

SUBMISSION

ON

Bill 140 – *Long-Term Care Homes Act, 2006*

BY THE

ONTARIO NURSES' ASSOCIATION

TO THE

Standing Committee on Social Policy

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## INTRODUCTION

The Ontario Nurses' Association (ONA) is the union representing 52,500 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 improved staffing, working conditions and levels of care in long-term care homes for many years. We welcome the opportunity to provide the perspective of frontline registered nurses (RNs) to the Standing Committee.

ONA has recently proposed improvements to Ontario's long-term care system so that quality resident care becomes the primary objective. The April 2005 coroner's inquest verdict at Casa Verde<sup>1</sup> nursing home adopted all 52 recommendations put forth by ONA. A key recommendation was for the Ontario government to fund staffing in nursing homes on an interim basis (recommendation 29) – pending an evidence-based study (recommendation 28) – to the level of 3.06 hours of nursing and personal care per day per resident, including .59 hours of care from RNs. An integral part of each of those recommendations was that the government should require long-term care operators to implement such staffing levels. More than a year later, the Ministry of Health and Long-term Care (MOHLTC) has yet to implement these important staffing measures that would prevent a similar tragedy.

ONA believes Bill 140 is missing key elements that are essential to safer long-term care home environments:

- evidence-based staffing standards and levels of resident care, and minimum staffing standards in the interim;
- improved health and safety, workload and working conditions for long-term care staff;
- enhanced transparency and accountability regarding public funding for the long-term care sector; and
- strengthened inspection and enforcement mechanisms.

Many of the residents in long-term care are in need of complex nursing care. These residents require the broader assessment skill set that registered nurses bring (both from a physical and cognitive care perspective), and without legislating minimum staffing requirements and levels of care, resident care is not going to improve.

The 2004 Annual Report of the Office of the Provincial Auditor of Ontario clearly sets out the role of, and relationship between, the Ministry of Health and Long-Term Care and long-term care facilities:

Long-term-care facilities provide care and services to individuals who are unable to live independently at home and require the availability of round-the-clock nursing service to meet their daily nursing and personal care needs....The Ministry's key responsibility regarding the operations of long-term-care facilities is to ensure that they are delivering services to residents in accordance with their service agreements with the Ministry and in compliance with applicable legislation and ministry policies.<sup>2</sup>

Legislating minimum staffing standards and levels of resident care is fundamental to ensure that resident daily nursing and personal care needs are met. It would also improve staff workload and working conditions in long-term care homes. While the focus of Bill 140 is on resident safety, we believe worker safety and working conditions is equally important to quality care. ONA also believes the government should be concerned about such recruitment and retention issues in long-term care, particularly in light of the coming wave of RN retirements.

While ONA recognizes that the McGuinty government has invested more funding in long-term care, we believe that enhanced transparency and accountability is needed to ensure that public funding is properly targeted for resident care, and that the funding is tracked to ensure it achieves its intended purpose and it is used to meet legislated standards.

The care needs of residents living in long-term care facilities in Ontario have increased – their conditions becoming less stable and more complex – since the beginning of the resident classification system in 1993.<sup>3</sup> Nursing and personal care staffing, however, has not kept up with this increase in resident acuity because of the elimination of minimum staffing standards. Bill 140 will make little difference in the daily lives of residents without minimum staffing standards and levels of care reinstated and clearly regulated.

Our submission begins by setting the context for our recommendations with an overview of the model for funding and regulation of long-term care homes staffing and care levels in Ontario. We then review specific provisions in Bill 140 that we propose require amendment.

## **BACKGROUND AND CONTEXT**

### **Government Funding for Levels of Long-Term Care in Ontario**

The government introduced a new system in 1993 for the funding and regulation of Long-Term Care (LTC) facilities.

Levels of resident care funding were introduced and are based on an annual classification of residents in long-term care homes. The level of care funding is based on an assessment of each resident based on the resident's chart and care plan at a single point in time. Each resident is given a classification running from "a" the lightest, to "g" the heaviest, care. These ratings are totalled for each home and converted to a number, which is its Case Mix Measure or CMM. A provincial average is then calculated and that average is given a value of 100, which is its Case Mix Index or CMI. Homes with a CMM above the provincial average will have a CMI of greater than 100 and Homes with a below average CMM will have a CMI of less than 100.

The provincial government decides how much funding will be allocated annually to nursing care for residents living in long-term care homes. It then divides this number by the total number of funded beds in the province and then divides it again by 365.

This average amount to spend per resident care per day is paid to homes with a CMI of 100. Homes with higher CMIs are paid a proportionally higher per diem and homes with lower CMIs are paid proportionally lower per diems.

There were two problems with the level of care funding system when it was set up and that continue today. The first problem is that no effort was made to tie staffing levels to care need and funding. While funding was equalized across the province, staffing levels continued to vary from one home to another without any relationship to care need. The second problem was that the system did not tie funding to the costs it was supposed to cover.

The funding provided by the government for long-term care is supplied in three separate envelopes. The above information regarding CMIs describes the funding for the Nursing and Personal Care (NPC) envelope. This funding can only be used for those purposes.

If, at the end of the year, the LTC facility has not spent all of those monies provided in the NPC envelope, it must return the surplus to the government.

There are two other envelopes – one for programming and one for accommodation. The programming envelope funds activities and rehabilitation. Funding from this envelope can only be spent for this purpose and any surplus at the end of the year must also be returned to the government.

The final envelope is for accommodation. This covers “room and board” type of costs such as food, housekeeping, administrative expenses, etc. Within this funding envelope there is a sub-envelope for food, which like the funding for nursing and personal care and programming may only be spent on that purpose. For the remainder of the funding in the accommodation envelope, spending is within the discretion of the facility. Surplus funds within this envelope at the end of the year are retained and constitute profit in the case of for-profit LTC facilities.

### **Government Regulation of Levels of Care**

At the same time that funding rules were changed, regulatory rules for levels of care were also changed. The NDP government at that time removed many requirements from the regulations in July 1993 and instead put most of them in “service agreements,” where the requirements could be tailored to meet the actual needs of the residents.

Nevertheless, the government maintained the regulation that required each nursing home to provide each resident with a minimum of 2.25 hours of nursing and personal care per day.

One of the obligations in the service agreement related to what nursing and personal care staffing the employer would provide to meet the care requirements of the residents. The facility operator was required to include a staffing schedule in the service agreement.

Effective June 1, 1996, the then Conservative government eliminated the requirement for the service agreement to contain a staffing schedule. At about the same time, the 2.25 hour minimum staffing regulation was also removed.

Following this regulatory change, Ontario long-term care facility associations retained the consulting firm of PricewaterhouseCoopers to compare care levels in Ontario to other jurisdictions in Canada, the United States and Europe. The Ministry of Health and Long-Term Care provided the funding to retain the consultant. The 2001 consultant's report<sup>4</sup> indicated that Ontario had the lowest level of staffing, including the lowest level of RN staffing, and its residents had care needs at least equal to, and in some respects greater than, the other jurisdictions studied.

The PricewaterhouseCoopers report set out the consequence of the repeal of the minimum hours of care regulation and service agreement requirements for residents living in long-term care homes. That report's care comparison, done in 1999/2000, indicated that average care had dropped from 2.25 to 2.04 hours of nursing and personal care, though acuity had regularly increased since 1996.

Further, the PricewaterhouseCoopers report documented that Saskatchewan residents received .59 hours of RN care per day. The report indicated that the Manitoba RN staffing level was .4 hours of care per resident per day. In contrast, the PricewaterhouseCoopers report documented that, in 1999/2000, Ontario long-term care facilities provided, on average, .23 hours of RN care per resident per day.<sup>5</sup>

Following release of the findings in the PricewaterhouseCoopers report, the previous government announced major funding increases for the long-term care sector in 2002 and 2003. The present government provided additional major funding for long-term care in 2004, as well as minor funding increases in 2005 and 2006. However, the long-term care facility associations note that most of this funding went into areas other than nursing and personal care so that staffing and care levels have not increased significantly.<sup>6</sup> More on the issue of minimum standards for staffing and levels of care follows in the next section as we review problem areas in Bill 140, as proposed, that must be fixed to ensure quality long-term care.

## **RECOMMENDATIONS – FIXING PROBLEM AREAS IN BILL 140**

### **1. Lack of Evidence-Based Minimum Standards for Staffing and Levels of Resident Care**

Bill 140 has a fundamental and glaring flaw. There is no assurance that residents will receive the level of care they need. There is no fundamental principle clearly setting out that residents have the right to access the care that they need. There is no ongoing evidence-based standard, or even a minimum staffing standard or level of care on an interim basis. There is not even a statutory requirement that the long-term care home have sufficient staff to meet its statutory obligations to residents. There is no provision for the adoption of quantifiable staffing standards or levels of care to ensure resident needs are met.

This omission is perplexing because the government is well aware of recommendations from the coroner's inquest at Casa Verde. Three key recommendations in that inquest related to establishing minimum staffing standards and levels of care. Recommendation 28 was "that the MOHLTC retain Price Waterhouse Coopers, or a similar consultant, to update the January 2001 Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario LTC Facilities and Selected Comparators, and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario LTC facilities given the significant number of Ontario residents with cognitive impairment and complex care in LTC facilities."<sup>7</sup>

Recommendation 30 was that "the MOHLTC...should set out standards based on this information...to ensure...residents are given appropriate nursing and other staff hours."<sup>8</sup>

There is no requirement in Bill 140 for an evidence-based study to determine hours of care by classification required by residents with different acuity levels.

Further, Recommendation 29 in the Casa Verde coroner's inquest proposed "that the MOHLTC in the interim, pending the evidence-based study should fund and set standards requiring LTC facilities to increase staffing levels to, on average, no less than .59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal care for the average Ontario case mix measure. The funding formula for the Nursing and Personal Care envelope must be immediately adjusted to reflect this minimum staffing."

Note that this level of care would bring Ontario to the care levels – 3.06 hours – documented in Saskatchewan in the Ministry-funded 2001 PricewaterhouseCoopers Levels of Care Study.

The government has stated that some residents in long-term care do not require the coroner's proposed interim minimum staffing and care levels.<sup>9</sup> There is no evidence to support the government's assertion.

On the contrary, there is evidence from other jurisdictions in Canada that they are moving to higher levels of staffing and care for residents in long-term care. Both Manitoba and Saskatchewan provide over 3 hours of care<sup>10</sup>, while Alberta has funded paid hours of care per resident at 3.6 per day<sup>11</sup> and New Brunswick is moving to 3.5 hours of care by 2008.<sup>12</sup>

Further, sixteen experts in the United States reviewed previous studies on staffing for quality of care and concluded that average nursing and personal care staffing levels of 3.51 hours per resident per day (including .72 RN hours) were too low in some facilities to provide high quality care. These experts recommend that to improve the quality of care of nursing home residents, staffing levels should be increased to 4.55 hours, including 1.15 RN hours.<sup>13</sup>

In Ontario, by comparison, the long-term care facility associations report that "OANHSS member homes provide on average 2.6 hours of care per resident per day," and the Ontario Long Term Care Association asserts that "Ontario is currently funding about 2.5 hours of care per resident per day when, given increasing acuity levels, care levels of 3 hours per resident per day are required."<sup>14</sup> Moreover, the proportion of total care provided by RNs is decreasing.

In addition, the 2004 provincial auditor's report made two staffing recommendations to the Ministry to ensure that long-term care homes "provide the level of care required by residents and that the assessed needs of residents are being met:"

- *track staff-to-resident ratios, the number of registered-nursing hours per resident, and the mix of registered to non-registered nursing staff and determine whether the levels of care provided are meeting the assessed needs of residents; and*
- *develop appropriate staffing standards for long-term-care facilities.*<sup>15</sup>

Clearly, the provincial auditor was concerned that, in order to meet residents' assessed needs, the Ministry had to determine whether the needs are being met and adopt "appropriate staffing standards."

The Ministry also provided the provincial auditor the following response on the status of current efforts to implement the auditor's recommendations:

- "determining staff deployment using a tool that captures numbers of all registered and non-registered staff in all resident floors and/or care areas;
- assessing in depth the care needed by and provided to residents using a standardized provincial assessment tool that gathers the relevant information;
- observing resident grooming, positioning, call-bell access, and so on, by walking through all resident areas; and
- reviewing call-bell response times."<sup>16</sup>

We agree with the Ministry's statement that they now more accurately identify how much staffing the home operator provides (first bullet). They claim they assess how much care is provided to residents (second bullet), but we disagree, because the tool they use only captures care need, not care provided.

Thus, in our opinion, the Ministry has not complied with the first bullet of the auditor's recommendations, only the first half of the second bullet and has declined to accept the validity let alone comply with the third bullet.

The provincial auditor has recommended that there be staffing standards and that staffing should not be limited to ad hoc decisions of the operator based upon funding actually received. Furthermore, the provincial auditor clearly intends that the staffing standards be sufficient to meet resident care need.

Ontario had the lowest levels of care in 2001 and continues to have the lowest levels of long-term care in 2006. Bill 140 will not improve the levels of care that residents receive on a daily basis. We recommend that Bill 140 be amended to reinstate minimum staffing standards of 3.5 hours (including .68 RN hours) in line with staffing standards in other jurisdictions.

As an interim measure, the government must, at least, adopt the Casa Verde coroner's recommendation of 3.06 hours (including .59 RN hours).

In any event, the government must implement the coroner's recommendation for an evidence-based study to determine appropriate staffing levels for LTC homes in Ontario.

Section 16 in Bill 140 does say that the services provided must "comply with any standards or requirements, including required outcomes, provided for in regulations." We propose that section 36 clearly mandate staffing standards be set out in regulation.

The only other section in Bill 140 that addresses staffing issues is section 36(2)(e), which deals solely with registered nurses and not any other category of frontline care giver.

The regulatory power in section 36(2)(e) only permits the Lieutenant Governor in Council to require certain classes of homes to have more RNs than the requirement under section 7(3) to have at least one registered nurse on duty and present in the home at all times (i.e., 24/7). We are proposing that the power under this section needs to enable Cabinet to adopt higher care levels based on the "class" or care need of the resident. This is consistent with the approach of the government in its opposition to a single standard of care for all residents. While we agree with the government that care provided should vary with and reflect the amount of care needed, the increase in acuity over the past decade is evidence that even the least acute residents require the minimum standards of care being proposed on an interim basis. It is crucial, however, that the wording of the regulation-making power in section 36(2)(e) be amended to permit levels of care to be set in relation to care need.

The requirement in section 7(3) to have at least one RN on duty and present in the home at all times does not guarantee residents will have a greater amount of RN care. It does not guarantee that each resident will be assessed by an RN. It does not guarantee that each resident will get even the smallest amount of RN care. The only way to guarantee resident hours of care is to set and to fund minimum standards for hours of care, including minimum standards for the quantity of RN care.

The College of Nurses of Ontario (CNO) Practice Guidelines require that care for residents whose condition is unstable or where the outcome is unpredictable require the assessment and leadership of an RN.

The provincial CMM results demonstrate the instability of resident condition and unpredictability of consequences has increased over time between January 1997 and January 2006:

- 92.86% of residents are a risk to themselves or others compared to 90.21% in 1997.
- 95.09% of residents are unable to cope compared to 92.81% in 1997.
- 63.19% of residents have cognitive impairments compared to 47.37% in 1997.
- 51.14% of families require support or assistance from staff at least weekly but not daily, while a further 11.72% of families require daily support or assistance daily compared to 40.88% and 8.08% respectively in 1997.
- The average medical diagnosis per resident is 3.39 compared to 2.89 in 1997.
- Inappropriate voiding causing hygienic or health risk rose from 73.81% in 1997 to 91.10%.
- Inappropriate bowel elimination causing hygienic or health risk rose from 60.65% in 1997 to 80.92%.

These CMM documents also reveal a substantial increase in average number of different medications (not doses) required by residents. In 1997, 4.33 scheduled medications per resident per 24 hours were ordered and now it is 7.35. This constitutes an increase of almost 70 per cent. When multiple medications are taken by residents, there is a greater possibility of harmful interactions amongst medications and, as a result, the need for more frequent and discrete nursing assessments. There is also an increase in the number of ordered medications that were not taken from 0.07 to 0.11.

There is also a significant increase in therapeutic interventions. Daily interventions have increased from .643 per resident to .970 or an increase of 44 per cent. Each of these interventions adds to an RN's workload and supervisory responsibilities, even if the RN is not physically doing the treatment.

A number of research studies have also examined the relationship between registered nurse staffing levels and the quality of care in nursing homes.

For example, higher RN staffing levels (.5 to .67 RN hours per resident per day) were found to be associated with lower pressure ulcer rates, urinary tract infections and hospitalizations.<sup>17</sup>

In another study, residents receiving 30 to 40 minutes of RN direct care per day were 84 per cent less likely to develop a pressure ulcer and 42 per cent less likely to experience deterioration in their ability to perform activities of daily living.<sup>18</sup> A further study identified staffing level thresholds for RNs – above which no quality improvements were observed – at between .55 and .75 RN hours per resident per day.<sup>19</sup> Improved RN staffing levels clearly contributes to the avoidance of adverse care outcomes and additional RN staffing improves quality care for residents.

It is for this reason that we strenuously oppose the power in section 7(4) to provide in regulation that an Administrator or Director of Nursing and Personal Care could be considered to meet the requirement to have a RN on duty and present in the home. Contemplating such a regulation is highly objectionable to RNs working in long-term care. As the above research shows, direct RN care has a measurable impact on resident care. The staff RN provides care to residents; the role of administrative classifications is quite different.

## **2. Lack of a Culture of Health and Safety for Long-Term Care Staff**

Long-term care homes are also workplaces for the staff that deliver care to the residents. Bill 140, like other health care legislation, continues to ignore the impact of unsafe working conditions for staff on the quality of care outcomes.

Findings from a recent Statistics Canada study show that nurses in long-term care report high levels of inadequate staffing and unsafe working conditions.<sup>20</sup> Almost one-half (47.3 per cent) of long-term care nurses reported inadequate staffing.<sup>21</sup>

The proportion of nurses in long-term care who sustained a work injury was 10 per cent.<sup>22</sup> In terms of specific injuries, 10.4 per cent of long-term care nurses sustained needlestick injuries in the past 12 months.<sup>23</sup> Almost half (49.6 per cent) of long-term care nurses reported being physically assaulted by a resident at work over the past year, while a similarly high proportion (48 per cent) reported suffering emotional abuse from a resident over the past 12 months.<sup>24</sup>

Finally, long-term care nurses in this Statistics Canada study reported serious concerns about the risk of exposure to infectious diseases in their workplace.<sup>25</sup> As a result, long-term care nurses report high job strain, back problems, and other chronic medical conditions.<sup>26</sup>

Bill 140, however, does not recognize worker health and safety as a fundamental principle. We believe this is misguided. We propose that Bill 140 also include reference to long-term care homes as workplaces and that they be operated with regard to the health and safety of its workforce.<sup>27</sup>

### **3. Resident's Plan of Care is Critical to Resident Well-Being**

While the government has made some additions to the Resident's Bill of Rights in Bill 140, we are uncertain about the extent to which the rights will be able to be enforced by residents in practice, and what the remedy might be if residents attempted to enforce these rights. Further, there is no provision in section 3(4) to set out in regulation how rights shall be enforced.

In our view, the resident's plan of care is much more important to a resident's well-being. The new Bill says, in Section 6 (11), that a resident is reassessed and the plan of care reviewed and revised at least every three months and when the resident's care needs change.

This definition of reassessments is a lower standard than in existing statutory obligations<sup>28</sup> requiring reassessments "on an ongoing basis." The new proposed language provides only for reassessments when the resident's care needs change. How, we ask, is it possible to identify such changed care needs until after an assessment has been undertaken? This can only work if assessments are done on an ongoing basis. We propose that the language be changed to reflect the existing obligation to conduct reassessments on an ongoing basis.

Further, the implementation of the new provincial tool for the determination of resident care needs – called RAI – is another reason to provide a per resident guaranteed minimum level of RN care to conduct assessments. The RAI Assessment Form itself indicates that the RAI Coordinator needs to be an RN. The reason is that these assessments are needed to establish the base condition for residents. Until these assessments are done residents cannot be found to be stable with predictable outcomes. For the purposes of these assessments, residents are all considered unstable.

Furthermore, the RAI Coordinator, in administering these assessments, is supposed to select appropriate protocols and care plans (known as RAPs). These forms indicate that they need to be performed by an RN. Once again the RAI Coordinator must have the advanced assessment skills and the knowledge of complexities in order to determine whether any of the protocols are appropriate.

The new RAI system is being implemented because it will capture potential concerns and complex care needs. Complexity is one of the criteria determined by the College of Nurses of Ontario to require involvement of the RN. The RAI tool is also being piloted as it aids critical thinking and better analyses. These criteria also belong to the role of RN.

Assessments using the RAI tool must be appropriately administered by an RN.

#### **4. Mandatory Reporting of Abuse and Neglect to the MOHLTC**

First of all, we note that Bill 140 does not provide a definition of neglect. We are assuming this is simply an oversight and will be corrected since each facility is to put in place a written policy to promote zero tolerance of abuse and neglect of residents pursuant to section 18. We note that Section 178 (2)(c) provides for defining neglect by regulation but, again, we believe definitions should be in the legislation. We also would propose that a provincial policy be provided by the MOHLTC that is directive but that facilities can enhance based on individual circumstances.

Section 22(4) excludes a practitioner from immunity who is found to have made a mandatory report maliciously. We believe this section has two flaws: there is no exception where the report is found to be accurate, and maliciousness is not defined.

It is conceivable that a report of neglect or inadequate care that is made following failed efforts to try to get the licensee to correct the problem could be found to have been made maliciously in the sense that it was self-interested. Bill 140 must be amended to exclude such situations from the term "maliciously." The same defect exists in Section 24(7) in the context of whistleblower protection.

While Section 22(5) makes it an offence to fail to comply with the mandatory reporting duty, Section 23 does not require the inspector or anyone else in the Ministry to take action if the report is accurate. This shortcoming must be changed.

## **5. Whistleblower Protection**

While the expansion of whistleblower protection in section 24 in relation to the provision currently found in the *Nursing Homes Act* is a step in the right direction, it is neither strong enough protection nor does the scope of protection extend far enough.

The proposed whistleblower protection does not create any new protections. We find two main flaws with the proposed version of whistleblower protection contained in section 24.

First, the Bill limits this protection to persons making disclosures to an inspector, the Director (appointed by the Minister) or to a coroner's inquest. There is no protection for disclosures to an elected representative (an MPP), the media or any other party. The prohibition of retaliation does not apply to retaliation against employees who speak to the media. Employees who speak to the *Toronto Star*, for example, the next time an expose is done on long-term care homes will have no protection.

Second, section 24 adds nothing to the existing collective agreement protection against discipline for unjust cause and to the protection under the *Labour Relations Act* against retaliation for union activity/representation of members.

Section 24 does not have the same level of protection for whistleblowers as is contained in federal legislation. For example, section 24 does not have the limited "justice with dignity" provision found in the federal accountability legislation where discharged whistleblowers are reinstated in some cases until the employer proves just cause for discharge.<sup>29</sup>

Without these further protections, the prospect of termination will act as a significant barrier to staff speaking out.

## **6. Restraints**

We are concerned about the ramifications of section 28(4), which excludes the administration of a drug or pharmaceutical agent that is included as a treatment in the resident's plan of care from the definition of restraint. In our view, this could lead to conflict with a registrant's duties to the College of Nurses. In addition, it seems that informed consent to such treatment may prove to be difficult to obtain from residents and the Bill should expressly set out how such situations should be addressed.

## **7. Office of Resident and Family Advisor**

It is not mandatory for the Minister to establish the Office of the Long-Term Care Homes Resident and Family Advisor as set out in section 35 but is permissive only. We believe the government must make a firm commitment and amend this section to make it mandatory. The Office also needs to be adequately resourced and mandated. The mandate should expressly include public advocacy on behalf of residents and their needs, rather than be left to be assigned to regulation.

## **8. Requirements for Admission**

Section 40 is deficient in not requiring the placement coordinator to determine that the home has sufficient staff and physical setting to meet the care needs of the new admission without jeopardizing the care of existing residents. We propose this amendment be added as a consideration.

## **9. Requirements for Assessments**

Paragraph 2 of Section 41(4) (e.g., functional capacity, behaviour, etc.) provides that assessments can be carried out by professionals other than physicians or registered nurses (e.g., social worker or any other person provided for in regulation). This is cause for concern if the initial assessments of residents coming into long-term care homes are not carried out by RNs. We would support adding in this proviso to ensure that situations like in the Casa Verde case are avoided. Therefore, we recommend that initial resident assessments be conducted by RNs and that ongoing resident assessments are also conducted by RNs.

## **10. Requirements for Eligibility**

Section 42(7) requires, as a condition for the licensee to approve the admission, that the staff of the home have the nursing expertise to meet the applicant's care needs but it does not require that the home has sufficient staff and physical setting to meet the care needs of the new admission without jeopardizing the care of existing residents. This condition for admission should be added.

## **11. Staff Qualifications**

Section 71 includes that staff "have the proper skills and qualifications to perform their duties." We believe it should also expressly require that the assignment of nursing and personal care duties must be in accordance with the Guidelines of the College of Nurses of Ontario, and that duties assigned to other regulated professions be in accordance with the standards for their professions. One glaring example is the failure to require that nursing responsibilities in the RAI (resident assessment) system be assigned exclusively to frontline registered nurses.

## **12. Training**

Section 74 requires every licensee to ensure all staff and volunteers have received training but it is deficient in not requiring the licensee to consult with a representative of the staff to identify training requirements. Section 74(2) is also deficient in not requiring the licensee to inform new hires of the whistleblower protection provisions set out in Section 24.

## **13. Information for Residents**

We contend that section 76 is deficient in not requiring inclusion of information on whistleblower protection in the package of information that is given to every resident.

## **14. Posting of Information**

Section 77(3)(k) is incomplete in not including copies of inspectors' actions listed under Section 149 (i.e., written notifications and requests).

## **15. Voidable Agreements**

Section 79 is inadequate in placing time limits (10 days) for the voiding of agreements not complying with Section 78 and for not requiring the licensee to reimburse the resident for payments made under agreements prior to their voiding, which are inconsistent with Section 78.

## **16. Satisfaction Surveys**

Section 83(4)(a) must be amended to require a copy of the Satisfaction Survey results be given to the representative of the workers (union representatives, if present, or the employee co-chair of the health and safety committee).

## **17. Emergency Plans**

Section 85 does not require each licensee to develop, and secure approval from the local Fire Marshall's office, a fire evacuation plan(s) appropriate for when residents are awake and when they are sleeping. This is clearly an issue of safety for residents and must be included.

## **18. Regulations**

On a broad level, our first concern relates to the number of areas in Bill 140 that may be set out in regulation (see sections 36, 87 and 178) rather than in legislation. Second, the regulations are not subject to a public consultation period such as is contained in other health care legislation introduced by the current government.

We also believe that any regulatory power should be subject to review after three years of operation to ensure the regulatory powers are appropriate and are appropriately implemented.

At a more specific level, section 87(2)(c) should be amended to mandate licensees to document the frequency of use of psychotropic medications and to forward such documentation to:

- the Ministry,
- Family and Resident Councils,
- unions representing staff at the home, and
- the worker co-chair of the Health and Safety Committee.

## 19. Funding

For obvious reasons, Part VI of the Bill is critical for resident well-being. Yet, sections 88(1) and 88(2) are permissive rather than mandatory. The Minister must provide funding and the Minister should attach conditions to ensure the funding is used appropriately.

In our view, these sections are symptomatic of the virtual absence of accountability of the Ministry in Bill 140 to properly and to competently regulate this sector.

In the Provincial Auditor's 2004 annual report, the following recommendation is set out:

*To help ensure that the funding provided to long-term-care facilities is sufficient to provide the level of care required by residents and that the assessed needs of residents are being met, the Ministry should:*

- *verify the reasonableness of the current standard rates for each funding category and develop standards to measure the efficiency of facilities providing service...;*

In response to this funding recommendation, the Ministry stated that, "while it funds facilities using a resident-needs-based funding formula, facility operators are required to ensure staffing mixes and patterns are sufficient to meet the needs of residents."<sup>30</sup> In our interpretation, the Ministry's statement indicates that they have not evaluated whether the funding they provide is adequate. It is clear, however, that the long-term care home operator is responsible to adequately staff to meet resident needs.

In addition, recent research has identified "we are beginning to acquire evidence from Canadian data that public investment in not-for-profit, rather than for-profit, delivery of long-term care results in more staffing and improved care outcomes for residents."<sup>31</sup> It is our contention that future funding decisions must take this information into account.

## 20. Non-Arms Length Transactions

Section 91 should be amended to require the Director (appointed by the Minister) to make public all non-arms length transactions of licensees in order to enhance transparency and accountability in the sector.

## **21. Licence Required**

Section 93 has two problems:

- Nursing Care is not defined. It is clear that many retirement homes fall into the definition of nursing homes because they are providing nursing care. The Ministry continues to abdicate responsibility to regulate these homes that are operating in violation of this section. We are aware that the government has commenced a consultation on provincial standards for care in retirement homes. Nonetheless, nursing care should be defined.
- The Bill has removed the requirement for there to be a valid Service Agreement before a licensee can operate a home and before the Ministry can forward funds to it. The Local Health Integration Networks (LHINs) legislation provides for service accountability agreements. This requirement should be added. We do note the requirement in section 188(10) for copies of the service accountability agreement to be posted in homes and communicated to residents.<sup>32</sup>

## **22. Limitations on Eligibility for a Licence**

Section 96 does not create an appeal mechanism where a decision is made to grant a licence, nor does it give such an appeal right to a Residents' Council, Family Council or the Union representing long-term care home workers. It also is deficient in not permitting such entities to be parties to an appeal from the applicant for the licence.

## **23. Beds Allowed under Licence**

Section 102 has the same problem as section 96. We believe Residents' Council, Family Council and the union representing long-term care home workers all should have the ability to be parties to an appeal from the licensee. Each of these groups has obvious interests in the outcome.

## **24. Limitations on Transfers**

Section 103 must include, as condition of the transfer, the recognition by the licensee of the Union and the collective agreement applicable to the previous location or operator of the beds. Section 103 also does not require the vendor to repay to the Ministry the full value of the capital financing provided to it by the Ministry. Such monies were intended to help expand access to long-term care beds to residents, not to increase the profit of the licensees.

We do not believe that the restriction is section 103(9) from transferring a licence or beds from a non-profit to a for-profit entity should have any exceptions to be provided for in regulations. Further, we propose that Bill 140 should provide a clear statement or fundamental principle in support of non-profit long-term care homes since research has identified better quality-of-care outcomes in non-profit facilities.<sup>33</sup>

## **25. Public Consultation**

In our view, section 104 is completely inadequate to remedy the current flaws in the consultation process.

Section 104 must require that documentation of the licence (applicant) be made public sufficiently in advance of the consultation, that the licence (applicant) and the Ministry answer questions from the public, and that the Ministry provide public reasons for granting the license as well as in cases where it is refused.

## **26. Exercise of Security Interest**

Section 105 does not require public consultation when a contract permits another person to manage the long-term care home. We believe this exclusion is flawed.

## **27. Management Contracts**

Section 109 should also require public consultation when the Director approves a written contract to manage the long-term care home.

## **28. Temporary Licences**

Section 110 must also require public consultation as these “temporary” licences could last up to five years, longer than regular licences under the current legislation.

## **29. Competitive Process**

Section 113 should be amended to require that the Minister publish evidence that demonstrates a competitive process for a licence to be issued or amended would be a) cost efficient and b) produce at least equal quality-of-care outcomes.

## **30. Northern Municipal Homes**

In our view, section 120 should be amended to make the requirement mandatory to establish and to maintain northern municipal homes in an upper or single-tier municipality. This requirement is all the more pressing in an environment of bed shortages.

## **31. Approval Required Establishing Municipal Home**

Section 128 should contain a parallel requirement for Ministry approval when a municipal home is closed to balance the requirement for such approvals when a municipal home is established.

Furthermore, whenever the Ministry gets involved (see sections 133 to 136) in correcting operating problems at a home, the Ministry should be obliged to consult with the staff and their unions as to the reasons for the intervention and solicit input as to solutions.

## **32. Powers on Inspections**

Section 144 does not require the Inspector to consult, during any inspection, with representatives of the Residents’ Council, the Family Council and the non-management workers and their unions. We believe this exclusion provides the Inspector with only one point of view.

### **33. Inspection Reports**

Section 146 should also be amended to require the Inspector to provide copies of the inspection report to each representative of the non-management workers and their unions. The frontline staff that provides the care should not be excluded from the inspection process and follow-up.

### **34. Actions where non compliance**

We can see no reason why section 149 should not require the Inspector to provide a copy of any action it takes under this section to representatives of the Residents' Council, the Family Council and the non-management workers and their unions. The section should also create a right of appeal to representatives of the Residents' Council, the Family Council and the non-management workers and their unions when an order is not issued.

### **35. Interim Managers**

Section 155 should require any interim manager, including a Ministry official, to recognize the collective agreement in place at the facility and to be bound by the LRA and HLDAA obligations of home operators.

Even though they will not be considered successor employers, interim managers are still acting as an agent for the licensee and should be bound by the licensee's obligation. Section 155(7) must be changed to provide that any negotiated changes to the collective agreement be binding on the operator of the beds after the interim manager ceases to operate the home. Section 155(8) must be amended to provide that the exercise of this power not be inconsistent with any applicable collective agreement.

### **36. Review of Inspector's Orders**

Section 160 should also be amended to provide a right to representatives of the Residents' Council, the Family Council and the non-management workers and their Unions to appeal inadequate orders and to be parties to any appeal from the licensee.

### **37. Appeals from the Director**

Section 161 should provide a right to representatives of the Residents' Council, the Family Council and the non-management workers and their unions of appeal against an order or decision of the Director, or the failure to make such an order or decision, and to act as parties to any appeal from the licensee.

### **38. Transition**

There is no provision for funding to upgrade Class C or B structures. This means there will continue to be homes that do not meet current standards. ONA's priority for any new funding, however, is that it be directed to residents in terms of increased staffing rather than bricks and mortar.

### **39. Repeals**

The repeal, in section 187, of the complete *Charitable Institutions Act* is overreaching. That Act applies to more than long-term care homes and its repeal will leave a gap (e.g., see definition section and sections 2,3,4,5,6,7,8 and 10).

## **CONCLUDING REMARKS**

Residents in long-term care homes receive their care from skilled frontline workers. However, the government has chosen to ignore the care requirements of residents by failing to include evidence-based or even interim minimum standards for staffing and levels of care in Bill 140.

This is the fatal flaw in the Bill and must be addressed.

We have also provided thirty-eight other recommendations for amendments to the Bill. We sincerely request that these recommendations be given serious consideration by the Committee 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.

<sup>2</sup> See *2004 Annual Report of the Office of the Provincial Auditor of Ontario*, Section 4.04, Long-Term Care Facilities Activity (follow-up to VFM Section 3.04, 2002 Annual Report), p. 381, accessed at [www.auditor.on.ca](http://www.auditor.on.ca).

<sup>3</sup> The provincial Case Mix Measure (CMM) for 2006 is 96.33, an increase of 3.15 per cent from 93.39 in 2005. The provincial CMM has increased 27.35 per cent since the classification system was introduced.

<sup>4</sup> *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, January 11, 2001, Prepared by PricewaterhouseCoopers LLP for the Ontario Long Term Care Association and the Ontario Association of Non-Profit Homes and Services for Seniors.

<sup>5</sup> *Ibid.*, p. xvii.

<sup>6</sup> See OANHSS Funding Submission to Standing Committee on Finance and Economic Affairs, December 2006, accessed at [www.oanhss.org](http://www.oanhss.org). Note that staffing increases have taken place to staff new beds that have been added to the LTC system but not to existing LTC homes.

<sup>7</sup> See Coroner's Inquest, Casa Verde Nursing Home, *Jury Verdict and Recommendations*, April 2005.

<sup>8</sup> *Ibid.*

<sup>9</sup> "The Ministry is of the view that quality of care is not guaranteed by setting minimum staffing levels or ratios." See *Report on the Inquest into the Deaths of Ezz-El-Dine El-Roubi and Pedro Lopez (a.k.a. Casa Verde)*, Office of the Chief Coroner, July 2006, p. 16.

<sup>10</sup> Manitoba provides 3.5 hours of care per day at Levels 3 and 4. Saskatchewan was providing 3.06 hours of care in 2001.

<sup>11</sup> See Alberta News Release, "Health and Wellness spending grows to \$10.3 billion," March 22, 2006.

<sup>12</sup> See Press Release, "Graham will increase hours of care in nursing homes and in home support." August 22, 2006.

<sup>13</sup> Harrington, C. et al. "Experts Recommend Minimum Nursing Staffing Standards for Nursing Facilities in the United States." *The Gerontologist* 40(1): pp. 5-16.

<sup>14</sup> See endnote 6 and OLTC Presentation to Standing Committee on Finance and Economic Affairs, December 7, 2006, accessed at [www.oltca.com](http://www.oltca.com).

<sup>15</sup> See *2004 Annual Report of the Office of the Provincial Auditor of Ontario*, Section 4.04, Long-Term Care Facilities Activity (follow-up to VFM Section 3.04, 2002 Annual Report), p. 385, accessed at [www.auditor.on.ca](http://www.auditor.on.ca). The Auditor's 3<sup>rd</sup> bullet we reference on p. 9 can be found at p. 19 in our submission.

<sup>16</sup> *Ibid.*, p. 386

<sup>17</sup> See Dorr D.A. et al. "Cost Analysis of Nursing Home Registered Nurse Staffing Times." *Journal of American Geriatrics Society* 2005, 53: 656-661.

<sup>18</sup> See Horn S.D., et al. "RN Staffing Time and Outcomes of Long-Stay Nursing Home Residents: Pressure ulcers and other adverse outcomes are less likely as RNs spend more time on direct patient care." *American Journal of Nursing*. 2005, 105:58-70.

<sup>19</sup> See Abt Associates Inc. "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes." *Report to Congress: Phase II Final Volume I*, p. 5.

<sup>20</sup> See Statistics Canada. *Findings from the 2005 National Survey of the Work and Health of Nurses*. December 2006.

<sup>21</sup> *Ibid.*, p. 30.

<sup>22</sup> *Ibid.*, p. 36. Note nine per cent of nurses reported being injured on the job in the past year. Note the proportion of hospital nurses who sustained a work injury was 10.6 per cent.

<sup>23</sup> *Ibid.*, p. 132.

<sup>24</sup> See pp. 134-135.

<sup>25</sup> See p. 136. Long-term care nurses are concerned about their own risk of contracting a serious disease in their workplace (44.8%) and are concerned about the availability (34.7%) and effectiveness (45.5%) of personal protective equipment.

<sup>26</sup> See pp. 145-147. Total nursing hours per resident per day is also associated with reduced worker injury rates. One study found that each additional hour of nursing care decreased the injury rate by nearly 16 per cent. See Trinkoff, A. M., et al. "Staffing and Worker Injury in Nursing Homes." *American Journal of Public Health*. July 2005, 95(7): 1220-1225.

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<sup>27</sup> Note the recent final report from the SARS Commission recommends incorporating the “precautionary principle” in “all relevant health statutes and regulations.” See The SARS Commission, *Executive Summary*. Volume 1, p. 30, December 2006.

<sup>28</sup> See section 20.10 in the *Nursing Homes Act*.

<sup>29</sup> See section 201 in *Federal Accountability Act* that amends section 19.6 in the *Public Servants Disclosure Protection Act*.

<sup>30</sup> See *2004 Annual Report of the Office of the Provincial Auditor of Ontario*, Section 4.04, Long-Term Care Facilities Activity (follow-up to VFM Section 3.04, 2002 Annual Report), p. 386, accessed at [www.auditor.on.ca](http://www.auditor.on.ca).

<sup>31</sup> See McGrail, Kimberley M. et al. “For-profit versus not-for-profit delivery of long-term care.” *CMAJ* 176(1): January 2, 2007, p. 58

<sup>32</sup> Note that we believe the government should reconsider its 2006 decision removing the weak accountability obligations that were inserted in the 2004 amending agreement and instead add stronger accountability obligations.

<sup>33</sup> See McGrail, Kimberley M. et al. “For-profit versus not-for-profit delivery of long-term care.” *CMAJ* 176(1): January 2, 2007, pp. 57-58.