
Registrant Handbook

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5.1 Policy statement

A registrant must ensure that the assisted living residence is operated in a manner that does not jeopardize the health or safety of its residents.¹ Registrants must fully inform prospective residents about the hospitality and personal assistance services offered in the residence.² Registrants must screen residents for suitability in relation to building design features, personal assistance services offered, and ability to make decisions on their own behalf.³

Where a resident's needs exceed the service delivery capacity of the residence or the resident becomes unable to make decisions on their own behalf, a registrant must develop an exit plan in consultation with: the resident; their physician; family and support network; and health authority case manager, if appropriate.⁴ Registrants must ensure that their exit plans include strategies for providing increased services to minimize risk and meet the higher care needs of residents awaiting a move out of the residence.

5.2 Entry and exit considerations

As a registrant, you must manage the entry to and exit by residents from your residence. The *Community Care and Assisted Living Act* places an obligation on you not to house people who are unable to make decisions on their own behalf.⁵ Please refer to section 5.3 below for further information on this fundamental prerequisite to residing in assisted living.

In terms of considering entry to your residence, you should fully inform prospective residents of:

- the requirement to be able to make decisions on their own behalf;
- the hospitality and personal assistance services you offer;
- the building's features that accommodate physical disabilities;
- the residence's emergency response system; and
- the building's evacuation plan.

In accepting a resident, you should ensure that the resident meets the following health and safety prerequisites:

- you are able to meet the prospective resident's service needs through the services you provide;
- the resident is able to express their wishes so as to be understood by personal assistance staff or by a spouse living with them who can communicate with staff on their behalf;

1 *Community Care and Assisted Living Act*, SBC 2002, c. 75, s. 26(5).

2 See Policy Tab 4, outcome 4.1.1.

3 See Policy Tab 4, outcome 4.1.2.

4 See Policy Tab 4, outcome 4.2.1.

5 SBC 2002, c. 75 s. 26(3).

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- the resident will not, through their behaviour, jeopardize the safety or well-being of others, and
- the resident is able to make the range of decisions that will allow them to function safely in the supportive semi-independent environment provided by an assisted living residence.

A resident is no longer suitable for your assisted living residence when the resident:

- no longer meets the above health and safety prerequisites;
- requires 24-hour supervision and continuous professional care; or
- is no longer able to make their own decisions.

Depending on their circumstances, such residents may move to extended care, a hospital or a family home.

To assist the transfer, you must develop an exit plan in conjunction with the resident and, as appropriate, their family, physician, support network and case manager. The exit plan should set out the resident's relocation plans, who is responsible for those arrangements and what additional services will be put in place to ensure the resident's health and safety while awaiting transfer to the new setting. Where the resident has been assessed eligible for placement into extended care, the local health authority must provide additional services to support the individual, just as it would if the resident were living in their own home in the community (see footnote 24).

5.3 How registrants should apply section 26(3) of the *Community Care and Assisted Living Act*

Section 26(3) of the *Community Care and Assisted Living Act* states that a registrant (an operator of a registered assisted living residence) must not house in an assisted living residence persons who are unable to make decisions on their own behalf. This policy will assist registrants⁶ in interpreting and applying this section of the Act.

What is the purpose of Section 26(3)?

Assisted living is a semi-independent form of housing. People live in their own private dwelling unit within the assisted living residence and can access the range of hospitality and personal assistance services the registrant provides.⁷ Residents contract⁸ with the assisted living registrant for their accommodation and the support services they require. In this way, assisted living promotes the privacy, independence and self-reliance of people who require help with some day-to-day tasks but who can otherwise live independently.

Section 26(3) has two purposes. First, it makes clear that, to live in the semi-independent environment of an assisted living residence, people must have the ability to make their own decisions. People who

6 When registrants provide 'publicly funded' assisted living, funding program case managers play an important role. See "What is the Role of Case Managers" at page 10 of this policy.

7 The definition of an assisted living residence in the *Community Care and Assisted Living Act* requires registrants to provide five hospitality services and one or two personal assistance services delivered at a prescribed service level.

8 Residents will often seek help from their family and/or case manager (where involved) to determine, along with the registrant, the type of accommodation and services they require.

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cannot make decisions on their own pose too great a risk to themselves, and potentially to others, and the Act does not allow registrants to house them, unless a spouse will be living with them in the residence or the person is on leave under section 37 of the *Mental Health Act*.⁹ See Appendix 1 for an explanation of these two exceptions.

Secondly, section 26(3) makes assisted living registrants responsible for ensuring that residents are able to make decisions on their own behalf. As a result, registrants must:

- Assure themselves, at the point of entry, that *prospective residents* are able to: 1) make an informed voluntary decision to enter the assisted living residence and 2) make the range of decisions necessary to function safely in the residence;
- Assure themselves, on an ongoing basis, that *residents* continue to be able to make the range of decisions necessary to function safely in the residence; and
- Initiate the exit process when residents are no longer able to make the range of decisions necessary to function safely in the residence.

By taking these measures, registrants will comply with section 26(3).

What decisions do assisted living residents need to be able to make?

The ability to make decisions on one's own behalf can span a broad range of competencies. Because the *Community Care and Assisted Living Act* addresses resident health and safety, not tenancy matters,¹⁰ the key competencies addressed by section 26(3) are the range of decisions that allow people to function safely in the supportive semi-independent environment provided by an assisted living residence.

Key areas of function include the ability to:

- initiate activities to the extent necessary to function safely for the periods they are alone in their unit;¹¹
- find their way within the assisted living residence given available cueing;
- recognize the consequences of decisions or actions and that some actions may result in injury or harm to themselves or others;
- recognize an emergency and summon help or follow directions;
- find their way back to the residence independently;¹²

9 RSBC 1996, c. 288.

10 The *Tenancy Statutes Amendments Act*, SBC 2006, c. 35 (Bill 27) was passed on May 18, 2006. This Act creates a framework in the *Residential Tenancy Act* that establishes the rights and responsibilities of landlords and tenants in assisted living and supportive housing. These amendments were not in force when this policy was issued. Please refer to <http://www.rto.gov.bc.ca/> for information on the status of the legislation. Until the amendments are brought into force, the Office of the Assisted Living Registrar will refer any complaints it receives about consumer protection to the appropriate contact at the Residential Tenancy Office.

11 Staff may assist residents with morning and evening routines but residents must be able to function safely when they are alone in the privacy of their room or suite.

12 While a resident may be experiencing a memory deficit, if they have an effective strategy to compensate for it, they may retain the ability to return safely to the residence. For example, a person may carry a card with the residence address that can be given to a taxi driver. Others may simply choose not to go out alone.

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- participate in regular reviews of their service needs, that is, respond to questions about needs and services offered; and
- seek assistance when they have a complaint about something happening at the residence, although family or friends may actually convey the matter to the Assisted Living Registrar.

The person must be able to perform all of these functions at the assisted living residence by himself or herself¹³ unless a spouse, who is willing and able to make decisions, is there to provide daily support on the person's behalf.

Where a court determines that a person is no longer able to make personal decisions related to their health care and daily living activities and has appointed a family member, friend, or the Public Guardian and Trustee to act as their committee of person then the person *is not appropriate* for assisted living unless their spouse is living with them in the residence. If a section 9 health care representation agreement has been fully enacted, meaning the person is now incapable, the person *is not appropriate* for assisted living.

In the following situations, a person would not necessarily be ineligible for assisted living. Further inquiry is needed to determine whether the person is still able to make the day-to-day decisions that would allow them to live safely in assisted living; that is, whether the person is able to perform the key functions listed above:

- the person has given a section 7 health care representation agreement;
- a temporary substitute decision maker is regularly making health care decisions for them; and/or
- the person has granted a power of attorney or a representation agreement, or the court has appointed a committee of estate, solely for the purpose of managing the person's financial and legal affairs.

See Appendix 2 for further information on the role and authority of formal substitute decision makers.

How do registrants decide if a person is unable to make decisions?

Since assisted living promotes residents' privacy, independence and self-reliance, registrants must be careful not to interfere unnecessarily in the private lives and personal decision making of residents. Instead, the Assisted Living Registrar expects registrants to keep a 'watchful eye'¹⁴ over residents.

The standard of care of 'keeping a watchful eye' means that registrants should not intrude by conducting tests of residents' decision-making ability. Instead, **the registrant's role is to watch for**

13 A person's ability to function may depend somewhat on the features of the specific assisted living unit or residence, for example, (1) a person may 'initiate' going to the bathroom appropriately when the bathroom is in plain view, whereas they may not remember to do so if the bathroom is out of sight at the end of a corridor; (2) a person may be able to find their way around a small residence, where distances are short and navigation within the building is simple. In a large residence, where distances are greater and involve a number of common areas, long corridors, elevators and multiple floors, it may be more complex for the resident to find their way.

14 As a standard of care, 'keeping a watchful eye' is higher than the responsibility expected of independent housing (where the person receives only housing from the operator) or supportive housing (where the resident receives housing and one or more hospitality services, for example, meals or laundry, but no personal care, *from the operator*) operators but not as high as that expected of operators of licensed residential care facilities. In other words, if a registrant notices a problem in relation to a resident's health or safety, they have a responsibility to follow up on the issue.

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behaviors or signs that suggest a person is not able to make decisions and, if such behaviors or signs are noted, make further inquiries of the person, and/or report the matter to the person's designated contact. In making such a report, the expectation is that the resident or their designated contact will engage a health professional, such as the family physician and/or case manager, to investigate the person's health status.

If the resident or their designated contact refuses to provide information or address the matter in a timely manner, and the registrant does not believe the resident is appropriate to enter or remain safely in the residence, the registrant should request that the person seek alternate accommodation.

Appendix 3 provides a flowchart of the steps a registrant will take to comply with section 26(3). The following sections describe the registrant's obligations at each step in the process.

What do registrants need to do at the point of entry?

This section outlines how registrants should screen prospective residents in terms of their ability to make the range of decisions that will allow them to function in the assisted living residence.

Presume ability to make decisions

Registrants should presume that prospective residents are able to make decisions *unless there are signs to the contrary*.¹⁵

Decide whether the person is making an informed decision to enter

Registrants must assure themselves that there are no signs that the prospective resident is unable to *make an informed voluntary decision* to enter the assisted living residence. Individuals on leave under section 37 of the *Mental Health Act*, or who will be living with a spouse in the residence, are exempted from the requirement to be able to make an informed decision to enter the assisted living residence.

During the pre-entry interview, registrants must give prospective residents information about the residence and its services, policies, and house rules. After providing the information, registrants should ask questions and look for signs that the person may not understand the information or may not be making a voluntary choice to enter the residence. If there are such signs, the registrant should make further inquiries to satisfy themselves that the person understands the information and is making an informed voluntary decision to enter the residence. Appendix 4 gives more information about this process.

Decide whether the person will be able to function safely

Registrants also must assure themselves that there are no signs that the prospective resident *will be unable to make the range of decisions necessary to function safely* in the residence. This requirement applies to seniors as well as to people with mental disorders and/or substance use disorders, including

¹⁵ This parallels section 3(1) of the *Adult Guardianship Act*, SBC 1996, c. 6, which states, "Until the contrary is demonstrated, every adult is presumed to be capable of making decisions about personal care..." Adopting this presumption does not absolve registrants from their obligations under section 26(3) of the *Community Care and Assisted Living Act*, SBC 2002, c. 75.

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those on leave under section 37 of the *Mental Health Act* (see Appendix 1). The key areas of function are described above in 'What decisions do assisted living residents need to be able to make?'

During the pre-entry interview, registrants should ask prospective residents questions about their general health, typical day and ability to function independently. In the discussion, the registrant should look for signs that the person *may not* be able to perform one or more of the key functions. If they see such signs, they should advise the person, their family and their case manager, where involved, that they require further information in order to gauge the person's ability to function safely in the residence. If the additional information is not forthcoming, the registrant must decline to accept the person.

Advise of their legal obligations as registrants

Registrants must explain that they have a legal obligation not to house people who are unable to make decisions on their own behalf and that this is interpreted to mean that residents must be on entry and remain able to perform the key areas of function described above in 'What decisions do assisted living residents need to be able to make?'

Registrants should also explain that if they see signs that a resident may not be able to perform one or more of the key functions, they will bring the matter to the resident's and their designated contact's attention, and the onus will be on the resident or their designated contact to have the matter reviewed by the health professionals, for example, the family physician and/or case manager, involved in the resident's care. When registrants provide assisted living to publicly subsidized assisted living residents, the registrant will also have an obligation to notify¹⁶ the case manager representing the funding program of any significant changes in the resident's ability to perform the key functions.

Before entry, registrants should provide prospective residents with written information about the section 26(3) requirements and ask them to acknowledge that:

- They or their designated contact¹⁷ may be asked by the registrant to review section 26(3) matters; and
- They will need to seek alternate accommodation if, based on observations or information from health professionals, the registrant concludes that the resident is unable to make the decisions that will allow them to live safely in that residence (such as, not be able to perform one or more of the key areas of function).

If the prospective resident is not able to perform one or more of the key areas of function but will be living with a spouse who is *willing and able* to make the decisions that will allow the resident to live safely, the registrant, and/or case manager if involved, must establish with the spouse a plan to support the resident when the spouse is absent for 1) an extended period of time, for example, due to a hospitalization, and 2) short periods of time, for example, an afternoon of shopping.

Appendix 5 provides a sample information sheet about these section 26(3) requirements. Registrants can use this sheet or develop their own written information for residents and their designated contacts.

¹⁶ Home and Community Care clients sign a consent that enables this exchange of information.

¹⁷ If a resident has no family member or friend who is willing and able to assist and the resident has given consent for the registrant to communicate directly with their physician or case manager, the registrant may contact the physician or case manager to inform them of the observations and concerns, and to request the physician or case manager to investigate the matter.

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What do registrants need to do on an ongoing basis?

Presume ability to make decisions

Registrants should presume that residents are able to make decisions *unless there are signs to the contrary*.

Observe the behavior of residents and identify concerns

Registrants must take reasonable steps to assure themselves that residents remain able to make the range of decisions necessary to function safely in the assisted living residence, or that their spouses remain willing and able to act on their behalf.

Assisted living is a supportive environment where staff have many points of contact with residents, which means that they have many opportunities to observe changes in their behavior or level of functioning. When staff note changes, they should monitor the situation and watch for signs of a possible decline in decision making ability. Signs include:

- A decline in functional ability, that is, where a resident's ability to perform tasks has declined; and
- Changes in behavior, habits, general appearance, social patterns, living conditions and overall health status.

See Appendix 6 for a listing of functional and behavioral signs that may indicate a decline in decision-making.

Registrants must have policies and procedures in place to guide staff in observing, documenting and reporting changes in resident functioning and behavior. If staff notice a sudden significant change in behavior or function, they should immediately report it to the registrant (or person in charge), who will then inform the designated contact and case manager, where involved.

In some cases, a resident's ability to function may be improved by a move to different unit in the residence, for example, closer to the dining area, or by modifications to the environment of their existing unit.

Report concerns to the resident and/or their designated contact

If staff observe a pattern of behaviors or functional decline that suggests that a resident has a problem with decision making, the registrant should bring the matter to the attention of the resident, and their designated contact, so that the person's health status can be reviewed by health professionals, that is the family physician and/or case manager involved in the resident's care. The review may include a consultation with a medical specialist, such as a geriatrician. See Appendix 7 for information on how health professionals assess a person's ability to make decisions.

The registrant is guided by the opinion of the health professionals involved in the resident's care. Where it appears that the underlying condition is manageable and the pace of decline in decision making ability/function is slow, or the condition is treatable and the decline in function is likely to be temporary and of short duration such that it will not have a significant impact on the resident's ability to

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live safely in the assisted living residence, the registrant is not required to initiate the exit process. In the latter case, adequate services should be put in place to maintain the resident's health and safety until their level of decision making ability/functioning is restored.

If it appears that the resident's condition is not temporary or remediable and the person is no longer able to make the range of decisions that will allow them to live safely in the assisted living residence, the registrant must initiate the exit process.

Resolve disagreements

If there is disagreement among any of the resident, family, registrant, or case manager about whether a resident is able to make the decisions necessary to function safely in the residence, various options for resolving the situation should be explored. For example, further information can be requested from health professionals, including the family physician. A geriatric or psychiatric consultation, or an assessment by the local mental health outreach team, could be sought. However, the role of health professionals is to provide a clinical opinion about the person's level of functioning in the area in question, not to determine if the resident should continue to live in the residence. The registrant or case manager, where involved, may set up a case conference with all parties to discuss the clinical findings, risks and available options, and determine a course of action.

Where consensus can not be reached among the resident, family, registrant, and case manager about whether a resident is able to make the decisions necessary to function safely in the residence, but the registrant does not believe the resident is appropriate to remain in the residence, the registrant should trigger the exit process by giving notice to the resident to end the tenancy.

What do registrants need to do at exit?

Where the registrant, in consultation with the resident, their designated contact and case manager, where involved, concludes that a resident is no longer able to make the range of decisions necessary to function safely in the residence, the registrant must initiate the exit process by requesting that the party acting on the resident's behalf, with the assistance of the case manager, where involved, seek alternate accommodation for the resident. In publicly funded assisted living, a case manager may initiate the move based on their assessment of a resident's level of functioning.

In either case, the registrant must develop an exit plan that sets out the resident's relocation plans, who is responsible for those arrangements and what additional services will be put in place in the intervening period to ensure the resident's health and safety is not in jeopardy while awaiting transfer. Registrants are expected to assist residents to relocate as quickly as possible, given alternate resources in the community. In this way, the registrant is complying with section 26(3).

What happens if the Registrar receives a complaint?

If the Registrar receives a complaint that a registrant is housing people who are unable to make decisions on their own behalf, the Registrar will investigate by requesting information from the registrant about:

- the manner in which the registrant disclosed their legal obligation not to house people who are unable to make decisions on their own behalf;

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- policies and procedures in place that guide registrant staff in watching for signs that residents are not able to make decisions/function safely in the residence and to bring those observations to the attention of the site manager or other person responsible.

Where the complaint involves a specific resident, the Registrar may request any documented observations or other information relevant to whether or not the resident is able to make the decisions necessary to function safely in the residence. The Registrar may request copies of the records¹⁸ cited by the registrant, such as a physician's opinion or a case manager's assessment. Where the information provided is considered insufficient or inconclusive, the Registrar will seek further information by asking the registrant to investigate the matter more fully with the resident and/or their designated contact. The resident or their designated contact would engage the resident's family physician or case manager in a further review of the resident's health status, which may trigger a geriatric or psychiatric consultation, or an assessment by the local mental health outreach team.

In some cases, the Registrar may visit the residence or delegate inspection powers to the Clinical Advisor or other inspector to review records or observe operating practices. The Registrar also may, under the *Freedom of Information and Protection of Privacy Act*,¹⁹ ask health authorities to disclose pertinent information and health authorities will respond according to their privacy policies. Based on the range of collateral information collected,²⁰ the Registrar may ask the Clinical Advisor to provide an opinion on whether a particular resident(s) is unable to make the range of decisions necessary to function safely in the residence.

If the Registrar's investigation leads to the conclusion that one or more people in the residence are unable to make the range of decisions that will allow them to live there safely, the Registrar may take action against the registrant's registration. The Registrar will develop policy to assist in the exercise of the Registrar's discretion about whether to apply or vary conditions to, or suspend or cancel a registration.²¹ For example, the Registrar would generally not take action against a registrant provided the registrant has responded in a timely way to develop an exit plan, has made every effort to ensure the resident's health and safety is not in jeopardy while awaiting transfer to alternate accommodation and has made every effort to expedite the relocation plan, recognizing that eviction is not usually a viable option.

18 Section 25(2)(b) of the *Community Care and Assisted Living Act* authorizes the Registrar to inspect and copy any records on the premises of a residence that is being inspected because the Registrar has reason to believe that a resident's health or safety is at risk.

19 *Freedom of Information and Protection of Privacy Act*, SBC 1996, c. 165.

S. 33.2: **Disclosure inside Canada only** – A public body may disclose personal information referred to in section 33 inside Canada as follows: (a) for the purpose for which it was obtained or compiled or for a use consistent with that purpose (see section 34); (c) to an officer or employee of the public body or to a minister, if the information is necessary for the performance of the duties of the officer, employee or minister; (d) to an officer or employee of a public body or to a minister, if the information is necessary for the delivery of a common or integrated program or activity and for the performance of the duties of the officer, employee or minister to whom the information is disclosed;

S. 34 (1): **Definition of consistent purposes** – A use of personal information is consistent under section 32 or 33.2 with the purposes for which the information was obtained or compiled if the use (a) has a reasonable and direct connection to that purpose, and (b) is necessary for performing the statutory duties of, or for operating a legally authorized program of, the public body that uses or discloses the information or causes the information to be used or disclosed.

20 Collateral information is information gathered from the registrant, family, physician or other key contacts that documents changes to the residents' behaviors, habits, general appearance and overall health status, typical social patterns and living conditions.

21 *Community Care and Assisted Living Act*, SBC 2002, s. 27 (a).

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What is the role of case managers?

When registrants provide 'publicly funded' assisted living, funding program case managers play an important role. Before referring their client to assisted living, the case manager will have screened the person in terms of their suitability for assisted living. As part of the screening process, the case manager also must form the opinion that the client has the ability to make the decisions necessary to function safely in an assisted living residence.²² While able to make decisions, some people may display behaviour that makes them unsuitable for most seniors' assisted living residences; for example, aggression or other socially unacceptable behaviour.

Where the screening process raises a concern about a client's capacity to function safely in assisted living, or a cognitive screening tool administered by the case manager or other health professional triggers the need for a more in-depth investigation of the client's cognitive capacity and decision making ability, the case manager will typically consult with the client's family physician, seek a geriatric or psychiatric consult about a particular issue or concern, and/or request that a mental health outreach team investigate the issue.

In discussing assisted living with their clients, case managers must explain to them, and any involved family members or designated contact that assisted living residents must have the ability to make the range of decisions necessary to function safely in an assisted living residence. Case managers also need to explain that a resident will have to seek alternate accommodation if the registrant, in conjunction with the case manager, determines that they are no longer able to make those decisions, such as, not be able to perform one or more of the key areas of function described above in 'What decisions do assisted living residents need to be able to make?'

If the client is not able to make the decisions necessary to function safely in an assisted living residence but will be living with a spouse who is *willing and able* to make decisions on their behalf, the case manager must establish, as part of the service plan, how to support the resident when the spouse is absent for both extended and short periods of time.

The case manager's involvement with the resident and screening does not absolve registrants from their responsibility under section 26(3). Registrants need to perform their own level of due diligence in screening prospective residents prior to entry to the residence, including reviewing functional assessment information provided by the case manager.

²² *Home and Community Care Policy Manual*, 5.E.3 Move In/Move Out Criteria Page 2 of 2 – Assessment Process – Health authorities are responsible for determining a client's eligibility for assisted living services based on a standardized assessment that includes identifying whether the person is able to make decisions on his or her behalf. Wherever possible, this assessment is to be conducted by a multidisciplinary clinical team, with involvement of the client, and where appropriate, their family.

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Case managers also play a key role in assessing their clients' ongoing functioning in the assisted living residence.²³ This role includes:

- Establishing protocols for registrants to notify them about changes in their client's level of functioning or behaviour;²⁴
- Initiating and/or attending ad hoc or regular case conferences;
- Conducting reassessments on an ongoing basis and when registrants or family note changes in a resident's level of functioning or behaviour;
- Consulting with family, physician, mental health outreach team, geriatrician, and others as necessary; and
- Where questions or concerns about decision making ability have been identified, working collaboratively with registrants to determine whether residents, or their live-in spouses, are able to make the range of decisions necessary to continue to function safely in assisted living.

When a client is no longer able to make the decisions necessary to function safely in assisted living, case managers must act to find the client alternate accommodation. This includes:

- Discussing relocation plans with the client and their family;
- Referring the person to a suitable alternate resource;
- Collaborating with the registrant as the registrant develops an exit plan, which sets out interim services the person will receive to ensure their health and safety is not jeopardized while awaiting transfer from the residence. The case manager authorizes additional services as required and allowed for under Home and Community Care Policy;²⁵ and
- Regularly reassessing how the client functions and collaborating with the registrant to review/update the interim service plan and priority for referral to another resource, until the transfer from assisted living occurs.

Some residents, who are living in an assisted living residence on a private pay basis, may choose to apply for benefits under the publicly subsidized Home and Community Care program, particularly, as their service needs increase and they require complex care. When the local Home and Community Care Program receives a referral from the assisted living resident or their family or physician, a case manager processes the referral in the same way as it would if the person were living in their own home in the community.

23 *Home and Community Care Policy Manual* 5.E.3, Move In/Move Out Criteria Page 1 of 2, Assessment Process – The clinical team is expected to re-assess the client's continued suitability for assisted living on an ongoing basis.

24 The case manager represents the program funding agency, which has a contractual relationship with the registrant. By referring a client and paying for their services, the case manager is expressing their view that the person is suitable for assisted living. If circumstances change, the case manager must be informed so that they can reevaluate their client's continued eligibility and suitability.

25 *Home and Community Care Policy Manual* 6.B.6, Page 1 of 1. Supports for Clients Awaiting Admission – Policy – Health authorities must ensure clients who are approved for admission to residential care are supported in the community with:

- an increase in the availability and flexibility of community health supports and home support services;
- a plan for crisis management; and
- preparation and counseling for admission to residential care.

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Appendix 1 Exceptions to Section 26(3)

1. Living with spouse

Section 26(6) of the *Community Care and Assisted Living Act*²⁶ provides an exception to section 26(3). It states that:

Subsection (3) does not apply to a person if the spouse of the person

- (a) will be housed in the assisted living residence with the person; and
- (b) is able to make decisions on behalf of that person.

In other words, section 26(6) enables a person to enter or remain in an assisted living residence, even though they are no longer able to make the range of decisions that will allow them to function safely in the residence, if their spouse, who is able to make decisions, is there *and is willing* to provide daily support on their behalf.²⁷

If the prospective resident objects to entering the residence, the spouse may only make the decision on their behalf if the spouse is their formal personal representative (formal representation is granted through a Committee of Person order or a section 9 Representation Agreement; see Appendix 2 for an explanation. However, while the spouse may have legal authority to make the decision, if the person is objecting, they may not be able to enforce their decision.

2. On leave under section 37 of the *Mental Health Act*²⁸

Section 26(4) of the *Community Care and Assisted Living Act*²⁹ provides a partial exception. It states that:

Subsection (3) does not apply to an involuntary patient on leave under section 37 of the *Mental Health Act*.

Under section 37 of the *Mental Health Act*, a person who has been involuntarily admitted to a designated mental health facility may leave the facility and live in a community specified by the Director

²⁶ SBC 2002, c.75.

²⁷ *Home and Community Care Policy Manual* 5.E.3, Move In/Move Out Criteria Page 1 of 2 – Criteria for Tenant Selection – A person can only be selected to move into an assisted living unit if the person meets all of the following criteria:

- requires both hospitality services and personal care services;
- is able to make decisions on his or her behalf that will allow the person to function safely in an assisted living residence, unless a spouse lives with the person and is willing and able to make decisions on the person's behalf;
- is at significant risk in their current living environment; and
- has been advised of the applicable client rate and permissible assisted living residence charges, and has agreed to pay all applicable costs.

²⁸ RSBC 1996, c. 288.

²⁹ SBC 2002, c. 75.

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of the facility. A form³⁰ sets out the conditions of the leave, which may include the specific location in the community and a prescribed medication regime. The person, who remains an involuntary patient, must abide by the conditions of the leave while living in the community, until discharged by the Director of the designated mental health facility.

Section 26(4) of the *Community Care and Assisted Living Act* enables people on leave under section 37 of the *Mental Health Act* to live in assisted living. The individual *is exempted from making an informed decision to enter* the assisted living residence as the Director of the mental health facility makes this decision for them.

Since this subsection does not establish, as does section 26(6), someone to live with the person and provide daily decision making support, the person *is not exempted from being able to make the range of day-to-day decisions* necessary to function safely in the assisted living residence. Prior to referring the person to assisted living, the Director should assure him/herself that the person will be able to make the range of decisions that will enable them to live safely there. In turn, the registrant should also consider this requirement at the point of entry to the residence.

³⁰ Form 20 under the Mental Health Act Regulation, BC Reg 233/99.

Appendix 2

Legislative Approaches to Substitute Decision Making

All adults, that is, persons 19 years of age or older, are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters.³¹ This includes accepting risks to themselves associated with the choices they are making.

However, risk to self becomes an issue if a person is no longer able to make decisions. While a fully capable person can accept any risk (regardless of whether others think it is best for them), as decision making ability declines, there is a greater onus on society to protect the individual by establishing a substitute decision maker to act on their behalf. Given some time and the necessary information and support, most adults can make their own decisions, either independently or with support from family or friends.

In BC, there are a number of laws that aim to assist adults who may not be capable of acting in their own best interests and are in need of decision making support. For example:

1. Under the *Mental Health Act*,³² when a person is seriously impaired because of a mental disorder, a physician licensed in BC can complete a **medical certificate** deeming the person no longer able to make their own admission and treatment decisions with respect to their mental disorder. The person can be admitted involuntarily to a designated mental health facility. Decision making, with respect to the person's admission, treatment and discharge, shifts to the Director of the designated mental health facility. Individuals can be admitted for up to 48 hours on the basis of one physician's certificate and up to 30 days when a second physician completes a certificate. The period of admission can be extended when a physician completes a renewal certificate.
2. Under the *Health Care (Consent) and Care Facility (Admission) Act*³³ health care providers³⁴ must seek **consent** from an adult before providing health care unless the adult is unable to give consent. The Act describes how health care practitioners decide whether an adult is incapable of giving consent. If the person is incapable of making the decision, someone else must make the decision on their behalf. The Act sets out a ranked list of substitute decision makers including: a Committee of Person, a representative or a temporary substitute decision maker, who is the nearest relative entitled to make the decision, or the Public Guardian and Trustee. The **temporary substitute decision maker** is limited to only making the health care decision at issue and for a limited period of time.

³¹ *Adult Guardianship Act*, SBC 1996, c. 6, s. 2(a), Guiding Principles.

³² RSBC 1996, c. 288.

³³ RSBC 1996, c. 181.

³⁴ For example: physicians, dentists, nurses, physiotherapists, psychologists, occupational therapists, optometrists, chiropractors and others.

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3. Under the *Patients Property Act*,³⁵ the Supreme Court can deem an adult incapable of managing their person or their affairs or both, and issue an order that appoints the applicant as their **committee**. In issuing the order, the Court hears evidence submitted by the applicant, including clinical evidence/opinions provided by two medical practitioners. If the medical evidence leads the Court to decide that the person is unable to manage their legal and financial affairs, the Court can appoint a **committee of estate**,³⁶ who has legal authority to make subsequent legal and financial decisions on the person's behalf. If the evidence leads the Court to decide that the person is unable to manage their personal affairs, that is, their health care and daily living decisions, the Court can appoint a **committee of person**,³⁷ who has legal authority to make subsequent personal decisions on the person's behalf. Committee orders remain in effect until the Court rescinds them because the adult is deemed to be capable.

In addition, the Director of a designated mental health facility can issue a 'certificate of incapability' under the *Patients Property Act*³⁸ that states an adult is incapable of managing their financial affairs and automatically appoints the Public Guardian and Trustee as their Committee of Estate. In practice, the Director decides to issue the certificate based on clinical evidence provided by a multidisciplinary incapability assessment. Based on subsequent clinical evidence, the Director may issue a 'certificate of capability'.

4. Under the *Representation Agreement Act*,³⁹ an adult may, when capable of doing so, plan for their future by making a **representation agreement**⁴⁰ authorizing a representative to make personal or financial decisions on their behalf if they are unable to make their own decisions. Section 9 of the Act sets out the range of personal decisions that a representative can be authorized to make. Section 7 sets out the financial and health care decisions a representative can make. The representation agreement comes into effect when a stipulated 'triggering condition' occurs.

35 RSBC 1996, c. 349.

36 *Patients Property Act*, RSBC 1996, c. 349, s. 15(1)(b)(1) Private Committee Handbook, p.1.

<http://www.trustee.bc.ca/pdfs/STA/PCS%20Handbook%20July%202004.pdf>

"As Committee of the Estate, you manage all the person's financial, business and legal affairs. This may include no more than apartment furnishings, and a pension, or it may be very large and complex." (p.1)

37 *Patients Property Act*, RSBC 1996, c. 349, s. 15(1)(b)(2). Private Committee Handbook, pp. 30–32.

<http://www.trustee.bc.ca/pdfs/STA/PCS%20Handbook%20July%202004.pdf>

"The role of a Committee of Person involves making decisions regarding an adult's personal care, where they are to reside, health care decisions, and who has access to visit with the adult." (p. 30)

38 RSBC 1996, c. 349.

39 RSBC 1996, c. 405.

40 *Representation Agreement Act*, RSBC, c. 405, s. 9(1) Other Provisions.

http://www.qp.gov.bc.ca/statreg/stat/R/96405_01.htm

In a representation agreement, an adult may also authorize his or her representative to do any or all of the following: (a) physically restrain, move or manage the adult, or have the adult physically restrained, moved or managed, when necessary and despite the objections of the adult; (b) give consent, in the circumstances specified in the agreement, to specified kinds of health care, even though the adult is refusing to give consent at the time the health care is provided; (c) refuse consent to specified kinds of health care, including life-supporting care or treatment; (d) give consent to specified kinds of health care, including one or more of the kinds of health care prescribed under section 34 (2) (f) of the *Health Care (Consent) and Care Facility (Admission) Act*; (e) accept a facility care proposal under the *Health Care (Consent) and Care Facility (Admission) Act* for the adult's admission to any kind of care facility; (f) make arrangements for the temporary care, education and financial support of (i) the adult's minor children, and (ii) any other persons who are cared for or supported by the adult; (g) do, on the adult's behalf, any thing that can be done by an attorney acting under a power of attorney and that is not mentioned in paragraphs (a) to (f) or in section 7 (1).

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5. Under the *Power of Attorney Act*,⁴¹ an adult may appoint another adult to act as their attorney, under a **power of attorney**, for a defined period of time, with authority to conduct specific financial or legal transactions on their behalf. If the power of attorney includes an 'enduring' clause, the attorney's authority will continue indefinitely if the person becomes unable to make their own decisions. The 'enduring' clause is triggered by medical evidence that the person is no longer able to make decisions. It is important to note that a power of attorney cannot make personal or health care decisions on behalf of the adult.
6. Under the federal Income Security Program, a **pension trusteeship** can be established. A family member or friend applies to be a person's trustee by completing a standard form, which one physician signs declaring that the person is incapable. The trustee can manage only monies paid through OAS/GIS/ CPP, not any other income or assets.

Being found incapable of making decisions affects a fundamental right of adults. As a result, all of the legislative approaches described above include a level of procedural safeguard, including limiting the duration and scope of substitute decision making.

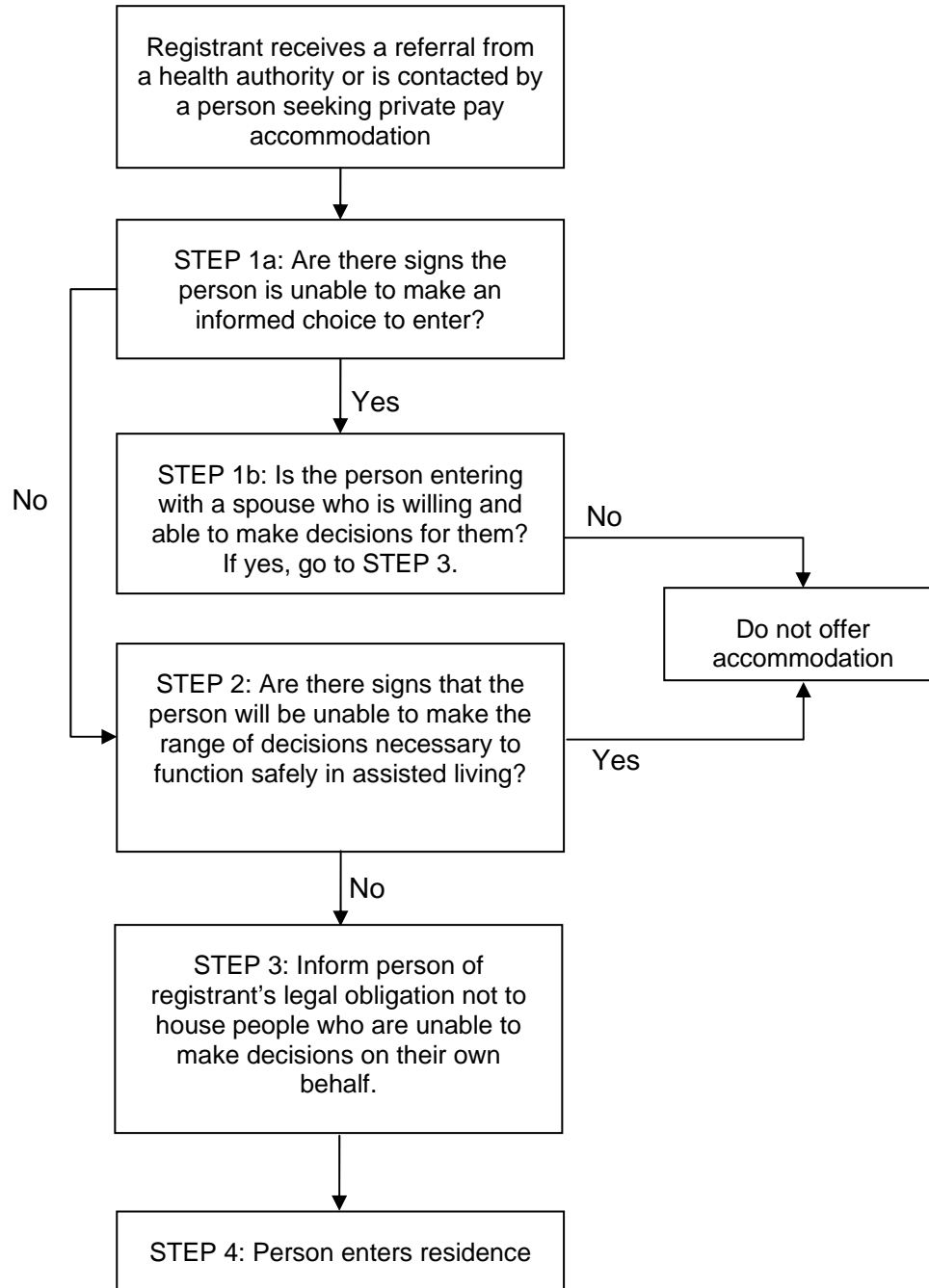
⁴¹ RSBC 1996, c. 370.

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Appendix 3 Steps to Complying with Section 26(3)

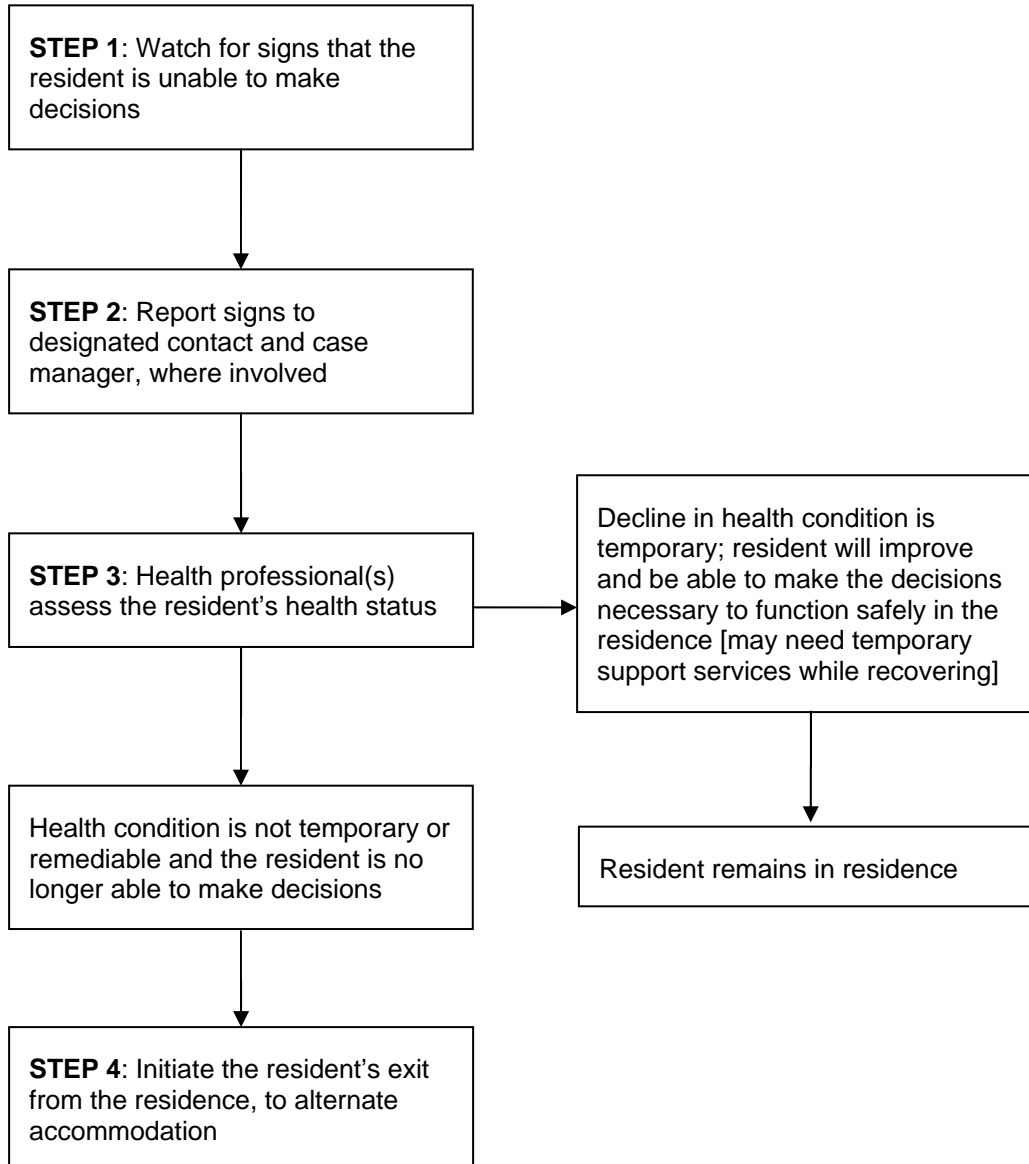
At Entry



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Ongoing



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Appendix 4 Making an Informed Decision

In discussions with a prospective resident, the registrant or their designate must:

- Communicate in a manner appropriate to the adult's skills and abilities; and
- Provide the level of information that a reasonable person would need in order to make decisions.

Typically, a family member or friend will accompany the person to help them understand the information presented, as well as help the person communicate their wishes and decisions.

Is the prospective resident making an informed decision to enter the assisted living residence?

This means that the prospective resident demonstrates an understanding of the information they have been given and, without coercion, indicates a *choice* to enter the residence. Individuals on leave under section 37 of the *Mental Health Act* would be *exempted from making an informed decision to enter* the assisted living residence as the Director of the mental health facility in which the individual has been residing makes this decision for them. Please see Appendix 1 for a discussion of what it means to be on leave under section 37 of the *Mental Health Act*.

The registrant gauges the person's understanding of the information that has been given by asking questions that will require the person to describe, in their own words, key information about the environment, the services provided and what is expected of residents.

The registrant *can assume* the person is making an informed voluntary decision *unless*, from the person's responses, the registrant concludes there are signs to the contrary. *Signs to the contrary* include where the person:

- Does not respond or provides inappropriate or unrelated responses to questions;
- Does not appear to understand what services are and are not offered;
- Does not appear to understand the consequences of not accepting the services available in assisted living;
- Does not appear to understand their own limitations and the associated risks of residing in the assisted living residence; or
- Is reluctant to sign a tenancy agreement.

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Appendix 5

Information for Residents About Making Decisions in Assisted Living

Assisted living provides housing, hospitality services and personal care for people who can live independently, but need regular help with day-to-day activities (such as dressing, grooming, bathing or taking medications).

Under British Columbia's *Community Care and Assisted Living Act*, you must be able to make the decisions that allow you to function safely in assisted living.⁴²

What Making Decisions that allow you to Function Safely Means

When you apply for assisted living, the operator will discuss with you whether you are able to manage on your own in the supportive environment of assisted living. Besides being able to make decisions about the services you will receive, you must be able to function safely for the periods you are alone in your assisted living unit, including recognizing an emergency and calling for help or following directions.

When Assisted Living is No Longer Appropriate

A time may come when you are no longer able to make the decisions necessary to function safely in assisted living. At that time, you will need to move from assisted living to other housing and/or care services that are more appropriate for your needs. This fact sheet will help you, your family and the operator of your assisted living residence to plan for that time.

Your Responsibilities

Before you enter assisted living, the operator will ask you to:

- Name a contact person who can assist you – usually a family member or friend; and
- Agree that you will seek other accommodation if, based on observations or information from health professionals, the operator and case manager (where involved) conclude you are no longer able to make the decisions that allow you to live safely in the residence.

The Operator's Responsibilities

Under the *Community Care and Assisted Living Act*, residence operators must take reasonable steps to assure themselves that you are able to make the decisions that enable you to safely live in their residence. If a spouse is assisting you, the operator needs to ensure your spouse is willing and able to continue acting on your behalf.

⁴² In some cases, a person may not be able to make all the decisions necessary to live in assisted living. That person may have a spouse who will live with them in the residence and is willing and able to assist them with making decisions. If so, the operator will need to establish a plan to support the person when the spouse is absent for extended periods, such as while in hospital, and short periods, such as an afternoon of shopping.

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If an assisted living operator sees signs that you are no longer able to function safely on your own, they will talk to you and your contact person. You and/or your contact are responsible for involving health professionals, such as your case manager or family physician, in exploring whether you can still manage in assisted living. If a health professional decides that the decline in your health functioning is temporary or you are still able to make the decisions that allow you to function safely, you will likely be able to remain in assisted living. Services may need to be put in place to maintain your health and safety if you are experiencing a temporary decline in functioning.

When the decline in your health functioning is permanent or you become unable to make the decisions that allow you to function safely in assisted living, the operator must, by law, ask you to find another place to live.

If a Move is Necessary

When it is decided that a move is necessary, the operator will talk with you, your contact person and your case manager (where involved) about your plans for seeking other accommodation. You will be expected to move as quickly as possible, as soon as other alternatives are available.

The operator will work with you and your contact person to develop an exit plan that sets out:

- Your relocation plans;
- Who is responsible for making these arrangements; and
- What, if any, additional services will be put in place to protect for your health and safety while you are awaiting your move.

For More Information

For more information about moving out of assisted living, please contact your residence operator at:

Appendix 6

Signs of Declining Decision Making Ability

1. Signs of a decline in functional ability, that is, where the resident's ability to perform tasks has declined, may include:

- Overall – needing an increasing level of cuing or assistance to do things the person was able to do in the past, or where cuing becomes ineffective;
- Dressing – unable to make a suitable selection of clothing, or unable to determine the sequence or orientation of clothing; for example, pants or shirt on backwards; underwear on top of outer clothing;
- Eating – regularly missing meals (and not eating), even with reminders (unable to ensure adequate nutrition to maintain health);
- Medications – refusing essential medications without rational explanation;
- Decline in personal hygiene;
- Toileting – inappropriate handling of incontinence (for example, placing soiled incontinent products in dresser drawer);
- Changes in sleep patterns;
- Way finding – frequently unable to locate own suite (or enters wrong suites). If problem occurs immediately after entry to assisted living, the matter may resolve once the resident has settled in;
- Wandering – wandering outside building and being unable to find way back (unable to problem solve and use alternative strategies to get back to the residence – for example, carry address and use taxi for return). If the problem occurs immediately following entry, the matter may resolve once the resident has settled in;
- Health and safety – declining ability to:
 - Use emergency call system (for example, internal call system or Lifeline), or alternatively, to call for help when problems arise;
 - Recognize the consequences of decisions or actions and that some actions may result in injury or harm to themselves or others;
 - Remember information crucial to their health and safety;
 - Comply with areas of the service plan that are critical to the person's health and safety; or
 - Participate in updates to the service plan (for example, does not express a choice in response to options; demonstrates that does not understand services, options and implications of decisions).

2. Changes in behaviour, such as new or increasing levels of behavior associated with:

- Hoarding, barricading in room, disheveled appearance;
- Becoming verbally aggressive/confrontational with other residents and staff;
- Repetitive behaviour (for example, repeatedly going to dining room or front desk asking if it is time for lunch; doing same after having eaten);

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- Increased activity at the end of the day, referred to as 'sun downing';
- High anxiety (for example, increased frequency of requests for reassurance);
- Self-neglect or engaging in unsafe activities;
- Frequent heavy consumption of alcohol or use of drugs;
- Allowing people into the residence who may place others at risk, for example, drug dealers; or
- Diminished communication, for example, responding inappropriately to questions/conversation.

Appendix 7

Assessing a Person's Ability to Make Decisions

Many individuals choosing to live in assisted living will have some impairment of their cognitive abilities, such as a mild dementia. To be appropriate for assisted living, the level of cognitive impairment must not interfere with the person's ability to make the range of decisions that will allow them to perform in the key functions described in 'What decisions do assisted living residents need to be able to make?'

Cognitive ability refers to the higher-level functions of the brain, including memory, comprehension, attention, initiation, calculation ability, use of speech, and executive functions such as planning, problem-solving and self-monitoring. Cognitive capacity refers to the *degree to which* someone possesses this broad range of abilities.

While cognitive capacity affects a person's ability to make decisions, tests of cognitive capacity⁴³ cannot fully predict whether a person is capable of making a decision and carrying out that decision, as evidenced by their ability to perform a particular function. Some individuals are able to compensate for their cognitive impairment and continue to function adequately.⁴⁴

Changes in behavior may also indicate a decline in cognitive capacity.⁴⁵ For example, a person displaying:

- New, or increasing, socially inappropriate behaviors;
- Self-neglect or unsafe activities;
- Increasing difficulty in initiating activities; and/or
- Increasing anxiety, repetitive behaviour or requests for reassurance.

If it is concluded that the person's cognitive capacity is declining, their ability to make decisions *may* be compromised.

When health professionals receive reports from assisted living registrants of changes in behavior or changes in a resident's level of functioning, they conduct a more in-depth assessment of the person's health status including an investigation into the underlying causes for any change in the person's ability to function/make decisions. This will most often include an investigation into the person's medical condition⁴⁶ and an assessment of the resident's ability to function in the assisted living environment.⁴⁷

43 Common assessments of cognitive capacity include the Mini Mental Status Examination (MMSE), the Modified Mini-Mental State (3MS) examination, and the Cognitive Performance Scale (CPS) derived from the MDS Assessment (used by Home and Community Care).

44 In December 1999, the Supreme Court of Canada's **Grismer** decision raised issues about the methods that driver licensing authorities use to assess driver fitness. The Court said that it was not enough to have a blanket rule that persons with a certain medical condition, or cognitive test score, cannot drive. Instead, drivers licensing authorities need to provide an individualized functional assessment to determine whether the person is able to compensate for their disability and still perform the function, that is, drive.

45 University of California, San Francisco – Memory and Aging Center: Alzheimer's Disease Research Center – <http://memory.ucsf.edu/Education/Topics/execfunction.html>.

46 Conducted by their family physician, with referrals to medical specialists as required.

47 Carried out most often by occupational therapists employed by the health authorities.

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Under section 26(3), health professionals cannot compel a resident to undergo an assessment of their decision making/functional abilities. The person will need to comply with the request voluntarily.

If the person does not comply with the request, the health professional, or team, may form an opinion based on collateral information. For example, collateral information can be gathered from the registrant, family, or other key contacts – documenting any changes to behaviors, habits, general appearance and overall health status, typical social patterns and living conditions.

A person should not be considered to be ‘unable to make decisions’ if their decline in function is likely to be temporary and of short duration such that it will not have a significant impact on their ability to live safely in the assisted living residence. For example, in residences housing people with mental health or addiction issues, there will be residents whose illnesses involve cycles, relapses and remissions, where decision making will vary during those different periods. A temporary decline in decision making ability could also be caused by a change in drug regimes.