

**ONTARIO NURSES' ASSOCIATION**

**SUBMISSION**

**ON**

***2019 PRE-BUDGET CONSULTATIONS***

**TO**

**STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS**

**Toronto, Ontario**

**Queen's Park  
Committee Room 1**

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**11:15 a.m.**



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## **Summary of ONA Recommendations for 2019 Ontario Budget**

ONA proposes the following recommendations for the 2019 Ontario budget.

1. The gap in care by registered nurses (RNs) for Ontario patients increased to more than 21,000 RNs required to catch up to the ratio of RN skilled care in the rest of the country. As part of the government's transformational strategy to address hallway care, we urge the government to develop a funded plan to close the gap in RN care in Ontario over the next four years.
2. ONA is calling for hospital funding to offset increased cost pressures of at least 4.5 percent in 2019 based on estimates of population growth, aging and inflation produced by the Financial Accountability Office of Ontario. This is to ensure our hospitals have the resources to properly maintain RN staffing for safe, quality patient care. To ensure appropriate capacity in the hospital sector, the government should develop a strategy for multi-year funding.
3. Restructuring the number and size of LHINs will not provide better and more accessible care for patients seeking local home care services and/or placement into long-term care homes. We call for the government to increase funding for expanded capacity in home care and to move toward a fully integrated *public* home care system that integrates the delivery of home care services and care coordination in the LHINs. Eliminating the duplication of resources and costs in Ontario's home care system that arise from the management of, and awarding of contracts, to for-profit private providers, will result in cost savings as public funding will shift to frontline care rather than to fund profit margins. These savings, from eliminating profit, can be redirected to more public home care services for Ontarians that are coordinated and delivered in the LHINs on a regional basis.
4. ONA is calling for the government to increase funding to long-term care homes to reflect the growing care needs of the increasingly aging and high acuity patient population. We are calling for funding per home to ensure there is an average of hours of RN care that is equivalent to at least one (1) RN for every 20 residents, each twenty-four (24) hour day. In addition, there should be at least (1) nurse practitioner (NP) for every 120 residents, given the present acuity of Ontario residents.
5. To ensure all public funding flowing to long-term care homes is provided directly to resident care, the Ministry of Health and Long-Term Care (MOHLTC) should develop a plan to ensure that all for-profit long-term care homes are eliminated and/or that for-profit homes are replaced by a non-for-profit home within five (5) years. In the alternative, any newly funded long-term care beds to build capacity in the sector should only be provided to not-for-profit homes.

## I. Introduction

The Ontario Nurses' Association (ONA) is the union representing 65,000 registered nurses (RNs) and health-care professionals, as well as 18,000 nursing student affiliates, providing care in hospitals, long-term care facilities, public health, the community, clinics and industry.

ONA welcomes the opportunity to provide the Standing Committee on Finance and Economic Affairs with recommendations from the perspective of front-line nurses with respect to our healthcare priorities for the 2019 Ontario budget.

A number of recent news reports indicate the government is contemplating restructuring of the Local Health Integration Networks (LHINs), which the government says is part of a larger review of health-care agencies and that they are working with partners in health care to develop their long-term transformational health-care strategy.

Every day nurses face the challenge of caring for their patients within a health-care system that is not integrated, that is under-resourced and that is difficult to navigate. Nurses have solutions and we extend our offer to partner with government.

Our pre-budget submission provides a way forward. It starts with the need for resources – both financial and human – in order to chart a course for a future that is patient-centred, integrated and coordinated.

We believe that to be patient-centred our focus must return to ensuring the care needs of our patients are met. This approach must be placed within the context of increasing patient acuity across all care sectors – hospitals, long-term care and home care. Better integration and coordination of care as a patient transitions between sectors will help but more capacity is also essential to ensure the right care is available in the right setting at the right time.

Nurses are advocates for our patients. We advocate for the care they need to achieve healthy outcomes. How can we provide the care our patients need when fewer RNs are available?

The most recent statistics from the College of Nurses (CNO) show that Ontario has 654 fewer RNs employed in nursing in Ontario in 2017.

This shortage of RNs means achieving healthy outcomes for our patients becomes more challenging without more resources. We believe this signals the need for a clear vision for the role of RNs in Ontario health care settings.

ONA's submission argues for an integrated approach to building capacity to address the outcome of eliminating hallway care in hospitals. We will focus on the requirement for building capacity in long-term care, in home care and in hospitals.

Capacity in long-term care is about more than more beds; it is also about the right care for the acuity of residents. Home care requires more coordination and less inconsistent, fragmented care from multiple providers.

We also make an appeal for addressing more capacity in assisted and supportive housing that we believe may be best suited as the most appropriate setting for a certain population of alternate level of care (ALC) patients.<sup>1</sup>

## **II. Human Resources to Build Health Care Capacity**

As of 2017, it is the third year in a row that Ontario has the lowest RN ratio per 100,000 population in the country.<sup>2</sup> In the latest data available from CIHI, Ontario has 689 RNs per 100,000 compared to 837 RNs for 100,000 people in the rest of Canada.

The gap in RN care for Ontario patients increased to more than 21,000 RNs required to catch up to the ratio of RN skilled care in the rest of the country. As part of the government's transformational strategy to address hallway care, we urge the government to develop a funded plan to close the gap in RN care in Ontario over the next four years.

A health human resources strategy for Ontario will also need to plan to replace RNs currently at retirement age. In 2017, there were 24,298 RNs aged 55-plus, or 25.5 per cent of Ontario's employed RN workforce that is eligible to retire in the coming years.<sup>3</sup>

In addition, the RN share of nursing employment in Ontario has been *falling* significantly over time – from 76.4 per cent in 2003 to 69.8 per cent in 2017. This trend raises serious concerns given the research literature relating higher RN staffing to improved patient health outcomes.

The Ontario Auditor General's 2016 Annual Report provided strong evidence for the need to improve RN staffing in our hospitals.<sup>4</sup> The Auditor General found that RN patient assignment is heavier in Ontario than what international best practices recommend.

The international best practice ratio of 1:4 (one RN for every four patients) in hospital medicine and surgery units is not being met in Ontario hospitals. The Auditor General also found that at the community hospitals they visited, nurse-to-patient ratios are as high as 1:6 during the day and 1:7 during the night shifts on medicine and surgery units. In fact, the auditor's survey of large community hospitals found that nurse-to-patient ratios for medicine units are as high as 1:9 for overnight shifts. Lack of funding was the reason hospitals gave for these extremely high patient ratios.

As the Auditor's report noted, comprehensive research shows "that every extra patient beyond four that is added to a nurse's workload results in a 7 per cent increased risk of death."<sup>5</sup> This means that patients in these units are at risk because there is extensive research evidence that shows improved outcomes for patients who receive *more* hours of RN care.<sup>6</sup>

More RN hours of care positively impact a variety of adverse outcomes for patients *and* reduce costs for our health- care system. RN staffing is associated with a range of *improved* patient outcomes: *reduced* hospital-based mortality; *fewer* cases of hospital-acquired pneumonia, unplanned extubation, failure to rescue, nosocomial bloodstream infections; and *shorter* lengths of stay.<sup>7</sup>

Research has also developed costing models related to cost savings realized from interventions and treatments related to avoidable adverse events that would no longer occur as a result of improved RN staffing levels. As an example, one study has demonstrated that higher RN staffing decreases the odds of readmission of medical/surgical patients by nearly 50 percent and reduces post-discharge emergency department visits.<sup>8</sup>

A further study by Needleman et al<sup>9</sup> concluded that raising the proportion of RN hours resulted in *improved* patient outcomes and *reduced the costs* associated with longer hospital stays and adverse outcomes compared to other options for hospital patient care staffing.

Another study<sup>10</sup> has shown improved patient care from additional RN staffing that prevents nosocomial complications, mitigates complications through early intervention, and leads to more rapid patient recovery, *creates medical savings* and shows the economic value of professional RN staffing.<sup>11</sup>

Further, a study<sup>12</sup> to determine the costs and savings associated with the prevention of adverse events by critical care RNs found annual savings from prevented adverse events (such as near misses) ranged from \$2.2 million to \$13.2 million, while RN staffing costs for the same time period amounted to \$1.36 million. This study concluded that although RN critical care staffing costs are significant, the potential savings associated with preventing adverse events is far greater.

This body of research findings clearly show that reductions in readmissions and the prevention of adverse events for patients with the addition of RN staffing would result in measureable cost savings for Ontario hospitals. Higher levels of RN staffing also assist with keeping patients and nurses safe.<sup>13</sup>

### **III. Financial Resources to Build Health Capacity and Hospital Care**

A 2017 report from the Financial Accountability Office of Ontario<sup>14</sup> estimates that demographic changes – population growth (1.2 per cent) and aging (1.1 per cent) – increased health care demand from income growth (.9 per cent), and inflation costs (2.1 per cent) will lead to pressures of approximately 5.3 per cent increases needed annually over the next five years. This independent analysis suggests hospital funding needs to increase by 5.3 per cent in 2019 to meet the real cost pressures that hospitals face.

In the context of current hospital funding, Grand River Hospital in Kitchener has recently announced it is planning layoffs to deal with a projected deficit of \$7.4 million. It is estimated this will result in the elimination of 50 positions, 80 per cent of which will be full-time, front-line positions, including RNs.

Hospital base operating funding was frozen for four straight years: 2012-13, 2013-14, 2014-15, and 2015-16. In 2016-17, hospitals received a much-needed 1 per cent increase to base operating funding and a subsequent 1 per cent increase allocated to hospitals later in the fiscal year.

In 2017-18, all hospitals received a minimum base increase of 2 per cent, while another 1 per cent of funding was directed to specialized provincial programs. In 2018-19, all hospitals received a 1 per cent increase to base operating funding and additional funding to support existing services, growth and priority programs, resulting in an overall increase of 4.3 per cent or \$822 million.

In real terms, hospitals have struggled for at least ten years with insufficient base operating funding to cover the full costs of inflation, population growth and aging. The Ontario population alone has grown by more than ten per cent.

The proportion of the population of Ontario aged 65 and over, which requires significant health care resources, is projected to reach between 23.8 per cent and 26.2 per cent by 2038 from 15.6 per cent in 2014.<sup>15</sup>

Hospital funding has not even accounted for inflation in many years. The Ontario Ministry of Finance projects CPI inflation to be 2.1 per cent in 2019 and 2.0 per cent in 2020.<sup>16</sup>

In October 2018, the Premier and the Minister of Health announced surge capacity funding of an additional \$90 million in 2018-19 to build 1,100 beds and spaces in hospitals and the community, including more than 640 new beds and spaces. In December, the Health Minister announced 92 newly renovated activation beds at the Humber River Hospital Church Street site in Toronto.

While the provincial announcements of new hospital funding and activation beds is a small step to address overcrowding in hospitals, successfully easing the congestion on a permanent basis, rather than temporarily, requires more capacity in the long-term care and home care sectors. Nurses know that we need much more capacity in our hospitals and more front-line RNs at the bedside to care for them.

Nurses also have first-hand experience with the realities of caring for patients in hallways and in 'unconventional spaces.' Temporary funding for additional surge capacity will not *so/ve* the problem. Ontario needs new, permanent investments in hospital capacity, in long-term care capacity and in capacity in home/community care. This increased capacity across sectors must include dedicated funding for permanent, not temporary, front-line RNs, if the care needs of patients are to be met.

The Ontario Hospital Association (OHA) estimated back in 2014 that a minimum of 3.6 per cent is required to cover non-labour cost growth of 1.5 per cent for equipment, supplies and other expenses; population growth pressures of 1.1 per cent per year, and costs due to aging estimated at 1 per cent annually.<sup>17</sup>

In 2019, the OHA is requesting an 'absolute minimum' increase of 3.45 per cent in hospital funding or \$656 million to cover inflation, population growth and aging.<sup>18</sup> An increase of 3.45 per cent is less than the minimum amount that was needed to cover costs in 2014, and the OHA notes that "hospitals regularly operate at over 100 per cent capacity."

The question the government faces is how many patients will be affected if hospital funding is not increased to a level that is sufficient to improve the care that should never be received in hallways and unconventional spaces that were never designed for that purpose. ONA believes hospitals will require funding to offset increased cost pressures of at least 4.5 per cent in 2019 based on estimates of population growth, aging and inflation produced by the Financial Accountability Office of Ontario.

This funding is designed to ensure patients receive care while capacity is built in long-term care and in home care. As the OHA notes, as of October 2018, 4,635<sup>19</sup> alternate level of care (ALC) patients were waiting for care in a more appropriate setting. Transformation will take time as the government strives to integrate the health-care system and to build further capacity. In the meantime, hospital care needs resources.

#### **IV. Expanding Capacity in Home Care and Long-Term Care**

The Auditor General noted in her 2015 Annual Report that "home care used to serve primarily clients with low to moderate care needs, but now serves clients with increasingly more complex medical and social-support needs." The Auditor also documents issues of duplication and omission in the contracts with about 160 private sector service providers who provide home care services, and comments on the resulting commercial confidentiality in the model so that the true costs are left unsubstantiated.

A number of organizations have expressed opinions about building capacity in sectors that care for patients discharged from hospital.



In the case of home care, some organizations advocate for moving the care coordination function currently provided in the LHINs into some 445 primary care organizations across Ontario. ONA firmly disagrees as we believe such a move would continue to fragment care and duplicate services, which are exactly the issues identified by the Auditor.

Other organizations are putting forward proposals to remove care coordination from the LHINs and to move this function directly into home care providers.

These proposals would also result in the same fragmented, inconsistent system, with duplication and omission of services, as set out in the findings by the Auditor.

From ONA's perspective, these proposals do not assist with furthering the integration of care after hospital discharge and improving access to appropriate coordination of home care services.

Rather, with care coordination services and the delivery of home care services combined together in the LHINs, we believe Ontarians would receive consistent, coordinated services throughout the province. In ONA's vision for home care, we therefore support care coordination continuing in the public, non-profit LHINs.

Our vision in which the LHINs directly employ all of the front-line staff responsible for home care delivery would result in much better continuity of care and set consistent standards across the system given the consolidation rather than fragmentation of service delivery.

It would also be a much better use of limited resources and would eliminate the needless and wasteful expenditure of resources on the current process of contracting to private sector providers. It would allow for public accountability and transparency for clients and families, rather than restrictions and barriers imposed by commercial confidentiality. Ontario's managed competition model siphons profit from public funding that should be designated for care.

There is evidence from the literature that shows when care coordinators are able to coordinate a range of services for the frail elderly based on need, the use of hospital emergency, acute care and long-term care declines.<sup>20</sup>

Restructuring the number and size of LHINs will not provide better and more accessible care for patients seeking local home care services and/or placement into long-term care homes.

As in home care, there is evidence in the literature<sup>21</sup> on the relationship between higher RN staffing levels in long-term care homes and improved quality of care outcomes for residents. Conversely, decreasing RN staffing has a negative impact on resident health outcomes.<sup>22</sup>

ONA believes systemic change is required in the long-term care sector to address the overarching issues of understaffing and underfunding.

Long-term care homes are staffed far too lean and the ratio of registered nurses to residents in nursing homes is far too low to allow adequate and safe care. Compounding this problem of understaffing is the widespread recruitment and retention issues for the RNs in this sector, and the unsafe use of agencies that send in temporary staff who are not familiar with the homes or residents.

Residents in today's long-term care homes are typically older and frailer, with higher acuity and more comorbidities, than the residents of the past. The data collected by the Ministry of Health and Long-Term Care from 2014 confirms that the average age of residents in long-term care was 85 years. Of these residents: 78 per cent required assistance (total or extensive) with the activities of daily living; 65 per cent suffered from depression; almost half had aggressive behaviors for medical reasons; more than half were medically "unstable"; 69 per cent had dementia/Alzheimer's disease; 50 per cent had heart disease; and 26 per cent had diabetes. Of the 71,000 residents in 2014, almost 23,000 were transferred to acute care hospitals. These residents are not a medically stable patient population.<sup>23</sup>

RN skills and scope of practice are essential to meet the growing clinical needs in order to provide the necessary care for the complex conditions of long-term care residents.

Since 2001, the provincial government has been provided with multiple expert reports, inquests, and other reviews in long-term care that each provide clear, strongly worded recommendations regarding an urgent need to increase staffing and funding in long-term care.<sup>24</sup>

Despite this series of reports – each containing an express finding that long-term care homes are insufficiently staffed to provide care and prevent harm to residents – the Ministry of Health has yet to implement a reasonable registered nurse-to-resident ratio or mandate a set number of hours of care, per resident, each day.

There remains insufficient funding and regulation to ensure adequate nursing and personal care staffing that is capable of meeting the needs of patients in long-term care facilities.

It is clear that there are similar problems of registered nurse staffing, funding, recruitment and retention in long-term care as in home care. Just as in home care, RNs are simply not paid enough in long-term care to attract and retain experienced staff.

As well, new graduates initially work in home care to obtain nursing experience and then move to an acute care hospital, as the hospital sector is more stable and better paid. Regional health authorities in other provinces have responded to these recruitment and retention challenges by moving to wage parity across sectors for nurses staffing.

Staffing and funding go hand in hand. The Casa Verde Inquest<sup>25</sup> recommendations speak to funding so as to set standards to increasing staffing levels and ensure wage parity. The Sharkey Report<sup>26</sup> recommends that guidelines be established to support funding to provide up to four hours of care per resident per day. The Donner Report<sup>27</sup> strongly recommends that the Sharkey Report be implemented, again drawing the connection between funding and staffing. It is virtually impossible to address staffing issues in long-term care without also properly funding long-term care.

Staffing in long-term care has been a chronic problem for decades. It is now reaching an untenable level that will only worsen with Ontario's aging population. Widespread changes and sufficient funding must be implemented, as these changes require additional staff – particularly RNs, due to resident acuity.

ONA is calling for the government to increase funding to long-term care homes to reflect the growing care needs of the increasingly aging and high acuity patient population. We are calling for funding per home to ensure there is an average hours of RN care that is equivalent to at least one (1) RN for every 20 residents, each twenty-four (24) hour day.

In addition, there should be at least (1) NP for every 120 residents, given the present acuity of Ontario residents. This should be a legislated, enforceable minimum, which would require a change to Section 8 of the Long-Term Care Homes Act and any applicable or new regulations.

To ensure all public funding flowing to long-term care homes is provided directly to resident care, the Ministry of Health should develop a plan to ensure that all for-profit long-term care homes are eliminated and/or that for-profit homes are replaced by a non-for-profit home within five (5) years. In the alternative, any newly funded long-term care beds to build capacity should only be provided to not-for-profit homes.<sup>28</sup>

## V. Conclusion

ONA welcomes the opportunity to provide our priorities to the Standing Committee for the 2019 Ontario budget. Our recommendations are put forth from the perspective of Ontario's front-line registered nurses and health-care professionals.

ONA is calling for hospital funding to offset increased cost pressures of at least 4.5 per cent in 2019 based on estimates of population growth, aging and inflation produced by the Financial Accountability Office of Ontario. This is to ensure our hospitals have the resources to properly maintain RN staffing for safe, quality patient care.

We call for increased funding for expanded capacity in home care and to move toward a fully integrated *public* home care system that integrates the delivery of home care services with care coordination in the LHINs.

ONA calls for a significant increase to fund long-term care homes to reflect the growing care needs of the increasingly aging and high acuity patient population. We are also calling for a plan to ensure public funding flowing to long-term care homes is provided directly to resident care, including newly funded long-term care beds to build capacity provided in not-for-profit homes.

Nurses know the government is consulting on a health-care transformational strategy. Nurses have much to offer the government in terms of solutions for integrated care for our increasingly acute patients and our aging population. We look forward to hearing more from the government and actively participating in consultations to bring forward solutions for the health-care system.

## Endnotes

- <sup>1</sup> We are not making recommendations on this as we do not have access to current ALC statistics. We believe nurses could offer helpful solutions if we were granted access.
- <sup>2</sup> Canadian Institute for Health Information (CIHI). *Regulated Nurses, 2017*. ONA calculations based on CIHI data as CIHI no longer reports nurse to population ratios.
- <sup>3</sup> College of Nurses of Ontario. *Membership Statistics Report, 2017*.
- <sup>4</sup> See 2016 Annual Report of the Office of the Auditor General of Ontario.
- <sup>5</sup> Auditor, p. 470.
- <sup>6</sup> See, for example, the literature cited in Tourangeau, Anne E. et al., "Impact of hospital nursing on 30-day mortality for acute medical patients." *Journal of Advanced Nursing* 57(1):33, 2007.
- <sup>7</sup> See, for example, Needleman, et al. "Nurse-staffing levels and the quality of care in hospital." *New England Journal of Medicine* 346(22): 1715-1722, 2002
- <sup>8</sup> Weiss, M. E., et al. "Quality and cost analysis of nurse staffing, discharge preparation, and post discharge utilization." *Health Services Research* 46(5):1473-1494, 2011.
- <sup>9</sup> Needleman, J., et al. "Nurse staffing in hospitals: Is there a business case for quality?" *Health Affairs* 25(1): 204-211, 2006.
- <sup>10</sup> Dall, Timothy M. et al. "The Economic Value of Professional Nursing," *Medical Care* 47(1):97-104, 2009.
- <sup>11</sup> The term "economic value of professional nursing" in this study refers to a monetary assessment of the value of incremental changes in nurse staffing that result in improved quality of patient care. This definition emphasizes the changes in nurse staffing that affect medical costs due to the impact on patient outcomes. Improved patient care that prevents or mitigates complications creates medical savings. Reduced lengths of recovery and mortality rates have national productivity implications.
- <sup>12</sup> Rothschild, J. M., et al. "The costs and savings associated with prevention of adverse events by critical care nurses." *Journal of Critical Care* 24(3): 2009.
- <sup>13</sup> Higher levels of RN staffing mix are associated with lower assault rates. See Staggs, V.S. "Nurse Staffing, RN Mix and Assault Rates on Psychiatric Units." *Research in Nursing & Health* 26(1): 26-37, 2013.
- <sup>14</sup> See Fiscal Accountability Office of Ontario, *Ontario Health Sector: Expense Trends and Medium-Term Outlook Analysis*, Winter 2017.
- <sup>15</sup> Statistics Canada. *The Daily*, "Population Projections: Canada, the provinces and territories, 2013 to 2063." September 17, 2014. Statistics Canada. *Annual Demographic Estimates: Canada, Provinces and Territories*, Catalogue no. 91-215-X, p. 62.
- <sup>16</sup> Ontario 2018 Economic Outlook and Fiscal Review, p. 7.
- <sup>17</sup> See Ontario Hospital Association, Submission to Standing Committee on Finance and Economic Affairs, January 23, 2014, p. 2.
- <sup>18</sup> OHA 2019 Pre-Budget Submission, p. 6.
- <sup>19</sup> *Ibid.*, p. 4.
- <sup>20</sup> Williams, A.P. et al. "Reducing Institutional and Community-Based Care," *Healthcare Quarterly* 12(2): 2009.
- <sup>21</sup> See, for example, Bostick, Jane E. et al. "Systematic Review of Studies of Staffing and Quality in Nursing Homes." *J Am Med Dir Assoc* July 2006: 366-376. For Canadian evidence, see McGregor, Margaret J, and Lisa A. Ronald, "Residential Long-Term Care for Canadian Seniors: Nonprofit, For-Profit or Does it Matter?" *IRRP Study*, No. 14, January 2011.
- <sup>22</sup> For example, see McDonald, S.M. et al. "Staffing Related Deficiency Citations in Nursing Homes." *Journal of Aging & Social Policy* 25(1):83-97, 2013 and Trivedi, T.K. et al. "Hospitalizations and Mortality Associated with Norovirus Outbreaks in Nursing Homes, 2009-2012." *Journal of American Medical Association* 308(16): 1668-1675, 2012.
- <sup>23</sup> ONTARIO NURSES' ASSOCIATION, Written Closing Submissions to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, September 20, 2018.
- <sup>24</sup> *Ibid.*
- <sup>25</sup> *Ibid.* A Coroner's Inquest was held and in 2005, the jury issued 85 recommendations aimed at preventing deaths in similar circumstances. Many of their recommendations were directed towards revising the long-term care funding and staffing model. They include recommending a new funding system, a study to determine appropriate staffing levels (and amounts of direct RN care required), funding to ensure parity in wages and benefits with hospital RNs, increases in the number of full-time RN positions, and a reduction

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in the use of agency nurses. The jury recommended that staffing level standards be increased immediately to at least 1 RN hour per day, per resident. This standard has not been implemented.

<sup>26</sup> Ibid. The Ministry commissioned "People Caring for People: Impacting the Quality of Life and Care of Residents of Long-Term Care Homes: A Report of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario" in 2008. The report was authored by Shirlee Sharkey (the Sharkey Report). Ms. Sharkey recommended that provincial guidelines be established to fund an average of up to four hours of care per resident per day, including up to an hour by licensed nurses. This recommendation was to be in place by 2012. These recommendations have not been implemented.

<sup>27</sup> Ibid. In 2012, Gail Donner chaired a report of the Long-Term Care Task Force that identified a number of familiar challenges in long-term care (the Donner Report). The Donner Report found that "the care needs of residents who live in long term care homes is becoming more complex and specialized" as older residents increasingly have "multiple co-morbidities". These co-morbidities require not only more staffing in general, but staffing with RNs in particular, who have the scope of practice required for complex acute residents. The Donner Report also highlighted the human resource challenges impacting on the leadership and skill capacity in long-term care, including wage disparity in the sector as compared to hospitals, and the serious issues of recruitment and retention and its impact on workload.

<sup>28</sup> The current average minutes of RN care in for-profit nursing homes that ONA represents is slightly more than 17 minutes of daily RN care per resident. This is extremely low relative to the level of RN care recommended by experts in the literature. In addition, the proportion of full-time RN positions in ONA-represented for-profit nursing homes is a dismally low 37.1%. Again, this is not conducive to safe, quality resident care, nor is it helpful for recruitment and retention of RN staff. Furthermore, a recent study conducted by the Bruyere Research Institute in Ottawa shows that residents of Ontario's for-profit nursing homes suffer from significantly higher mortality and hospitalization rates than residents of non-profit facilities. The study followed more than 53,000 residents in Ontario's nursing homes between January 2010 and March 2012, and found that for-profit residents were 33 per cent more likely to be hospitalized and 16 per cent more likely to die during the first six months of their stay. See Tanuseputro, Peter et al. "Hospitalization and Mortality Rates in Long-Term Care Facilities: Does For Profit Status Matter?" JAMDA 16: 874-883, 2015. Additionally, for-profit operators pay RNs less than their comparators in the non-profit homes causing additional issues with retention and recruitment while operators ensure they are able to generate profit.