

# **ONTARIO NURSES' ASSOCIATION**

## **Response to Draft Regulations under Bill 140 – *The Long-Term Care Homes Act, 2007***

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## INTRODUCTION

The Ontario Nurses' Association (ONA) is the union representing 54,000 front-line registered nurses and allied health professionals working in Ontario hospitals, long-term care facilities, public health, the community and industry.

ONA has been advocating for many years for staffing standards, improved working conditions, and a minimum standard of care for residents in long-term care homes. The April 2005 Coroner's Inquest Verdict at Casa Verde<sup>1</sup> nursing home adopted all 52 recommendations put forth by ONA. Although the Ministry of Health and Long-Term Care (MOHLTC) provided a response to the coroner outlining the Ministry response to the Casa Verde recommendations, a minimum staffing standard has not been adopted, as recommended, that would prevent similar tragedies and that would improve the quality of care for residents (see Casa Verde recommendations 29 and 37, in particular).

ONA was optimistic that this oversight would soon be corrected when Section 17 under Bill 140 was amended to include staffing and care standards to be provided for in the regulations. On May 5, 2009, the Ministry finally released draft regulations covering Parts I, II and III under Bill 140, the *Long Term Care Homes Act, 2007* for a 30-day consultation. To the dismay of ONA and the over 75,000 residents living in long-term care homes in Ontario, the draft regulations do not contain minimum staffing standards that would provide the foundation for the implementation of any minimum resident care standards.

Because many residents require the advanced assessment skills within the scope of practice of registered nurses (both physical and cognitive care), ONA contends the government's failure to include in the regulations minimum daily staffing requirements for nursing and personal care of 3.5 hours per resident, including .59 hours of care from registered nurses, means it has failed to improve resident care in long-term care homes.

We have specific problems with the process employed by the Ministry in releasing the regulations under Bill 140. First, the Ministry has released regulations with full knowledge that the Ombudsman is currently reviewing the regulatory requirements for the long-term care sector but has not issued a report.

Second, the Shirlee Sharkey Implementation Committee has also not released their final report, which will no doubt have bearing on the regulations, particularly staffing levels. Third, the Ministry has released the first set of regulations without any overall outline of what will be contained in the second set. For this reason, we will be commenting on items that are missing in the current set of regulations without knowing whether they might be included in the second set.

We are also assuming but must request that once the regulatory regime is completed, the Ministry will have a plan for a transition period and will build in a training and orientation component to ensure that current staff and licensees are updated on the changes.

Finally, we are calling on the Ministry to improve transparency for public funding in the long-term care sector by regulating reporting of actual worked hours of daily nursing and personal care being delivered in each long-term care home, and providing for a requirement that this staffing information be posted on the long-term care section of the Ministry website.

## **Part I - DEFINITIONS**

### **“Nursing Care”**

Currently, the definition of “nursing care” in the draft regulation combines nursing care and personal care in the same definition. We believe this definition is in need of revision because it is not accurate, and it is also deceptive to residents and the public because staff members providing personal care are not providing nursing care. Only registered nursing staff members are regulated to provide nursing care in accordance with the *Regulated Health Professions Act*. We strongly request the current combined definition be separated into two definitions. The definition of “nursing care” should be revised to state: “skilled nursing care provided by registered nurses or registered practical nurses or registered nurses in the extended class.” The definition of “personal support care” should be rewritten to state: “personal support care given by unregulated care providers under the supervision of registered nursing staff.”

### **“Abuse”**

We believe that “neglect” of resident needs should be included as an instance of emotional and/or physical abuse.

The definition of physical abuse should also include withholding or rationing the necessities of daily living that may result in physical harm (such as incontinence care) and the use of chemical restraints before all other interventions are attempted.

Financial abuse should also include theft of a resident's identity.

### **“Neglect”**

We believe insufficient staffing levels to meet assessed resident needs, and to provide for resident physical comfort, amount to neglect. Failure to provide sufficient staffing levels to meet assessed resident needs and to provide for resident physical comfort should be added into the definition of neglect.

## **Part II – RESIDENTS: RIGHTS, CARE AND SERVICES**

### **Initial Plan of Care**

Section 6(1) in the regulation does not specify who is to develop the initial plan of care and who is to communicate the initial plan of care to “direct care staff.”

We take the position that the initial plan of care and assessments must be conducted by a registered nurse as recommended by the Casa Verde coroner's inquest (see recommendations 35 and 36. In addition, because the comprehensive plan of care is not required to be developed for a 21-day period, it is all the more important that an RN conduct the initial assessment pursuant to the College of Nurses of Ontario (CNO) practice expectations under direct practice planning and direct practice implementation.

We also believe the initial plan of care is missing key indicators as baseline data that are listed as taking place in the assessments for the comprehensive plan of care. Indicators that should also be included in the initial plan of care include: advance directives, vital signs, cognitive assessments, immunization and infection risk history, hydration, nutritional status, weight, and vision, hearing and continence requirements. In addition, current family contact information is important.

The reason these additional elements are necessary is because the CCAC eligibility assessment information may have been conducted as much as nine months earlier.

### **Comprehensive Plan of Care**

Because multiple disciplines will be involved in conducting the interdisciplinary assessments required under Section 7, it is important to specify that the comprehensive plan of care be led by a registered nurse. This is to meet the practice expectations under the College of Nurses that an RN lead a team effort to develop plans of care to achieve identified resident goals when overall care requirements are more complex.

There is also no specific requirement for who is to communicate the comprehensive plan of care to “direct care staff” and within a specified timeframe after the 21-day comprehensive plan of care is developed. We believe this is the role of the RN and should be communicated to direct care staff over a period of 48 hours.

The assessment for cognitive ability must be conducted by a PIECES-trained RN as recommended by Casa Verde (see recommendations 41 and 46).

### **Care and Services**

Section 17 in the *Long Term Care Homes Act, 2007* specifies that the licensee meet staffing and care standards provided for in the regulations. As currently written, the regulations do not provide for staffing and care standards as recommended, in particular, by the Casa Verde Inquest (see recommendations 29 and 37). In addition, Section 60(6) in Regulation 832 to the *Nursing Homes Act* provides: A licensee of a nursing home shall ensure that there is a sufficient number of registered nurses, registered practical nurses and health care aides on duty in the home at all times to provide the nursing care required by the residents of the home (O. Reg. 340/96, s. 4). A regulated staffing standard to meet assessed needs of residents must be written into the regulations.

In addition, the Ministry should reinstate, in regulation, the requirement for any annual service agreements to contain Program Description and the LTC Facility Staffing Schedule.

The Program Description should describe the individual programs the operator will provide at the home to meet its obligations under Sections 8 to 16 as well as any other relevant sections.

The Staffing Schedule should be negotiated each year between the Ministry and the home following the release of the latest resident acuity data and will contain the specific classifications with weekly hours for each that will deliver the programs set out in the Program Description and deliver the care that is required to meet the needs of the residents as identified in the acuity assessment process (now the MDS-RAI tool).

The regulations in Section 9 outline four interdisciplinary programs for residents that every licensee is to provide related to falls prevention and management, skin and wound care, continence care and bowel management, and pain management. We are assuming that the additional programs listed in Sections 8 to 16 of Bill 140 will be addressed in the next set of regulations.

We also believe that Sections 14 and 15 in the regulations should come under the required risk programs listed under Section 9. In addition, any “interdisciplinary program” as listed under Sections 9-13 in the regulations must be led by a registered nurse to meet practice expectations of the College of Nurses under leadership. This should be specifically set out in the regulations and “interdisciplinary program” should be defined.

Each of the programs under Section 9 must have a provision for training, orientation, and annual retraining of staff under Section 9(2). As well, it should be specified that RNs are involved in the evaluation of the programs under Section 9(2).

The intent of the phrase “wherever possible” in Section 9(1)(3) is problematic if it means that a continence program is voluntary rather than mandatory. The qualifier should be deleted.

Under Section 10, the list of items to be monitored and reported on should also include the use of pharmaceuticals, which may be correlated with falls.

It is our position that the assessments and reassessments under Section 11 concerning skin and wound care are properly within the scope of practice for RNs and so reference to “registered nursing staff” should be changed to Registered Nurses.

Under Section 12, it should be specified that the assessment in 12(2)(a) is conducted by a registered nurse and the “individualized plan” in 12(2)(b) be prepared by an RN. It is also critical that the RN have specified time to communicate the assessment to direct care staff.

Section 12(2)(c) must make reference to appropriate staffing and adherence to lift policies during toileting. Similarly, Section 12(2)(e) must make reference to appropriate staffing levels for changing incontinence products.

We believe that Section 12(2)(e) does not meet the standards of the residents bill of rights and should be amended to include that incontinence products need to be monitored on a frequent basis and changed whenever wet or soiled or upon request by residents or family members. This section should also prohibit rationing of incontinence products.

Our members find Section 12(2)(f) insulting, inaccurate and inappropriate. We demand that it be removed entirely. It is the operators who have control over staffing decisions and the intent of this section should be directed to operators who fail to have sufficient staffing to ensure products are changed when necessary. You will note that it was staff that alerted the Ministry to practices by operators to ration incontinence products and to prevent staff from changing products until they were beyond any definition of “clean, dry and comfortable.”

Section 12(2)(h) should be amended so that it is clear that “direct care staff” are involved in the annual evaluation of incontinence products.

Section 13(2) should be amended to add registered nurses and registered nurses (extended class) as participants in the development of the pain management program.

It is our opinion that Sections 14 and 15 are incomplete and do not address the many recommendations in the Casa Verde Inquest. For example, Section 14 does not set out the requirement for an anti-violence policy. We assume additional regulations on these matters will be set out in the second set.

Section 14(1)(1) must make it clear that the assessments and reassessments are to be conducted by PIECES-trained registered nurses as recommended by Casa Verde.

In Section 14(1)(3), the “strategies and interventions” must include a plan that sets out the requirements for registered nurses to be allotted specified time to communicate the assessments and to work with the personal support workers to train them on the interventions. There should be a requirement for training, orientation and retraining as necessary.

As well, Section 14(2)(b) must include a plan and specified time to provide training to staff on the “procedures and interventions” as developed. The procedures must spell out the steps to take when staff members or other residents are at risk of harm and/or when they have been harmed.

Under Section 16, we believe the concept of “zero tolerance” should be defined in the regulations or reference made to Section 20 in Bill 140.

Section 16(c) limits “procedures and interventions” to staff but fails to consider physicians, EMS workers, Boards of Directors, owners of private homes, volunteers and any others.

In Section 18, staff and families must also be notified.

In Section 19(a), the requirements for unusual occurrences and critical incident reports should be mandated to ensure provincial standards.

The Ministry must ensure the written policy under Section 20 is aligned with the College of Nurses policy on restraints: “least restraint means all possible alternative interventions must be exhausted before deciding to use a restraint” (College of Nurses, Practice Standard on Restraints, 2008). In particular, Bill 140 permits chemical restraints when the drug is ordered as part of the resident’s plan of care. We are concerned that such orders may take place outside of a plan of care in the case of interventions that take place during the night. Section 20 should make reference to all possible alternative interventions at all times.

Section 20(1)(c) should make reference to the definition of “common law duty” as set out in Section 36(1) of Bill 140. Similarly, Section 20(1)(e) should make reference to the definition of PASDs as set out in Section 33(2) of Bill 140. Both definitions of the terms “common law duty” and “PASDs” should be included in the regulations.

Under Section 21 (2), note these requirements can only be met if minimum staffing standards are implemented that provide for sufficient daily nursing and personal care staff per resident.

A major gap under the regulations related to Part II of Bill 140 is the absence of any further expansion of whistleblower protection for staff. We expect that additional regulations on this matter in the second set of regulations will extend whistleblower protection rights to cover disclosures to entities protecting the public interest beyond those set out in Section 26(1) of Bill 140. As well, regulations must provide that where an officer of the Ontario Labour Relations Board (OLRB) finds evidence that a complainant has been subject to action described in Section 26(2) that would violate Section 26(1), and the complainant has made a disclosure under Section 24, then the OLRB shall order the immediate reversal of the action taken under Section 26(2) and the operator shall not re-impose the action until it establishes to the satisfaction of the OLRB or a Board of Arbitration, established pursuant to Section 48 of the *Labour Relations Act*, that the action was in no way motivated by the disclosure.

### **Part III – ADMISSION OF RESIDENTS**

We are extremely concerned the Ministry has failed to consult with staff in Community Care Access Centres (CCACs) on the regulations relating to eligibility for admission to long-term care homes.

ONA members working in CCACs have discovered a confusing disconnect between the definition of placement coordinators in the regulations and the current classifications/titles of staff doing the work in the restructured CCACs. There is incongruence between the new position titles and duties being developed in CCACs where there are placement coordinators who make the offer of a long-term care bed and placement case managers who are now performing the information and counseling sessions as set out in Section 29 of the regulations under the title of “placement coordinator.” Similarly, Section 34(3) indicates the placement coordinator manages the process for out-of-province applications, whereas that responsibility falls to the placement case manager in CCACs. In addition, the determination of eligibility under Section 34 in the regulations is now being performed by case managers because the completion of the MDS-RAI tool has to be done by a regulated health professional. This pattern of incongruence repeats throughout the regulations under Part III.

Part III continues to use the term “Category” rather than the term “Priority,” which is the term CCACs will be using with the Client Health Related Information System (CHRIS) across Ontario.

Under Section 34, note the determination of eligibility processes are now changing in hospital settings and being transferred to CCACs for Alternative Level of Care patient placements. This may impact social workers who are performing the assessments under Section 43(1)(d). We believe a definition of the assessment under this section should be added to specify whether this is an interdisciplinary approach under the leadership of a registered nurse. It is also not clear the addition of the speech-language pathologist is qualified to conduct the wide range of assessments that are mandated.

The use of the term “agent” under Section 34(1)(d) should be defined. In addition, Section 34(1)(c) and (d) call for “up-to-date” assessments and should be defined.

The regulations should add that admissions to long-term care homes will not take place during evenings, nights or on weekends as recommended by Casa Verde. In addition, the regulations do not provide any appeal mechanism beyond the Ministry when admission is denied.

The regulations should provide for conditional admission to specifically deal with crisis admissions.

Section 63 should specifically note that the 90 days maximum use of short-stay is per calendar year to ensure consistent interpretations across CCACs.

Section 67 should define the “interdisciplinary team approach” and specify that it is led by the registered nurse pursuant to the practice expectations of the College of Nurses. As well, Section 67(3) should specify that the “staff” member has the relevant qualifications and training in the areas outlined, which we believe means it should be the registered nurse. We also propose the addition of two further categories under 67(3): emergency preparedness and the precautionary principle.

Section 67(5) should specify that the recording is done on an infection control sheet that is set up precisely for that purpose.

Section 67(9) must specify use of the precautionary principle, and proper training and fit testing for protective equipment.

Section 67(12)(5) must specify “prevailing practices” means collective agreement in the case of unionized staff.

Section 67(13) must ensure the written policy respecting pets provides for procedures when residents have allergies.

## **CONCLUDING REMARKS**

Residents in long-term care homes receive their care from skilled and caring front-line workers. However, the government has chosen to ignore the care requirements of residents by failing to include minimum standards for staffing and levels of care in the regulations according to Section 17 of Bill 140.

This fatal flaw must be corrected in the second set of regulations if residents are to receive the care to meet their assessed needs and their escalating medical/psychological needs.

We believe the regulations have taken a step in the right direction, in particular, with improvements to continence care and the spouse/partner reunification requirements. However, many gaps remain.

We have provided a number of recommendations for additional improvements in the area of continence care and in other areas in the initial set of regulations. We sincerely hope these recommendations will be given serious consideration by the Ministry so that residents in long-term care will receive the care they deserve.

## **ENDNOTES**

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<sup>1</sup> See Coroner’s Inquest, Casa Verde Nursing Home, *Jury Verdict and Recommendations*, April 2005.