6(1) **Execution of Documents Prior to Admittance**

That a policy be established requiring the execution of financial and legal documents prior to admittance to the Dearness Home; and that extraordinary cases be dealt with on their own merits.

ADOPTED DECEMBER 6, 1961 [6(1) AUG 1999]

6(2) **Termination of Residence**

That a policy be established whereby the Dearness Home Administrator be empowered to terminate the residence in the Home of those residents conducting themselves in a manner detrimental to the operation of the Home or to the welfare of their fellow residents.

ADOPTED FEBRUARY 18, 1963 [6(2) AUG 1999]

6(3) **Funeral and Burial Expenses**

That a policy be established whereby the City Treasurer be authorized to retain and maintain $1,000.00 for funeral and burial expenses in the general trust account of all Dearness Home residents who have assets in excess of this amount; it being noted that several residents are accumulating funds in their personal trust accounts by the amount of refund from their Old Age Security cheques.

ADOPTED DECEMBER 20, 1965; AMENDED MAY 31, 1974; MAY 15, 1978 [6(3) AUG 1999]

6(4) **Inventory Prior to Departure**

That for the protection of Dearness Home Administrators and Assistant Administrators who may resign in the future, a policy be established whereby a complete inventory be taken of all equipment and furnishings on hand at the Home prior to their departure.

ADOPTED NOVEMBER 18, 1966 [6(4) AUG 1999]

6(5) **Refund from Residents' Monthly Income**

That a policy be established whereby the refund (from their monthly income) to all residents of the Dearness Home be in accordance with the regulations as authorized by the Ministry of Community and Social Services through regulations made under the *Homes for the Aged and Rest Homes Act*, R.S.O. 1990, Chapter H.13 from time to time.

ADOPTED JUNE 19, 1967 [6(5) AUG 1999]
6(6) Minnie Rickard Bequest Fund

That a policy be established to provide that only the revenue earned by the Minnie Rickard Bequest Fund be used to purchase added comforts from time to time for the residents of the Dearness Home.

ADOPTED MAY 21, 1968 [6(6) AUG 1999]

6(7) Inspections by Committee of Management

That a policy be established to provide for the semi-annual inspection of the Home by the Dearness Home Committee of Management (the Community and Protective Services Committee) being held at the Committee's first meeting in January with the second inspection approximately 6 months later at the discretion of the Committee.

ADOPTED OCTOBER 21, 1968 [6(7) AUG 1999]

6(8) Purchasing of Items in Excess of $500.00

That a policy be established to provide that the purchase by the Dearness Home of all items in excess of $500.00 be made through the City's Purchasing Division.

ADOPTED OCTOBER 18, 1971 [6(8) AUG 1999]

6(9) Releasing of Assets Once Residents' Costs Paid

That a policy be established to provide that whenever a resident of the Dearness Home dies, leaves the Home of his own volition or is required to leave the Home and the City holds assets in trust on his behalf, the Finance Division be authorized to release the balance of such assets when the maintenance costs incurred by the resident have been paid in full.

ADOPTED JANUARY 17, 1972 [6(9) AUG 1999]

6(10) Execution of Will by Residents

That a policy be established to provide that when a resident is admitted, a simple form of Will should be executed by those who do not have one, it being pointed out that this will be of assistance in clearing the estate.

ADOPTED MARCH 20, 1972 [6(10) AUG 1999]

6(11) Funeral Expenses for Indigent Residents

That a policy be established requiring the Dearness Home to assume responsibility for the funeral expenses for indigent residents who die in the Home.

ADOPTED JUNE 19, 1972 [6(11) AUG 1999]
6(12) Interest from Bequest Fund

That a policy be established whereby the Administrator of the Dearness Home, after consultation with the Chair of the Dearness Home Committee of Management and the Residents’ Council, be authorized to use the interest from the Bequest Fund for the purchase of suitable items for the Dearness Home and its residents.

ADOPTED JUNE 4, 1973 [6(12) AUG 1999]

6(13) Administration of Mortgages

That a policy be established to provide that no charge be levied to residents of the Dearness Home for administering mortgages held in trust by the City of London for their maintenance.

ADOPTED JULY 3, 1973 [6(13) AUG 1999]

6(14) Personal Trust Funds

That a policy be established to provide that in accordance with Section 35 of R.S.O. 1990, Reg. 637, made under the Homes for the Aged and Rest Homes Act, R.S.O. 1990, Chapter H.13, the Dearness Home Residents’ Personal Trust Funds shall be released to the residents, or to such other person as may be duly authorized in writing by the resident to receive such funds, provided in the latter case that the Dearness Home Administrator is satisfied that any funds released to anyone other than a resident will be used for the sole benefit of the resident concerned; it being understood that Maintenance Trust Accounts (where they exist) which could involve substantial sums of money, and which are administered by and under the control of the Finance Division, are not in any way the subject of this policy.

ADOPTED DECEMBER 15, 1975 [6(14) AUG 1999]

6(15) Admission Policy

That the following policy be established with respect to admissions to the Dearness Home, namely:

(a) in keeping with the current philosophy (guidelines) of the Senior Citizens Bureau of the Ministry of Community and Social Services, as set out in the Ministry’s policy statement dated August, 1975 [See Appendix 6(15A)], the Administrator, subject to Sections (b) and (c), is authorized to admit to the Dearness Home applicants who, in the opinion of the Home Physician, qualify for Residential Care;
(b) applicants who do not qualify for residential care nor fall under the Ministry's admission guidelines (e.g. extended care, under age between 55 and 60) may be approved for admission by the Committee of Management upon the joint recommendation of and after an assessment by the Home Physician and the Home Administrator. Any such admission shall not result in changing the established bed ratio of 285 residential vs. 200 extended care nor shall it result in an increase in staff. Furthermore, any such admission where applicable shall be subject to the Ministry's approval;

(c) in addition to the normal requirements a non-resident applicant may be considered for admission by the Committee of Management providing:

(i) there is a vacancy and no waiting list exists, and one of the following three conditions exists:

- the applicant is able to pay full maintenance costs; or
- the applicant was a former resident who resides in the City for at least three out of the ten immediate past years; or
- the applicant's immediate family (son, daughter, brother, sister) resides in the City;

(d) the Committee of Management shall report any admission to the City Council.  
ADOPTED FEBRUARY 16, 1976 [6(15) AUG 1999]

6(16) Opening Residents' Mail

That a policy be established whereby applicants for admission, as well as residents currently in the Dearness Home, on whose behalf the Corporation of the City of London is acting or will be required to act as Trustee, will be interviewed and invited to enter into an agreement with the Corporation of the City of London authorizing the Corporation's designated official to open mail addressed to the resident containing:

(a) Cheques relating to maintenance charges;

(b) Medical reports, records and payments required to facilitate the Home Physician in the performance of his duties;

it being noted that, an applicant for admission or a resident already in the Home who does not wish to enter into such an agreement with the Corporation of the City of London, will not be disqualified from residency in the Dearness Home.  
ADOPTED APRIL 17, 1978 [6(16) AUG 1999]
6(17) Committee of Management

That the Community and Protective Services Committee (CPSC) be designated to continue to serve as the Committee of Management for Dearness Services under the provisions of the *Homes for the Aged and Rest Homes Act*, R.S.O. 1990, and that a minimum of four meetings a year of the Committee of Management be held at the Home, it being noted that all matters relating to personnel, legal or property will be referred to the Board of Control for its concurrence prior to being recommended to the Municipal Council.

ADOPTED DECEMBER 3, 1979; AMENDED NOVEMBER 2, 1992, JUNE 17, 2002 [6(17) AUG 1999]

6(18) Discharge Policy

That the Discharge Policy set out in Appendix 6(18A) be established to facilitate a procedure for residents of the Dearness Home who require more nursing care than the Home is set up to provide and should be transferred to a chronic care facility.

ADOPTED APRIL 7, 1986 [6(18) AUG 1999]

6(19) Use of Low Flow Oxygen

That the following policy be established to provide for the use of low flow oxygen in the Dearness Home in situations where there is chronic respiratory disease, on the understanding that the use of this policy would be undertaken only on the direction of the Home’s Medical Director:

(a) oxygen will be delivered only by use of low flow oxygen concentration;

(b) low flow oxygen therapy will be used only for residents with chronic respiratory disease who are non-smokers and who can be housed in a private room. Fire hazard will be assessed by medical, nursing, maintenance personnel. Concentrators will not be used outside the designated private room;

(c) the electrical safety of the equipment will be assessed by the maintenance engineers and by the company providing the oxygen equipment. The service agreement will be included with all such equipment. It must be recognized that the Dearness Home has no back-up emergency electrical supply in the event of a power failure;

(d) oxygen therapy is provided through the Ontario Drug Benefit Program and as such is covered to 100% of the cost, leaving no charge to be made to either the resident or the Home;

(e) low flow oxygen therapy will be ordered by the physician by a written order specifying method of administration, rate of flow and number of hours per day.
Administration of such therapy will be the direct responsibility of the registered nurse (who has had special in-service education in the operation of the equipment);

(f) each involved discipline will develop a written procedure for the above equipment and its use in keeping with the Ministry guidelines for use of oxygen.

ADOPTED JULY 5, 1988 [6(19) AUG 1999]

6(20) Preferred Accommodation Charges

That a policy be established whereby residents of the Dearness Home who are covered under the Extended Health Care Program and who have the ability to pay, be charged the additional rate of Preferred Accommodation to the extent provided for in the Regulations of the Homes for the Aged and Rest Homes Act, R.S.O. 1990, Chapter H.13; and that Preferred Accommodation charges be implemented as at November 15, 1989.

ADOPTED OCTOBER 2, 1989 [6(20) AUG 1999]

6(21) Holding of Beds

That the policy set out in Appendix 6(21A) concerning the holding of Dearness Home residents' beds while out of the home or their permanent room be established, to be effective as of September 1, 1990.

ADOPTED JUNE 11, 1990 [6(21) AUG 1999]

6(22) Level of Treatment Intervention & Health Care Directive

That the policy set out in Appendix 6(22A) concerning the level of treatment intervention and health care directives be established.

ADOPTED MAY 2, 1994 [6(22) AUG 1999]
6(15A) Appendix to Admission Policy

In the admission policy of every Home there should be an aspect of assessment and selection clearly understood by everyone, including Members of the Board or Committee, the Physician to the Home, the Administrator, the Nursing Supervisor and the Social Worker.

Since April 1, 1972, two levels of care are defined for Residents of Homes for the Aged: Residential, which corresponds to the type of care previously known as Normal (Ambulatory), and Extended Care. The services for Extended Care mean:

Care and maintenance given to a resident that includes skilled nursing and personal care given by or under the supervision of a registered nurse or where the Director approves, a registered nursing assistant under the direction of the physician of the Home appointed under subsection 4 of section II of the Act, for a minimum of one and one-half hours per day;

(Regulation 1, Section (ac) of the Homes for the Aged and Rest Homes Act and Regulations, R.S.O. 1990, Chapter H.13, and Regulation 1, Section (bb) of the Charitable Institutions Act and Regulations, R.S.O. 1990, Chapter C.9.)

Applicants for admission must be examined and classified by the Home Physician as requiring either Residential or Extended Care services. In Homes where the Corporation or Municipality has chosen not to provide Extended Care services, applicants who have been certified eligible for such care should not be admitted. The Ministry of Community and Social Services is discouraging Charitable and Municipal Homes for the Aged from unreasonably increasing the present accommodation for Residents who require Extended Care services. Many Residents in Residential Care, through progressive physical and mental deterioration, will eventually require Extended Care facilities and will have priority for accommodation over applicants from the community eligible for Extended Care benefits.

Within the two levels of care, i.e., Residential and Extended Care, the Home for the Aged team responsible for deciding on admission of applicants must still retain a clear appreciation of proper placement of an individual. In this regard, the familiar long-standing categories of Normal (Ambulatory), Special and Bed Care no longer apply, but the definition of these categories is an excellent guide in considering available and appropriate placement.

Normal Care has had a variety of descriptive titles, including Residential, Ambulatory and Domiciliary. For admission of applicants the following criteria should be established:

(a) The applicant is not ill, but is infirm, handicapped or disabled due to a previous injury or illness;
(b) The applicant is mentally or physically limited in his/her ability to properly care for himself/herself independently;

(c) Care required is primarily supervisory and some assistance with activities of daily living;

(d) The medical condition is known to be stabilized or under clinical control;

(e) The treatment, if any, is standardized and includes only maintenance medication;

(f) Care needs cannot be met adequately with the services available in the community. Care needs through Outreach services such as Homemakers and Nursing Services, foster home care, and Meals-on-Wheels, etc., should be fully explored.

Special Care is necessary for those Residents who have a high degree of mental confusion and loss of intellect. Consequently, they must depend on someone to guide and protect them. Their degree of dependency can vary from mild bouts of mental confusion to almost complete loss of consciousness of their environment. Tendency to wander and lose themselves, once out of the Home, is always a concern and some restriction of movement is required to guard against serious consequences. In this category are many congenital and acquired mental impairments. Those suffering from cerebral arteriosclerosis or senile dementia are the most common. Advanced Parkinson's disease accounts for a fair number; less frequent are the cerebral palsies.

Physicians must be aware of the legal distinctions between commitment under the Mental Health Act, R.S.O. 1990, Chapter M.7, and necessary appointment of a committee under the Mental Incompetency Act, R.S.O. 1990, Chapter M.9. The Homes for the Aged and Rest Homes Act, R.S.O. 1990, Chapter H.13, per se (and certainly the Charitable Institutions Act, R.S.O. 1990, Chapter C.9) does not give any type of committal power to Home authorities.

Bed Care is required for those who, because of their infirmities, are required to spend a greater portion of their time in bed and are dependent on others for assistance in feeding and moving out of bed. The title "Bed Care" does not imply that they are necessarily unable to be moved out of bed to sit safely supported in a chair for various periods of time. This may be a terminal stage of senility or due to the advanced stage of otherwise stable chronic disease and accounts at this time for a good percentage of the Residents of most of the Homes for the Aged, more particularly in Municipal Homes in contrast to those in Homes operated by Charitable Corporations.

No person should be admitted to a Home for the Aged or maintained in the Home whose health or well-being might be considered to be in jeopardy, because a Home does not and should not supply the treatment or facilities of a hospital or related health-care facility. A good guide to the care that should be supplied by a Home for the Aged is the level of care that could be expected in an individual's own home in the community.
Some situations with which a Home is not prepared to cope are as follows:

**Active Infections**

No person running a fever or exhibiting active disease, such as inflammation of joints or wounds, chest infections including tuberculosis, skin infections and infestations.

**Open Sores and Unhealed Wounds**

From such as eroding carcinoma, various ulcers or unhealed wounds, surgical or traumatic. All these require special dressings and sterile techniques. This does not apply to clean-healing incisions (post-operative).

**Indwelling Catheters**

To prevent contracted bladder and genito-urinary infections, these persons need constant laboratory control, precise sterile techniques and facilities for producing sterile trays. An individual with a supra-pubic cystotomy may be admitted providing it is functioning satisfactorily and there has been a complete urological investigation and consultation.

This policy on indwelling catheters has the full endorsement of the Advisory Committee on Geriatric Studies of the Minister of Community and Social Services, such prominent specialists in urology as Dr. Peter O. Crassweller, F.R.C.S.(C), F.A.C.S., Chief of Urology, Toronto Western Hospital, and Dr. Gerald Ranking, F.R.C.S.(Eng), F.R.C.S.(C), the Ontario Association of Homes for the Aged, Home Physicians and Directors of Nursing. They have consistently taken the position that the care of persons requiring indwelling catheter drainage is not one with which the staff of a Home for the Aged is prepared to cope.

**Colostomy**

Is not a barrier to admission if well controlled and not requiring undue nursing attention.

**Terminal Disease**

The term alone indicates it is disease-oriented and the facilities of the Home are not designed for P.R.N. orders or continuing emergency coverage. A less restrictive policy should apply where terminal disease has developed during long-standing residence in the Home. Unless complications develop that require special nursing care and treatment facilities not available, subject to the physician's decision the Resident may be allowed to live out the life remaining in the Home.
Inherently Unstable Conditions

These include mental and physical disease. The Home is not the place for active paranoidal or constant or explosive mental illness. Obstreperous or noisy individuals who would be a continuing source of annoyance to other Residents should not be admitted. The Home must be seen as a living environment - a "home" in the truest sense of the word to the majority of elderly men and women who reside therein. Individuals suffering from mental illness or mental deficiency who require care, supervision and control for their own protection or welfare or the protection of others, as defined in the Mental Health Act, R.S.O. 1990, Chapter M.7, should be admitted to a Mental Hospital or other psychiatric facility.

Memorandum #34/73 "Admission from Psychiatric Facilities" should be consulted for further clarification of procedures for dealing with psychiatric problems.

Unstable or poorly controlled epilepsy, brittle or unstable diabetes, cardiac or pulmonary insufficiency requiring oxygen administration, or those with a haemorrhagic diathesis, from such as gastro-intestinal or genito-urinary sources which could conceivably necessitate emergency transfusions, require more nursing care and disease control than is available in a Home for the Aged, and should not be admitted.

Toxic Drugs

The control of drug administration is the responsibility of the Home Physician. When he prescribes drugs which require frequent clinical checks and periodic laboratory analyses to avoid serious side effects, i.e., hypotension, agranulocytosis, anaemia, leucopenia, potassium depletion, liver and kidney damage, etc., it indicates that such testing facilities are readily available, that he is familiar with the contraindications to their use (particularly in elderly people), and he assumes such follow-up assessment as is recognized good clinical practice. If this is not available and such medication is required, as posted in admission forms, the Home Physician should recommend rejection of the application and the Members of the Board or Committee should refuse admission. In the event an attending physician wishes to continue to treat and prescribe for a Resident, he must take complete twenty-four hour responsibility for the clinical and laboratory follow-up on any medication he may order to be given and such orders must be signed by the prescribing physician.

Incomplete Convalescence

A Home for the Aged is not intended as a convalescent hospital. Because of the orientation and purpose of a Home, admitting applicants or re-admitting Residents who have been transferred to a general hospital for medical or surgical treatment, before recovery is established and stable, may well endanger their potential maximum return to health. Therefore, no one should be admitted or re-admitted who is in unstable and uncertain phases of recovery from infections, accidents or surgery.
6(18A) Appendix to Discharge Policy

When one or more of the following criteria are met, an assessment for discharge will be made by the Discharge Committee of Dearness Home and the individual will be placed on a prioritized list for discharge.

CRITERIA FOR DISCHARGE

(1) Persons who are socially incapable of peaceful social co-existence with others by reason of over-indulgence in alcohol or illicit drugs.

(2) Persons who are suffering from psychotic mental illness to the extent that they require treatment in a psychiatric facility.

(3) Persons who have become physically disabled to the point of requiring treatment in a chronic care hospital setting.

(4) Persons who wish to transfer to other Homes for the Aged for personal reasons.

(5) Persons who wish to leave the Dearness Home for personal reasons and who have set up satisfactory alternative living arrangements.

The GUIDELINES for the Discharge Committee are as follows:

With respect to the individual needs of some Residents whose needs may not be met by the Home owing to either Home policy or Home capability and those Residents who wish to voluntarily withdraw from the Home, there shall be a Discharge Committee composed of the following members:

(i) Medical Director
(ii) Manager of Nursing Services
(iii) Administrator and/or Assistant Administrator
(iv) Registered Nurse (Unit Supervisor)
(v) Resident and/or next-of-kin

(a) All members shall have opportunity for input into specific resident assessment with respect to discharges but the Medical Director and Administrator must offer a joint opinion for discharge.

(b) The Committee shall meet as often as necessary.

(c) Written documentation on behalf of the Committee shall be entered on the multi-disciplinary progress note.
(d) Before discharge is recommended, the Committee shall explore every possible option and, prior to discharge, explore and assist with appropriate referral; it being understood that every attempt will be made to ensure that the discharge be as least traumatic as possible to the resident and their next-of-kin.
6(21A) Appendix to Holding of Beds Policy

POLICY:

To provide guidelines for (1) resident vacation and (2) bed retention, both within and outside of the Home.

PROCEDURE:

(1) Where a resident has been transferred to an infirmary room from his/her room and there is a reasonable expectation he/she will be able to return to that room, there will be a regular and ongoing review of the resident's status. The underlying premise is that the resident will return to his/her regular room at the earliest opportunity.

(2) Where a resident has been transferred to another room, other than an infirmary room, from his/her regularly occupied room and the transfer is for a duration exceeding seven consecutive days, the transfer will be deemed to be permanent. Amendments to the resident record system will be initiated immediately upon permanent transfer, by the Unit Manager.

(3) Where a resident qualifies for residential care and is in hospital, the resident shall be charged the full per diem.

(4) Where a resident qualifies for residential care, is in hospital for over 90 days, and wishes to retain his/her room, the request will be subject to review by the Dearness Home Admissions & Discharge Committee.

(5) Where a resident qualifies for extended care and is transferred to hospital, he/she will be charged 100% of the extended care co-payment for the period established by the regulations. After this period has elapsed (currently 14 days) he/she will be charged the full residential per diem. If after 90 days, he/she wishes to retain his/her room, the request will be subject to review by the Dearness Home Admissions & Discharge Committee. Upon re-admission, he/she will automatically regain his/her former extended care status.

(6) Residents who qualify for residential care may leave the Home on vacation subject to provincial guidelines but will not be exempt from paying the daily per diem.

(7) Residents who qualify for extended care may leave the Home for vacation subject to provincial guidelines but will not be exempt from paying the daily per diem.
PREAMBLE & PHILOSOPHY:

Our Dearness Mission Statement expresses our commitment to:

- Providing the opportunity for each resident to experience a quality of life which enhances the dignity of the individual.

- Developing each resident care plan with the participation of the resident and their family.

Our Dearness Residents' Rights Statement recognizes a residents' right:

- To refuse medical treatment and medication and to be informed of the medical consequences of any refusal.

Each resident shall have the right to choose the level of intervention that will be effected for acute inter-current illness.

POLICY:

In the event of a witnessed cardio-respiratory arrest, the acute care level of intervention, which includes C.P.R., will be initiated unless the resident, or their representative, has expressed a desire for a less intense intervention.

PROCEDURE:

Procedure Pre-Admission

(1) Prospective residents will be informed about and provided a copy of the Level of Treatment Intervention and Health Care Directive by the Admissions Coordinator.

(2) If the prospective resident wishes to discuss the options described in this policy, we will offer them the opportunity to discuss the options with the Manager of Nursing Services and other members of our Dearness Care Team. We would also encourage prospective residents to discuss the options with their families, friends, cleric, attending physician, or other trusted individuals.

Procedure Post-Admission

(1) Medical treatment options will be reviewed with the resident/representative/power of attorney prior to the first Care Team meeting. In doing this, the Unit Manager will co-ordinate referral and/or assistance from all members of the Care Team.
(2) The health care directive will be a routine item for discussion at the initial and all subsequent Care Team meetings. At each such meeting, the attending physician is expected to provide the resident/power of attorney with a clear picture of the current medical status, along with expected outcomes from any aggressive treatment for acute intercurrent illness (i.e. pneumonia).

(3) At the time of the Care Team meeting, the resident/representative/power of attorney will be requested to provide direction to the Attending Physician as to their preference with respect to the level of intervention expected. Any need for intervention prior to this meeting will be dealt with as necessary.

(4) The categories of intensity of intervention are:

- **Supportive Care:** Provide comfort measures such as personal care and pain relief. No C.P.R.
- **Limited Care:** Do give antibiotics and other medications orally. No intravenous therapy. No C.P.R.
- **Moderate Care:** Medications may be administered via I.V. therapy. Also consider transfer to acute care for treatment. No C.P.R.
- **Acute Care:** C.P.R. is started. (Dearness staff with certificate of competence.)

(5) The resident/representative/power of attorney direction will be entered on the resident chart as a Physician’s Order.

(6) The Attending Physician will review the order at least quarterly or at the request of the resident/representative/power of attorney and indicate on the quarterly medication review.

(7) For residents deemed incompetent, current legislation will prevail.

(8) If there is a question of competency, the Attending Physician may request a second medical or legal opinion.

(9) If the resident/representative/power of attorney wishes a change in the health care directive at any time, this wish will be respected. Thereafter, participants in the decision for change will meet with the attending physician to review the resident's current intensity of intervention level.
REFERENCES:

C.P.R. (Cardiopulmonary Resuscitation)

What is C.P.R.? It is an emergency procedure which attempts to restore breathing and heartbeat in a person whose heart or breathing, or both have stopped (cardiorespiratory-arrest). THE EVENT MUST BE WITNESSED. The objective of this basic life support is to take over for these failed body functions for a limited period of time. It must be followed by advanced life support in a hospital, which may include drugs, mechanical ventilation, or other technology.