renewal Strategy do not need to comply with this requirement until December 31, 2014.

## Section 11 – Floor Space

Every floor of the Home on which residents reside must have adequate space for the completion of documentation by staff and secure storage of resident records.

## Section 12 – Furnishings

There must be sufficient indoor and outdoor furnishings, including tables, sofas, chairs and lamps, to meet the needs of residents. Bedroom furnishings for residents such as beds, bedside tables, easy chairs and clothes closets must be provided for the residents in accordance with the requirements set out in the Regulation.

## Section 13 – Privacy Curtains

Every resident bedroom occupied by more than one resident must have sufficient privacy curtains to provide privacy.

## Section 14 – Shower Grab Bars

Every resident shower must have at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

## Section 15 – Bed Rails

When bed rails are used, the resident must be assessed and his or her bed system must be evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, in order to minimize risks associated with bed rails. Steps must be taken to prevent residents from being entrapped in the bed rails and to address any other safety issues, including height and latch reliability.

“Evidence-based practice” means making clinical decisions based on the most current and valid research findings such as systematic reviews, randomized controlled trials, and descriptive and quantitative studies.

“Prevailing practice” means using predominant, generally accepted, widespread practice as the basis for clinical decisions.

**Key Consideration**

To reduce the risk of residents being entrapped, the bed rail system must be assessed for every resident. For more information on how to develop, implement and evaluate a bed rail assessment, including preventative measures, see the Health Canada Guidance document: “Adult Hospital Beds: Patient Entrapment Hazards, Slide Rail Latching Reliability, and other Hazards”: [http://www.hc-sc-gc-ca/dhp-mps/md-im/applic-demanded/Guide-Id/md\\_gd\\_beds\\_im\\_Id\\_lits-end.php](http://www.hc-sc-gc-ca/dhp-mps/md-im/applic-demanded/Guide-Id/md_gd_beds_im_Id_lits-end.php).

**Section 16 – Windows**

Every window in the Home that opens to the outdoors and is accessible to residents must have a screen and must not be able to be opened more than 15 centimetres.

**Key Consideration**

A process to check windows to ensure they comply with the requirements in this section of the Regulation should be a part of a Home’s regular preventative maintenance program.

**Section 17 – Communication and Response System**

The Home must be equipped with a resident-staff communication and response system that is available in every area accessible by residents. The system must be on at all times and allow calls to be cancelled only at the point where the call was made. The system must be easily visible, accessible and usable by residents, staff and visitors at all times, and must be available at each bed, toilet, bath and shower location used by residents. When activated, the communication and response system must clearly indicate where the signal is coming from. Systems that use sound must be properly calibrated to ensure that staff can hear the sound.

## Section 18 – Lighting

Lighting in various areas of the Home must meet the requirements set out in the Regulation. The requirements differ depending on whether or not the Home was built in accordance with the Long-Term Care Home Design Manual, 2009.

### Key Consideration

“Continuous consistent lighting” as referred to in the Regulation does not mean that lights must be on 24 hours a day, seven days a week; it means that the lighting level must be consistent in the areas specified by the Regulation. For example, if the inspector is holding an instrument that measures lux, the lux must be at least 322.92 in enclosed stairways and all corridors of the Home built in accordance with the Long-Term Care Home Design Manual, 2009.

## Section 19 – Generators

The Home must be served by a generator that is available at all times and has the capacity to maintain during a power outage **all** of the following:

- The heating system;
- Emergency lighting in hallways, corridors, stairwells and exits; and
- Essential services, including **all** of the following:
  - dietary services equipment required to store food at safe temperatures and prepare and deliver meals and snacks;
  - the resident-staff communication and response system;
  - elevators; and
  - life support, safety and emergency equipment.

Despite these requirements, the following requirements apply to Homes with certain classes of beds:

- The Home with new beds or Class A beds is not required to have a generator that maintains the essential services referred to above until July 1, 2012, unless the Home’s generator had that capacity on July 1, 2010.
- The Home with Class B, C or upgraded D beds is not required to comply with the requirements referred to above until December 31, 2016. However, if the Home with these types of beds is redeveloped and the redevelopment is completed before December 31, 2016, the Home must comply with these requirements as of the day that the redevelopment is complete.
- The Home with Class D beds does not have to comply with the requirements referred to above.

However, all Homes with Class B, C, upgraded D or D beds must have guaranteed access to a generator that will be operational within three hours of a power outage and capable of maintaining the heating system, emergency lighting and essential services referred to above.

#### Key Consideration

Homes with Class B, C, upgraded D or D beds that do not have a generator available at all times should enter into an agreement with an external service provider to have guaranteed access to a generator that can be operational on site within three hours of a power outage.

### Section 20 – Cooling Requirements

A written hot weather-related illness prevention and management plan that meets the needs of the residents must be developed and implemented when required to address the adverse effects on residents related to heat. The plan must be consistent with evidence-based practices and, if there are none, in accordance with prevailing practices.

Any Home without central air-conditioning is required to have at least one separate designated cooling area for every 40 residents.

### Section 21 – Air Temperature

The Home must be maintained at a minimum temperature of 22 degrees Celsius.

### Section 22 – Plumbing

All plumbing fixtures in the Home with hose attachments must be equipped with a back flow device.

### Section 23 – Compliance with Manufacturers' Instructions

Staff must use all equipment, supplies, devices, assistive aids and positioning aids in the Home in accordance with manufacturers' instructions.

## Part II Care Plans and Plans of Care

### A. Overview

Section 6 of the LTCHA and sections 24 to 29 of the Regulation set out the requirements relating to plans of care and care planning, including assessing and reassessing residents and planning, delivering and evaluating their care, beginning when they are first admitted to the Home.

The LTCHA and the Regulation require an integrated interdisciplinary approach to care planning and delivery as well as the involvement of the resident, his or her substitute decision-maker (if any) and any person designated by either of them, in developing and implementing the plan of care.

### B. LTCHA Requirements

#### Section 6 – Plan of Care

Every resident (except a short-stay respite care resident) must have a written plan of care that sets out the planned care, the goals the care is to achieve, and clear directions for staff and others who provide direct care to the resident. The plan of care must be based on an assessment of the resident and the resident's needs and preferences. The plan of care must cover all aspects of the resident's care, including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care.

Staff and others involved in the resident's care must collaborate with each other in assessing the resident so that their assessments are integrated and are consistent with and complement each other. Staff and others involved in the resident's care must also collaborate with each other in developing and implementing the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. Collaboration is also required when the resident is being reassessed and the plan of care is being reviewed and revised.

Every resident, his or her substitute decision-maker and persons designated by either of them must be given an opportunity to participate fully in developing and implementing the resident's plan of care. This opportunity must also be provided when the resident is being reassessed and when the plan of care is being reviewed and revised.

When a resident is admitted to the Home, the resident must be assessed and an initial plan of care must be developed based on the assessment as well as the assessment, reassessments, and information provided by the CCAC placement co-ordinator.

The care set out in the plan of care must be provided to the resident as specified in the plan. Staff and others who provide direct care to a resident must be kept aware of the contents of the resident's plan of care and must have convenient and immediate access to it. The following items must be documented:

- The provision of the care set out in the plan of care;
- The outcomes of the care set out in the plan of care; and
- The effectiveness of the plan of care.

Every resident must be reassessed and the plan of care must be reviewed and revised at least every six months and at any other time when:

- A goal in the plan is met;
- The resident's care needs change or care set out in the plan is no longer necessary; or
- The care set out in the plan has not been effective.

If the plan of care is being revised because care set out in the plan has not been effective, different approaches must be considered in the revision of the plan of care.

The plan of care must be explained to the resident, his or her substitute decision-maker and any person designated by either of them.

#### Key Linkages

Section 6 of the LTCHA does not apply to short-stay respite care residents. There is no requirement to develop an initial plan of care or plan of care for a short-stay respite care resident. However, these residents must have a 24-hour admission care plan in accordance with sections 25 (3) and 26 (5) of the Regulation.

Section 26 (3) of the Regulation specifies the domains of care that must be included in the assessment that is the basis of the plan of care. Care domains that must be addressed in this assessment include those set out in the Resident Assessment Instrument Minimum Data Set 2.0 (RAI-MDS 2.0).

Requirements under the LTCHA and the Regulation supersede the requirements found in other documents, such as assessment instruments or policies.

### Key Considerations

An initial plan of care must be developed based on the assessments made by the Home as well as the assessment, reassessments and information provided by the CCAC placement co-ordinator.

There is no requirement that the plan of care (or the 24-hour admission care plan required by section 24 of the Regulation) be in a single document. The plan of care, or parts of the plan of care, may be called something other than a “plan of care” by the Home. The plan of care may include one or more documents in the Home commonly referred to as care plans, kardex, goal statements, Medication Administration Records (MAR), Treatment Administration Records (TAR), Physician Order sheets and Medical Directive sheets, bath lists, physiotherapy/activation plans, recreational activities plans, snack lists and diet books used by dietary staff when preparing and serving meals.

## Section 7 – Consent

Nothing in the LTCHA 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.

## C. Regulatory Requirements

### Section 24 – 24-Hour Admission Care Plan

With the exceptions set out below, a 24-hour admission care plan must be developed for every resident admitted to the Home (including short-stay respite care residents) and must be communicated to direct care staff within 24 hours of admission.

The care plan must identify the resident and must include **all** of the following:

- Any risks the resident may pose to himself or herself (including any risk of falling) and interventions to mitigate those risks;
- Any risks the resident may pose to others (including potential behavioural triggers) and safety measures to mitigate those risks;
- The type and level of assistance required relating to activities of daily living;
- Customary routines and comfort requirements;
- Drugs and treatments required;
- Known health conditions, including allergies and other conditions the Home should be aware of, including interventions;
- Skin condition, including interventions; and
- Diet orders, including food texture, fluid consistencies and food restrictions.

The care set out in the care plan must be based on an assessment of the resident and his or her needs and preferences as well as the assessment, reassessment and other information provided by the CCAC placement co-ordinator.

The care plan must set out the planned care for the resident and clear directions to staff and others who provide direct care to the resident.

Every resident, his or her substitute decision-maker and any person designated by either of them must have the opportunity to participate to the extent possible in the development and implementation of the care plan and in reviews and revisions of the care plan.

The care set out in the care plan must be provided to the resident as specified in the care plan. Staff and others who provide direct care to a resident must be kept aware of the contents of the care plan and must have convenient and immediate access to it. The care provided as well as the outcomes of the care must be documented.

Every resident must be reassessed and his or her care plan must be revised whenever:

- The resident's care needs change;
- The care set out in the plan is no longer necessary; or
- The care set out in the plan has not been effective.

If the care plan is being revised because care set out in the plan of care has not been effective, different approaches must be considered in the revision of the care plan.

The care plan must be explained to the resident, his or her substitute decision-maker and any other person designated by either of them.

Other provisions in the LTCHA and the Regulation that apply to the plan of care also apply to the 24-hour admission care plan. These provisions relate to the Residents' Bill of Rights (section 3 (1) of the LTCHA), restraining by physical devices (sections 31 (1) and (2) of the LTCHA), PASDs (sections 33 (3) and (4) of the LTCHA), oral care (section 34 (2) of the Regulation), continence care and bowel management (section 51 (2) (b) of the Regulation) and medical directives and orders relating to drugs (section 117 (a) of the Regulation).

The care plan is no longer relevant once the initial plan of care is developed.

Despite the above requirements, there is no requirement to develop a care plan for a resident who is:

- Being urgently relocated to another Home operated by the same licensee to protect his or her health or safety; or
- Transferring to a related temporary Home, a re-opened Home, or a replacement Home operated by the same licensee.

### Key Considerations

The LHIN Service Accountability Agreement (L-SAA) policy titled “Policy for the Operation of Short-Stay Beds under the Long-Term Care Homes Act, 2007” (the Short-Stay Policy) sets out additional requirements for the operation of short-stay program beds. The Short-Stay Policy applies to Convalescent Care Program, Interim Bed Program, and Respite Care Program beds.

Section 2.1.2 of the Short-Stay Policy requires that the following tools be used to develop the 24-hour admission care plan:

- The Resident Assessment Instrument Home Care (RAI-HC) completed by the CCAC placement co-ordinator as part of the admissions process and current to within three months of admission;
- Other assessments and relevant information provided by the CCAC placement co-ordinator;
- Relevant hospital reports; and
- Assessments by the Home’s staff.

The Short-Stay Policy requires the RAI-MDS 2.0 to be used to assess the care needs of residents in the Respite Care Program whose stay exceeds 14 days and to support the revision of the 24-hour admission care plan, as required for those residents. Requirements for the use of RAI-MDS 2.0 are set out in the “RAI-MDS 2.0 LTC Homes – Practice Requirements,” as amended from time to time, which is listed in “Schedule F” to the L-SAA.

## Section 25 – Initial Plan of Care

With the exceptions set out below, an initial plan of care must be developed for each resident. The assessment required to develop an initial plan of care must be completed within 14 days of the resident’s admission. The initial plan of care must be developed within 21 days of admission.

Definition

The “initial plan of care” is a plan of care for the purposes of the LTCHA and the Regulation. The initial plan of care is the first plan of care to be developed for the resident. Once the initial plan of care is developed, the 24-hour admission care plan is no longer relevant.

Despite the above requirements, there is no requirement to develop an initial plan of care for a resident who is:

- Being urgently relocated to another Home operated by the same licensee to protect his or her health or safety;
- Transferring to a related temporary Home, a re-opened Home, or a replacement Home operated by the same licensee; or
- Being admitted to the short-stay respite care program.

## Section 26 – Plan of Care

Every resident (except short-stay respite care residents) must have a plan of care. The plan of care must identify the resident and include his or her demographic information. The plan of care must also identify the people who participated in developing the plan and the dates of their participation.

The plan of care must be based on an interdisciplinary assessment of specified care domains including **all** of the following:

- Customary routines.
- Cognition ability.
- Communication abilities, including hearing and language.
- Vision.
- 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.
- Psychological well-being.
- Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
- Continence, including bladder and bowel elimination.

- Disease diagnosis.
- Health conditions, including allergies, pain, risk of falls and other special needs.
- Seasonal risk relating to hot weather.
- Dental and oral status, including oral hygiene.
- Nutritional status, including height, weight and any risks relating to nutrition care.
- Hydration status and any risks relating to hydration.
- Skin condition, including altered skin integrity and foot conditions.
- Activity patterns and pursuits.
- Drugs and treatments.
- Special treatments and interventions.
- Safety risks.
- Nausea and vomiting.
- Sleep patterns and preferences.
- Cultural, spiritual and religious preferences and age-related needs and preferences.
- Potential for discharge.

A registered dietitian who is a member of the staff of the Home must complete a nutritional assessment for every resident on admission and whenever there is a significant change in a resident's health condition. The registered dietitian must also complete the nutritional status and hydration status assessments.

#### Key Considerations

These provisions are designed to foster an integrated, interdisciplinary approach to planning, delivering and evaluating residents' care.

When planning, delivering and evaluating care and services, the care team should consider how services in each program integrate with and complement each other to ensure the best therapeutic outcomes for residents.

## Section 27 – Care Conference

An interdisciplinary care conference must be held within six weeks of every resident's admission to the Home, and at least annually thereafter, to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker. The resident, his or her substitute decision-maker and persons designated by either of them must be given an opportunity to participate in the care conferences. A record must be kept of the date, the participants in the conference and the results of these conferences.

Despite the above requirements, there is no requirement to hold a care conference for a resident who is:

- Being urgently relocated to another Home operated by the same licensee to protect his or her health or safety;
- Transferring to a related temporary Home, a re-opened Home or a replacement Home operated by the same licensee; or
- Being admitted to the short-stay respite care program.

### Section 29 – Changes in Plan of Care, Consent

When a resident is reassessed and the resident’s plan of care is reviewed and revised, any relevant consent or directive regarding “treatment,” including a “course of treatment” or a “plan of treatment” as defined in the *Health Care Consent Act, 1996*, must be reviewed and, if necessary, revised.

#### Key Consideration

For more information regarding consent, see the *Health Care Consent Act, 1996*.

## Part II General Requirements for Programs

### A. Overview

Sections 17 and 18 of the LTCHA and section 30 of the Regulation set out the staffing and care standards, and general requirements that apply to the organized programs required under the LTCHA: nursing and personal support services, restorative care, recreational and social activities, dietary services and hydration, medical services, information and referral assistance, religious and spiritual practices, accommodation services and volunteer programs.

These general requirements also apply to the interdisciplinary programs required under section 48 of the Regulation: falls prevention and management, skin and wound care, continence care and bowel management, and pain management.

### B. LTCHA Requirements

#### Section 17 – Staffing and Care Standards

The Home must meet the staffing and care standards provided for in the Regulation.

#### Section 18 – Standards for Programs and Services

All programs required under the LTCHA must comply with the standards or requirements, including outcome measures, that are set out in the Regulation.

### C. Regulatory Requirements

#### Section 30 – General Requirements

Each of the Home's organized programs, set out in sections 8 to 16 of the LTCHA, and each of the interdisciplinary programs, set out in sections 48 to 52 of the Regulation, must meet **all** of the following requirements:

- There must be a written description of the program that includes its goals and objectives, relevant policies, procedures and protocols, methods to reduce risk and monitor outcomes, including protocols for referring residents to specialized resources where required.
- All equipment, supplies, devices, assistive aids or positioning aids used by staff with a resident as part of the program must be appropriate for the resident based on the resident's condition.
- The program must be evaluated and updated at least once a year in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

- A written record of each evaluation must be maintained. The written record must include the date of the evaluation, the names of the persons who participated, a summary of the changes made and the date those changes were implemented.

All actions taken with respect to every resident under a program must be documented, including assessments, reassessments, interventions and the resident's responses to interventions.

## Part II Nursing and Personal Support Services

### A. Overview

Section 8 of the LTCHA and sections 31 to 47 of the Regulation set out the requirements for organized programs of nursing and personal support services.

### B. LTCHA Requirements

#### Section 8 – Nursing and Personal Support Services

There must be organized programs of nursing services and personal support services that meet the assessed needs of residents. At least one registered nurse (RN) who is both an employee of the Home and a member of the Home’s regular nursing staff must be on duty and present in the Home at all times, except as set out in the Regulation.

Definitions

“Regular nursing staff” means a member of the registered nursing staff who works in a Home at fixed or prearranged intervals (section 6 of the Regulation).

“Personal support services” means services to assist with the activities of daily living, including personal hygiene services, and includes supervision in carrying out those activities (section 8 of the LTCHA).

Key Linkage

The nursing and personal support services programs must comply with the general requirements for all programs, as set out in section 30 of the Regulation.

### C. Regulatory Requirements

#### Section 31 – Nursing and Personal Support Services

A written staffing plan is required for the nursing and personal support services programs.

The staffing plan must:

- Provide for a staffing mix consistent with residents’ assessed care and safety needs and that meets the requirements set out in the LTCHA and the Regulation;
- Set out the organization and scheduling of staff shifts;
- Promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;

- Include a back-up plan that addresses situations when nursing and personal support services staff cannot come to work, including the staff that provide the 24-hour RN coverage; and
- Be evaluated and updated annually, in accordance with evidence-based practices, and, if there are none, in accordance with prevailing practices.

A written record of each evaluation must be maintained. The written record must include the date of the evaluation, the names of the persons who participated, a summary of the changes made and the date those changes were implemented.

#### Key Linkages

As set out in section 53 of the Regulation, responsive behaviour approaches to care must be integrated into the care provided to residents.

As set out in section 57 of the Regulation, restorative care approaches must be integrated into the care provided to residents.

### Section 32 – Personal Care

Every resident must receive individualized personal care, including hygiene care and grooming, on a daily basis.

### Section 33 – Bathing

Every resident must be bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by his or her hygiene requirements, unless contraindicated by a medical condition.

#### Definition

“Bathing” includes tub baths, showers and full-body sponge baths (section 33 of the Regulation).

## Section 34 – Oral Care

Every resident must receive oral care that includes:

- Morning and evening mouth care, including the cleaning of dentures;
- Physical assistance or cuing as needed to brush his or her own teeth;
- Assistance, if required, to insert dentures prior to meals and at any other time as requested by the resident or required by the resident's plan of care; and
- An offer of an annual dental assessment or other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required.

## Section 35 – Foot Care and Nail Care

Every resident must receive preventive and basic foot care services and fingernail care, including the cutting of toenails and fingernails.

### Key Consideration

A resident may not be charged for basic foot and nail care, including the cutting of toenails and fingernails.

## Section 36 – Transferring and Positioning Techniques

Staff must use safe transferring and positioning devices or techniques when assisting residents.

## Section 37 – Personal Items and Personal Aids

Every resident's personal items, including personal aids such as dentures, glasses and hearing aids must be labelled within 48 hours of admission or acquisition and cleaned as required. If required, every resident must receive assistance to use personal aids.

## Section 38 – Notification re Personal Belongings, etc.

Every resident or the resident's substitute decision-maker must be notified when the resident requires new personal belongings or when his or her personal aids or equipment require repair.

## Section 39 – Mobility Devices

Mobility devices, including wheelchairs, walkers and canes, must be available at all times to every resident who requires them on a short-term basis.

## Section 40 – Dress

Every resident must be assisted with getting dressed as required. The resident must be dressed appropriately for the time of day and in keeping with his or her preferences, in his or her own clean clothing and appropriate clean footwear.

## Section 41 – Bedtime and Rest Routines

Every resident must have his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

## Section 42 – End-of-Life Care

Every resident must receive end-of-life care when required in a manner that meets his or her needs.

## Section 43 – Communication Methods

Strategies must be developed and implemented to meet the needs of residents:

- With compromised communication and verbalization skills;
- With cognitive impairment; and
- Who cannot communicate in the languages used in the Home.

### Key Linkage

As set out in section 26 of the Regulation, every resident's communication abilities must be assessed as part of the development of his or her plan of care.

## Section 44 – Availability of Supplies

Supplies, equipment and devices must be readily available at the Home to meet the nursing and personal care needs of residents.

## Section 45 – 24-Hour Nursing Care – Exceptions

Section 45 of the Regulation describes the exceptions to the 24-hour RN requirement set out in section 8 (3) of the LTCHA (i.e., that at least one RN who is both an employee of the Home and a member of the Home's regular nursing staff must be on duty and present in the Home at all times). The exceptions are as follows:

### Homes with a licensed capacity of 64 or fewer beds:

The Home may use an RN who works in the Home pursuant to a contract or agreement between the RN and the Home and who is a member of the regular nursing staff.

In an emergency situation when the back-up staffing plan required by section 31 (3) (d) of the Regulation fails, the Home may use:

- an RN who works at the Home pursuant to a contract between the Home and an employment agency or other third party **provided that** the Director of Nursing and Personal Care (DONPC) or an RN who is both an employee and a member of the regular nursing staff of the Home is available by telephone, or
- a registered practical nurse (RPN) who is a member of the Home’s regular nursing staff **provided that** the DONPC or an RN who is both an employee and a member of the regular nursing staff of the Home is available by telephone.

#### Homes with a licensed capacity of more than 64 and fewer than 129 beds:

In the case of a planned or extended leave of absence of an employee of the Home who is an RN and a member of the regular nursing staff, the Home may use an RN who works at the Home pursuant to a contract or agreement with the Home and who is a member of the regular nursing staff.

In an emergency situation when the back-up staffing plan required by section 31 (3) (d) of the Regulation fails, the Home may use an RN who works at the Home pursuant to a contract or agreement between the Home and an employment agency or other third party **provided that** the DONPC or an RN who is both an employee and a member of the regular nursing staff of the Home is available by telephone and an RPN who is both an employee of the Home and a member of the regular nursing staff is present in the Home.

Definition

“Emergency” means an unforeseen situation of a serious nature that prevents a registered nurse from getting to the Home (section 45 of the Regulation).

## Section 46 – Certification of Nurses

Every member of the registered nursing staff (RN(EC)s, RNs, and RPNs) of the Home must have the appropriate current certificate of registration with the College of Nurses of Ontario.

Key Linkage

As set out in section 234 of the Regulation, a record must be kept for each staff member that includes, where applicable, verification of the staff member’s current certificate of registration with the relevant College of the regulated health profession of which he or she is a member, or verification of the staff member’s current registration with the regulatory body governing his or her profession.

## Section 47 – Qualifications of Personal Support Workers

Any person hired by the Home on and after July 1, 2011 as a personal support worker, or to provide personal support services, regardless of his or her title, must have successfully completed a personal support worker program that meets the vocational standards established by the Ministry of Training, Colleges and Universities, the standards established by the National Association of Career Colleges, or the standards established by the Ontario Community Support Association. The program must be a minimum of 600 hours in duration, counting class time and practical experience time.

Despite these requirements, the following persons may be hired by the Home to provide personal support services:

- An RN or RPN who, in the opinion of the DONPC, has adequate skills and knowledge to perform the duties of a personal support worker;
- A person who was working or employed at a Home at any time in the 12-month period before July 1, 2011 as a personal support worker and who has at least three years of full-time experience, or the equivalent, considering part-time experience, as a personal support worker;
- A student who is enrolled in an educational program for RNs or RPNs and who, in the opinion of the DONPC, has adequate skills and knowledge to perform the duties of a personal support worker; or
- A person who is enrolled in a personal support worker program described above and who is completing the practical experience requirements of the program, but the person must work under the supervision of a member of the registered nursing staff and an instructor from the program.

The Home must cease to employ as a personal support worker, or as someone who provides personal support services, regardless of title, a person who was required to be enrolled in a personal support worker program as described above or the educational program for RNs or RPNs as described above, if the person ceases to be enrolled in the program or fails to successfully complete the program within five years of being hired.

## Part II Required Programs

### A. Overview

Sections 48 to 52 of the Regulation set out the requirements for the following four interdisciplinary programs:

- Falls Prevention and Management.
- Skin and Wound Care.
- Continence Care and Bowel Management.
- Pain Management.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 48 – Required Programs

The following programs must be developed and implemented:

- A falls prevention and management program.
- A skin and wound care program.
- A continence care and bowel management program.
- A pain management program.

Each program must meet the requirements set out in section 30 of the Regulation and must provide for screening protocols and assessment and reassessment instruments.

Definition

A “clinically appropriate assessment instrument” is an instrument that is valid and reliable, is recognized by experts in the field, and provides an in-depth assessment of the resident’s condition.

Key Linkage

See section 18 of the LTCHA and section 30 of the Regulation for the general requirements that apply to all organized programs required under the LTCHA.

## Section 49 – Falls Prevention and Management

This program must, at minimum, provide strategies to reduce or mitigate falls. These strategies must include monitoring residents, reviewing residents' drug regimes, implementing restorative care approaches, and using equipment, supplies, devices and assistive aids.

When a resident has fallen, he or she must be assessed and, when the resident's condition or circumstances requires it, a post-fall assessment must be conducted using a clinically appropriate assessment instrument specifically designed for falls.

The equipment, supplies, devices and assistive aids required for the falls prevention and management program must be readily available at the Home.

Definition

“Readily available” means that the Home must have a large enough stock of supplies and equipment on hand at all times to meet program goals. It does not mean that all supplies and equipment required by all residents must be available at all times.

## Section 50 – Skin and Wound Care

This program requires the provision of routine skin care to maintain skin integrity and prevent wounds. Strategies must be implemented to promote resident comfort and mobility and to promote the prevention of infection, including the monitoring of residents. There must be strategies to transfer and position residents in order to reduce and prevent skin breakdown and to reduce and relieve pressure, including the use of equipment, supplies, devices and positioning aids. This program must include treatments and interventions, including physiotherapy and nutrition care.

Every resident who is at risk of altered skin integrity must be assessed by a member of the registered nursing staff within 24 hours of being admitted to the Home, whenever he or she returns to the Home from hospital and after any absence of more than 24 hours.

Definition

“Altered skin integrity” means potential or actual disruption of epidermal or dermal tissue (section 50 (3) of the Regulation).

Every resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, must be:

- Assessed by a member of the registered nursing staff using a clinically appropriate skin and wound assessment instrument;
- Treated immediately to reduce or relieve pain, promote healing and prevent infection, as required; and
- Reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Every resident with altered skin integrity must also be assessed by a registered dietitian who is a member of the staff of the Home. Any changes to his or her plan of care related to his or her nutrition or hydration plan must be implemented.

Key Linkage

See section 6 of the LTCHA and sections 24 to 29 of the Regulation for requirements relating to the resident's plan of care.

Every resident who is dependent on staff for repositioning must be repositioned every two hours or more frequently as required. A resident must only be repositioned while asleep if clinically indicated.

Equipment, supplies, devices and positioning aids must be readily available at the Home, as required, to relieve pressure, treat pressure ulcers, skin tears or wounds, and promote healing.

## Section 51 – Contenance Care and Bowel Management

This program must, at a minimum, provide for **all** of the following:

- Treatments and interventions to promote continence and to prevent constipation, including nutrition and hydration protocols;
- Toileting programs, including protocols for bowel management;
- Strategies to maximize residents' independence, comfort and dignity, including the use of equipment, supplies, devices and assistive aids; and
- Annual evaluation of residents' satisfaction with the range of continence care products, in consultation with residents, their substitute decision-makers and direct care staff. This evaluation must be considered when continence products are purchased.

Every resident who is incontinent must be assessed as set out in the Regulation and, where required, a clinically appropriate incontinence assessment instrument must be used. The resident must have an individualized plan to promote and manage bowel and bladder continence as part of his or her plan of care and the plan must be implemented.

Every resident who is unable to toilet independently some or all of the time must receive assistance from staff to manage and maintain continence. Every resident who is assessed as being potentially continent or continent some of the time must receive the assistance and support from staff to become continent or continent some of the time. Continence care products must not be used as an alternative to providing toileting assistance.

Every resident who requires continence care products must have sufficient changes to remain clean, dry and comfortable. There must be a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes. Residents must be provided with a range of continence care products that:

- are based on their individual assessed needs;
- properly fit the residents;
- promote resident comfort, ease of use, dignity and good skin integrity;
- promote continued independence where possible; and
- are appropriate for the time of day, and for the individual resident's type of incontinence.

#### Key Considerations

Continence care requirements are based on the assumption that wherever possible, every resident who is able to toilet independently will do so and every resident who requires assistance to toilet will receive the assistance. Even incontinent residents should use the toilet if they are capable of doing so and have an appropriate toileting plan.

The Home must provide a range of continence care products that meets specified criteria as set out in section 51 (2) (h) of the Regulation. There is no one product that will satisfactorily meet all of these requirements.

The Home must not charge any resident for any continence product that is within the range of products offered by the Home. If the Home provides a range of continence care products that satisfactorily meets all the requirements of section 51 (2) (h) but a resident would like a different product, the resident may be charged for the different product.

## Section 52 – Pain Management

The pain management program must, at a minimum, provide for **all** of the following:

- Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired;
- Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and aids;
- Comfort care measures; and
- Monitoring of residents' responses to, and the effectiveness of, pain management strategies.

When initial interventions do not relieve a resident's pain, the resident's pain management needs must be assessed using an appropriate assessment instrument.

## Part II Responsive Behaviours

### A. Overview

Section 53 of the Regulation sets out the requirements relating to the care for residents with responsive behaviours.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 53 – Responsive Behaviours

**All** of the following must be developed to meet the needs of residents with responsive behaviours:

- Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
- Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
- Resident monitoring and internal reporting protocols.
- Protocols for the referral of residents to specialized resources where required.

Definition

“Responsive behaviours” mean behaviours that often indicate an unmet need in a person whether cognitive, physical, emotional, social, environmental or other, or a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person (section 1 of the Regulation).

### Key Considerations

Responsive behaviour describes a means by which a person with dementia or other conditions may communicate his or her discomfort with something related to, for example, the physical body (e.g., urinary tract or other infection), social environment (e.g., boredom, invasion of space), or the physical environment (e.g., lighting).

In the past, these behaviours have often been termed “disruptive”, “challenging” or “aggressive”. This terminology negatively labels residents.

By calling these behaviours “responsive”, focus is placed on understanding the meaning behind the behaviour and what the resident may be trying to communicate. This focus requires a holistic approach to assessment that takes into consideration physical, cognitive, emotional, social, environmental and other conditions that might be triggering the behaviour.

Understanding these behaviours as a person’s response to something negative or confusing in his or her environment or as a means of communication can help staff develop appropriate responses and interventions for the resident.

These approaches, strategies and protocols must be integrated into the care that is provided to all residents, based on the assessed needs of residents with responsive behaviours, and co-ordinated and implemented on an interdisciplinary basis. These approaches, strategies and protocols must also be developed and implemented using evidence-based practices, and, if there are none, in accordance with prevailing practices. The approaches, strategies and protocols must be evaluated and updated at least annually in accordance with evidence-based practices, and, if none, in accordance with prevailing practices. A written record of each evaluation must be kept. The written record must include the date of the evaluation, the names of the persons who participated, a summary of changes made and the date those changes were implemented.

For every resident who demonstrates responsive behaviours, the Home must:

- Identify the behavioural triggers for the resident (where possible);
- Develop and implement strategies to respond to these behaviours (where possible);  
and
- Take actions to respond to the resident’s needs, including assessments, reassessments and interventions, and document the resident’s responses to the interventions.

### Key Consideration

For more information on a responsive behaviours approach to caregiving, see the Murray Alzheimer Research and Education program website at [www.marep.uwaterloo.ca](http://www.marep.uwaterloo.ca)

### Key Linkages

Section 221 (3) of the Regulation requires staff who provide direct care to residents to receive additional training in techniques and approaches related to responsive behaviours.

The orientation for volunteers must include information on techniques and approaches to respond to the needs of residents with responsive behaviours (section 223 (2) 6 of the Regulation).

See section 55 of the Regulation for the requirements to minimize the risk of harm related to altercations, responsive behaviours and potentially harmful interactions.

## Part II Altercations and Other Interactions

### A. Overview

Section 54 of the Regulation sets out the preventive actions that must be taken to minimize altercations and other potentially harmful interactions between residents.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 54 – Altercations and Other Interactions Between Residents

Steps must be taken to minimize the risk of altercations and potentially harmful interactions between and among residents. These steps include identifying factors based on assessment, other information and observation that could potentially trigger such altercations, and identifying and implementing interventions.

#### Key Considerations

Some of the ways that residents may act or behave towards other residents are not included in the definition of abuse in the Regulation.

For example, the actions of a resident who does not understand or appreciate their consequences are not included in the definitions of emotional abuse and verbal abuse. However, a verbal altercation, such as name calling or teasing, can escalate to a physical altercation and become a potentially abusive situation if staff does not intervene.

Section 19 of the LTCHA requires the Home to protect residents from abuse by anyone. To prevent altercations, staff must be proactive in identifying triggers and must deal with potentially harmful interactions before they escalate into a harmful situation.

#### Key Linkages

See sections 76 (2) 3 and 76 (7) 1 of the LTCHA for staff training requirements relating to the policy to promote zero tolerance of abuse and abuse recognition and prevention.

See section 55 of the Regulation for the requirements to minimize the risk of harm related to altercations, responsive behaviours and harmful interactions.

## Part II Behaviours and Altercations

### A. Overview

Section 55 of the Regulation sets out the requirements to minimize the risk of harm related to altercations, responsive behaviours and potentially harmful interactions.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 55 – Behaviours and Altercations

Procedures and interventions must be developed and implemented to assist residents who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

All direct care staff must be advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring as they pose a potential risk to residents or others.

#### Key Considerations

Section 19 of the LTCHA requires the Home to protect residents from abuse by anyone. The Home must address all behaviours, including those that may not be responsive. See sections 53 and 54 of the Regulation for requirements relating to responsive behaviours and altercations and other interactions between residents.

To help identify residents whose behaviours should be monitored, the Home can use information provided by family members and substitute decision-makers as well as admission assessments provided by the CCAC placement co-ordinator (health assessment; RAI-MDS HC). Any psychogeriatric or other assessments should also be considered.

## Part II Restorative Care

### A. Overview

Section 9 of the LTCHA and sections 56 to 64 of the Regulation set out the requirements for an organized interdisciplinary program based on a restorative care philosophy.

### B. LTCHA Requirements

#### Section 9 – Restorative Care

There must be an organized interdisciplinary program with a restorative care philosophy that promotes and maximizes residents' independence. As part of this program, every resident must receive physiotherapy and other therapy services where relevant to his or her assessed care needs.

### C. Regulatory Requirements

#### Section 56 – Restorative Care

Sections 57 to 64 describe the organized interdisciplinary program with a restorative care philosophy required under section 9 (1) of the LTCHA.

#### Section 57 – Integrating Restorative Care into Programs

Restorative care approaches must be integrated into all the care provided to residents and must be co-ordinated to ensure that each resident is able to maintain or improve his or her functional and cognitive capacities in all aspects of living, to the extent of his or her abilities.

#### Key Linkage

See section 30 of the Regulation for the general requirements that apply to all organized programs.

#### Key Consideration

Restorative care helps residents improve or maintain their ability to perform activities of daily living. Restorative care includes promoting continence and increasing muscle strength and balance. Integrated restorative care approaches can also help reduce falls and the use of restraints.

A restorative care approach promotes independence, health and well-being, and improves quality of life.

## Section 58 – Transferring and Positioning

When transferring and positioning residents, staff must use techniques and devices that maintain or improve, wherever possible, residents' weight bearing capability, endurance and range of motion.

## Section 59 – Therapy Services

The Home must arrange or provide occupational therapy and speech-language therapy as well as on-site physiotherapy on an individual basis or in a group setting based on residents' assessed care needs.

## Section 60 – Space and Supplies – Therapy Services

There must be safe, appropriate space in the Home to provide therapy services and sufficient therapy equipment available at all times to meet the needs of residents.

## Section 61 – Therapy Services Staff Qualifications

Therapy services for residents described in section 59 of the Regulation and that are arranged or provided by the Home under section 9 of the LTCHA must be provided by therapists who have a current certificate of registration with the appropriate college of a regulated health profession.

Despite these requirements, therapy services provided by the Home may be provided by support personnel who are members of the staff of the Home who work under the direction of a member of the appropriate regulated health profession and the supervision of the designated lead of the restorative care program (see section 64 of the Regulation) and who:

- Have successfully completed a training program in restorative care, or are enrolled in such a program; or
- Have successfully completed a relevant training course provided by the Home that is designated and supervised by a qualified therapist who is a member of the appropriate college of a regulated health profession.

The Home must cease to employ as support personnel a person who was required to be enrolled in the training program referred to above if the person ceases to be enrolled in the program or fails to successfully complete the program within three years of being hired. (However, the three-year period only begins on July 1, 2010 for support personnel who provided therapy sessions at the Home prior to July 1, 2010.)

Therapy services arranged by the Home may be provided by support personnel of a regulated health professional referred to above, working under the direction and supervision of that regulated health professional.

## Section 62 – Social Work and Social Services Work

There must be a written description of the social work and social services work provided in the Home. The work must meet the needs of the residents.

## Section 63 – Social Work and Social Services Work Qualifications

Social workers or social services workers who provide services in a Home must be registered under the *Social Work and Social Services Work Act, 1998*.

## Section 64 – Designated Lead

A person must be designated as the lead to co-ordinate the restorative care program, including the services of social workers and social service workers. The designated lead must have either:

- A current general certificate of registration with a college of a regulated health profession or the Ontario College of Social Workers and Social Service Workers; or
- A post-secondary diploma or degree in recreation and leisure studies, kinesiology, therapeutic recreation or other related field from a community college or university and at least one year of experience in a health care setting.

### Key Consideration

The same person can be designated as the lead for the restorative care program and the recreational and social activities program as long as the person meets the qualification requirements for both positions.

## Part II Recreational and Social Activities

### A. Overview

Section 10 of the LTCHA and sections 65 to 67 of the Regulation set out the requirements for an organized recreational and social activities program.

### B. LTCHA Requirements

#### Section 10 – Recreation and Social Activities

There must be an organized program of recreational and social activities to meet the interests of the residents. The program must include services for residents with cognitive impairments and residents who are unable to leave their rooms.

### C. Regulatory Requirements

#### Section 65 – Recreational and Social Activities Program

The Home must provide supplies and appropriate equipment and develop, implement and communicate to residents and their families a schedule of recreational and social activities. The schedule must include a range of indoor and outdoor activities, leisure and outings that are of a type and frequency to benefit all residents and reflect their interests. The activities must be offered during days, evenings and weekends.

Every resident and his or her family must have an opportunity to provide input on the development and scheduling of recreational and social activities. Every resident must be given information about activities in the community that may interest him or her. Every resident must be assisted and supported to participate in activities that may be of interest if he or she is not able to do so independently.

#### Key Linkages

See section 30 of the Regulation for the general requirements that apply to all organized programs required under the LTCHA.

Paragraph 23 of section 3 (1) of the LTCHA (Residents' Bill of Rights) provides that every resident has the right to pursue cultural, religious, spiritual and other interests, to develop his or her potential, and to be given reasonable assistance by the Home to pursue these interests and develop his or her potential.

## Section 66 – Designated Lead

A person must be designated to lead the recreational and social activities program. Persons designated after July 1, 2010 must have a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university, and at least one year of experience in a health care setting.

### Key Consideration

The same person can be designated as the lead for the restorative care program and the recreational and social activities program as long as the person meets the qualification requirements for both positions.

## Section 67 – Recreational and Social Activities Qualifications

All staff members providing recreational and social activities services at the Home for the first time on or after July 1, 2010 must have a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university, or be enrolled in a community college or university diploma or degree program in such a field. The Home must cease to employ a staff member who is hired to provide these services, if the person ceases to be enrolled in the program, or fails to successfully complete the program within three years of being hired.

# PART II Nutrition Care, Dietary Services and Hydration Programs

## A. Overview

Section 11 of the LTCHA and sections 68 to 78 of the Regulation set out the requirements for an organized program of nutrition care, dietary services and hydration. The Home must identify any risks to residents' nutrition and hydration and take appropriate action. These requirements include the qualifications and minimum hours of work for staff that provide nutrition care, dietary services and hydration.

## B. LTCHA Requirements

### Section 11 – Dietary Services and Hydration

There must be an organized program of nutrition care and dietary services for the Home as well as an organized program of hydration for the Home to meet the needs of residents. Every resident must receive food and fluids that are safe, adequate in quantity, nutritious and varied.

Key Linkage

Paragraph 4 of section 3 (1) of the LTCHA (Resident's Bill of Rights) provides that every resident has the right to be properly fed in a manner consistent with his or her needs.

## C. Regulatory Requirements

### Section 68 – Nutrition Care and Hydration Programs

The Home must develop and implement, in consultation with a registered dietitian who is a member of the Home's staff, policies and procedures related to nutrition care, dietary services and hydration, including identifying any risks and implementing interventions to mitigate and manage those risks. These programs must also include a system to monitor and evaluate the food and fluid intake of residents with identified nutrition or hydration risks, and a weight monitoring system to measure and record every resident's:

- Weight on admission and monthly thereafter; and
- Body mass index and height upon admission and annually thereafter.

See section 30 of the Regulation for the general requirements that apply to all organized programs required under the LTCHA.

#### Key Considerations

The registered dietitian who assists in developing the policies and procedures cannot be a consulting dietitian from a supplier or manufacturer; he or she must be a member of the staff of the Home.

Homes are not required to monitor the food and fluid intake of all residents – just those at risk of nutrition or hydration problems.

### Section 69 – Weight Changes

An interdisciplinary assessment must be conducted of every resident who experiences any of the following weight changes:

- A change of 5 per cent of body weight, or more, over one month.
- A change of 7.5 per cent of body weight, or more, over three months.
- A change of 10 per cent of body weight, or more, over 6 months.
- Any other weight change that compromises the resident's health status.

Actions must be taken if any of these changes are observed and outcomes must be evaluated.

### Section 70 – Dietary Services

The dietary services program must include menu planning, food production, dining and snack service, and the availability of supplies and equipment for food production and dining and snack service.

### Section 71 – Menu Planning

The Home's menu cycle must be a minimum of 21 days in duration and must include menus for regular, therapeutic and texture modified diets for meals and snacks as well as alternative choices of entrees, vegetables and desserts at lunch and dinner, and alternative choices of beverages at meals and snacks. If the Home's menu cycle does not meet a resident's nutrition needs, the Home must develop an individualized menu for the resident.

### Key Consideration

See <http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index-eng.php> to obtain a copy of Canada's Food Guide.

The requirement to provide individual menus would apply, for example, to residents with complicated therapeutic dietary needs (e.g., renal diets) and residents who may not be able to sit down at meal times (e.g., constant wanderers who need "finger foods" that can be eaten on the go).

All menus must provide for adequate nutrients, fibre and energy based on the current Dietary Reference Intakes (DRIs) and a variety of foods each day from all food groups, including fresh seasonal foods, in keeping with the current Canada's Food Guide.

All menu cycles must be approved by the Home's dietitian and reviewed by the Residents' Council. The menu cycle must be reviewed and updated at least annually. The planned menu items must be offered and available to residents at each meal and snack. Every resident must be offered a minimum of three meals daily, a between-meal beverage in the morning and afternoon, a beverage in the evening after dinner, and a snack in the afternoon and evening. A full breakfast must be available to residents up to at least 8:30 a.m. and the evening meal must not be served before 5:00 p.m. Food and beverages that are appropriate for the residents' diets must be accessible to staff and available to residents 24 hours a day.

## Section 72 – Food Production

There must be an organized food production system that provides a 24-hour supply of perishable foods, a three-day supply of non-perishable foods and a three-day supply of nutritional supplements used in the Home. The food production system must include standardized recipes and production sheets for all menus, preparation of all menu items according to the planned menu, and a system for documenting and communicating all menu substitutions. Menu substitutions must be comparable to the planned menu.

All food and fluids in the food production system must be prepared, stored and served using methods that preserve nutritive value, appearance, food quality and taste, and that prevent adulteration, contamination and food borne illness.

A record must be kept for at least one year of purchases related to the food production system, including food delivery receipts, the approved menu cycle and menu substitutions. If food or beverages are prepared in the Home for persons who are not residents of the Home, records must be kept for at least seven years in accordance with the requirements set out in section 72 (5) of the Regulation.

There must be sufficient space to support the menu requirements and institutional food service equipment with adequate capacity to prepare, transport and hold perishable hot and cold food at safe temperatures. There must be institutional food service equipment with adequate capacity to clean and sanitize all dishes, utensils and equipment used in food production, dining and snack service.

The Home must have **all** of the following:

- Policies and procedures for the safe operation and cleaning of equipment related to the food production system and the dining and snack service;
- Cleaning schedule for all equipment; and
- Cleaning schedule for the food production, servery and dishwashing areas.

Staff must comply with these policies, procedures and schedules.

### Section 73 – Dining and Snack Service

The daily and seven-day menus must be communicated to residents. The Residents' Council must have the opportunity to review meal and snack times, subject to the meal time requirements in section 71 (6) of the Regulation. Meal services must take place in a congregate setting unless a resident's assessed needs indicate otherwise. All residents must be monitored during meals and all staff members assisting residents must be aware of the residents' diets, special needs and preferences. Meals must be served course by course unless otherwise indicated by the resident or by the resident's assessed needs. Foods and fluids must be served at a temperature that is both safe and palatable to the residents. Every resident must have sufficient time to eat at his or her own pace. Every resident must be provided with any eating aids, assistive devices, personal assistance, and encouragement required to allow him or her to safely eat and drink as comfortably and independently as possible. Staff must use proper techniques to assist residents with eating, including safe positioning of residents requiring assistance.

No person shall help at the same time more than two residents who need total assistance with eating or drinking. Meals must not be served to residents who require assistance until someone is available to provide assistance.

#### Key Consideration

The requirement for a Home to serve meals course by course (section 73 (1) 8 of the Regulation) does not mean that staff must remove dishes between courses.

Resident dining areas must be equipped with appropriate furnishings and equipment, including comfortable chairs and tables of an appropriate height to meet the needs of residents, and appropriate seating for staff providing assistance with eating.

## Section 74 – Registered Dietitian

The Home must have at least one registered dietitian who is a member of the staff and who is on site at the Home for at least 30 minutes per resident per month to carry out clinical and nutrition care duties. Where the registered dietitian for the Home is also a nutrition manager for the Home, any time spent working in the capacity of nutrition manager does not count towards the 30 minutes per resident per month time requirement for the registered dietitian.

### Key Consideration

The minimum 30 minutes per resident per month that the dietitian is required on site at the Home includes reviewing menus, developing and documenting plans of care, and participating in the annual evaluation of the medication management program.

### Key Linkage

The registered dietitian must complete a nutritional assessment for every resident on admission and whenever there is a significant change in the resident's health condition. The dietitian must also assess the resident's nutritional status, including height, weight and any risks relating to nutrition care or hydration status and any risks related to hydration, in accordance with the plan of care requirements set out in section 26 of the Regulation.

## Section 75 – Nutrition Manager

There must be at least one nutrition manager for the Home. A person hired as a nutrition manager after July 1, 2010 must be a member of the Canadian Society of Nutrition Management or a registered dietitian. The minimum number of hours that the nutrition manager must work in the Home is set out in a formula in the Regulation and is based on the number of residents in the Home. This formula does not include any hours spent fulfilling other responsibilities. One of the Home's nutrition managers must be the lead of the nutrition care and dietary services program for the Home.

### Key Consideration

Nutrition manager hours devoted to producing meals and other food and beverages for non-residents are not included in the minimum number of hours.

## Section 76 – Cooks

There must be at least one cook who works at least 35 hours per week in that position on site at the Home.

If the Home has only one cook who works at least 35 hours per week in that position on site at the Home, this cook, if hired on or after July 1, 2010, must have one of the following qualifications:

- A. A chef training or culinary management diploma or certificate,
  - granted by a college established under the *Ontario Colleges of Applied Arts and Technology Act, 2002*, or
  - granted by a registered private career college, for successfully completing a program approved by the Superintendent of Private Career Colleges under the *Private Career Colleges Act, 2005*;
- B. A diploma or certificate granted in another jurisdiction and a set of skills that, in the reasonable opinion of the Home, is equivalent to those that the Home would expect of a person who has a diploma or certificate as set out in A. above;
- C. A certificate of qualification as a Cook issued by the Director of Apprenticeship under the *Apprenticeship and Certification Act, 1998*, or after Part III of the *Ontario College of Trades and Apprenticeship Act, 2009* comes into force, by the Registrar of the College under that Act; or
- D. A post-secondary diploma in food and nutrition management or a post-secondary degree in food and nutrition.

If this cook was employed at the Home prior to July 1, 2010, the cook must have one of the following qualifications:

- 1. One of the above qualifications (A through D above);
- 2. Successfully completed a Food Service Worker program at a college established under the *Ontario Colleges of Applied Arts and Technology Act, 2002* or a Food Service Worker program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the *Private Career Colleges Act, 2005*; or
- 3. Completion of a food handler training program by October 1, 2010 unless he or she met the qualifications in 1. or 2. above before that date.

If the Home has more than one cook who works at least 35 hours per week in that position on site at the Home, only one of the cooks must meet the above qualifications.

Definition

“Food handler training program” means the program offered or approved by the board of health for the public health unit where the Home is located (section 78 (5) of the Regulation).

#### Key Considerations

Other cooks working in the Home, other than the section 76 cook, must meet the qualifications set out in section 78 of the Regulation for food service workers.

Cooks with a “Red Seal” endorsement on their certificate exceed the qualifications set out in section 76 of the Regulation.

The 35 hours per week worked by the section 76 cook are included in the calculation of food service worker hours under section 77 of the Regulation.

### Section 77 – Food Service Workers, Minimums

There must be sufficient food service workers (including cooks) for the Home to meet the minimum staffing hours per week set out in this section of the Regulation for:

- Preparing resident meals and snacks;
- Distributing and serving resident meals;
- Receiving, storing and managing the inventory of resident food and food service supplies; and
- Daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service.

The minimum staffing hours per week for food service workers is set out in a formula in the Regulation which is based on the number of residents in the Home.

Definition

A “food service worker” is a member of staff in the Home who is routinely involved in the storage, preparation, cooking, delivery or serving of food; cleaning kitchen equipment and utensils; or maintaining the kitchen and serveries in a clean and sanitary condition, but does not include the nutrition manager for the Home (see section 1 of the Regulation). All cooks in the Home are food service workers.

#### Key Consideration

Food service worker hours devoted to producing meals and other food and beverages for non-residents are not included in the minimum staffing hours.

## Section 78 – Training and Qualifications

Food service workers (other than the section 76 cook) hired on or after July 1, 2010 must have successfully completed or be enrolled in a Food Service Worker program at a college established under the *Ontario Colleges of Applied Arts and Technology Act, 2002* or a Food Service Workers program provided by a registered private career college and approved by the Superintendent of Private Career Colleges under the *Private Career Colleges Act, 2005*.

If a food service worker who is enrolled in a Food Service Worker program when hired does not complete the required training within three years of being hired, that person will no longer be able to work as a food service worker at the Home.

Food service workers who were employed at the Home prior to July 1, 2010 and who do not have the above qualifications must have completed a food handler training program by October 1, 2010, unless they met the enrolment and completion requirements relating to a Food Service Worker program as described above before that date.

The above qualifications for food service workers hired on or after July 1, 2010 do not apply to:

- students hired on a seasonal or part-time basis who have successfully completed a food handler training program;
- persons who are members of the Canadian Society of Nutrition Management or a registered dietitian;
- persons who have any of the following qualifications:
  - A. A chef training or culinary management diploma or certificate,
    - granted by a college established under the *Ontario Colleges of Applied Arts and Technology Act, 2002*, or
    - granted by a registered private career college, for successfully completing a program approved by the Superintendent of Private Career Colleges under the *Private Career Colleges Act, 2005*;
  - B. A diploma or certificate granted in another jurisdiction and a set of skills that, in the reasonable opinion of the Home, is equivalent to those that the Home would expect of a person who has a diploma or certificate as set out in A. above;
  - C. A certificate of qualification as a Cook issued by the Director of Apprenticeship under the *Apprenticeship and Certification Act, 1998*, or after Part III of the *Ontario College of Trades and Apprenticeship Act, 2009* comes into force, by the Registrar of the College under that Act; or
- persons who have a post-secondary diploma in food and nutrition management or a post-secondary degree in food nutrition.

Definition

“Food handler training program” means the program offered or approved by the board of health for the public health unit where the Home is located (section 78 (5) of the Regulation).

Key Consideration

Staff who do not complete the Food Service Worker program within three years of being hired (section 78 (2) of the Regulation) can be employed in other positions in the Home for which they are qualified, but not as food service workers.

## Part II Medical Services

### A. Overview

Section 12 of the LTCHA and sections 79 to 84 of the Regulation set out the requirements for an organized program of medical services.

### B LTCHA Requirements

#### Section 12 – Medical Services

There must be an organized program of medical services for the Home.

### C. Regulatory Requirements

#### Section 80 – Availability of Medical Services

Every resident must have access to medical services in the Home 24 hours a day.

Key Linkage

See section 30 of the Regulation for the general requirements that apply to all organized programs required under the LTCHA.

#### Section 81 – Individualized Medical Directives and Orders

A medical directive or order can only be used if it is individualized to the resident's condition and needs.

#### Section 82 – Attending Physician or RN(EC)

Every resident must receive a physical examination conducted by a physician or a registered nurse in the extended class (RN(EC)) upon admission and once a year thereafter. Written reports of the findings of the examination must be produced. Attending physicians and RN(EC)s must attend regularly at the Home to provide services, including assessments and must participate in after-hours and on-call coverage.

A resident or his or her substitute decision-maker can retain his or her own physician or RN(EC) to provide the medical services required. If this is not done, the Home, in consultation with the Medical Director, the resident and the resident's substitute decision-maker, must appoint a physician or RN(EC) to provide the resident's medical services.

The Home must enter into a written agreement with every physician and RN(EC) who is retained or appointed.

See section 72 of the LTCHA and section 214 of the Regulation for the requirements relating to the Home's Medical Director.

### Section 83 – Agreement with Attending Physician

An attending physician must enter into a written agreement with the Home that includes the term of the agreement, the Home's responsibilities and the physician's responsibilities or duties, including the physician's accountability to the Medical Director for meeting the Home's policies, procedures and protocols for medical services, provision of medical services, and provision of after-hours and on-call coverage.

### Section 84 – Agreement with Registered Nurse in the Extended Class

An RN(EC) who attends to residents must enter into a written agreement with the Home that includes the term of the agreement, the Home's responsibilities, the responsibilities or duties of the RN(EC), including the RN(EC)'s accountability to the Medical Director for meeting the Home's policies, procedures and protocols for medical services, provision of services, provision of after-hours and on-call coverage, and informing the Home of the name of the physician with whom the RN(EC) has a consultative relationship.

## Part II Religious and Spiritual Practices

### A. Overview

Section 14 of the LTCHA and section 85 of the Regulation set out the requirements for an organized program that gives every resident the reasonable opportunity to practise his or her religious and spiritual beliefs, and to observe the requirements of those beliefs.

### B. LTCHA Requirements

#### Section 14 – Religious and Spiritual Practices

There must be an organized program at the Home that gives every resident the reasonable opportunity to practise his or her religious and spiritual beliefs, and to observe the requirements of those beliefs.

Key Linkage

Paragraph 23 of section 3 (1) of the LTCHA (Residents' Bill of Rights) provides that every resident has the right to pursue cultural, religious and spiritual interests and to be given reasonable assistance by the Home to pursue these interests.

### C. Regulatory Requirements

#### Section 85 – Religious and Spiritual Practices

The organized program of religious and spiritual practices must include arrangements to provide worship services, resources and non-denominational spiritual counselling on a regular basis for every resident who desires them, depending on the availability of these services within the community.

There must be mechanisms in place to support and facilitate residents' participation in religious and spiritual programs. The Home must also make arrangements for one-to-one visitation, as desired by the resident, and must help residents who have hearing or visual impairments to participate in religious and spiritual practices, all depending on the availability of these services within the community. A person who has sufficient knowledge and experience to co-ordinate religious services and spiritual care in a multi-faith setting must be designated to lead the program.

Key Linkage

See section 30 of the Regulation for the general requirements that apply to all organized programs required under the LTCHA.

## Part II Accommodation Services

### A. Overview

Section 15 of the LTCHA and sections 86 to 92 of the Regulation set out the requirements for an organized program of accommodation services. These services include housekeeping, laundry services and maintenance services.

### B. LTCHA Requirements

#### Section 15 – Accommodation Services

There must be organized programs of housekeeping, laundry services to meet the linen and clothing needs of the residents, and maintenance services. The Home and all furnishings and equipment must be kept clean and sanitary and maintained in safe working condition and in a good state of repair. Residents' linen and clothing must be collected, sorted, cleaned and delivered.

### C. Regulatory Requirements

Key Linkage

See section 30 of the Regulation for the general requirements that apply to all organized programs required under the LTCHA.

#### Section 86 – Accommodation Services Programs

When housekeeping, laundry and/or maintenance services are provided by someone who is not an employee of the Home, the Home must have a written agreement with the service provider that sets out the service expectations. There must be written policies and procedures for monitoring and supervising persons who provide occasional maintenance or repair services pursuant to this agreement. These policies and procedures may take into account whether the person is subject to the requirements for a criminal reference check and signed declarations set out in section 215 of the Regulation.

## Section 87 – Housekeeping

Housekeeping services must be provided seven days a week. Procedures must be developed and implemented for:

- Cleaning the Home, including resident bedrooms (including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces) and common areas and staff areas (including floors, carpets, furnishings, contact surfaces and wall surfaces);
- Cleaning and disinfecting in accordance with manufacturer’s specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
  - resident care equipment (such as whirlpools, tubs, shower chairs and lift chairs),
  - supplies and devices (such as personal assistance services devices and assistive aids and positioning aids), and
  - contact surfaces;
- Removal and safe disposal of dry and wet garbage; and
- Addressing incidents of offensive lingering odours.

A sufficient supply of housekeeping equipment and cleaning supplies must be readily available to all staff. The staff member designated under section 229 (3) of the Regulation to co-ordinate the infection prevention and control program must be involved in selecting the low level disinfectant.

Key Linkage

Section 229 (3) of the Regulation requires that a staff member be designated to co-ordinate the infection prevention and control program.

## Section 88 – Pest Control

There must be an organized preventive pest control program that uses the services of a licensed pest controller, and includes records indicating the dates of visits and actions taken. Immediate action must be taken to deal with pests.

## Section 89 – Laundry Service

Procedures must be developed and implemented to ensure that residents’ linens are changed at least once a week and more often as needed, that residents’ personal items and clothing are labelled in a dignified manner within 48 hours of admission or acquisition of new clothing, that residents’ soiled clothes are collected, sorted, cleaned and delivered to the resident, and that there is a process to report and locate residents’ lost clothing and personal items.

There must be a sufficient supply of clean linen, face cloths and bath towels at all times in the Home for use by residents.

Industrial washers and dryers must be used to wash and dry all laundry. The Home may provide residential washers for the use of residents and their family members, and for laundry from programs that does not require industrial sanitation.

## Section 90 – Maintenance Services

Maintenance services must be available in the Home seven days per week to ensure that the interior and exterior of the building and its operational systems are maintained in good repair. Schedules and procedures must be in place for routine, preventive and remedial maintenance.

Procedures must be developed and implemented to ensure that **all** of the following are met:

- Electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that at least meets manufacturer specifications;
- Equipment, devices, assistive aids and positioning aids are kept in good repair, excluding the residents' personal aids or equipment;
- Heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual;
- All plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
- Gas or electric fireplaces and heat generating equipment (other than the heating system mentioned above) are inspected by a qualified person at least annually;
- Hot water boilers and hot water holding tanks are serviced at least annually;
- The temperature of the water serving all bathtubs, showers and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
- Immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
- The temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
- If the Home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
- If the Home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water.

Documentation must be kept of the inspections and servicing referred to above.

The Home's mechanical ventilation systems must be functioning at all times, except when the Home is operating on power from an emergency generator.

### Section 91 – Hazardous Substances

All hazardous substances at the Home must be labelled properly and kept inaccessible to residents at all times.

### Section 92 – Designated Lead – Housekeeping, Laundry, Maintenance

There must be a designated lead for each of the housekeeping, laundry and maintenance services programs. The same person may be designated lead for more than one program. A lead that is designated after July 1, 2010 must have a post-secondary degree or diploma, knowledge of evidence-based practices, and if there are none, prevailing practices regarding housekeeping, laundry and maintenance, as applicable, and a minimum of two years experience in a managerial or supervisory capacity.

#### Key Consideration

The same person can be the designated lead for housekeeping, laundry and maintenance provided that the person meets the qualifications set out in section 92 (2) of the Regulation (where the lead is designated after July 1, 2010).

## Part II Pets

### A. Overview

Section 93 of the Regulation sets out the requirements for written policies respecting pets in the Home.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 93 – Pets

There must be a written policy respecting pets in the Home.

#### Key Consideration

The policy should address any health and safety issues related to pets in the Home, such as the pets' health and temperament and up-to-date vaccinations.

## Part II Volunteers

### A. Overview

Section 16 of the LTCHA and sections 94 and 95 of the Regulation set out the requirements for an organized volunteer program at the Home.

### B. LTCHA Requirements

#### Section 16 – Volunteer Program

There must be an organized volunteer program at the Home that encourages and supports the participation of volunteers in the lives and activities of residents.

### C. Regulatory Requirements

#### Section 94 – Volunteer Program

A staff member must monitor or direct a volunteer whenever it is necessary to ensure the safety of a resident.

Key Linkage

See section 30 of the Regulation for general requirements that apply to all organized programs required under the LTCHA.

#### Section 95 – Designated Lead

There must be a designated lead for the volunteer program who is a member of the staff. The designated lead must have at least one year of experience with seniors in an organized program or one year of experience with persons in a health care setting, and must have experience or knowledge in the recruitment, selection, orientation, placement and supervision of volunteers.

Key Linkage

Volunteers must receive an orientation to the Home. The requirements relating to the volunteer orientation are set out in section 77 of the LTCHA and section 223 of the Regulation.

New volunteers who are accepted on or after July 1, 2011 by the Home must have a criminal reference check that includes a vulnerable sector screen. These volunteers will be required to provide the Home with a signed declaration disclosing the information set out in section 215 of the Regulation. The requirements relating to criminal reference checks are set out in sections 75 (2) of the LTCHA and section 215 of the Regulation.

# Part II Prevention of Abuse and Neglect

## A. Overview

Sections 19 and 20 of the LTCHA and sections 96 to 99 of the Regulation set out the requirements for the Home to protect a resident from abuse by anyone and from neglect by the Home or its staff.

## B. LTCHA Requirements

### Section 19 – Duty to Protect

The Home must protect its residents from abuse by anyone and from neglect by the Home or its staff. This requirement does not apply when the resident is absent from the Home (e.g., during a casual absence), unless the resident is still receiving care or services from the Home, staff or volunteers.

#### Definitions

The following definitions apply to all references of abuse or neglect in the LTCHA and the Regulation.

Section 2 (1) of the LTCHA provides that “abuse” in relation to a resident means physical, sexual, emotional, verbal or financial abuse, as defined in the Regulation.

Section 2 (1) of the Regulation defines the following types of abuse:

“Emotional Abuse” means,

- any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization by anyone other than a resident, or
- any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

“Financial Abuse” means any misappropriation or misuse of a resident’s money or property.

“Physical Abuse” means,

- the use of physical force by anyone other than a resident that causes physical injury or pain (this does not include the use of force that is appropriate to provide care or to assist a resident with activities of daily living, unless the force used is excessive in the circumstances) (section 2 (2) of the Regulation),
- administering or withholding a drug for an inappropriate purpose, or

- the use of physical force by a resident that causes physical injury to another resident.

“Sexual Abuse” means,

- any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by the licensee or a staff member, or
- any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than the licensee or a staff member.

The definition of sexual abuse does not include,

- touching, behaviour or remarks of a clinical nature that are appropriate to providing care or assisting a resident with activities of daily living, or
- consensual touching, behaviour or remarks of a sexual nature between a resident and the licensee or a staff member that is in the course of a sexual relationship that began before the resident was admitted to the Home or before the licensee or staff member became a licensee or staff member (section 2 (3) of the Regulation).

“Verbal Abuse” means,

- any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature that diminishes a resident’s sense of well-being, dignity or self-worth, which is made by anyone other than a resident, or
- any verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety and the resident making the communication understands and appreciates its consequences.

Section 5 of the Regulation defines “neglect” as follows,

“Neglect” means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

#### Key Consideration

Altercations and harmful interactions among residents that are not covered under the above definitions but could escalate into abusive situations are addressed in sections 54 and 55 of the Regulation. Addressing these situations early should be a key part of preventing abuse in the Home.

## Section 20 – Policy to Promote Zero Tolerance

There must be a written policy to promote zero tolerance of abuse and neglect of residents. This policy must be communicated to all staff, residents and substitute decision-makers. This policy must comply with the Regulation and the Home must ensure compliance with the policy.

At a minimum, the policy must meet **all** of the following:

- State that abuse and neglect are not to be tolerated;
- Clearly set out what constitutes abuse and neglect;
- Provide for a program for preventing abuse and neglect that complies with the Regulation;
- Contain an explanation of the duty under section 24 of the LTCHA to make mandatory reports;
- Set out procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; and
- Set out the consequences for those who abuse or neglect residents.

### Key Linkages

Section 23 of the LTCHA requires the Home to immediately investigate and take appropriate action relating to every alleged, suspected or witnessed incident of abuse of a resident by anyone and incident of neglect of a resident by the Home or its staff that is known by or reported to the Home. The results of the investigation and the action taken must be reported to the Director. Section 104 of the Regulation sets out the information that must be included in this report.

Any person who has reasonable grounds to believe that a resident has been or may be abused by anyone or neglected by the Home or staff that resulted in harm or a risk of harm to a resident must immediately report this suspicion to the Director under section 24 of the LTCHA.

Section 25 of the LTCHA requires the Director to conduct an inspection or make inquiries when he or she receives information regarding the abuse of a resident by anyone or neglect of a resident by the Home or staff that resulted in harm or a risk of harm to the resident.

## C. Regulatory Requirements

### Section 96 – Policy to Promote Zero Tolerance

Section 96 of the Regulation specifies additional requirements for the Home's policy to promote zero tolerance of abuse and neglect of residents. The policy must meet **all** of the following:

- Include procedures and interventions to assist and support residents who have been abused or neglected, or allegedly abused or neglected;
- Contain procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;
- Identify measures and strategies to prevent abuse and neglect;
- Identify how allegations of abuse and neglect will be investigated by the Home, including who will undertake the investigation and who will be informed of the investigation; and
- Identify the training and retraining requirements for all staff including training about the power imbalances between staff and residents, the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and situations that may lead to abuse and neglect and how to avoid them.

#### Key Consideration

Procedures and interventions to assist and support residents who have been abused or neglected may include counselling.

#### Key Linkage

See sections 76 (2), (3), (4) and (7) of the LTCHA for staff training requirements relating to abuse and neglect.

## Section 97 – Notification Regarding Incidents

A resident's substitute decision-maker, if any, and any other person specified by the resident must be notified as follows:

- Immediately when the Home becomes aware of any alleged, suspected or witnessed incident of abuse or neglect that has caused physical injury or pain to the resident or that caused distress to the resident that could be harmful to the resident's health or well-being.
- Within 12 hours when the Home becomes aware of any other alleged, suspected or witnessed incident of abuse or neglect.

The resident and the resident's substitute decision-maker, if any, must be notified of the results of an investigation by the Home under section 23 (1) of the LTCHA as soon as the investigation is completed.

The Home is not required to, but may notify a person of anything under this section if there are reasonable grounds to believe that the person is responsible for the abuse or neglect.

### Key Considerations

If a resident wants a person notified about an incident of abuse or neglect, the Home must notify that person (unless there are reasonable grounds to believe that the person is responsible for the incident). A resident is not required to specify a person to be notified.

In the case of abuse or neglect, a Home must notify a resident's substitute decision-maker – even if that person has indicated that he or she does not wish to be notified (unless there are reasonable grounds to believe that the person is responsible for the incident). The requirement to notify a resident's substitute decision-maker applies even if the resident has indicated that he or she does not wish to have the substitute decision-maker notified.

## Section 98 – Police Notification

The appropriate police force must be notified immediately of any alleged, suspected or witnessed incidence of abuse or neglect of a resident that the Home suspects may constitute a criminal offence.

### Key Considerations

The Home's policy to promote zero tolerance of abuse and neglect of residents may include procedures and protocols for staff to follow in complying with the requirement to notify police. The Home may wish to consult with its local police force to develop appropriate procedures and protocols.

The Home is required to notify the police even if a capable resident asks that the police not be called. There are no exceptions to the requirement to notify the police if the Home suspects that the abuse or neglect may be a criminal offence.

In some circumstances, it may be immediately clear from the outset of an incident that police must be called. In other circumstances, the Home may only suspect that a criminal offence has occurred once the Home has had time to investigate the incident. Once the suspicion arises, the Home must call the police.

## Section 99 – Evaluation

The effectiveness of the Home's policy to promote zero tolerance of abuse and neglect of residents must be evaluated at least once every calendar year to identify changes and improvements required to prevent future occurrences. Every incident of resident abuse or neglect must be analyzed promptly after the Home becomes aware of it, and the results of the analysis must be considered in the evaluation. The changes and improvements identified in the evaluation must be implemented promptly.

A written record of the annual evaluation must be prepared promptly and include the changes and improvements required to prevent future occurrences, the date that the changes or improvements were implemented, the date of the evaluation, and the names of the persons who participated in the evaluation.

# Part II Reporting and Complaints (Complaints)

## A. Overview

Sections 21 and 22 of the LTCHA and sections 100 to 102 of the Regulation set out the requirements that the Home must meet when establishing procedures for initiating and dealing with complaints.

## B. LTCHA Requirements

### Section 21 – Complaints Procedure – Licensee

The Home must have written procedures for initiating complaints to the Home and for how the Home deals with complaints.

### Section 22 – Licensee to Forward Complaints

Written complaints to the Home about a resident’s care or about the operation of the Home must be sent immediately to the Director.

#### Key Consideration

“Written” complaints include written notification in any format, including anything handwritten, such as letters, notes, correspondence, e-mails, facsimile documents and text messages.

## C. Regulatory Requirements

### Section 100 – Complaints Procedure – Licensee

The written complaint procedures required under section 21 of the LTCHA must incorporate the requirements of section 101 of the Regulation.

### Section 101 – Dealing with Complaints

Every written or verbal complaint made to the Home or a staff member concerning the care of a resident or the operation of the Home must be dealt with as follows:

- The complaint must be investigated and resolved where possible.
- A response must be made to the person who made the complaint, indicating what the Home has done to resolve the complaint, or that the Home believes the complaint to be unfounded and the reasons for this belief. This response must be provided within 10 business days of the receipt of the complaint.

- Where the complaint alleges harm or risk of harm to one or more residents, the investigation must commence immediately.
- For those complaints that cannot be investigated and resolved within 10 business days, the Home must acknowledge receipt of the complaint within 10 business days of receiving the complaint and must include the date when the complainant can reasonably expect a resolution. The Home must also provide, as soon as possible, a follow-up response that indicates what the Home has done to resolve the complaint, or that the Home believes the complaint to be unfounded and the reasons for this belief.

Unless the complaint is a verbal complaint that the Home is able to resolve within 24 hours, the Home must keep a documented record of the complaint that includes **all** of the following:

- The nature of each verbal or written complaint;
- The date the complaint was received;
- The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- The final resolution, if any;
- Every date on which any response was provided to the complainant and a description of the response; and
- Any response made in turn by the complainant.

The Home must review and analyze the documented record for trends at least quarterly, take the results of the review and analysis into account in determining improvements required in the Home, and keep a written record of each review and of the improvements made.

## Section 102 – Transitional, Complaints

As far as possible, the Home must deal with complaints made but not resolved before July 1, 2010 in the manner set out in section 101 of the Regulation.

## Part II Reporting and Complaints (Mandatory Reports)

### A. Overview

Sections 23 to 28 of the LTCHA and sections 103 to 106 of the Regulation set out the requirements for reporting, investigating and handling complaints, including complaints of abuse and neglect of a resident. These sections also set out requirements for mechanisms to ensure that complaints of abuse and neglect are reported, and that individuals who come forward with complaints are protected from retaliation.

### B. LTCHA and Regulation Requirements

#### LTCHA Section 23 – Licensee Must Investigate, Respond and Act

Every alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the Home or staff that the Home knows of, or that is reported to the Home, must be investigated immediately. The Home must take appropriate action to respond to every incident.

The Home must report to the Director the results of every investigation into the above alleged, suspected or witnessed incidents, and must report on the appropriate actions taken to respond to such incidents. The report must be made as required by the Regulation.

#### Key Considerations

The licensee and its staff members should carefully review the definitions of abuse set out in the LTCHA and the Regulation.

It is important to note the following definitions in section 2 of the Regulation regarding resident-to-resident interactions (see pages 2-61 and 2-62 of this Guide for a fuller description of these definitions):

“Emotional Abuse” means any threatening or intimidating gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences.

“Physical Abuse” means the use of physical force by a resident that causes physical injury to another resident.

Physical force applied by one resident against another would be considered physical abuse and trigger these reporting requirements only when the force results in physical injury.

### Key Considerations (cont'd)

“Verbal Abuse” means any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences.

Based on these definitions, not all resident-to-resident interactions that seem abusive require reporting to the Director. Homes and their staff members should ensure that when they consider reporting resident-to-resident interactions that the interactions fall within the definitions of abuse set out in the Regulation.

Even when a resident-to-resident interaction does not fall within the definitions of abuse, the Home must comply with the provisions of the Regulation dealing with Responsive Behaviours, Altercations and Other Interactions and Behaviours and Altercations (sections 53 to 55 of the Regulation) to minimize the risk of altercations and potentially harmful interactions between and among residents.

## Regulation Section 104 – Licensees Who Report Investigations Under Section 23 (2) of the LTCHA

This section identifies the types of information that must be included in the report that the Home provides on the results of investigations and actions taken with respect to the abuse or neglect of residents.

In making the report to the Director, the licensee must include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

- A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
- A description of the individuals involved in the incident, including names of all residents involved in the incident, names of any staff members or other persons who were present at or discovered the incident, and names of staff members who responded or are responding to the incident.
- Actions taken in response to the incident, including what care was given or action taken as a result of the incident, and by whom, whether a physician or RN(EC) was contacted, what other authorities were contacted about the incident, if any, whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and the outcome or current status of the individual or individuals who were involved in the incident.

- Analysis and follow-up action, including the immediate actions that have been taken to prevent recurrence, and the long-term actions planned to correct the situation and prevent recurrence.
- The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

As noted in the Reporting of Abuse, Neglect and Other Significant Matters table (page 2-72), the Home must provide this report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or earlier if required by the Director. If the Home cannot provide a report within 10 days that includes all of the information required, it must send in a preliminary report within 10 days and provide a final report within a timeframe to be determined by the Director.

#### Key Consideration

The Home should use the Mandatory Critical Incident System (MCIS) form to provide any preliminary reports and the final report required under section 104 of the Regulation.

## LTCHA Section 24 – Reporting Certain Matters to Director

Any person who has reasonable grounds to suspect that any of the incidents in the table below has occurred or may occur must immediately report the incident, as well as the information on which the suspicion is based, to the Director.

The table sets out the different types of incidents that all persons must report and how quickly these incidents must be reported. It also sets out the acceptable method of reporting by the Home and the timing of follow-up reporting on the results of investigations and actions, as communicated to the Homes by the Director in a separate memorandum dated August 4, 2010.

## Reporting of Abuse, Neglect and Other Significant Matters

Type of Incident	Initial Notification			Report of Results of Investigations and Actions	
	Timeframe for Reporting	Method of Reporting:		Timeframe for Report	Method of Reporting
		Bus. Hrs.	After Hrs.		
Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident	Immediately	MCIS Form Online	Pager	Within 10 days of becoming aware of incident or sooner if required by Director	Fully completed MCIS Form
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	Immediately	MCIS Form Online	Pager	Within 10 days of becoming aware of incident or sooner if required by Director	Fully completed MCIS Form
Unlawful conduct that resulted in harm or a risk of harm to a resident	Immediately	MCIS Form Online	Pager	Within 10 days of becoming aware of incident or sooner if required by Director	Fully completed MCIS Form
Misuse or misappropriation of a resident's money	Immediately	MCIS Form Online	MCIS Form Online	Within 10 days of becoming aware of incident or sooner if required by Director	Fully completed MCIS Form
Misuse or misappropriation of funding provided to a licensee under the LTCHA or under the <i>Local Health System Integration Act, 2006</i>	Immediately	MCIS Form Online	MCIS Form Online	Within 10 days of becoming aware of incident or sooner if required by Director	Fully completed MCIS Form

### Key Considerations

The requirement to report to the Director set out in section 24 of the LTCHA applies to every person.

The MOHLTC has an online reporting system for both mandatory reports and critical incidents (section 107 of the Regulation) that is used by the Home. Mandatory Critical Incident System (MCIS) forms should be used by the Home to file both the initial and follow-up reports for the types of incidents identified in the table above.

Any person who is aware of an incident listed in the table above and who does not have access to the Home's Mandatory Critical Incident Reporting System should report using the toll-free Long-Term Care ACTION Line at 1-866-434-0144.

The MOHLTC's normal business hours are Monday to Friday from 8:30 a.m. to 5:00 p.m. All other times and statutory holidays are considered "after hours".

The MOHLTC's current method for after-hours emergency contact by the Home is an after-hours pager.

Section 108 of the Regulation defines the term "misuse" of funding provided to a licensee for the purposes of mandatory reporting requirements in the LTCHA (paragraph 5 of section 24 (1) and paragraph 6 of section 25 (1)) as the use of funds provided by the MOHLTC or a LHIN for a purpose other than a purpose specified as a condition of funding or in a manner that is not permitted under a restriction that was specified as a condition of the funding.

Staff, volunteers, residents, residents' family members or any other persons who have reasonable grounds to suspect a misuse or misappropriation of funding that has already occurred or may occur must report the suspected misuse to the Director (section 24 of the LTCHA). The reporting may be made by directly calling the toll-free Long-Term Care ACTION Line at 1-866-434-0144. Upon receipt of that information, the Director must have an inspector make inquiries or conduct an inspection (section 25 of the LTCHA).

Section 21 of the LTCHA and section 101 of the Regulation require the Home to have a documented complaints procedure.

### Key Consideration

Section 24 of the LTCHA does not require persons to report an assault on a staff member by a resident. However, if a staff member or any other person is taken to hospital for an injury arising from such an assault, the matter must be reported as a critical incident under paragraph 4 of section 107 (3) of the Regulation. There may also be requirements to report staff injury to the Ministry of Labour.

A resident is not required to report under section 24 of the LTCHA, but he or she may do so.

It is an offence for anyone, other than a resident who is incapable, to include false information in a report to the Director.

Practitioners, including physicians (or any other person who is a member of a College under the *Regulated Health Professions Act, 1991*), drugless practitioners and members of the Ontario College of Social Workers and Social Service Workers, have a duty to report under section 24 (1) of the LTCHA, even when the report is based on confidential or privileged information. No action for making the report can be taken against a practitioner unless he or she acted maliciously or without reasonable grounds for the suspicion.

The following persons are guilty of an offence if they fail to make a report under section 24 (1) of the LTCHA (section 24 (5) of the LTCHA):

- The licensee or person who manages the Home under a management contract.
- An officer or director of the corporation, if the licensee or person who manages the Home is a corporation.
- A member of the committee of management of a Home or board of management of a Home approved under Part VIII of the LTCHA.
- A staff member other than those exempted under section 105 of the Regulation.
- Any person who provides professional services to a resident in the areas of health, social work or social services work.
- Any person who provides professional services to a Home in the areas of health, social work or social services work.

The following persons are guilty of an offence if they coerce, intimidate or discourage anyone from reporting, or authorize, permit or concur in a contravention of the duty to make a report under this section (section 24 (6) of the LTCHA):

- The licensee or person who manages the Home under a management contract.
- An officer or director of the corporation, if the licensee or person who manages the Home is a corporation.
- A member of the committee of management of a Home or board of management of a Home approved under Part VIII of the LTCHA.
- A staff member other than those exempted under section 105 of the Regulation.

Nothing in section 24 of the LTCHA abrogates any privilege that may exist between a solicitor and the solicitor's client.

### Regulation Section 103 – Complaints – Reporting Certain Matters to Director

The Home that receives a written complaint about a matter that the Home reports or reported to the Director under section 24 of the LTCHA must submit a copy of the complaint to the Director along with a written report documenting the Home's response to the complainant under section 101 (1) of the Regulation. This documentation must be submitted as soon as the Home has completed its investigation, or sooner if required by the Director.

### Regulation Section 105 – Non-Application re Certain Staff

Contract staff or agency staff members who only provide occasional maintenance or repair services to the Home and who do not provide direct care to residents are not subject to the offence provision for failing to report a matter to the Director as required under section 24 (1) of the LTCHA.

Definitions

“Contract staff” refers to persons who work at the Home pursuant to a contract or agreement with the Home.

“Agency staff” refers to persons who work at the Home pursuant to a contract or agreement between the Home and an employment agency or other third party.

See section 2 (1) of the LTCHA for the definition of “staff” for the purposes of the LTCHA and the Regulation.

## LTCHA Section 25 – Inspection or Inquiries Where Information Received by Director

This section sets out the situations under which the Director must have an inspector conduct an inspection or make inquiries to ensure compliance with the LTCHA and the Regulation. These situations include all the circumstances in the Reporting of Abuse, Neglect and Other Significant Matters table (page 2-72); any violation of the whistle-blowing protections in section 26 of the LTCHA; and when any failure to comply with a requirement under the LTCHA may have occurred.

The Director may receive information related to incidents from any source. “Information” includes written complaints, reports received from the Home under section 23 (2) of the LTCHA, and reports received under section 24 of the LTCHA.

An inspector must visit the Home immediately if the information indicates that any of the following may have occurred:

- Improper or incompetent treatment or care of a resident that resulted in serious harm or risk of serious harm to the resident.
- Abuse of a resident by anyone or neglect of a resident by the Home or staff that resulted in serious harm or a risk of serious harm to the resident.
- Unlawful conduct that resulted in serious harm or a serious risk of harm to the resident.
- A violation of whistle-blowing protections in section 26 of the LTCHA.

In cases where other information is received that raises concerns about the operation of a Home, the Director must have an inspector conduct an inspection or make inquiries if the Director has reasonable grounds to believe that there may be a risk of harm to a resident.

If the Director receives information about the operation of a Home and does not have to conduct an inspection or make inquiries, the Director may disclose the information to another person, including the Home, the Residents’ Council or the Family Council.

If the Director discloses the information to the Residents’ Council or the Family Council, the Director is required to provide the information to the Home.

## LTCHA Section 26 – Whistle-Blowing Protection

It is an offence to retaliate, whether by action or omission, or to threaten to retaliate against someone for disclosing anything to the Director or an inspector or for providing evidence in a legal proceeding. Retaliation includes:

- Dismissing, disciplining or suspending a staff member;
- Imposing a penalty on anyone; and
- Intimidating, coercing or harassing anyone.

It is an offence to discharge or threaten to discharge a resident or to subject a resident to discriminatory treatment (including threatening any family member, substitute decision-maker or person of importance to a resident that such action will be taken) because of anything that is disclosed to the Director or an inspector or for giving evidence in a legal proceeding, even if the resident or other person acted maliciously or in bad faith. “Discriminatory treatment” includes any change or discontinuation of any service to or care of a resident or the threat to do so.

It is an offence for any of the following persons to discourage a person from disclosing anything to the Director or an inspector or from providing evidence in a legal proceeding:

- The licensee or person who manages the Home under a management contract.
- An officer or director of the corporation, if the licensee or person who manages the Home is a corporation.
- A member of the committee of management of a Home or board of management of a Home approved under Part VIII of the LTCHA.
- A staff member.

It is also an offence for any of the above persons to encourage a person to fail to disclose anything to the Director or an inspector or to fail to provide evidence in a legal proceeding.

No legal action or other proceeding can be commenced against any person for disclosing anything to the Director or an inspector or for providing evidence in a legal proceeding unless the person acted maliciously or in bad faith.

### **LTCHA Section 27 – Complaint to Ontario Labour Relations Board**

This section sets out steps that a staff member can take if he or she believes that an employer has retaliated against him or her contrary to section 26 of the LTCHA. The staff member may have the matter dealt with by final and binding settlement by arbitration under a collective agreement, if a collective agreement exists, or may file a complaint with the Ontario Labour Relations Board (“Board”).

Section 27 of the LTCHA sets out the powers of the Board in dealing with such a complaint.

The burden of proof before the Board that an employer or person acting on behalf of the employer did not contravene the whistle-blower protections under section 26 of the LTCHA rests on the employer or person acting on behalf of the employer.

### **LTCHA Section 28 – Obstruction – Information to Inspectors, Director**

It is an offence for anyone to attempt to prevent someone from providing information to an inspector or the Director that they are required or permitted to provide under the LTCHA or the Regulation.

Section 182 of the LTCHA sets out the penalties that apply to individuals and corporations convicted of an offence under the LTCHA.

### **Regulation Section 106 – Transitional, Investigation and Reports**

Section 106 identifies the sections of the LTCHA and Regulation that apply to complaints, investigations and reports that occurred before the LTCHA and the Regulation came into force. The Reporting and Complaints – Overview of Transitional Rules table (below) provides an overview of these provisions.

## Reporting and Complaints – Overview of Transitional Rules

Requirement of LTCHA & Regulation 79/10	Transitional Rule under Regulation 79/10	Summary of Transitional Rule
Critical incident reporting under section 107 of the Regulation	107 (6)	The Home must report incidents/ occurrences that happened before July 1, 2010 as required under the <i>Nursing Homes Act, Charitable Institutions Act, Homes for the Aged</i> and <i>Rest Homes Act</i> or Program Manual (if not previously reported)
The Home's complaint procedures under section 101 of the Regulation	102	Applies to the extent possible to complaints made before July 1, 2010 that were not finally dealt with by the Home
The Home's investigation of abuse/neglect under section 23 of the LTCHA and section 104 of the Regulation	106 (1)	Applies to incidents known by or reported to the Home after July 1, 2010, even if they occurred before July 1, 2010, unless investigated and resolved before July 1, 2010
Mandatory reporting to the Director under section 24 of the LTCHA	106 (2)	Applies to matters that occur or may occur after July 1, 2010
Inspections or inquiries under section 25 of the LTCHA where information received by Director	106 (3)	Applies to information received after July 1, 2010 even if matter occurred before July 1, 2010
Whistle-blower protections under section 26 of the LTCHA	106 (4)	Applies to retaliation that occurs after July 1, 2010 even if it relates to a disclosure or evidence given before July 1, 2010

## Part II Reporting and Complaints (Critical Incidents)

### A. Overview

Section 107 of the Regulation identifies the critical incidents in the Home that must be reported and sets out the requirements that the Home must follow for reporting these incidents to the Director.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 107 – Reports re Critical Incidents

Section 107 identifies the critical incidents that the Home must report to the Director immediately (including after-hours reporting if the incident occurs after normal business hours) and those that must be reported within one business day.

#### Key Consideration

The MOHLTC's normal business hours are Monday to Friday from 8:30 a.m. to 5:00 p.m. All other times and during statutory holidays are considered "after hours." The MOHLTC's current method for after-hours emergency contact is an after-hours pager.

Regardless of whether an incident must be reported immediately or within one business day, within 10 days of becoming aware of the incident (or sooner if required by the Director), the Home must make a written report that provides follow-up information regarding the incident and how the Home responded. Section 107 (4) of the Regulation sets out the types of information to be included in the follow-up report.

#### Key Consideration

The MOHLTC has an online reporting system for critical incidents. The Home should use the MCIS forms to file the initial incident report and the subsequent reports which describe how the incident was handled and the outcome of the incident. Completing the full report using the MCIS will meet the reporting requirements set out in section 107(4) of the Regulation.

The table below sets out the different types of critical incidents that the Home must report, how quickly they must be reported and the acceptable method of reporting:

### Critical Incident Reporting

Type of Incident	Initial Notification			Follow-up Report	
	Timeframe for Reporting	Method of Reporting:		Timeframe for Report	Method of Reporting
		Bus. Hrs.	After Hrs.		
Emergency including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding	Immediately	MCIS Form Online	Pager	Within 10 days or sooner if required by Director	Fully completed MCIS Form
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	Within one business day of becoming aware of the incident	MCIS Form Online	N/A	Within 10 days or sooner if required by Director	Fully completed MCIS Form
Unexpected or sudden death including a death resulting from an accident or suicide	Immediately	MCIS Form Online	Pager	Within 10 days or sooner if required by Director	Fully completed MCIS Form
Resident who is missing for three hours or more	Immediately	MCIS Form Online	Pager	Within 10 days or sooner if required by Director	Fully completed MCIS Form
Resident who is missing for less than three hours and who returns to the Home with no injury or adverse change in condition	Within one business day of becoming aware of the incident	MCIS Form Online	N/A	Within 10 days or sooner if required by Director	Fully completed MCIS Form

## Critical Incident Reporting (cont'd)

Type of Incident	Initial Notification			Follow-up Report	
	Timeframe for Reporting	Method of Reporting:		Timeframe for Report	Method of Reporting
		Bus. Hrs.	After Hrs.		
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	Immediately	MCIS Form Online	Pager	Within 10 days or sooner if required by Director	Fully completed MCIS Form
Outbreak of a reportable disease or communicable disease as defined in the <i>Health Protection and Promotion Act</i>	Immediately	MCIS Form Online	Pager	Within 10 days or sooner if required by Director	Fully completed MCIS Form
Contamination of the drinking water supply	Immediately	MCIS Form Online	Pager	Within 10 days or sooner if required by Director	Fully completed MCIS Form
Missing or unaccounted for controlled substance	Within one business day of becoming aware of the incident	MCIS Form Online	N/A	Within 10 days or sooner if required by Director	Fully completed MCIS Form
Injury in respect of which a person is taken to hospital (Note: This applies to anyone taken to hospital and is not restricted to residents.)	Within one business day of becoming aware of the incident	MCIS Form Online	N/A	Within 10 days or sooner if required by Director	Fully completed MCIS Form
A medication incident or adverse drug reaction in respect of which a resident is taken to hospital.	Within one business day of becoming aware of the incident	MCIS Form Online	N/A	Within 10 days or sooner if required by Director	Fully completed MCIS Form

The Home must promptly notify a resident's substitute decision-maker or anyone designated by the resident or his or her substitute decision-maker of any serious injury to or illness of the resident. Notice must be provided in accordance with instructions provided by the persons who are to be notified.

As a transitional matter, the Home must report incidents (previously referred to as unusual occurrences or occurrences) that occurred before the LTCHA came into force on July 1, 2010 in a way that meets requirements under predecessor legislation (i.e., the *Nursing Homes Act*, *Charitable Institutions Act*, or *Homes for the Aged and Rest Homes Act*) and any agreements made under any of those Acts.

#### Key Consideration

As a transitional matter, the requirements for reporting unusual occurrences or occurrences that were set out in the Long-Term Care Homes Program Manual continue to apply to incidents that occurred before the LTCHA came into force on July 1, 2010.

## Part II Minimizing of Restraining

### A. Overview

Sections 29 to 36 of the LTCHA and sections 109 to 113 of the Regulation set out the requirements relating to minimizing the restraining of residents, and when and how physical devices and personal assistance service devices (PASDs) are to be used in a Home. These requirements address resident safety issues.

### B. LTCHA and Regulation Requirements

#### LTCHA Section 29 – Policy to Minimize Restraining of Residents, etc.

There must be a written policy to minimize the restraining of residents and to ensure that any necessary restraining is done in accordance with the LTCHA and the Regulation. The policy must comply with the Regulation and the Home must ensure compliance with the policy.

#### Key Linkages

Staff in the Home must receive initial training and retraining on the Home's policy to minimize the restraining of residents (sections 76 (2) and (4) of the LTCHA).

Direct care staff must receive additional training on how to minimize the restraining of residents and, when restraining is necessary, how to do so in accordance with the LTCHA and the Regulation. Direct care staff must also receive training in the application, use and potential dangers of physical devices used to restrain and PASDs (section 76 (7) of the LTCHA; sections 221 (1) and section 221 (4) of the Regulation).

#### Regulation Section 109 – Policy to Minimize Restraining of Residents, etc.

The written policy to minimize restraining of residents under section 29 of the LTCHA must address **all** of the following:

- Use of physical devices.
- Duties and responsibilities of staff, including:
  - who has the authority to apply a physical device to restrain a resident or release a resident from a physical device, and
  - ensuring that all appropriate staff are aware at all times of when a resident is being restrained by use of a physical device.
- Restraining under the common law duty pursuant to section 36 (1) of the LTCHA when immediate action is necessary to prevent serious bodily harm to the person or others.
- Types of physical devices that can be used.

- How consent to the use of physical devices as set out in section 31 of the LTCHA and the use of PASDs as set out in section 33 of the LTCHA is to be obtained and documented.
- Alternatives to the use of physical devices, including how these alternatives are planned, developed and implemented, using an interdisciplinary approach.
- How the use of restraining in the Home will be evaluated to minimize restraining and ensure that any restraining that is necessary is done in accordance with the LTCHA and the Regulation.

### LTCHA Section 30 – Protection From Certain Restraining

The Home must ensure no resident of the Home is restrained:

- In any way, for the convenience of the Home or staff.
- As a disciplinary measure.
- With a physical device other than in accordance with section 31 of the LTCHA or under the common law duty described in section 36 of the LTCHA.
- By the administration of a drug to control the resident, other than under the common law duty described in section 36 of the LTCHA.
- 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 of the LTCHA or the common law duty described in section 36 of the LTCHA.

#### Definitions

The LTCHA and the Regulation regulate the use of any physical device to restrain a resident. There is no definition of the term “physical device”.

“Physical device” refers to any device that is used to limit or inhibit a resident’s movement.

“Limit or inhibit” means that the person or the person’s body movement is significantly impeded or his or her freedom of movement has been restricted in a significant way.

For example, a person may not be able to get out of a chair or may not be able to move or reposition himself or herself because the physical device prevents such movement or repositioning.

A PASD is defined in section 33 (2) of the LTCHA as a device used to assist a person with a routine activity of living. The provisions in the LTCHA and the Regulation relating to PASDs only apply where the PASD limits or inhibits the resident’s freedom of movement and the resident is not able, either physically or cognitively, to release himself or herself from the PASD. Routine activities of living include eating, drinking and ambulation.

### Key Considerations

The LTCHA and the Regulation distinguish between a device that is used as a PASD and a device that is used to restrain. Whether a physical device that limits or inhibits movement is being used to restrain a resident or to assist a resident with a routine activity of living depends on the purpose for which the device is used at that point in time.

This distinction is essential to an understanding of requirements in the LTCHA and the Regulation that relate to restraining with a physical device as opposed to using a PASD.

If a device that could be used to assist a resident with a routine activity of living is being used to restrain a resident, the requirements for restraining by use of a physical device apply. For example, a table affixed to a wheelchair would be considered restraining with a physical device if it is being used to restrain a resident because there is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. However, a table affixed to a wheelchair would not be considered to be restraining with a physical device if it is being used to support a routine activity of living – like eating – and is removed after the resident finishes eating. It would be considered to be a PASD when used in this context as it is supporting a routine activity of living.

The LTCHA identifies a set of practices that do not constitute the restraining of a resident:

- Use of a physical device from which a resident is physically and cognitively able to release himself or herself.
- Use of a PASD to assist a resident with a routine activity of living.
- Administration of a drug to a resident as a treatment set out in a resident's plan of care.
- Use of barriers, locks or other devices or controls at exits and entrances to the Home or its grounds, unless the resident is prevented from leaving.
- Use of barriers, locks, or other devices or controls at stairways as a safety measure.

### Key Consideration

A resident is not considered to be restrained using a physical device if the resident is able to release the restraint himself or herself – that is, the resident understands how to release the device and is physically able to do so. The resident must be able to easily remove the device. If the resident must struggle or takes an extended period of time to remove the device, he or she is considered to be restrained with a physical device.

## LTCHA Section 36 – Common Law Duty

Nothing in the LTCHA 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.

If a resident is being restrained by a physical device based on this common law duty, the Home must ensure that the device is used in accordance with any requirements in the Regulation and must comply with any other requirements in the Regulation.

Under the common law duty, a resident may not be restrained by the use of a drug unless a physician has ordered its use. If a resident is restrained by the use of a drug under the common law duty, the Home must comply with any requirements in the Regulation.

The common law duty gives staff the authority to act quickly when immediate action is required to prevent serious bodily harm to the resident or others in an emergency situation. The assumption is that the speed with which the Home must respond to prevent bodily harm to either the resident or another person means that there is no time to meet the requirements specified under section 31 of the LTCHA.

Use of the common law duty should not be a routine part of any plan of care. The common law duty enables the Home to address unexpected occurrences in order to prevent serious bodily harm to the resident or to others. It is not to be used for any other reason. If restraining with a physical device is considered necessary as a routine part of a resident's care, the Home must comply with all the conditions under section 31 of the LTCHA.

Under section 31 of the LTCHA, only a physician or a RN(EC) may authorize restraining using a physical device.

With respect to using a physical device to restrain a resident under the common law duty set out in section 36, both the LTCHA and the Regulation are silent about who may authorize the use of the physical device.

Where the common law duty is used, the Home is understood to be responding quickly and taking immediate action in order to prevent serious bodily harm to the resident or to others. In these circumstances, certain types of staff may not be in the Home at the time of the emergency. The Home should consider the relationship between the urgent nature of restraining under section 36 of the LTCHA and the presence of appropriate staff when developing the policy on restraining under the common law duty in accordance with section 109 (c) of the Regulation.

In accordance with section 137 (1) of the Regulation, an RN may also order the administration of a drug when the common law duty is used.

## LTCHA Section 31 – Restraining by Physical Devices

A resident may only be restrained with a physical device if the restraining is included in the resident's plan of care and **all** of the following conditions are met:

- There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.
- 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 to the resident or another person.
- 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 to the resident or another person.
- A physician or RN(EC) has ordered or approved the restraining.
- 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.
- The plan of care provides for everything required immediately below.

If a resident is being restrained by a physical device, **all** of the following must be met:

- The device is used in accordance with any requirements provided for in the Regulation;
- The resident is monitored while restrained, in accordance with the requirements provided for in the Regulation;
- The resident is released and repositioned, from time to time, while restrained, in accordance with the requirements provided for in the Regulation;
- The resident's condition is reassessed and the effectiveness of the restraining is evaluated, in accordance with the requirements provided for in the Regulation;
- The resident is restrained only for as long as is necessary to address the risk to the resident or another person;
- The method of restraining used is discontinued if, as a result of the reassessment of the resident's condition, an alternative to restraining, or a less restrictive method of restraining that would be reasonable, in light of the resident's physical and mental condition and personal history, is identified that would address the risk to the resident or another person; and
- Any other requirements provided for in the Regulation are satisfied.

### Key Considerations

Procedures for obtaining consent must be consistent with the requirements of the LTCHA and other applicable legislation (e.g., the *Health Care Consent Act, 1996*, *Substitute Decisions Act, 1992*).

The Home must obtain consent to apply a physical device to restrain a resident.

The consent must be obtained from the resident or, if the resident is not capable, from the resident's substitute decision-maker.

The only exception to this requirement is if the resident is restrained under the common law duty set out in section 36 of the LTCHA.

The Home may not ask a resident or the resident's substitute decision-maker for up-front "blanket authority" to restrain a resident using a physical device (or any other type of restraining permitted by the LTCHA) should the need ever arise.

If a resident has been assessed under section 31 of the LTCHA as requiring restraining with a physical device on a continuing basis and consent from the resident or the resident's substitute decision-maker has been obtained, the Home is not required to obtain consent every time the physical device is applied.

If a resident or the resident's substitute decision-maker refuses to consent to the restraining, the Home can only restrain the resident under the common law duty set out in section 36 of the LTCHA. The Home may wish to consult its legal counsel for legal advice about an application to the Consent and Capacity Board to review whether the substitute decision-maker made the decision with respect to treatment in accordance with the *Health Care Consent Act, 1996*.

Restraining using a physical device is a "last resort" option. The intent of the requirements in the LTCHA and the Regulation is to minimize restraining with a physical device.

The Home's interdisciplinary team must consider and evaluate alternatives to the use of a physical device in collaboration with the resident and/or the resident's substitute decision-maker before considering restraining the resident.

Other requirements specified in the Regulation support the minimizing of restraining, including developing strategies to address residents' behaviours and developing a falls prevention and management program. Both of these requirements may reduce or eliminate the need for restraining with a physical device. See sections 53 (Responsive Behaviours) and 49 (Falls Prevention and Management) of the Regulation.

Section 31 of the LTCHA applies to all restraining with a physical device, including situations where a device that could be used as a PASD is being used to restrain. All requirements must be met before a resident is restrained using a physical device, subject to the common law duty of a caregiver to restrain a person when immediate action is necessary to prevent serious bodily harm to the person or to others (see sections 36 (1) and (2) of the LTCHA).

Any method of restraining with a physical device must meet the test of reasonableness.

Section 112 of the Regulation specifies the devices that may never be used to restrain a resident either under section 31 or section 36 of the LTCHA or which may never be used as a PASD to assist a resident with a routine activity of living.

## Regulation Section 110 – Requirements Relating to Restraining by a Physical Device

**All** of the following requirements must be met when restraining a resident by a physical device under section 31 or section 36 of the LTCHA:

- Staff apply the physical device in accordance with any manufacturer’s instructions.
- The physical device is well maintained.
- The physical device is not altered except for routine adjustments in accordance with any manufacturer’s instructions.

Section 110 (2) of the Regulation specifies the additional requirements that apply when a resident is being restrained by a physical device under section 31 of the LTCHA. All of the following requirements must be met:

- Staff may only apply the physical device that has been ordered or approved by a physician or RN(EC).
- Staff must apply the physical device in accordance with any instructions specified by the physician or RN(EC).
- The resident must be monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff authorized by a member of the registered nursing staff.
- The resident must be 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).
- The resident must be released and repositioned any other time when necessary based on the resident’s condition or circumstances.
- The resident’s condition must be reassessed and the effectiveness of the restraining must be evaluated by a physician, an RN(EC) 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.

### Key Considerations

No other staff may be authorized by any of the above professionals to assess a resident who is being restrained.

All of the requirements in section 31 of the LTCHA and section 110 of the Regulation apply when restraining with a physical device. This includes a situation where a device that could be used as a PASD is being used to restrain a resident.

A resident may be restrained using a physical device only so long as there is a significant risk that the resident or another person will suffer serious bodily harm if the resident is not restrained (see section 31 (3) of the LTCHA).

Reassessment every eight hours is a minimum standard. Whether or not eight hours have passed since the last reassessment, the resident must be reassessed as soon as staff determine, based on their monitoring, that the resident's behaviour no longer poses a significant risk and that a less restrictive physical device could be used or that the use of the physical device could be discontinued.

A physical device cannot be applied under section 31 of the LTCHA to restrain a resident who is in bed, except to allow for a clinical intervention that requires the resident's body or a part of the resident's body to be stationary or if the physical device is a bed rail used in accordance with section 15 of the Regulation, pursuant to section 110 (6) of the Regulation.

Physical devices applied to a person's body while in bed may have negative outcomes, including the development of contractures and pressure sores, and may result in serious injuries including death.

Before a resident is restrained while in bed in order to permit a clinical intervention, the requirements in section 31 of the LTCHA and all applicable sections of the Regulation must be met.

If a resident is restrained in any other place – for example, in a wheelchair – to provide a clinical intervention, the Home must meet the requirements in section 31 of the LTCHA and all applicable sections of the Regulation.

Section 110 (3) of the Regulation specifies the additional requirements that apply when a resident is being restrained by a physical device under the common law duty set out in section 36 of the LTCHA. **All** of the following requirements must be met:

- The resident must be monitored or supervised on an ongoing basis and must be released from the physical device and repositioned when necessary based on his or her condition or circumstances.
- The resident's condition must be reassessed by a physician, an RN(EC) attending the resident or a member of the registered nursing staff at least every 15 minutes and at any other time when necessary based on the resident's condition or circumstances.
- The Home must comply with the provisions of section 31 of the LTCHA before continuing to use a physical device to restrain a resident when immediate action is no longer necessary.

After a physical device has been used, the reason for using it must be explained to the resident or, when the resident is incapable, to the resident's substitute decision-maker.

#### Key Consideration

Restraining under the common law duty enables a Home to respond quickly to high-risk situations. A resident being restrained by a physical device under these circumstances may be highly agitated and may require ongoing and heightened monitoring and reassessment.

As set out in section 110 (5) of the Regulation, the Home is required to provide appropriate post-restraining care when the resident is released from the physical device or when the use of the physical device is discontinued, in order to ensure the safety and comfort of the resident.

#### Key Consideration

If a person has been restrained for an extended period of time, he or she may need post-restraining care once he or she is released (e.g., a person may be at risk of falling once the restraint is removed). Post-restraining measures may include providing gait and balance training or reassurance, and assisting the resident to walk. This applies to any restraining done under either section 31 or 36 of the LTCHA.

Sections 110 (7) and 110 (8) of the Regulation set out the record-keeping requirements relating to the use of restraints.

The Home must document every use of a physical device to restrain a resident under section 31 of the LTCHA. Documentation must include **all** of the following:

- The circumstances precipitating the application of the physical device.
- The alternatives considered and why those alternatives were inappropriate.
- The person who made the order, what device was ordered, and any instructions relating to the order.
- Consent.
- The person who applied the device and the time of application.
- All assessment, reassessment and monitoring, including the resident's response.
- Every release of the device and all repositioning.
- The removal or discontinuance of the device, including the time the device was removed or its use discontinued.
- The post-restraining care provided.

The Home must document every use of a physical device to restrain a resident under section 36 of the LTCHA (Common Law Duty). Documentation must include **all** of the following:

- The circumstances precipitating the application of the physical device.
- The person who made the order, what device was ordered, and any instructions relating to the order.
- The person who applied the device and the time of application.
- All assessment, reassessment and monitoring, including the resident's response.
- Every release of the device and all repositioning.
- The removal or discontinuance of the device, including the time the device was removed or its use discontinued.
- The post-restraining care provided.

### LTCHA Section 32 – Restraining Using Barriers, Locks, etc.

Not yet proclaimed into force.

As Section 32 has not yet been proclaimed into force, the Home may only confine a person under the common law duty in situations where immediate action is necessary to prevent serious bodily harm to the person or to others (see section 36 of the LTCHA).

## LTCHA Section 33 – PASDs That Limit or Inhibit Movement

Section 33 of the LTCHA sets out requirements for the use of PASDs. A PASD is a personal assistance services device that is used to assist a person with a routine activity of living. The requirements under the LTCHA and the Regulation only apply to PASDs where 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 himself or herself from the PASD. A PASD may only be used if its use is included in the resident's plan of care and **all** of the following conditions are met:

- Alternatives to the use of the 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.
- The use of the PASD is reasonable, given the resident's physical and mental condition and personal history, and is the least restrictive PASD that would be effective to assist the resident.
- A physician, RN, RPN, occupational therapist, or physiotherapist has approved the use of the PASD.
- The resident or, if the resident is incapable, the resident's substitute decision-maker has consented to the use of the PASD.
- The resident's plan of care provides for any other requirements set out in the Regulation.

If a device that limits or inhibits freedom of movement is being used to restrain a resident rather than to assist the resident with a routine activity of living, then the requirements relating to restraining by physical device set out in section 31 of the LTCHA apply.

### Key Considerations

Section 33 of the LTCHA only applies to PASDs which are being used to assist a resident with a routine activity of living, that limit or inhibit a resident's freedom of movement and from which a resident is not physically or cognitively able to release himself or herself.

Physical devices that are used as PASDs must be distinguished from physical devices that are used to restrain a resident when there is a risk that the resident or another person would suffer serious harm if the resident were not restrained.

Even if the PASD is only being used to support a routine activity of living, the fact that it is limiting or inhibiting body movement may make it potentially dangerous unless precautions are taken.

### Key Considerations (cont'd)

“Routine activities of living” include hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, and positioning.

Section 33 of the LTCHA does not apply to devices that:

- do not limit or inhibit a person’s freedom of movement; or
- are being used to restrain a resident. (This is addressed under section 31 of the LTCHA.)

“Limit or inhibit” means that the person or the person’s body movement is significantly impeded or that his or her freedom of movement has been restricted in a significant way. For example, a person may not be able to get out of a chair or may not be able to move or reposition himself or herself due to the use of the device.

## Regulation Section 111 – Requirements Relating to the Use of a PASD

A PASD used under section 33 of the LTCHA to assist a resident with a routine activity of living must be removed as soon as it is no longer required to provide this assistance unless the resident requests that it be retained.

### Key Consideration

If a PASD that limits or inhibits a resident’s freedom of movement is not removed as soon as it is no longer required to support a routine activity of living, a resident is considered to be restrained using a physical device – whether that is the Home’s intent or not. If a resident requests that the device be retained or is able to remove the device himself or herself, the resident is not being restrained.

A PASD used under section 33 of the LTCHA must be **all** of the following:

- Well maintained.
- Applied by staff according to manufacturer’s instructions.
- Not altered except for routine adjustments according to manufacturer’s instructions.

## LTCHA Section 34 – Records on Restraining of Residents

The Home must keep records regarding the restraining of residents and the use of PASDs.

### Key Linkage

These records must be kept in the manner set out in sections 110 (7) and 110 (8) of the Regulation.

## LTCHA Section 35 – Prohibited Devices that Limit Movement

The Home must ensure that no device set out in the Regulation is used on a resident to:

- Restrain the resident; or
- Assist the resident with a routine activity of living, if the device would have the effect of limiting or inhibiting the resident's freedom of movement.

## Regulation Section 112 – Prohibited Devices that Limit Movement

**All** of the following devices must not be used in the Home:

- Roller bars on wheelchairs and commodes or toilets.
- Vest or jacket restraints.
- Any device with locks that can only be released by a separate device, such as a key or magnet.
- Four-point extremity restraints.
- Any device to restrain a person to a commode or toilet.
- Any device that cannot be immediately released by staff.
- Sheets, tensors or other types of strips or bandages used other than for a therapeutic purpose.

### Key Consideration

These prohibited devices are considered potentially dangerous for the following reasons:

- Roller bars fit into the sides of a wheelchair or commode and are intended to keep a person from getting out. Serious injuries can result when residents slip out from under them.
- Vest or jacket restraints can cause injury or death if a resident's agitation increases (responsive behaviours) or the physical device becomes loose while the resident is being restrained.
- Devices with locks that can only be released by a separate device, such as a key or magnet, can cause injury or death if the resident must be released quickly or in an emergency (e.g., fire) and the key or magnet cannot be located immediately.
- Four-point extremity restraints totally restrict the movement of the resident, render a resident helpless and are inappropriate for the population served in the long-term care home sector.
- Devices used to restrain a resident to a commode or toilet can lead to serious injury if the resident's agitation increases (responsive behaviours) or the commode tips.
- Sheets, wraps, tensors or other types of strips or bandages may result in entrapment or strangulation.

## Regulation Section 113 – Evaluation

The Home must undertake a monthly analysis of the restraining of residents by use of a physical device under section 31 of the LTCHA or pursuant to the common law duty set out in section 36 of the LTCHA.

At least once every calendar year, the Home must evaluate the effectiveness of the Home's policy to minimize restraining of residents under section 29 of the LTCHA and determine the changes and improvements required to minimize restraining and ensure that any restraining that is necessary is done according to the LTCHA and the Regulation.

The Home must consider the results of the monthly analysis in the annual evaluation and any changes or improvements arising from the annual evaluation must be implemented promptly. The Home must prepare a written record of the monthly analysis, the evaluation and any changes or improvements as well as the date of the evaluation, the names of the persons who participated in the evaluation, and the date that the changes were implemented.

Section 137 of the Regulation sets out the requirements that the Home must meet if a resident is restrained by the administration of a drug under the common law duty. See the “Drugs” section of this Guide.

The Home must also review all instances of restraining of residents by the administration of a drug under the common law duty as part of the quarterly evaluation of the Home's medication management system (see section 115 of the Regulation). The annual evaluation of the medication management system must include a review of the quarterly evaluations in the previous year (see section 116 of the Regulation).

## Key Consideration

### **Clarification of Physical Devices**

The following provides clarification about whether the specified practices constitute restraining with a physical device.

#### **1. Braces**

Braces may be required as a result of any number of medical conditions to support weak limbs. They are used to support a limb and to promote resident independence, including mobility. This use is not considered restraining with a physical device. This use must be documented in the plan of care.

#### **2. Splints**

Splints are used to immobilize a limb – usually as a result of a fracture. Splints are used for therapeutic purposes. This use is not considered restraining with a physical device. This use must be documented in the plan of care.

#### **3. Tilted wheelchair**

If a wheelchair is tilted to prevent a person from leaving the wheelchair, it is considered restraining with a physical device. Before a tilted wheelchair may be used to restrain a person, the Home must meet the requirements of section 31 of the LTCHA and section 110 of the Regulation. If the wheelchair is tilted for therapeutic or comfort purposes – for example, to relieve pressure, promote sleep or lessen edema – the tilting of the wheelchair is not considered a physical device used to restrain. However, therapeutic or other circumstances prompting the need for the practice must be documented in the plan of care. Once the goal is achieved, the wheelchair should no longer be tilted or it would be considered to be a restraining.

#### **4. Gloves or mitts**

A glove or mitt placed on a resident's hand to prevent a resident from doing something – for example, scratching a sore or wound – is not considered restraining with a physical device as the glove or mitt does not limit or inhibit the resident. His or her body movement is not impeded nor is his or her freedom of movement restricted in a significant way.

## Key Consideration (cont'd)

**5. Pelvic restraints**

The Regulation does not prohibit the use of pelvic restraints as a physical device to restrain. In some cases, a Home may use these devices not to restrain but to prevent a resident who uses a wheelchair from sliding, leaning forward or leaning laterally, and to aid in the proper positioning of the hips. Pelvic restraints thus enable a resident who cannot support himself or herself to sit upright in a wheelchair. If pelvic restraints are used for this purpose, they are a PASD that assists the resident with routine activities of living. When the Home uses pelvic restraints for this purpose, it must meet the requirements of section 33 of the LTCHA and section 111 of the Regulation. When the Home uses these devices to restrain a resident, the Home must meet the requirements of section 31 of the LTCHA and section 110 of the Regulation.

*Regardless of the purpose for which pelvic restraints are used, they are restrictive devices which should be used with caution and the resident should be monitored appropriately.*

**6. Half lap trays**

Half lap trays are less restrictive than full lap trays and allow a resident greater freedom of movement. However, there are many different types of half lap trays that provide varying degrees of freedom and ease of movement. Some types of half lap trays may be as restrictive as full lap trays, depending on the resident's condition. When the Home uses a half lap tray as a PASD to assist with a routine activity of living, it must comply with the requirements of section 33 of the LTCHA and section 111 of the Regulation.

It is possible that a half lap tray could be used as a physical device to restrain a resident, depending on the type of half lap tray used and the resident's condition. If the Home uses a half lap tray as a physical device to restrain a resident, it must comply with the requirements of section 31 of the LTCHA and section 110 of the Regulation.

**7. Arm rest supports**

Arm rest supports are not considered a physical device to restrain as these supports do not limit or inhibit the resident. The resident's body movement is not impeded nor is his or her freedom of movement restricted significantly. Their use must be documented in the plan of care.

**Key Consideration (cont'd)****8. Seat belts**

If a seat belt attached to a wheelchair is being used as a physical device to restrain, the Home must meet the requirements of section 31 of the LTCHA and section 110 of the Regulation.

If a seat belt is being used as a device to support an activity of living – such as going outside on a recreational outing (where some bumps may be encountered) or to support positioning of a resident in a wheelchair, the Home must meet the requirements of section 33 of the LTCHA and section 111 of the Regulation.

If the seat belt is used by a resident who is both physically and cognitively able to release the seat belt on his or her own, the seat belt is not a restraint or a PASD.

**9. Bed rails**

Bed rails are a device that may limit or inhibit movement because they surround the bed. Bed rails pose significant risk of entrapment. (See the requirements relating to bed rails in section 15 of the Regulation.)

The Regulation does not differentiate between full or partial bed rails. While partial bed rails are less limiting than full bed rails, partial bed rails could still be used as a physical device to restrain depending on the resident's physical condition. Partial bed rails may represent a danger to some residents due to entrapment.

If full or partial bed rails are used as a physical device to restrain, the Home must meet the requirements of section 31 of the LTCHA and section 110 of the Regulation.

If full or partial bed rails are used to support a routine activity of living such as assisting a resident to position himself or herself, to sleep (to keep from falling out of bed) or get up, then the full or partial bed rails are considered PASDs and the Home must meet the requirements in section 33 of the LTCHA and section 111 of the Regulation.

In either case, the requirements in section 15 of the Regulation apply.

## Part II Drugs

### A. Overview

Sections 114 to 137 of the Regulation set out requirements relating to the Home’s medication management system. The purpose of the system is to ensure the accurate acquisition, receipt, dispensing, storage, administration, and destruction and disposal of all drugs used in the Home to meet the medication requirements of residents in a safe and timely manner and to ensure the best health outcomes for residents.

The Regulation includes requirements to address medication incidents, adverse drug reactions, and the use of any drug or drug combinations, including psychotropic drugs, which could potentially put residents at risk.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Key Consideration

For the purposes of the LTCHA and the Regulation, section 4 of the Regulation defines “drug” broadly to include prescription drugs and non-prescription drugs (e.g., those that are available over the counter, such as acetaminophen).

The definition of “drug” under the Regulation includes natural health products.

Substances that are manufactured, offered for sale or sold as part of a food, drink or cosmetic are not drugs.

#### Section 114 – Medication Management System

The Home must develop an interdisciplinary medication management system that provides safe medication management and optimizes effective drug therapy outcomes for residents. Written policies and protocols must be developed to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the Home.

These policies and protocols must reflect evidence-based practices and, if there are none, prevailing practices. They must be approved by the DONPC, the pharmacy service provider and, where appropriate, the Medical Director.

## Section 115 – Quarterly Evaluation

An interdisciplinary team must meet at least quarterly to evaluate the effectiveness of the Home's medication management system, and to recommend any changes to improve the system. The interdisciplinary team must include the Medical Director, the Administrator, the DONPC and the pharmacy service provider.

The quarterly evaluation must include **all** of the following:

- A review of drug utilization trends and patterns, including the use of any drug or combination of drugs, including psychotropic drugs, which could potentially place residents at risk.
- A review of the reports of medication incidents and adverse drug reactions required under sections 135 (2) and (3) of the Regulation.
- A review of all instances when a resident was restrained by use of a drug under the common law duty set out in section 36 of the LTCHA.
- Identifying changes to improve the system in accordance with evidence-based practices and, if there are none, prevailing practices.

The changes identified in the quarterly evaluation must be implemented and a written record must be kept of the evaluation and the changes made.

## Section 116 – Annual Evaluation

An interdisciplinary team must meet annually to evaluate the effectiveness of the medication management system in the Home and to recommend any changes necessary to improve the system. The interdisciplinary team must include the Medical Director, the Administrator, the DONPC, the pharmacy service provider and a registered dietitian who is on staff.

The annual evaluation must include a review of the results of the quarterly evaluations in the previous year and must be undertaken using an assessment instrument designed specifically for this purpose. The annual evaluation must identify changes to improve the system in accordance with evidence-based practices and, if there are none, prevailing practices. The changes identified in the annual evaluation must be implemented and a written record must be kept of the evaluation and the changes made.

### Key Consideration

The Home may consider using the Medication Safety Self Assessment (Institute for Safe Medication Practices, Canada) as part of the annual evaluation of its medication management system. See <http://www.ismp-canada.org/lmssa/>.

## Section 117 – Medical Directives and Orders – Drugs

All medical directives or orders for the administration of a drug to a resident must be reviewed whenever the resident's condition is assessed or reassessed in developing the resident's plan of care. No medical directive or order for the administration of a drug to a resident shall be used unless it is individualized to the resident's condition and needs.

## Section 118 – Information in Every Resident Home Area or Unit

Recent and relevant drug reference materials, the pharmacy service provider's contact information, and contact information for at least one poison control centre or similar body must be available in every resident home area or unit in the Home.

## Section 119 – Retaining of Pharmacy Service Provider

A pharmacy service provider must be retained for the Home. The pharmacy service provider must hold a certificate of accreditation for the operation of a pharmacy under section 139 of the *Drug and Pharmacies Regulation Act*.

There must be a written contract between the Home and the pharmacy service provider. This contract must set out the responsibilities of the pharmacy service provider, including the pharmacy service provider's obligation to:

- Provide drugs to the Home on a 24-hour basis, seven days a week, or arrange for their provision by another holder of a certificate of accreditation for the operation of a pharmacy under section 139 of the *Drug and Pharmacies Regulation Act*.
- Perform all the other responsibilities of the pharmacy service provider under the Regulation.

## Section 120 – Responsibilities of Pharmacy Service Provider

The pharmacy service provider must participate in **all** of the following activities:

- For each resident of the Home, the development of medication assessments, medication administration records and records for medication reassessment, and the maintenance of medication profiles.
- Evaluation of therapeutic outcomes of drugs for residents.
- Risk management and quality improvement activities, including review of medication incidents, adverse drug reactions and drug utilization.
- Developing audit protocols for the pharmacy service provider to evaluate the medication management system.
- Educational support to the staff of the Home in relation to drugs.
- Drug destruction and disposal under section 136 (3) (a) of the Regulation if required by the Home's policy.

## Section 121 – System for Notifying Pharmacy Service Provider

There must be a system to notify the pharmacy service provider within 24 hours of a resident's admission, discharge, medical or psychiatric absence and death.

## Section 122 – Purchasing and Handling of Drugs

No drug can be acquired, received or stored in the Home or kept by a resident in accordance with section 131 (7) of the Regulation unless the drug has been:

- Prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in Section 123 of the Regulation.
- Provided by or through an arrangement made by the pharmacy service provider or the Government of Ontario.

This does not apply in exceptional circumstances such as when a drug prescribed for a resident cannot be provided by or through an arrangement made by the pharmacy service provider.

### Key Consideration

Exceptional circumstances could include, for example, a specific drug that is usually only available from a hospital or when a drug cannot be obtained in the dosage required for a resident due to severe inclement weather.

## Section 123 – Emergency Drug Supply

A Home that maintains an emergency drug supply must ensure that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the DONPC and the Administrator are kept. There must be a written policy that covers the location, reordering, access, use, tracking and documentation of the drugs in the supply.

At least annually, the Medical Director, in collaboration with the pharmacy service provider, the DONPC and the Administrator must conduct an evaluation of the use of drugs kept in any emergency drug supply to determine the need for the drugs. Any recommended changes resulting from the evaluation must be implemented.

## Section 124 – Drug Supply

Drugs obtained for use in the Home must be acquired based on resident usage and no more than a three-month supply shall be kept in the Home at any time. This requirement does not apply to the Home's emergency drug supply.

## Section 125 – Monitored Dosage System

A monitored dosage system that promotes ease and accuracy in administering drugs to residents and that supports monitoring and drug verification activities must be used.

## Section 126 – Packaging of Drugs

Drugs must be kept in their original labelled container or package provided by the pharmacy service provider or the Government of Ontario until they are either administered to a resident or destroyed.

## Section 127 – Changes in Directions for Administration

There must be a policy that deals with changes in the administration of a drug to a resident due to modifications of directions for use that are made by a prescriber, including temporarily discontinuing the drug. The policy must be developed and approved by the DONPC, the pharmacy service provider and, where appropriate, the Medical Director.

Definition

“Prescriber” means a person who is authorized under a health profession Act as defined in the *Regulated Health Professions Act, 1991* to prescribe a drug within the meaning of that Act.

## Section 128 – Sending of Drugs with a Resident

There must be a policy that governs the sending of a drug with a resident who is leaving the Home on a temporary basis (e.g., on an absence) or who is being discharged from the Home. This policy must be developed and approved by the DONPC, the pharmacy service provider and, where appropriate, the Medical Director.

## Section 129 – Safe Storage of Drugs

Drugs must be stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, that is secure and locked, that protects the drugs from heat, light, humidity and other environmental conditions, and that complies with the manufacturer’s instructions for the storage of the drugs. These requirements do not apply to drugs that a resident is permitted to keep on his or her person or in his or her room in accordance with section 131 (7) of the Regulation.

Controlled substances must be stored in a separate, double-locked stationary cupboard in the locked area or in a separate locked area within a locked medication cart.

Definition

“Controlled substance” means a controlled substance within the meaning of the *Controlled Drugs and Substances Act* (Canada).

## Section 130 – Security of Drug Supply

Steps must be taken to keep the drug supply secure. All areas where drugs are stored must be kept locked at all times when not in use. Access to these areas must be restricted to persons who may dispense, prescribe or administer drugs in the Home (as set out in the Regulation) and to the Administrator.

The daily count sheets of controlled substances must be audited monthly to identify any discrepancies. Immediate action must be taken if any discrepancies are discovered.

## Section 131 – Administration of Drugs

No drug shall be used by or administered to a resident in the Home unless the drug has been prescribed for the resident. Drugs must be administered in accordance with the directions for use specified by the prescriber.

No person shall administer a drug to a resident in the Home unless that person is a physician, dentist, RN or an RPN.

Despite these requirements, a member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical if **all** of the following are met:

- The staff member has been trained by a member of the registered nursing staff in the administration of topicals;
- The member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and
- The staff member who administers the topical does so under the supervision of the member of the registered nursing staff.

Definition

“Topical” means a drug in the form of a liquid, cream, gel, lotion, ointment, spray or powder that is applied to an area of the skin and is intended to affect only the local area where it is applied.

Despite the above requirements, a resident may administer a drug to himself or herself if the administration has been approved by the prescriber in consultation with the resident.

Where a resident of the Home is permitted to administer a drug to himself or herself, there must be written policies to ensure that the resident who does so understands:

- The use of the drug;
- The need for the drug;
- The need for monitoring and documentation of the use of the drug; and

- The necessity for safekeeping of the drug by the resident where the resident is permitted to keep the drug on his or her person or in his or her room.

No resident who is permitted to administer a drug to himself or herself may keep the drug on his or her person or in his or her room except:

- As authorized by a physician, RN(EC) or other prescriber who attends the resident; and
- In accordance with any conditions that are imposed by the physician, the RN(EC) or other prescriber.

### Section 132 – Natural Health Products

The Home must ensure that when a resident wishes to use a drug that is a natural health product and that has not been prescribed, there are written policies and procedures to govern the use, administration and storage of the natural health product.

Definition

For the purpose of section 132 of the Regulation, “natural health product” means a natural health product as that term is defined from time to time by the *Natural Health Products Regulations* under the *Food and Drugs Act* (Canada) other than a product that is a substance that has been identified in the regulations made under the *Drug and Pharmacies Regulation Act* as being a drug for the purposes of that Act despite clause (f) of the definition of “drug” in section 1 (1) of that Act.

Nothing in the Regulation prevents a resident from using, in accordance with the Home’s policies and procedures, a natural health product that has not been prescribed.

If a prescriber has prescribed a natural health product for a resident, that product is considered a drug for the purposes of the Regulation. The Home must follow the requirements set out in sections 114 to 131 and sections 133 to 137 of the Regulation with respect to that drug.

If a resident is using a natural health product that has not been prescribed, sections 114 to 131 and sections 133 to 137 of the Regulation do not apply to that product. The Home’s written policies and procedures governing the use, administration and storage of natural health products would apply to that product.

### Key Considerations

The Regulation does not prevent a resident from using natural health products. The Home's policies and procedures will outline the use, administration and storage of these products in the Home. The level of staff involvement in administering natural health products that have not been prescribed for a resident is at the discretion of the Home, as set out in its policies and procedures.

The Home's policies and procedures should reflect the level of interest in the use of natural health products within the Home without being overly restrictive or preventing a resident from using the products given the fundamental principle set out in section 1 of the LTCHA and the Residents' Bill of Rights set out in section 3 of the LTCHA. For example, the Home's policy may permit a resident to store, use and self-administer any natural health product, or the Home may require that natural health products be administered by staff or by a family member or substitute decision-maker.

A natural health product that has been prescribed for a resident by a prescriber must be obtained through the Home's pharmacy service provider since the product is considered a "drug" under the Regulation. Where a natural health product has not been prescribed for a resident, there is no requirement that the resident purchase the product through the Home's pharmacy service provider.

The following database on Health Canada's website lists the licensed natural health products that are covered under the *Food and Drugs Act*.

<http://www/hc-sc.gc.ca/dhp-mps/prodnatur/applications/licen-prodlnhpd-bdpsnh-eng.php?>

## Section 133 – Drug Record (Ordering and Receiving)

A drug record must be established, maintained and kept in the Home for at least two years, in respect of every drug that is ordered and received in the Home. **All** of the following information must be recorded in the drug record:

- The date the drug is ordered.
- The signature of the person placing the order.
- The name, strength and quantity of the drug.
- The name of the place from which the drug is ordered.
- The name of the resident for whom the drug is prescribed, where applicable.
- The prescription number, where applicable.
- The date the drug is received in the Home.
- The signature of the person acknowledging receipt of the drug on behalf of the Home.
- Where applicable, the information required under section 136 (4) relating to the destruction and disposal of a controlled substance.

## Section 134 – Residents’ Drug Regimes

When a resident is taking any drug or combination of drugs, including psychotropic drugs, the Home must monitor and document the resident’s response to the drug and the drug’s effectiveness appropriate to (or in keeping with) the risk level of the drug.

Appropriate action must be taken to respond to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs.

At least quarterly, the Home must reassess each resident’s drug regime and document the assessment.

### Key Consideration

The level of monitoring and documentation relates to the risk level of the drug. Once the appropriate therapeutic dosage is determined, heightened monitoring may not be required depending on the resident’s condition and response to the drug.

### Definitions

“Medication incident” means a preventable event associated with the prescribing, ordering, dispensing, storing, labelling, administering or distributing of a drug, or the transcribing of a prescription. It includes:

- An act of omission or commission, whether or not it results in harm, injury or death to a resident; or
- A near-miss event where an incident does not affect a resident but had it done so, harm, injury or death could have resulted.

“Adverse drug reaction” means a harmful and unintended response by a resident to a drug or combination of drugs, which occurs at doses normally used or tested for the diagnosis, treatment or prevention of a disease or the modification of an organic function.

## Section 135 – Medication Incidents and Adverse Drug Reactions

Every medication incident involving a resident and every adverse drug reaction must be documented, together with a record of the immediate actions taken to assess and maintain the resident's health.

A medication incident involving a resident or adverse drug reaction must be reported to the resident, the resident's substitute decision-maker, the DONPC, the Medical Director, the prescriber of the drug, the resident's attending physician or RN(EC), and the pharmacy service provider.

All medication incidents (whether involving a resident or not) and adverse drug reactions must be documented, reviewed and analyzed. Corrective action must be taken as necessary to respond to these incidents and a written record must be kept of the review, analysis and corrective action.

The Home is required to review all medication incidents and adverse drug reactions quarterly in order to reduce and prevent such incidents and adverse drug reactions. Any changes and improvements identified in the review must be implemented and a written record must be kept of the quarterly review, changes and improvements.

### Key Linkages

The Home must ensure that reports of any medication incidents and adverse drug reactions are considered as part of the quarterly evaluation described in section 115 of the Regulation.

The annual evaluation of the medication management system described in section 116 of the Regulation must include a review of the quarterly evaluations during the previous year.

## Section 136 – Drug Destruction and Disposal

A drug is considered to be destroyed when it is altered or denatured to such an extent that its consumption is rendered impossible or improbable.

The Home must have a written drug destruction and disposal policy that provides for the ongoing identification, destruction and disposal of:

- All expired drugs, drugs with illegible labels and drugs in containers that do not meet the requirements for marking containers specified in the *Drug and Pharmacies Regulation Act*.

- A resident's drugs where:
  - the prescriber attending the resident orders that the use of the drug be discontinued;
  - the resident dies, subject to obtaining the written approval of the person who has signed the medical certificate of death under the *Vital Statistics Act* or the resident's attending physician; or
  - the resident is discharged and the drugs prescribed for the resident are not sent with the resident under Section 128 of the Regulation.

For drugs that are to be destroyed and disposed of, the Home's policy must also provide for **all** of the following:

- Until the destruction and disposal occurs, the drugs must be safely and securely stored within the Home, separate from drugs that are available for administration to a resident.
- Controlled substances must be stored in a double-locked storage area, separate from any controlled substances available for administration to a resident.
- Drugs must be destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
- Drugs other than controlled substances must be destroyed by a team acting together made up of one member of the registered nursing staff appointed by the DONPC and one other staff member appointed by the DONPC.
- Controlled substances must be destroyed by a team acting together made up of one member of the registered nursing staff appointed by the DONPC and a physician or pharmacist. This requirement is subject to any requirements that apply under the *Controlled Drugs and Substances Act (Canada)* or the *Food and Drugs Act (Canada)*.
- The team that destroys controlled substances must document the following information in the drug record:
  - the date of removal of the drug from the drug storage area.
  - the name of the resident for whom the drug was prescribed, where applicable.
  - the prescription number of the drug, where applicable.
  - the drug's name, strength and quantity.
  - the reason for destruction.
  - the date when the drug was destroyed.
  - the names of the members of the team who destroyed the drug.
  - the manner of destruction of the drug.

The Home's drug destruction and disposal system must be audited at least annually to verify that the Home's procedures are being followed and are effective. Any changes identified in the audit must be implemented and a written record must be kept regarding the annual audit and the implementation of changes arising from the audit.

## Section 137 – Restraining by Administration of Drug, etc., Under Common Law Duty

An RN may order the administration of a drug for the purposes of restraining a resident under the common law duty of a caregiver to restrain a person when immediate action is necessary to prevent serious bodily harm to the person or to others, as set out in section 36 of the LTCHA.

### Key Linkages

Restraining a resident by the administration of a drug is prohibited under the LTCHA with one exception: a resident may be restrained by the administration of a drug under the common law duty. In this situation, the administration of the drug must be ordered by a physician (section 36 (3) of the LTCHA) or by an RN (section 137 (1) of the Regulation).

This means that the RN may order the administration of a drug that has been prescribed for the resident.

The Home must document each time a drug is administered to restrain a resident under the common law duty. The documentation must include **all** of the following:

- The circumstances precipitating the administration of the drug.
- Who made the order, what drug was administered, the dosage given, how the drug was administered, the time or times when the drug was administered and who administered the drug.
- The resident's response to the drug.
- All assessments, reassessments and monitoring of the resident.
- Discussions with the resident or, where the resident is incapable, the resident's substitute decision-maker (following administration of the drug) to explain the reasons for using the drug.

Section 36 of the LTCHA enables a Home to restrain a resident by the administration of a drug in an emergency situation when immediate action is necessary to prevent serious bodily harm to the resident or to others. Section 36 is not to be invoked for any other reason.

Under section 30 (4) of the LTCHA, the administration of a drug to a resident as a treatment set out in a resident's plan of care is not considered restraining a resident. Under the *Health Care Consent Act, 1996*, treatment requires informed consent from the resident or where the resident is incapable, from the resident's substitute decision-maker.

All instances of restraining residents by the administration of a drug under the common law duty must be reviewed as part of the quarterly evaluation of the medication management system required under section 115 of the Regulation.

The annual evaluation of the medication management system must include a review of the quarterly evaluations in the previous year, as set out in section 116 of the Regulation.

## Part II Absences

### A. Overview

Sections 138 to 143 of the Regulation identify the types of absences permitted for residents and the lengths of these absences. These sections also set out the requirements that a Home must meet before a resident leaves for an absence, during a resident's absence and after a resident returns.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 138 – Absences

This section sets out the reasons and lengths of time that long-stay and short-stay residents may be absent from the Home, as well as the requirements that a Home must meet before a resident leaves and after he or she returns from an absence. The types and lengths of absences are as follows:

#### Absences for Long-Stay Residents & Interim Bed Short-Stay Residents

Type of Absence	Maximum Length of Absence
Medical absences	30 days
Psychiatric absences	60 days
Vacation absences	21 days in a calendar year ( <i>i.e., from January 1 to December 31</i> )
Casual absences	48 hours in a week ( <i>i.e., between midnight on a Saturday and midnight on the following Saturday</i> )

#### Absences for Convalescent Care and Respite Care Short-Stay Residents

Type of Absence	Maximum Length of Absence
Medical absences	14 days
Psychiatric absences	14 days
Casual absences	48 hours in a week ( <i>i.e., between midnight on a Saturday and midnight on the following Saturday</i> )

Casual, medical, psychiatric and vacation absences are defined in section 1 of the Regulation.

### Key Considerations

Medical and psychiatric absences are for the purpose of assessment or care. There is no requirement that the resident be admitted to a hospital or other setting when receiving this care.

The Home may not extend the length of a resident's medical or psychiatric absence except in the circumstances described in sections 146 (5) and 146 (6) of the Regulation relating to discharge. Long-stay residents who are discharged from the Home because they exceed the permitted length of medical or psychiatric absence will have a high priority on the waiting list (in the "readmission" category) if they apply to be readmitted to the Home.

The use of medical or psychiatric absence days does not reduce a resident's available vacation or casual absence days.

When residents want to leave for a "long weekend," they can take two casual absences back-to-back (i.e., Friday/Saturday from one week and Sunday/Monday from the next week). Long-stay residents can also augment a casual absence with some of their vacation absence if they have not used all of their vacation absence.

Residents in convalescent care or respite care short-stay programs are not eligible for vacation absences.

### Key Linkage

For more information about the interim bed short-stay program, see section 143 and sections 189 to 197 of the Regulation.

A long-stay resident returning from an absence must receive the same class of accommodation, the same room and the same bed in the room that he or she had before the absence unless he or she requires a different bed or room as a result of a change in his or her needs.

A resident in the convalescent care or respite care short-stay program need only be provided with the same class of accommodation that he or she had before the absence if he or she returns to the Home before the end of the period for which he or she was admitted to the Home.

Before a resident leaves for a medical or psychiatric absence, a physician or RN(EC) attending the resident must authorize the absence in writing (except in an emergency situation). The Home must give notice of the absence to the resident's substitute decision-maker and any other person designated by either of them at least 24 hours before the

resident leaves the home or, if not possible to do so, as soon as possible. The Home must share information about the resident's drug regimen, known allergies, diagnoses and care requirements with the health care providers involved in the resident's care during the absence.

### Section 139 – Absent Residents

When a resident is absent from the Home, the Home is not responsible for providing the care and treatment required under other sections of the Regulation.

### Section 140 – Recording of Absences

The Home must record every absence of a resident.

#### Key Consideration

An appropriate place to record absences may be the resident's record.

### Section 141 – Licensee to Stay in Contact

The Home must stay in contact with a resident or with his or her health care providers during a medical or psychiatric absence in order to determine when the resident will return. The Home must stay in contact with a resident during a vacation absence to determine when the resident will return.

### Section 142 – Care During Absence

Before a long-stay resident or interim bed short-stay resident leaves for a casual or vacation absence and before a convalescent care or respite care short-stay resident leaves for a casual absence, a physician or RN(EC) attending the resident or an RN who is a member of the staff must provide written instructions about the care the resident will need during his or her absence from the Home.

A member of the Home's staff must communicate to the resident or his or her substitute decision-maker **all** of the following:

- The need to take all reasonable steps to ensure that the resident receives the care that he or she requires;
- The Home will not be responsible for the care and safety of the resident during his or her absence;
- The resident or his or her substitute decision-maker assumes full responsibility for the resident's care, safety and well-being during the absence; and
- The need to notify the Administrator if the resident is admitted to a hospital or the date of the return changes.

## **Section 143 – Where Interim Bed Resident Considered to be Long-Stay Resident**

A resident of the interim bed short-stay program is considered to be a long-stay resident for the purposes of sections 138 (Absences), 141 (2) (Licensee to Stay in Contact), and 142 (Care During Absence) of the Regulation.

## Part II Discharge

### A. Overview

Sections 144 to 151 of the Regulation set out the requirements for and restrictions on discharging residents from a Home.

### B. LTCHA Requirements

None.

### C. Regulatory Requirements

#### Section 144 – Restriction on Discharge

A Home must not discharge a resident except in those situations permitted or required by the Regulation.

#### Section 145 – When Licensee May Discharge

A Home may (but is not required to) discharge a resident when:

- The resident is at the Home and the Home is informed by the DONPC, the resident's physician or RN(EC) attending the resident, after consultation with the interdisciplinary team providing the resident's care, that the resident's requirements for care have changed and the Home cannot provide a sufficiently secure environment to ensure the safety of the resident or persons who come into contact with the resident;
- The resident is absent from the Home and the Home is informed by the resident's physician or RN(EC) attending the resident that the resident's requirements for care have changed and the Home cannot provide a sufficiently secure environment to ensure the safety of the resident or persons who come into contact with the resident;
- The resident decides to leave the Home and signs a request to be discharged;
- The resident leaves the Home and informs the Administrator that he or she will not be returning to the Home;
- The resident is absent from the Home for more than seven days and the resident has not informed the Administrator of his or her whereabouts, and the Administrator has been unable to locate the resident;
- For long-stay and interim bed short-stay residents, the resident's casual absence during the period between midnight on a Saturday and midnight on the following Saturday exceeds 48 hours and the resident does not have any remaining vacation absence days available in the calendar year; or

- For convalescent care and respite care short-stay residents, the resident's casual absence during the period between midnight on a Saturday and midnight on the following Saturday exceeds 48 hours.

## Section 146 – When Licensee Shall Discharge

The Home must discharge a short-stay resident at the end of the period for which the resident was admitted to the Home, unless the resident is in the interim bed short-stay program and the CCAC placement co-ordinator is authorizing an extension of the admission. The Home must not discharge a resident in the interim bed short-stay program without first confirming whether the CCAC placement co-ordinator intends to authorize an extension.

### Key Linkage

See section 196 of the Regulation regarding the CCAC placement co-ordinator's role in extending an interim bed resident's stay and the conditions for an extension.

The Home must discharge a short-stay resident in the convalescent care or respite care program if the resident is on a medical or psychiatric absence that exceeds 14 days, if the resident is on a vacation absence or if the Home is being closed. However, the Home must not discharge the resident if the resident is on a medical or psychiatric absence and is unable to return to the Home or the Home has been notified by the resident, the resident's substitute decision-maker or other person that the resident cannot return due to an emergency in the Home or an outbreak of disease, or due to an emergency or natural disaster in the community that prevents the immediate return.

The Home must discharge a long-stay resident or a resident in the interim bed short-stay program if the resident is on a medical absence that exceeds 30 days, is on a psychiatric absence that exceeds 60 days, or the Home is being closed. However, the Home must not discharge the resident if the resident is on a medical or psychiatric absence and is unable to return to the Home due to an emergency in the Home or an outbreak of disease, or the Home has been notified by the resident, the resident's substitute decision-maker or other person that the resident cannot return due to an emergency or natural disaster in the community that prevents the immediate return.

The Home must discharge a long-stay resident or a resident in the interim bed short-stay program if the total length of the resident's vacation absences during the calendar year exceeds 21 days. However, the Home must not discharge the resident if the resident is unable to return to the Home due to an emergency in the Home or an outbreak of disease, or the Home has been notified by the resident, the resident's substitute decision-maker or other person that the resident cannot return due to an emergency or natural disaster in the community or a short-term illness or injury that prevents the immediate return.

### Key Consideration

See section 138 of the Regulation for more information about the permitted lengths of absences.

Examples of an emergency in the Home could include fire or flood. An emergency in the community could include tornado, flood, ice storm, or train derailment involving hazardous waste.

The Home must discharge a resident from a specialized unit if an interdisciplinary reassessment under section 204 of the Regulation indicates that the resident no longer requires and benefits from the accommodation, care, services, programs and goods provided in the specialized unit and alternative arrangements have been made for the resident.

### Key Linkages

See section 204 of the Regulation for the reassessment requirement related to residents in specialized units.

A specialized unit must be designated by the Director. See sections 198 to 206 of the Regulation.

The Home must discharge a resident when the Home is aware that the resident has died and the resident is deemed to have been discharged on the date of death.

## Section 147 – Discharge when Beds Closed

The Home may discharge a resident whose bed is closed if it is not possible to transfer the resident to another bed in the Home. However, in these circumstances, the Home must not discharge the resident if:

- The notice of the bed closure required under section 306 of the Regulation was not given;
- The resident received less than 16 weeks notice of the bed closure because the Director agreed to a shorter notice period or to dispensing with the notice under section 306 of the Regulation; or
- Section 307 of the Regulation applied when the resident was transferred to the bed, but the Home did not comply with that section.

See sections 306 and 307 of the Regulation for the notice requirements that apply when a bed is closed.

See sections 308 to 313 of the Regulation for the notice and other requirements that apply when the Home is closing.

## Section 148 – Requirements on Licensee Before Discharging a Resident

Except when the resident dies, notice of discharge must be given to the resident, the resident's substitute decision-maker and any person directed by either of them as far in advance of discharge as possible. If circumstances do not permit advance notice, the notice must be given as soon as possible after discharge.

Before discharging a resident because the Home can no longer provide a sufficiently secure environment to ensure the safety of the resident and others, the Home must do **all** of the following:

- Ensure that alternatives to discharge have been considered and, where appropriate, tried;
- In collaboration with the appropriate CCAC placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
- Ensure the resident and the resident's substitute decision-maker and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and
- Provide a written notice to the resident, the resident's substitute decision-maker and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the Home and to the resident's condition and requirements for care, that justify the Home's decision to discharge the resident.

Where a resident is being discharged because the resident requests to be discharged, tells the Administrator that he or she will not be returning to the Home, or a long-stay resident exceeds the total length of casual absences and does not have any remaining vacation absence days, the Home must offer to help the resident in planning for discharge by identifying alternative accommodation, health service organizations and other resources in the community, and contacting or referring the resident to these appropriate organizations and resources.

## Section 149 – Responsibility of Placement Co-ordinator

If desired by the resident, the CCAC placement co-ordinator must assist in arranging alternative accommodation, care or services for a resident who is being discharged because the Home can no longer provide a sufficiently secure environment to ensure the safety of the resident and others, or is being discharged from a specialized unit because the resident no longer requires or benefits from being in the specialized unit.

## Section 150 – Licensee to Assist with Alternatives to Long-Term Care Home

When, as set out in a resident's plan of care, a resident's condition has improved to the extent that he or she no longer requires the care and services provided by the Home, the Home must offer to contact the appropriate CCAC placement co-ordinator for the purpose of providing information to the resident about alternatives to living in a Home.

### Key Consideration

A resident is not obligated to accept the Home's offer to contact the CCAC placement co-ordinator and should not be pressured to do so. A resident whose condition has improved cannot be forced to leave the Home and must not be given the impression that this is required. Some residents who no longer require care may feel intimidated by the prospect of being discharged, such as a resident who has sold his or her home in the community and no longer has a place to which he or she can return. Other residents may welcome the opportunity to be discharged and may require assistance from the CCAC placement co-ordinator and others to do so.

## Section 151 – Transitional, Absences and Discharges Due to Absences

This section sets out the transitional rules that apply where residents have taken absences prior to July 1, 2010.

# Part IV Councils – Residents’ Council

## A. Overview

Sections 56 to 58 and 61 to 68 of the LTCHA set out the requirements relating to Residents’ Councils.

## B. LTCHA Requirements

### Section 56 – Residents’ Council

The Home must establish a Residents’ Council. Only residents of the Home may be members of the Residents’ Council.

### Section 57 – Powers of Residents’ Council

The Residents’ Council has the power to do **all** of the following:

- Advise residents about their rights and obligations under the LTCHA.
- Advise residents about the rights and obligations of the Home under the LTCHA and under any agreement relating to the Home.
- Attempt to resolve disputes between the Home and residents.
- Sponsor and plan activities for residents.
- Collaborate with community groups and volunteers concerning activities for residents.
- Advise the Home of any concerns or recommendations the Council has about the operation of the Home.
- Provide advice and recommendations to the Home regarding what residents would like to see done to improve care or the quality of life in the Home.
- Report to the Director any concerns and recommendations that in the Council’s opinion ought to be brought to the Director’s attention.
- Review,
  - inspection reports and summaries received under section 149 of the LTCHA,
  - the detailed allocation, by the Home, of funding under the LTCHA and the *Local Health System Integration Act, 2006* and amounts paid by residents,
  - the financial statements related to the Home filed with the Director under the Regulation or provided to a LHIN, and
  - the operation of the Home.

If the Residents’ Council has advised the Home of any concerns or recommendations about the operation of the Home or of any concerns or recommendations brought to the Director’s attention, the Home must respond in writing to the Residents’ Council within 10 days of receiving the advice.

Definition

“Detailed allocation” means the reconciliation report for a calendar year submitted to the Minister under section 243 (1) (a) of the Regulation and to the LHIN for the geographic region in which the Home is located required by regulations made under the *Local Health System Integration Act, 2006*, and the auditor’s report on that reconciliation report (section 211 of the Regulation).

### Section 58 – Residents’ Council Assistant

The Home must appoint a Residents’ Council assistant. The Residents’ Council assistant must be acceptable to the Council. The Residents’ Council assistant must take instructions from the Residents’ Council, ensure confidentiality where requested and report to the Residents’ Council.

## C. Regulatory Requirements

None.

## Part IV Councils – Family Council

### A. Overview

Sections 59 to 68 of the LTCHA set out the requirements relating to Family Councils.

### B. LTCHA Requirements

#### Section 59 – Family Council

The Home may have a Family Council. If there is no Family Council, a family member or person of importance to a resident may request the establishment of a Family Council.

If the Home receives such a request, the Home must assist in the creation of the Family Council within 30 days of receiving the request. The Home must notify the Director within 30 days when a Family Council has been established.

A family member of a resident or person of importance to a resident has the right to be a member of the Family Council. Despite this right, the following persons may not be members of the Family Council:

- The licensee, and anyone involved in the management of the Home on behalf of the licensee;
- An officer or director of the licensee or of a corporation that manages the Home on behalf of the licensee or, in the case of a Home approved under Part VIII of the LTCHA, a member of the committee of management or board of management for the Home;
- A person with a controlling interest in the licensee;
- The Administrator;
- Any other staff member; and
- A person who is employed by the MOHLTC or has a contractual relationship with the Minister or with the Crown regarding matters for which the Minister is responsible and who is involved as part of their responsibilities with long-term care home matters.

If there is no Family Council, the Home must advise residents' families and persons of importance on an ongoing basis of their right to establish a Family Council and must convene semi-annual meetings to advise these persons of this right.

#### Key Considerations

To be a member of a Family Council, a person must be a family member of a resident or a person of importance to a resident. A person can no longer be a member of the Family Council after the death or transfer of the resident, unless the person is a person of importance to another resident in the Home.

A “person of importance” may include a friend or a significant other.

## Section 60 – Powers of Family Council

The Family Council has the power to do **all** of the following:

- Provide assistance, information and advice to residents, family members of residents and persons of importance to residents, including when new residents are admitted to the Home.
- Advise residents, family members of residents and persons of importance to residents about their rights and obligations under the LTCHA.
- Advise residents, family members of residents and persons of importance to residents about the rights and obligations of the Home under the LTCHA and under any agreement relating to the Home.
- Attempt to resolve disputes between the Home and residents.
- Sponsor and plan activities for residents.
- Collaborate with community groups and volunteers concerning activities for residents.
- Review,
  - inspection reports and summaries received under section 149 of the LTCHA,
  - the detailed allocation, by the Home, of funding under the LTCHA and the *Local Health System Integration Act, 2006* and amounts paid by residents,
  - the financial statements related to the Home filed with the Director under the Regulation and with the LHIN, and
  - the operation of the Home.
- Advise the Home of any concerns or recommendations the Council has about the operation of the Home.
- Report to the Director any concerns and recommendations that in the Council’s opinion ought to be brought to the Director’s attention.

If the Family Council has advised the Home of any concerns or recommendations about the operation of the Home or of any concerns or recommendations brought to the Director’s attention, the Home must respond in writing to the Family Council within 10 days of receiving the advice.

Definition

“Detailed allocation” means the reconciliation report for a calendar year submitted to the Minister under section 243 (1) (a) of the Regulation and to the LHIN for the geographic region in which the Home is located required by regulations made under the *Local Health System Integration Act, 2006*, and the auditor’s report on that reconciliation report (section 211 of the Regulation).

## Section 61 – Family Council Assistant

At the request of the Family Council, the Home must appoint a Family Council assistant who is acceptable to the Council to assist the Family Council. The Family Council assistant must take instructions from the Family Council, ensure confidentiality where requested and report to the Family Council.

## C. Regulatory Requirements

None.

## Part IV Councils – General

### A. Overview

Sections 62 to 68 of the LTCHA and section 211 of the Regulation set out further requirements relating to Residents' Councils and Family Councils.

### B. LTCHA Requirements

#### Section 62 – Licensee to Co-operate with and Assist Councils

The licensee must co-operate with the Residents' Council, the Family Council, the Residents' Council assistant and the Family Council assistant.

#### Section 63 – Licensee Duty to Meet with Council

The licensee must meet with the Residents' Council or the Family Council if invited to do so.

#### Section 64 – Attendance at Meetings – Licensees, Staff, etc.

The licensee may only attend a meeting of the Residents' Council or the Family Council if invited and must ensure that staff, including the Administrator, and others involved in the management or operation of the Home attend a meeting only if invited.

#### Section 65 – No Interference by Licensee

The licensee must not interfere with the meetings or operation of the Residents' Council or the Family Council, must not prevent a member of either Council from entering the Home to attend a meeting or performing any functions as a member, and must not hinder, obstruct or interfere with the member carrying out those functions. The licensee must not prevent a Residents' Council assistant or a Family Council assistant from entering the Home to carry out his or her duties or otherwise hinder, obstruct or interfere with the assistant in carrying out those duties.

The licensee must ensure that staff, including the Administrator, and others involved in the management or operation of the Home do not do anything that the licensee must not do as set out in this section.

#### Section 66 – Immunity – Council Members, Assistants

No action or other proceeding can be commenced against a member of a Residents' Council or Family Council or a Residents' Council assistant or Family Council assistant for anything done or omitted to be done in good faith in his or her capacity as a member or assistant.

## Section 67 – Duty of Licensee to Consult Councils

The Home must consult regularly with the Residents' Council and the Family Council. The consultation must take place at least every three months.

## C. Regulatory Requirements

None.