Section 5

Power of Attorney

There are four types of Powers of Attorney in Ontario:

1) **General Power of Attorney for property.**
This Power of Attorney can be given by the Care-Receiver if someone is needed to help manage finances of the Care-Receiver or, for example, assist in the sale of a property. The Care-Receiver must be mentally capable to execute this type of document.
The provincial Public Guardian and Trustee is the substitute decision-maker of last resort if there is no other appropriate person. A Guardian of the Person is someone authorized by a court to make personal decisions for a Care-Receiver upon his/her becoming mentally incapable. The Guardian must stay in contact with and consult with the Care-Receiver and make decisions that are best for the Care-Receiver. Family and friends can apply to the Consent and Capacity Board to become the substitute decision-maker for medical treatment admission to a long-term care facility and personal assistance services in a long-term care facility. They become a board-appointed representative that ranks above spouse, partner and other family members. As well, family and friends can apply to the Superior Court of Ontario to be appointed as Guardian of the person with authority for treatment. A Guardian of the Person ranks highest on the hierarchy of substitute decision-makers named in the law.

Consent and Capacity Board:
Phone – 416 327-4142
Web site – www.ccboard.on.ca

Office of the Public Guardian & Trustee:
Phone – 416 314-2800
Web site – www.attorneygeneral.jus.gov.on.ca

2) **Continuing Power of Attorney for Property** is a legal document that gives someone the power to act as an agent for legal actions with property. This person becomes an "attorney". A Continuing Power of Attorney for property lets the "attorney"

go on acting for the Care-Receiver when that person becomes mentally incapable. To be "mentally capable" means that a person must have the ability to understand information relevant to making a decision and the ability to appreciate the reasonably foreseeable consequences of a decision or lack of decision. The document must be called a continuing Power of Attorney, or state that the "attorney" can act when the Care Receiver becomes mentally incapable. It is wise to chose someone trustworthy as Continuing Power of Attorney for Property while the Care-Receiver is mentally capable.

3) **Power of Attorney for Personal Care** is a legal document giving someone the power to make personal care decisions for the Care-Receiver when they become mentally incapable. This person is also called an "attorney". Personal Care decisions are those made about health care including medical treatment, diet, housing, clothing, hygiene and safety. A Power of Attorney is needed for residents of long-term care facilities.

4) **Banking Power of Attorney** is a form issued by Care-Receiver's bank to name someone who will manage financial affairs. This document applies to the bank only and does not overrule the legal Continuing Power of Attorney. Have a lawyer verify the document.

Kits for Powers of Attorney for Personal Care and for a Continuing Power of Attorney for Property are available free of charge from the office of the Public Guardian and Trustee - Telephone 416-314-2800.

The Advocacy Centre for the Elderly (ACE) has prepared a booklet on Continuing Powers of Attorney. It is available by calling ACE at 416- 598-2656.

The "attorney" acting on behalf of the Care-Receiver is entitled to payment. Consult a lawyer to determine the amount if it has not been specified in the document.

Have a number of copies made of original documents of Power of Attorney since they will be required for many of the services needed.

If the Care-Receiver is incapable of executing a Continuing Power of Attorney for Property, then it is necessary to look at the finances and property, and the need for financial management. If the Care-Receiver's only income is from public pensions, and that person has no other assets than personal items of nominal value then a relative or friend may apply to become a trustee to manage the individual's pension cheques. This is done by providing Human Resources Skills Development Canada - Income Security Programmes with forms: "Certificate of Incapacity" and an "Undertaking to Manage Finances". These forms are available from Human Resources Skills Development Canada at 1-800-277-9914.

Community Legal Education Ontario (CLEO) has publications on other areas of law as well. Most are free and can be ordered by calling 416-408-4420 or by visiting www.cleo.on.ca on the internet.

Centralize all banking and payment of bills, and consider supervising finances.

The Health Care Consent Act

This Act was enacted to establish a framework for health care decision-making. Decisions with respect to treatment, admission to long-term care facilities and personal assistance services in long-term care facilities are all covered by the Health Care Consent Act. This Act allows other substitute decision-makers to make some personal care decisions when the Care-Receiver does not have a Power of Attorney for personal care, and becomes mentally incapable.

Advance Care Planning – Power of Attorney
Advance Care Planning is about the care-receiver making choices now about how they wish to be cared for in the future if they become incapable of making decisions. The Care-Receiver gives someone who is trustful the position of substitute decision-maker. This person gives informed consent for health care, nutrition, shelter, clothing, hygiene or safety. It is the Care-

Receiver's choice whether to do advance care planning or not. The health care providers are required to take direction from your substitute decision-maker. This person makes decisions when the Care-Receiver becomes incapable of doing so. The personal care wishes expressed while capable are legally binding. The care wishes can be expressed to the substitute decision-maker in any form of writing or face-to-face or with a recording device. Then the appointment is made in writing through a Power of Attorney for Personal Care. This document must be signed and dated by the Care-Receiver with 2 witnesses who then co-sign it. The health care provider decides whether the Care-Receiver is capable of making decisions about medical treatment, admission to a long-term care facility or personal assistance services in a long-term care facility.

An Advance Care Directive or living will is used to document the care wishes so the substitute decision-maker can refer to it when making care decisions in the future.

A Power of Attorney for Person Care may be used for the same purpose as an advance care directive or living will but it also appoints the substitute decision-maker. A lawyer is not required to prepare documents for advance care planning but might be helpful in explaining options.

When there is no substitute decision-maker through a Power of Attorney for Person Care, a health care provider must turn to the hierarchy of substitutes named in the law to make health decisions. The highest-ranking person on this list who is available, capable and willing to make these decisions, will become the substitute decision-maker.

1. Spouse, common-law spouse or partner
2. Child (16 yr. or older) or parent of Care-Receiver
3. Parent with right of access only
4. Brother or sister
5. Any other relative by blood, marriage or adoption

Advance Directives is the opportunity to tell the doctor, facility staff and family how you would like the care managed when the Care-Receiver cannot make decisions. Advance Directives help

ease some of the burden for the caregiver by providing a documented record for future treatment. The directives can be done before the Care-Receiver becomes unable to do so. The choices are written down to eliminate any risk of confusion, and provide a range of treatment options. The options could include the transfer to a hospital or receiving antibiotics or cardiopulmonary resuscitation (CPR).

There are four levels of intervention or treatment options:

Level one - supportive/comfort care
- no CPR

Level two - limited therapeutic care
- no CPR

Level three- transfer to acute care hospital
- no intensive care unit

Level four - transfer to acute care with CPR
- Intensive care unit

The success of CPR in an emergency situation is based on the age and health of the person involved. The nursing home and doctor will explain the Advance Directives process and will give the caregiver a copy of the Advance Directives form to review, and to be filled out. This form will be filed as part of the health care record. The doctor will review the Advance Directives with the caregiver on an annual basis as part of the interdisciplinary care conference. The Advance Directives can be changed at any time. The nurse in charge is informed and makes sure the Advance Directives form is updated and the doctor is informed of the changes. If a Living Will has been created, the Director of Care of the nursing home will translate the wishes into the Advance Directives.

(Source: For Section 5 - Long-Term Care Facilities in Ontario: The Advocate's Manual - Advocacy Centre for the Elderly)

Your Notes - Section 5

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