ONTARIO NURSES' ASSOCIATION

Submission on *Bill 21 – Retirement Homes Act, 2010*

Standing Committee on Social Policy

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INTRODUCTION

The Ontario Nurses' Association (ONA) is the union representing 55,000 front-line registered nurses and allied health professionals and more than 12,000 nursing student affiliates providing care in Ontario hospitals, long-term care facilities, public health, the community and industry.

ONA has been advocating for quality care in home care, long-term care and in acute care for many years. We welcome the opportunity to provide our frontline perspective to the Standing Committee on the regulation of retirement homes.

While ONA supports government action to regulate retirement homes, it is our view that Bill 21 requires much revision if the retirement homes industry is to be effectively regulated and the interests of residents living in retirement homes are to be protected.

We believe that the line has become blurred between care provided in long-term care homes and the type of care that should be provided in retirement homes. We are concerned that Bill 21 does not contain safeguards to ensure that retirement homes do not become a lesser regulated private-payment alternative to publicly funded long-term care homes. Bill 21 must be amended to provide clear limits on the care that can be provided in retirement homes and clear provisions for how any publicly funded interim beds are to be used in retirement homes. Our concern is magnified since many details in the provisions in Bill 21 are to be set out in regulations. Retirement homes must not be regulated in such a manner that they become a substitute for long-term care homes.

Our submission begins by setting the context for our recommendations with an overview of current developments related to the placement of patients from hospitals into retirement homes that we believe is an unacceptable level of care unless properly regulated as long-term care beds. We then make specific proposals for a regulatory scheme for retirement homes that differs significantly from that contained in Bill 21.

BACKGROUND AND CONTEXT

We believe that there are two fundamental principles that should guide the regulation of retirement homes in Ontario.

The first principle involves the issue of whether government has oversight over the regulatory regime or whether it is essentially self-regulated and controlled by the retirement home industry. Bill 21 is built on a self-regulatory model for the retirement home industry with a board that will be dominated and controlled by industry representatives. We believe this is a mistake and will not protect the interests of residents living in retirement homes. Our view is that retirement homes should not only be regulated and inspected by the Ministry of Health and Long-Term Care (MOHLTC), but the MOHLTC should take over responsibility for the carriage of Bill 21.

The second principle involves limitations on the appropriate level of care to be provided in retirement homes. Extensive work has been done by the MOHLTC to regulate and set standards for long-term care homes in Ontario. Similarly, the MOHLTC is developing policy with respect to pilot projects involving the placement of hospital Alternate Level of Care (ALC) and Rehabilitation patients into retirement homes.

We are not alone in putting forth concerns related to the placement of ALC patients into retirement homes. The September 2009 Nineteenth Annual Report of the Geriatric and Long Term Care Review Committee to the Chief Coroner for the Province of Ontario contains a case study of a 92 year old woman transferred from a hospital to a retirement home. On admission to the retirement home, the woman's clinical status quickly deteriorated. The woman's daughter documented daily concerns about her mother's care in the retirement home. Her mother was urgently transferred and admitted to hospital with severe dehydration. She died six weeks later. The Committee concluded their review of this case with the following observations:

> From the review, the Committee was unable to ascertain what level of service was offered at the private care home. There was no program description, staffing model, or funding model/sources available for review. The woman had very significant care needs even for a Ministry of Health and Long-Term Care funded long term care home, to meet. In fact, one of the long term care homes in the daughter's preferred geographic area rejected the woman's application due to her high care needs. Upon review, it was evident that the private care home did not possess the expertise, care, and services necessary to provide for the woman's significant care needs. Retirement homes have lower staffing ratios than long term care homes and it is hard to imagine how a private retirement home could meet the care needs of a resident like this woman without significant staffing enhancements….The lack of staff time may have contributed to the woman not receiving sufficient fluids resulting in the development of hypernatremia and dehydration….
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> The circumstances surrounding this woman's death should alert health care professionals that, despite pressures to move the frail elderly out of hospitals to other

settings, such as private care homes to await placement in a long term care home, it is important to remember that these elderly clients are awaiting long term care home placement precisely because their care needs are so heavy that they are difficult, if not impossible, to provide in a community, private care setting.[1]

The Committee also made the following four recommendations as a result of their review of this case:

1. All general hospitals in Ontario, and specifically this general hospital, should be reminded of the importance of carefully evaluating the types of frail elderly patients being considered for placement in private care homes (retirement homes). Clinically stable patients with minimal care and supervision needs are usually the most appropriate for programs in private care homes.
2. Health care professionals should be reminded that frail elderly patients who are totally functionally dependant and have significant care needs are not appropriate for placement in the private care homes. While awaiting placement in a Ministry of Health and Long-Term Care licensed long term care home, these frail elderly patients should remain in a setting that is as resource-intensive as a licensed long term care home.
3. Programs in private care or retirement homes in the Province of Ontario providing care to the frail elderly residents awaiting placement in a licensed long term care home should be held to the same standards for care and services as a licensed long term care home. Implicit in this recommendation is the need to ensure the same regulations and inspections with regular public reporting of findings that exists for licensed long term care homes.
4. Private care homes or retirement homes in the Province of Ontario should be subject to regulations, oversight, and regular inspection by a public sector agency in order to ensure that care and safety needs are met. The guiding priority should be the care and safety needs of the frail elderly and not the type of facility in which the placement occurs.

These are important recommendations to the Coroner to keep in mind as we propose an alternative regulatory scheme for retirement homes. These recommendations are particularly important because the practice of placing ALC patients in retirement homes continues in a number of communities in Ontario: Windsor, Hamilton, Peterborough and Ottawa.[2]

RECOMMENDATIONS

1. Administration, oversight and inspection by the Ministry of Health and Long-Term Care, not self-regulation by the retirement homes industry.

The administration and oversight of Bill 21 is the responsibility of the Minister Responsible for Seniors. We believe that the more appropriate Minister to administer Bill 21 and to provide oversight of the regulation of retirement homes is the Minister of Health and Long-Term Care.

In Part II, Bill 21 creates a new bureaucracy – the Retirement Homes Regulatory Authority. We believe this model, essentially one of self-regulation by the retirement homes industry, is a mistake. As recommended by the September 2009 Geriatric and Long Term Care Review Committee to the Chief Coroner, we believe the more appropriate model to regulate retirement homes should include regulation, oversight, and regular inspection/enforcement by a retirement home division within the Ministry of Health and Long-Term Care. In our view, this is the best approach to ensure that the care and safety needs of retirement home residents are met.

The Ministry of Health and Long-Term Care also has the required expertise and capacity to provide inspection, compliance and enforcement because of responsibility for these functions within the long-term care homes sector. It is critical that a mandatory inspection process be put in place and that inspectors are required to consult, during any inspection, with representatives of the Residents' Council, and the non-management workers and their unions. We believe the current exclusion under S. 77 provides inspectors with only one point of view.

In addition, the MOHLTC is already involved in developing policy to ensure that any interim or temporary beds funded by hospitals or Local Health Integration Networks (LHINs) to house hospital ALC patients in retirement homes will be in compliance with all existing long-term care homes legislative requirements. ONA understands that MOHLTC policy is that any ALC patients going from hospital to retirement homes will be funded as long-term care homes beds and will have all the processes, regulations, and licensing requirements applied. This should be specified in Bill 21.

As is already the case under Bill 21, the retirement home industry will continue to be responsible for funding the regulatory regime.

2. Limitations need to be put in place on the appropriate level of care to be provided in retirement homes.

Bill 21 does not define the level of care that is appropriate in the retirement home context. The Bill does not set out staffing requirements. It is clear from MOHLTC policy that the level of care required for hospital ALC patients means that these interim beds must be treated as long-term care homes beds in compliance with long-term care homes legislative requirements. However, Bill 21 does not regulate the level of care that is allowed in retirement homes for these residents or for any other residents.

ONA does not want private-payment retirement homes to become a substitute for publicly funded long-term care homes. Retirement homes are the appropriate level of care for residents with limited needs for assistance with activities of daily living. We agree with the assessment of the September 2009 Geriatric and Long Term Care Review Committee to the Chief Coroner: "Clinically stable patients with minimal care and supervision needs are usually the most appropriate for programs in private care homes." In addition, we agree with their recommendation that "frail elderly patients who are totally functionally dependant and have significant care needs are not appropriate for placement in the private care homes."

Bill 21 must specify limits on the appropriate level of care that can be provided in retirement homes. Otherwise, we have a situation where hospital ALC and rehabilitation patients in interim beds must, according to MOHLTC policy, meet the long-term care homes legislative requirements, but other residents requiring significant care needs who are admitted to retirement homes would be regulated at a different standard unless the maximum level of appropriate care is specified in regulation in Bill 21.

For example, S. 62(1) provides for an assessment and a plan of care to be developed in accordance with regulations, and S. 63(3) indicates that if the resident assessment meets prescribed criteria, then information must be provided about alternatives to a retirement home. Limitations on the level of appropriate care for retirement homes must be specified in legislation, not in regulation. Once residents attain the maximum level of care, all legislative requirements of long-term care homes must apply and such beds must be licensed as long-term care homes beds, or the residents must be transferred to receive appropriate levels of care in long-term care facilities.

Bill 21 also does not define who delivers the care in retirement homes, what qualifications are required under S. 65(1), who conducts assessments under S. 62(3), who prepares the written plan of care in S. 62(4), who approves plans of care under S. 62(9), and who revises the plan of care in S. 62(12).

We are also concerned about sections in Bill 21 that refer to higher levels of inappropriate care being provided in retirement homes. For example, Bill 21 allows confinement to secure units and restraints in certain circumstances in S. 68 and in S. 70.

We believe levels of care involving restraints and secure units are inappropriate for retirement homes and should not be included unless regulated under the legislative requirements for long-term care homes.

As well, we are concerned about the ramifications of S. 68(1), which excludes the administration of a drug 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 duty to the College of Nurses' policy on least restraints. Further, Bill 21 should explicitly require that residents be transferred to a long-term care facility that can provide the appropriate, safe care if restraints or secure units are part of treatment plans. Ineffectively treating cognitively impaired residents not only endangers that resident but other residents in the home and staff.[3] In addition, it seems that informed consent to such treatment may prove to be difficult to obtain from residents. S. 70(9) does not provide a process for comprehensive rights advice, for example, for incapable residents. In any event, restraints and secure units are not appropriate in retirement homes.

3. A culture of health and safety for retirement home staff needs to be included.

Retirement homes are also workplaces for the staff that deliver care to the residents. Bill 21 continues to ignore the impact of unsafe working conditions for staff on the quality of care outcomes for residents.

Bill 21 does not recognize worker health and safety as a fundamental principle. We believe this is misguided. We propose that Bill 21 also include reference to retirement homes as workplaces and that they be operated with regard to the health and safety of its workforce.[4]

As well, WSIB coverage is currently optional and Bill 21 should provide for mandatory coverage of all staff working in retirement homes. WSIB coverage is mandatory for long-term care homes providing a minimum of two hours of nursing or personal care a day per resident. We can see no justification for excluding retirement homes from mandatory WSIB coverage. Different standards obviously create serious problems for staff in retirement homes if they have to rely upon employer sick leave plans to cover work related accidents or illnesses instead of WSIB coverage.

Finally, we agree with many other stakeholders that Bill 21 should require mandatory sprinklers in all retirement homes.

4. Whistleblower protection is not strong enough.

While the inclusion of whistleblower protection in S. 115 is welcome, 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.

First, Bill 21 limits this protection to persons making disclosures to an inspector, the Registrar or 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 any media outlet the next time a death occurs in a retirement home will have no protection.

Second, S. 115 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.

S. 115 does not have the same level of protection for whistleblowers as is contained in federal legislation. For example, the whistleblower protection 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.[5]

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

5. Details are in regulations rather than in legislation.

On a broad level, our first concern relates to the number of areas in Bill 21 that may be set out in regulation, rather than in legislation.

S. 121 sets out numerous areas for regulation that are more appropriately set out in legislation, such as plans of care, levels of care, the definition of retirement homes, and any limitations to the application of the *Health Care Consent Act.*

Finally, we believe the Act should be initially reviewed in three years rather than five years as set out in S. 120.

CONCLUSION

Retirement homes should not be a lesser regulated private-payment alternative to publicly funded long-term care homes. The Ministry of Health and Long-Term Care should be designated to provide oversight, inspection and enforcement of retirement homes. Bill 21 should set out the maximum appropriate levels of care to be provided in retirement homes. When the maximum appropriate level of care is required, all legislative requirements for long-term care homes would apply.

This regulatory regime will ensure that the care needs of residents living in retirement homes are met.

We sincerely request that our recommendations be given serious consideration by the Standing Committee so that residents in retirements home will receive the appropriate level of care they deserve.

ENDNOTES

[1] See Nineteenth Annual Report of the Geriatric and Long Term Care Review Committee to the Chief Coroner for the Province of Ontario, September 2009, p. 40.

[2] See, for example, in Ottawa. Tam, Pauline. "Ottawa, Queensway Carleton to relocate dozens of elderly patients to care home." Ottawa Citizen, January 20, 2010.

[3] See Coroner's Inquest, Casa Verde Nursing Home, *Jury Verdict and Recommendations*, April 2005.

[4] Note the 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.

[5] See section 201 in *Federal Accountability Act* that amends section 19.6 in the *Public Servants Disclosure Protection Act.*