

# FIRST AVAILABLE BED POLICIES & DISCHARGE TO A LONG-TERM CARE HOME FROM HOSPITAL

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Many people end up thinking about long-term care<sup>1</sup> for themselves or their family member only after a catastrophe has happened, such as a stroke, broken hip, or death of a caregiver. Often, they have little or no notice that placement will be required, and are only faced with having to make this decision after the person has been admitted to the hospital. This is obviously not the best time or place to be making such a decision, and the mass of information and the pressure is not conducive to making the best decision.

A case from British Columbia made headlines a few years ago when a 91-year-old woman was shipped from a hospital in Trail, British Columbia, to a long-term care home over 100 kilometers away from her 96-year-old husband of 70 years, who was also in the hospital. She died within 48 hours of the forced transfer: her husband died less than two weeks later. The transfer was blamed on the hospital's "first available bed" policy and led to questions in the British Columbia Legislature and a review by the Deputy Minister of Health.

After this case hit the headlines, others came forward with similar stories of elderly persons being transferred from hospital to far-away homes because of these policies. People argued that this was a common situation, due to hospital-cutbacks and requirements for beds.

In Ontario, similar issues have been brought up in the Legislature. Shelley Martel pointed to the problem in Sudbury when the Ministry of Health and Long-Term Care applied a crisis designation to the hospital, requiring those who had been made "ALC"<sup>2</sup> to accept the first available bed in an area which could include beds in Manitoulin Island, Espanola, or even Parry Sound, due to the lack of beds in Sudbury long-term care homes.<sup>3</sup>

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<sup>1</sup> In Ontario, long-term care homes are facilities governed by the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8.

<sup>2</sup> An "ALC" or "alternate level of care" designation means that the patient is ready to be discharged to a long-term care home in the community but for the fact that there are no such beds available. In most cases, this allows the hospital to charge the patient the "chronic care co-payment", which is the same as the basic accommodation rate in long-term care, pursuant to regulation R.R.O. 1990, Reg 552, to the *Health Insurance Act*.

<sup>3</sup> Hansard, Legislative Assembly of Ontario (December 6, 2005), Shelley Martel, MPP, Nickel Belt.

This is not a unique situation. In my practice, I deal with this issue on a frequent basis. Many hospitals in Ontario have “first available bed” policies, whether they are called this or not. The policy may require the patient to select a long-term care home from an available bed in a certain designated geographical area, or they are simply told that there is a bed available in a specific home which has a “suitable bed” (as determined by the hospital) and which they must accept and move to immediately. Usually, the person is told that if they do not comply with this policy, they will be charged the “daily rate”. This is the rate charged for an acute care bed for someone who does not have OHIP or other insurance. Although there is no specific number, I have seen this rate range from \$500 to \$1,500 per day.

## **FIRST AVAILABLE BED POLICIES**

In Ontario, because of years of cut-backs and bed closings, many hospitals complain of beds being taken up by those awaiting placement in long-term care homes. These patients are often referred to as “bed-blockers”, a pejorative description of seniors who, through no fault of their own, are awaiting placement in long-term care while occupying an acute care hospital bed. These patients are perceived as taking away beds from more deserving patients who have arrived at the hospital’s emergency room, need surgery, etc, but for whom there are no available beds. While the needs of those patients are not to be denigrated, the assumption that the solution to this problem should be placed on the seniors is misplaced. While everyone recognizes the needs of those who are awaiting the beds, few understand why those occupying them still need them: it is assumed that they should accede to others and move to wherever the system has determined is necessary. This is not only an incorrect assumption, it is also not a legal one.

Placement in a long-term care in Ontario is regulated by the *Long-Term Care Homes Act* and specifically its regulations. The process for placement is that a person or their substitute decision-maker applies for long-term care through the local Community Care Access Centre (CCAC). CCACs have employees working out of the hospital who are in charge of the placement process for those in hospital. The hospital may also have a social worker or discharge planner who is the person’s primary contact regarding placement. However, one must understand that they are not neutral as they are hospital employees who are therefore required to enforce hospital policy. One should always deal with the CCAC case manager when possible.

Generally, a decision will be made by the patient’s care team if the person requires long-term care. Depending upon the hospital and the individual situation, this may or may not include the participation of the patient and their family. Once a patient is “designated” by the physician as requiring long-term care, the hospital will attempt to have the person moved as quickly as possible. Consent will be sought from the patient or their substitute decision-maker for the application to long-term care, if it has not

already commenced. In most cases, the patient or the substitute decision-maker will agree to do so.<sup>4</sup>

At some point, the patient or their substitute decision-maker will be advised of the hospital policy regarding the acceptance of the “first available bed”. Many hospitals give a copy of their policy to the patient or their substitute decision-maker, advising them that they must accept the first bed available in the designated area, or they must choose beds from a “short list” of beds which are in homes that have either short or no waiting lists. In other cases, when a bed becomes available, they will be told that they have to take it. Some hospitals will require the patient or their substitute decision-maker to sign a “contract” indicating that they “agree” with this policy. In no case should patients or their substitute decision-makers ever sign such a contract or agreement.

The hospital policy may include “choices”. These may include: accept the first available bed; return home to wait for their facility choice; go to a retirement home to await their facility choice; or pay the “daily rate” for the hospital bed. It is argued here that none of these choices is legal.

The regulations to the *Long-Term Care Homes Act* state that a person may choose up to five long-term care homes.<sup>5</sup>

The question therefore, is what latitude is allowed for choosing the homes. Choice is regulated within the *Health Care Consent Act*.<sup>6</sup> Part III of that Act governs the admission of persons into a care facility, which is defined as follows:

“care facility” means,

- (a) a long-term care home as defined in the *Long-Term Care Homes Act, 2007*, or,
- (b) a facility prescribed by the regulations as a care facility.<sup>7</sup>

(Note: As of yet, there are no facilities prescribed in the regulations.)

The application process requires the person or their substitute decision-maker to apply for the homes. Valid consent is required prior to placing the person on a waiting list. The *Health Care Consent Act* is the statute that defines “consent”. There is no specific section regarding consent to admission to a care facility, so one must look to section 11 which deals with “treatment” and modify it for placement. The section states as follows:

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<sup>4</sup> Where the patient or substitute decision-maker refuse to consent, the process will either be discontinued or one of a number of hearings may be heard pursuant to the *Health Care Consent Act*. These will not be discussed in the context of this paper

<sup>5</sup> O. Reg. 79/10, s. 166(1)(d).

<sup>6</sup> S.O. 1996, C. 2, Sched. A.

<sup>7</sup> *HCCA*, s. 2(1).

### **Elements of consent**

11(1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud.

### **Informed consent**

- (2) A consent to treatment is informed if, before giving it,
- (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
  - (b) the person received responses to his or her requests for additional information about those matters.

### **Same**

- (3) The matters referred to in subsection (2) are:
1. The nature of the treatment.
  2. The expected benefits of the treatment.
  3. The material risks of the treatment.
  4. The material side effects of the treatment.
  5. Alternative courses of action.
  6. The likely consequences of not having the treatment.

### **Express or implied**

- (4) Consent to treatment may be express or implied.

When choosing a long-term care home, therefore, one has the freedom to choose whatever one believes to be appropriate for them. Where there is a substitute decision-maker, this is further supported by their duties as set out in the *Health Care Consent Act*:

- 42(1) A person who gives or refuses consent on an incapable person's behalf to his or her admission to a care facility shall do so in accordance with the following principles:
1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

### **Best interests**

- (2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,
  - (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
  - (b) any wishes expressed by the incapable person with respect to admission to a care facility that are not required to be followed under paragraph 1 of subsection (1); and
  - (c) the following factors:
    1. Whether admission to the care facility is likely to,
      - i. improve the quality of the incapable person's life,
      - ii. prevent the quality of the incapable person's life from deteriorating, or
      - iii. reduce the extent to which, or the rate at which, the quality of the incapable person's life is likely to deteriorate.
    2. Whether the quality of the incapable person's life is likely to improve, remain the same or deteriorate without admission to the care facility.
    3. Whether the benefit the incapable person is expected to obtain from admission to the care facility outweighs the risk of negative consequences to him or her.
    4. Whether a course of action that is less restrictive than admission to the care facility is available and is appropriate in the circumstances.

The requirements on the substitute decision-maker as set out above, therefore, are even more restrictive: the substitute decision-maker can **only** make his or her choice based upon these rules.

Nowhere in the *Long-Term Care Homes Act* or its regulations is there any discussion of there being a requirement that the choice is to include anything other than the **person's** own choice, or what is in their **best interest**. Nowhere does hospital policy, the requirements of the acute care system, or any other such thing make its way into the equation. Therefore, based upon the legislation, the person is free to choose whatever long-term care homes they like.

The question then becomes whether the hospital is required to keep the person while they wait for their choice. Many homes have multi-year waiting lists. Does the hospital have to keep the person until their choice arises?<sup>8</sup>

The *Public Hospitals Act* contains a regulation making provision, stating that the Minister may make regulations regarding the “the admission, treatment, care, conduct, control and discharge of patients or any class of patients.”<sup>9</sup> The regulations regarding discharge are as follows:

16(1) If a patient is no longer in need of treatment in the hospital, one of the following persons shall make an order that the patient be discharged and communicate the order to the patient:

1. The attending physician or midwife or, if the attending dentist is an oral and maxillofacial surgeon, the attending dentist.
2. A member of the medical, dental or midwifery staff designated by a person referred to in paragraph 1.

(2) Where an order has been made with respect to the discharge of a patient, the hospital shall discharge the patient and the patient shall leave the hospital on the date set out in the discharge order.

(3) Despite subsection (2), the administrator may grant permission for a patient to remain in the hospital for a period of up to twenty-four hours after the date set out in the discharge order.

Based upon this, it would appear that as soon as a patient no longer required treatment, they must be discharged from hospital, the only exception being a 24 hour grace period. However, the reality is that persons who are awaiting placement no longer require treatment, yet they are allowed to stay in hospital until a bed becomes available.

Hospitals often use this section as the basis for their being able to require people to accept the first available bed. However, this is not the case. The hospital can either choose to enforce this section, meaning **everyone** who requires long-term care will be discharged, whether a bed is available or not, or not to enforce it with respect to those awaiting long term care. Hospitals are presently picking and choosing when to rely on this regulation: when it suits them they enforce it, when it doesn't, they don't. Rules of natural justice can be used to argue that they cannot do this. Furthermore, the hospital owes a duty to the person, meaning that they cannot be forcibly discharged to the community when they are unable to live there safely. This is the same argument that

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<sup>8</sup> In fact, there is nothing in the legislation that requires the person to apply to more than one long-term care home: there is only a **maximum** stated.

<sup>9</sup> *Public Hospitals Act*, R.S.O. 1990, c. P.40, s. 32(1).

one can make regarding discharge to a retirement home: people cannot be forced to “wait” placement from there when they are entitled to care. Retirement homes are not part of the health system, and one cannot be forced into one as an alternative to waiting for a bed while in hospital. Retirement homes are not regulated in the same ways as long-term care, the health care provided therein is not part of the health care system, and therefore is private pay, and safety cannot be assured.

There is also often a disagreement as to what “acceptable” means. Obviously, not every “available” bed is appropriate for every person awaiting placement from hospital. For example, one person may require a bed on a secure unit while another person does not. Often these hospital policies indicate that it is the physician or “team” which will determine whether these beds are “appropriate” for the person. This is often a bone of contention in these placements. However, it is clear from the *Health Care Consent Act*, that it is up to the person or their substitute decision-maker to determine what is appropriate: nowhere is there any role for the treatment team in this type of placement decision. In fact, it is between the person and the CCAC to resolve these issues, the treatment team has no voice in this whatsoever.

There is other evidence to back up this position. In 2002, similar issues arose in the health care system. At that time, applicants for long-term care could choose as many homes as they liked, and those in hospital were being made to choose many homes, sometimes every home in their area or in the next. Those applying from hospital were a “category 3”. The regulations were amended in 2002. The category of those applying from hospitals was changed to a “category 2” but the number of homes which could be chosen was restricted to a maximum of three. While the regulations could have been amended to include first available bed policies, they were not. More recently, despite the overhaul of the legislation pertaining to long-term care, the government chose not to condone first available bed policies. The *Long-Term Care Homes Act, 2007*, which was proclaimed on July 1, 2010, makes no mention of first available bed policies.

Additionally, in 1996, amendments were made to the regulations to the *Health Insurance Act*. Again, this was in response to complaints that people were refusing to apply to or accept long-term care placements from hospital because they did not have to pay for the bed in the hospital. These regulations specified that those in hospital, who, in the opinion of the physician, were more or less permanent residents of a hospital or other institution, could be charged the “chronic care co-payment”.<sup>10</sup> This allowed the physician to designate a patient as being “alternative level of care” or “ALC”, allowing them to stay in hospital to await admission to a complex continuing care hospital or long-term care home, while charging them the same rate as they would pay in one of those institutions.<sup>11</sup>

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<sup>10</sup> R.R.O. 1990, Reg. 552, s. 10.

<sup>11</sup> *Complex Continuing Care Co-payment, 2009*, Ministry of Health and Long-Term Care, available at: <http://www.health.gov.on.ca/english/public/pub/chronic/chronic.html>.

Not only does the chronic care co-payment and the designation of “ALC” indicate that those needing long-term care can stay in hospital pending placement, it also disallows the hospital from charging the person more than that rate. Therefore, the argument that the “daily rate” can be charged is contrary to the *Health Insurance Act*.

For all of these reasons, hospitals in Ontario may not utilize “first available bed” policies to resolve their bed shortage issues. Placement into homes which are not of their choosing can be detrimental to their health. Often these homes are far from families and other support systems: the deleterious effects on both the person and their families can be quite great, even leading to the death of the person transferred. As well, it can be argued that the reason that some of these homes have available beds is because the homes are themselves unsatisfactory in some way. People should not be required to accept below-standard care, because there are no beds in appropriate homes.

This does not mean that the person can simply wait in hospital for a specific long-term care home where that home has a three-year waiting list, unless it can be proven that that home is the only one which can meet the person’s needs. Applicants and their substitute decision-makers must be reasonable when making their choices. In addition, staying in hospital may not, in fact, be in the best interest of the person, given the rise of communicable diseases such as antibiotic resistant illnesses and the like. One must weigh all of these issues when making a placement decision.

In the case of *Gray v. Ontario*, a group of family members of developmentally challenged residents of residential institutions asked the court to determine whether or not the Ministry of Community and Social Services could close the institutions. The Division Court held that the Ministry had the authority to do so. A second question was then asked, which was as follows:

If the Minister acted within her jurisdiction in closing the institutions, is the Minister required to obtain the consent of the resident or his or her next of kin or substitute decision maker to the community placement selected for the resident? If so, how are disputes to be resolved concerning community placement?<sup>12</sup>

The Applicants submitted to the Court that the consent of the resident or their substitute decision-maker was required regarding any relocation. They went on to argue that in some cases, community placements and the pre-planning were being carried out without regard to the wishes of the residents’ next of kin. The Respondents disagreed that consent was required.<sup>13</sup> The Court determined that consent was required. It went on to state:

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<sup>12</sup> *Gray v. Ontario*, [2006] O.J. No. 226 (Division Court) ¶4.

<sup>13</sup> *Gray v. Ontario*, para. 27.

Consent to a particular residential placement is required due to the fundamental importance of this issue to the developmentally disabled person.... Due to their vulnerability, inappropriate residential placements have the likelihood of being harmful and may be life threatening to many of these profoundly affected adults. The provision of consent by a substitute decision maker may be seen in some cases as a circumstantial guarantee of suitable placement. Perhaps more importantly, the refusal of consent by a substitute decision maker will serve to require further consideration or an adjudication of the issue, so as to operate as a safeguard against erroneous decisions. In any event, the requirement for consent accords respect to the disabled person.

. . . .

In summary, I am of the opinion that the consent of a developmentally disabled adult or his or her substitute decision maker is required to any choice of community residential placement. This is because of the direct and substantial effect this choice will have on the individual's health, safety and personal welfare and is in accordance with the principles of fundamental justice. It is well within the recognized jurisdiction of the Superior Court of Justice in the exercise of its *parens patriae* jurisdiction to declare this right and to see that it is respected.<sup>14</sup>

The Court recognized the importance of placement to the person and the potential for harm to these adults. It is argued here that as with the developmentally challenged, the choice of long-term care home can similarly affect the elderly person's health, and therefore deference to the decision of the person or their substitute decision-maker must be made.

Arguments could also be made with respect to the *Charter of Rights and Freedoms*. For example, it could be argued that such forced placements are contrary to a person's section 7 right to life, liberty and security of the person. Because the long-term care home is the home of the person, as well as part of the health care system, and may be where they live for the rest of their life, I believe that an argument could be made that to force them to go to a place they do not wish to go to would be contrary to this section.

Finally, within the context of placement in a long-term care home, recourse to the courts is not necessary. The legislation allows the person themselves to make the final decision with respect to where they wish to be admitted pursuant to, at the time, the *Nursing Homes Act* (now the *Long-Term Care Homes Act*) and *Health Care Consent Act*. With respect to substitutes, their decision is limited by section 42 of the *Health Care Consent Act*. The ability to challenge that decision is left not to the hospital, physician or other medical party involved in the person's case, but rather to the CCAC,

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<sup>14</sup> *Gray v. Ontario*, paras. 31 & 33.

who has the authority to challenge it to the Consent and Capacity Board.<sup>15</sup> However, this challenge must be based upon the substitute decision-maker's failure to comply with the statutory principles for giving or refusing consent. Nowhere in these principles is there a section which requires them to consider "hospital policy", only to comply with the competent wishes of the incapable person or their best interest.

## **MINISTRY OF HEALTH AND LONG-TERM CARE CRISIS DESIGNATIONS**

The placement of applicants in categories is governed by the regulations and is to be done by the placement co-coordinator. According to the regulations, a person shall be placed in the "crisis" category (1) "if the applicant requires immediate admission as a result of a crisis arising from the applicant's condition or circumstances."<sup>16</sup> Similar wording appears in the definition of crisis in the *Health Care Consent Act* which states that pertaining to admission, a "crisis means a crisis relating to the condition or circumstances of the person who is to be admitted to the care facility."<sup>17</sup>

Local Health Integration Networks (LHINs) are now able to designate hospitals as being in "crisis" if the hospital is "experiencing severe capacity pressures".<sup>18</sup>

If an applicant or hospital is designated as crisis, the person is not limited to choosing five long-term care homes and he or she goes to the top of the list for the homes he or she selected.<sup>19</sup>

## **CONCLUSION**

When patients from hospital are applying for admission to a long-term care home, it is their interest, not that of the hospital, which is foremost in the placement process. Not to recognize this is detrimental to the health of the seniors, and may have serious health effects and can even lead to death.

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<sup>15</sup> *HCCA*, s. 54.

<sup>16</sup> O. Reg. 79/10, s. 171(1).

<sup>17</sup> *HCCA*, s. 39.

<sup>18</sup> O. Reg. 79/10, s. 171(4).

<sup>19</sup> O. Reg. 79/10, s. 166(2).