

ONTARIO NURSES' ASSOCIATION

SUBMISSION

ON

**Proposed Phase 1 Regulations under
the Fixing Long-Term Care Act, 2021**

TO

**Ministry of Long-Term Care
ltc.comments@ontario.ca
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The Ontario Nurses' Association (ONA) is the union representing 68,000 registered nurses (RNs) and health-care professionals across Ontario and in every sector of health care. Our membership includes thousands of front-line nurses and health-care professionals in the long-term care (LTC) sector.

ONA has spoken out at every stage of Bill 37, the *Providing More Care, Protecting Seniors, and Building More Beds Act, 2021*. This Bill repeals the current *Long-Term Care Homes Act, 2007* (LTCHA) and enacts in its place the *Fixing Long-Term Care Act, 2021* (FLTCA). Notwithstanding the new title, the FLTCA is not a substantially new Act. It is almost clause by clause the existing Act with a number of amendments – some minor and some consequential.

Alongside other health-care unions, LTC families and stakeholders, ONA raised concerns at the legislative stage of Bill 37 about understaffing and underfunding and called for an end to for-profit care. We continue to call for the repeal of Bill 124, which suppresses wages of our members in non-profit LTC homes. ONA also participates in the Long-Term Care Minister's Strategic Long-Term Care Advisory Table and continues to advocate strongly on these issues. We are deeply committed to systemic change in this sector.

We now welcome this opportunity to provide feedback on the first phase of regulation development for Bill 37. The government has laid out additional details, descriptions and expectations in detailed regulations. These proposed regulations cover reporting mechanisms, descriptions of required policies, and how to implement those policies.

The following are some key concerns:

- ONA opposes regulations that allow for an exception to the 24/7 RN staffing giving homes the ability to use anyone they feel is qualified during a pandemic.
- Of concern is the failure to designate the IPAC lead as an RN.
- There is a missed opportunity to augment the role of Nurse Practitioners (NPs) as Medical Directors and enhance whistle-blowing protections for staff.
- Further, the proposed regulations fail to introduce stronger penalties for bad actors. Our position is that fines – especially when there is not political will to enforce – are not enough of a deterrent for for-profit corporations. Government must phase-out for-profit care and new bed licenses should not be awarded to for-profit homes. We urge government to listen to our concerns and address these issues immediately.

Another overarching concern is that ONA fundamentally opposes the government's approach to policy-making through regulations rather than through legislation. This approach removes oversight, democratic accountability and transparency, and

undermines the longevity and credibility of the policies enacted. Regulations can be amended by cabinet, behind closed doors and without a public hearing process whereas legislation is passed only by rules of the legislature. Simply put, legislation undergoes a more thorough vetting by the public, health-care stakeholders, the media and opposition politicians than do regulations.

ONA is generally supportive of government regulatory proposals that add further details on some of the matters relative to the LTCHA and its regulations, particularly around medication administration and monitoring. That said, we are concerned that these details could easily be amended, deleted, or added to without consultation or transparency as they are regulations and will not be enshrined in legislation.

Nurses and health-care professionals know what is needed to ensure systemic change in LTC. ONA urges government to carefully consider our recommendations, which are informed by the knowledge and clinical experiences of our members in the LTC sector. ONA is always available to meet with government to provide additional information or clarity on any of the recommendations contained in this submission.

Hours of Care, Skill Mix, and Retention

The proposed regulations under “targets and periodic increases” (Section 33) set out the calculation method for direct care targets as part of the commitment of an average of four hours of care per resident per day. As ONA made clear in our submission at the legislative stage of Bill 37, a commitment to four hours of direct care by nurses and PSWs must be a minimum care standard set within each LTC home not as a provincial or Ministry target.¹ This is required to have an accurate picture of the staffing situation in each LTC home. In particular, it would avoid a situation where those homes that do exceed the four-hour of care standard float the provincial average up and provide cover for those homes that regularly do not.

Second, this staffing standard for LTC must be increased as quickly as possible. The target date in the current legislation of March 31, 2025 is far too long.

Currently in the LTC sector, the staffing levels are lower than ever. Without staffing, there cannot be adequate care for residents. This is especially true of RN staffing because residents have increasingly complex and chronic conditions. ONA continues to advocate for the LTC staffing model for the four hours to be a legislated, enforceable minimum to ensure a skill mix that is appropriate: 20 per cent of the direct care provided by RNs, 25 per cent by Registered Practical Nurses (RPNs) and 55 per cent by Personal Support Workers (PSWs) and one Nurse Practitioner (NP) for every 120 residents.

In their final report, the Long-Term Care COVID-19 Commission echoed ONA's skill mix recommendations in their recommendations #44 and 46.ⁱⁱ The Commission stated that ONA's skill mix recommendation is a reasonable mix considering the acuity level of long-term care residents, particularly the continuing decline of mental cognition. The Commission emphasized that more registered nursing staff are required in the long-term care sector.ⁱⁱⁱ

To support recruitment and retention of LTC staff, ONA recommends that the government ensure parity with hospitals in salary, benefits, pension, and working conditions. We continue to call for the repeal of Bill 124, which suppresses wages of our members in non-profit homes. The Long-Term Care COVID-19 Commission's recommendation #49 states that the Ministry of Long-Term Care must insist that licensees make changes in working conditions that lead to less reliance on agency and part-time staffing, and provide funding adequate to support these changes, this includes more full-time direct care positions and action to better align wages and benefits within the LTC sector and with those provided in public hospitals.^{iv}

Minimum Staffing

ONA has concerns about regulations outlined in "24-hour nursing care — exceptions" (Section 49). The LTCHA has kept the requirement to meet the legislated standard of having one RN in the building 24 hours per day, 7 days per week, who is both an employee of the licensee and a member of the regular nursing, but we oppose the exemptions in regulations that give licensees the ability to use anyone the home feels qualified during a pandemic.

The regulations state that during a pandemic that prevents an RN from getting to the home, allowing "a member of a regulated health profession who is a staff member of the home and who has a set of skills that, in the reasonable opinion of the licensee, would allow them to provide care to a resident, may be used if the Director of Nursing and Personal Care or an RN is available for consultation." ONA strongly opposes these regulations as they do not factor in consideration of the level of care required by residents and the corresponding skill level to deliver that care. It is when residents are most unstable, ill with a novel infectious disease, that they most need RN care. This was painfully evident during the pandemic.

ONA's position remains that the requirement of one RN in the building 24 hours per day, 7 days per week should be the minimum expectation. Staffing larger homes with only one RN on site is insufficient. Such staffing leaves ONA members with no other RNs to

collaborate with or to share the load when needed. As the number of residents in a home increase, so does the acuity and need to assist other non-regulated staff with their duties. This issue will be exacerbated under the proposed regulations as they provide a manner in which licensees can justify limiting the registered staffing in any home during a pandemic, at precisely the time when this skill set is needed even more to oversee IPAC measures and care of infected residents. In short, increasing nursing, particularly RN hours, reduces infections, outbreaks and saves lives as demonstrated by the studies below.

There is ample research that shows there are better outcomes for residents with higher RN staffing. Gorges and Konetzka found that, compared to LTC facilities with COVID-19 outbreaks, those without outbreaks had higher staffing ratings, as well as higher Nurse Aides (PSWs), total nurse and RN/total nurse hours.^v Thus, more staffing and more total nursing hours were found to be related to fewer COVID-19 outbreaks in the LTC facilities studied.^{vi} It also suggested that in facilities with at least one COVID-19 case, higher PSW and total nursing hours are related to a lower probability of a COVID-19 outbreak, as well as fewer COVID-19 deaths.^{vii}

Similarly, in a study by Harrington et al., a higher proportion of nursing homes with COVID-19 residents had decreased total RN staffing levels (less than the minimum recommended 0.75 hours per resident per day), as well as decreased total nurse staffing levels (less than the minimum recommended 4.1 hours per resident per day).^{viii} Nursing homes with COVID-19 were twice as likely to have low RN hours (less than 0.75 hours per resident per day) compared to those without COVID-19 residents.^{ix} The findings from this study also demonstrate that staffing measures, and particularly RN hours, were the strongest predictors of nursing homes having COVID-19 positive residents.^x

In a study by Spurlock et al., higher nurse staffing levels were found to be a protective factor against COVID-19 cases and deaths in California nursing homes.^{xi} Homes with more total nursing staff hours and RN staffing hours were noted to have reduced COVID-19 cases by almost half.^{xii} Further, nursing homes with higher RN staffing levels also had reduced COVID-19-related resident deaths by approximately half.^{xiii} Crucially, total staffing was found to be the most important factor associated with fewer COVID-19 infections, deaths, and outbreaks earlier on in the study, while RN staffing emerged as the most important factor as the pandemic continued.^{xiv} Spurlock et al. (2020) hypothesize that this might be because RN staff have the knowledge, skills, and judgement to provide training, supervision, and infection control management within homes to mitigate the spread of COVID-19. Researchers also found a correlation between higher nursing turnover and higher COVID-19 case rates within nursing homes, which provides huge implications for effective recruitment and retention of nursing home staff.^{xv}

Overall, these studies provide further evidence to support that sufficient staffing, in particular RN staffing, is a crucial protective factor in mitigating the spread and death toll of COVID-19 in LTC homes. It leads to better care and health outcomes for residents. ONA continues to urge the government to put a strong focus on nurse retention and recruitment in LTC to ensure that residents have access to the quality care they need and deserve.

Discharge

The proposed regulations for “Discharge” (Sections 156-164) introduce new details and extensive description of discharges from short stay, during a pandemic. This is concerning as the role of Placement Coordinators employed by Home and Community Care Support Services (HCCSS) remains unclear with respect to short-notice discharges. ONA has advocated for government to keep Placement Coordinator positions in the public sector as part of care coordination teams to maintain continuity of care as seniors and others transition from home care to LTC. ONA is also aware of the consistent backlog of assessments mostly due to the lack of home care resources available to support short-notice discharges in the community.

Nurse Practitioners (NPs) in LTC

The proposed regulations regarding “Medical Director” (Section 252) present a lost opportunity to expand the eligibility for the role of Medical Director to include NPs who have the requisite training and scope of practice to fulfill this role. Throughout the pandemic, many homes experienced challenges with Attending Physicians’ availability and response times. NPs were leaders during the pandemic and the regulations should allow for NPs to serve as Medical Directors.

ONA opposes the regulations outlined under “Agreement with RN in extended class” (Section 90), which require NPs to inform the licensee of the physician with whom they have a consultative relationship. This is a lost opportunity to remove this requirement as NPs can, and do, operate autonomously. ONA is very concerned that this regulation will further impact the ability for homes to hire additional NPs by limiting their practice.

ONA is a strong advocate for NPs in LTC. In our legislative submission on Bill 37, we recommend one NP for every 120 residents in a home.^{xvi} ONA’s lobbying on this issue was instrumental in pushing for the government announcement of \$57.6 million, beginning in 2022–23, to hire 225 NPs in the LTC sector as part of their 2021 Ontario Economic Outlook and Fiscal Review.^{xvii}

Research has demonstrated that the presence of an NP in a home increases the quality of care provided to residents. The LTC Staffing Study recommended that homes expand the use of NPs to support clinical leadership in the home, particularly since Medical Directors are not present daily.^{xviii} Ontario's Long-Term Care COVID-19 Commission (“LTC Commission”) highlighted that NPs have not been embraced in the sector to the degree that they should be and urged greater recognition of their contribution and impact on quality of care.^{xix}

Operation of the Homes

The proposed regulations related to “Operation of the Homes” (Section 250 - 252) proscribe the role, training, experience, and number of hours required to qualify for leadership roles in LTC settings, including Administrators, Directors of Nursing and Personal Care, and Medical Directors. These qualifications are more extensive than in the previous legislation.

ONA has previously made recommendations to the LTC Commission about the qualifications and leadership skills required for the Directors of Nursing and Administrators. Specifically, we recommend that the qualifications for the Director of Nursing should be enhanced to include a requirement for more clinical experience as a RN in a LTC setting.^{xx} ONA recommends that the DON must have at least three years of experience working as an RN in LTC and five years of experience working in a managerial or supervisory capacity in a health-care setting.

We also made recommendations to the LTC Commission that the Administrator be a regulated health professional and that the supervisory/managerial experience must be in a health-care setting given that they are directing health-care workers in the provision of care.^{xxi} Given the important role of an Administrator, the qualifications for Administrators must be further enhanced.

Further, the Long-Term Care COVID-19 Commission’s recommendation #50, under recruiting and retaining staff, calls for LTC home licensees to recruit home management that have the leadership skills and capacity to lead and to create a respectful and inclusive workplace. In order to improve staff morale, licensees must create a workplace culture that is compassionate and values-based.^{xxii}

Infection Prevention and Control (IPAC)

The clear experience of the COVID-19 pandemic is that IPAC procedures were insufficient and failed to keep residents and health-care workers safe. The earlier waves

of COVID-19 demonstrated the critical need for homes to have IPAC expertise. The LTC sector must have new, evidence-based IPAC standards with proper education and certification and leadership must be required to participate in IPAC-related activities.

In the proposed regulations for “IPAC” (Section 102(4)(g)) require every licensee of an LTC home to have an IPAC program. In terms of the requirements, there is a reference to the precautionary principle. The proposed regulations state: “that the program is implemented in a manner consistent with the precautionary principle as set out in the standards and protocols issued by the Director under subsection (2) and the most current medical evidence.” While ONA supports the recognition of the precautionary principle, we have concerns about linking it to “standards and protocols issued by the Director and the most current medical evidence.”

ONA’s position is that the precautionary principle should be defined as Justice Archie Campbell, Chair of the SARS Commission, stated: “that safety comes first...reasonable efforts to reduce risk need not await scientific proof.”^{xxiii} We recommend that the proposed regulations very clearly state that “the program must be implemented in a manner consistent with the precautionary principle.” Another subsection could then be created to address “that the program is implemented as set out in the standards and protocols issued by the Director under subsection (2) and the most current medical evidence.”

The proposed regulations for “IPAC” (Section 102 (5)) also establish a requirement for licensees to designate an IPAC Lead with IPAC as their primary role within the home. Among the specified qualifications for the IPAC Lead is that an incumbent could take up to a three-year period to obtain certification in infection control from the Certification Board of Infection Control and Epidemiology. We have concerns that eligibility requirements for this certification appear to allow for non-regulated health professionals and work experience is limited to 3000 hours of infection prevention work experience earned during the previous three (3) years.^{xxiv}

The proposed regulations also introduce minimum staffing for IPAC (Section 102 (15)). ONA is supportive of the changes, which include the following:

1. In a home with a licensed bed capacity of 69 beds or fewer, at least 17.5 hours per week.
2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.
3. In a home with a licensed bed capacity of 200 beds or more, at least 35 hours per week.

ONA’s recommendation remains that the IPAC Lead must be an RN who is an Infection Control Practitioner who is trained and certified in IPAC Canada-endorsed courses,

including IPAC Canada's: Novice Infection Prevention and Control course and Basic Infection Prevention and Control Program at Centennial College in Toronto or Queen's University in Kingston.^{xxv} This requirement should be included in the regulations. We have serious concerns that the proposed regulations open the door to an IPAC lead who is not a regulated health professional. We believe that the person in the role must be a regulated health professional to ensure there are linkages between IPAC and quality resident care.

Quality Improvement Initiative

The proposed regulations cover a "Continuous Quality Improvement Initiative" (Section 165 – 169) adding much more detail than in the LTCHA. Specifically, the proposed regulations require every licensee of a LTC home to establish a Continuous Quality Improvement (QI) Committee, which is an interdisciplinary committee that includes nursing and PSW staff, Resident Council and Family Council, among others.

ONA supports the establishment of a QI Committee. However, it is essential that nurses and other health-care workers on the committee be paid for their staff time on the committee. This requirement must be added to the regulations. If it is not included in regulation, then the time will not be paid. If the worker is at work, they must be backfilled to avoid staffing shortages.

ONA has previously recommended that government proactively track key quality improvement including Infection Control practices, resident and family/caregiver satisfaction, staff turnover and satisfaction, along with resident focused and common indicators of resident care such as falls, skin integrity and number of medications.

While it is positive that the proposed regulations require the work of the QI Committee to be posted in an annual report, questions remain around how the QI work will be measured and benchmarked. There are also questions about whether the work of the QI Committee is linked to the role of Health Quality Ontario. This can't just be a paper exercise. There must be accountability.

Whistle-blowing

The proposed regulations for whistle-blowing (Section 117) expand protection to disclosing of information to Resident Councils and Family Councils. ONA is supportive of these changes. Strong whistle-blowing protections are essential so that risks to staff and residents are reported and acted upon.

Even before the COVID-19 pandemic, nurses and health-care professionals in LTC have been reluctant to come forward with concerns or attach their names to complaints given fears of reprisal and impact on their employment. Whistle-blowing protection is even more important for staff who are racialized, immigrants or newcomers, especially when their status in Canada is tied to their employment. In addition, many LTC homes are small workplaces thus anonymity becomes very important. This culture of fear prevents action from being taken to improve the care environment for residents and staff alike.

Particularly for nurses, ONA continues to advocate for government to broaden the scope of protected activities and to ensure that nurses are also protected from potential regulatory consequences from the College of Nurses of Ontario. Specifically, our recommendation to the LTC Commission was that whistle-blower protection must be strengthened, including adding language:

- a. to protect workers' identity so that they can make a confidential complaint regarding their employer's health and safety practices;
- b. to broaden the scope of protected activities to include acting in compliance with the Act or seeking enforcement of the Act and reporting health and safety concerns internally to their employer; and
- c. to minimize risk to residents from disease and/or staffing shortages.^{xxvi}

Administrative Monetary Penalties (AMPs)

The proposed regulations introduce "AMPs" (Section 350) when a compliance order has not been met to deal with bad actors. The regulations empower the Director or an inspector to issue a fine when a licensee has failed to comply with the Act, the fine will be multiplied every time it is not met.

ONA's position is that license revocation is a more effective tool for dealing with bad actors. However, the ability to issue fines already existed in the LTCHA and was not used to prevent the worst failures of care during the COVID-19 pandemic. Instead, we are seeing the for-profit corporations who were responsible for some of the worst disasters in the pandemic, including chains cited by the military for extreme neglect, being rewarded by the government with new beds and renewed 30-year licenses. The pandemic experience has further taught us that fines are not enough of a deterrent for large corporate chains. Under the LTCHA, the government already had the ability to fine up to \$100K but did not do so. This is unacceptable. Where is the accountability or justice for residents, their families, and staff?

Elimination of For-Profit Homes

ONA's position remains that for-profit homes must be eliminated from the LTC sector. As we highlighted in our legislative submission on Bill 37, the provincial Conservative government in Saskatchewan is ending its contract with for-profit chain Extencicare, which saw the province's deadliest COVID-19 outbreak in one of its homes.^{xxvii} Ontario should do the same and immediately stop promoting for-profit LTC and awarding thousands of beds to the for-profit chains, including the worst performers responsible for the worst mass casualty in our LTC history.

In our previous legislative submission for Bill 37, ONA's recommendation was that fines should be used for a first offence only. Recognizing that monetary fines are not enough of a deterrent for for-profit corporations, we recommend that a second offence should require a 30 per cent reduction in the compensation of the Chief Executive Officer. A third offence should require mandatory takeover of supervision of the home by the Minister or designate appointed as supervisor.^{xxviii}

ONA also opposes the change to the preamble of the LTCHA included in Bill 37, which diluted the clear commitment "to the promotion of the delivery of Long-Term Care Home services by not-for-profit organizations", by inserting the words "and mission driven." "Mission driven" is not defined and could mean anything. There is no detail in the proposed legislation as to what must be contained in that mission focus. ONA's recommendation is that the previous language should remain outlining a clear commitment to not-for-profit LTC.

Conclusion

Registered nurses and health-care professionals in LTC are passionate about their residents and the care they provide. We all know that residents deserve no less than excellent care, dignity and respect. For decades, ONA has invested our time and expertise to advocate for improvements in LTC. During the legislative stage of Bill 37, we submitted extensive recommendations during the rushed process. We also participated actively in the LTC COVID-19 Commission and the LTC Home Public Inquiry prior to that.

ONA recognizes that the proposed regulations covered in this submission are only the first phase of implementation of the FLTCA, with additional regulations related to staffing and hours of care to come. We continue to advocate for the commitment to four (4) hours of direct care by nurses and PSWs to be a minimum care standard set within each home, not as a provincial or Ministry target or average. In addition, the skills mix must be legislated provincially, not determined in regulations or left to the whim of each home to determine. There must be commitments to full-time jobs and wage parity with the hospital sector to retain and recruit nurses and address the ongoing staffing crisis.

As ONA made clear in our previous submission on Bill 37, we oppose measures in both legislation and the regulations that may lead to further privatization in the sector. The pandemic experience has proven that profit-driven companies are not up to the vital task of providing health care to residents and that they do not provide a safe, quality environment. Ontario must work to phase-out for-profit homes.

The humanitarian crisis in LTC homes that unfolded and continues throughout the COVID-19 pandemic has shown clearly what nurses and health-care workers have been sounding the alarm about for decades: systemic change is desperately needed in this sector. ONA members are urging the provincial government to listen to our recommendations that we know will lead to positive concrete changes.

ⁱ ONA (2021) Submission on Bill 37, Providing More Care, Protecting Seniors, and Building More Beds Act, 2021. Accessed via <https://www.ona.org/campaigns-actions/read-onas-submissions/>

ⁱⁱ Ontario's Long-Term Care COVID-19 Commission (2021). Final Report. Accessed via: <http://www.ltccommission-commissionsld.ca/report/index.html>

ⁱⁱⁱ Ibid.

^{iv} Ibid.

^v Gorges, R.J., & Konetzka, R.T. (2020). Staffing levels and COVID - 19 cases and outbreaks in U.S. nursing homes. *Journal of the American Geriatrics Society (JAGS)*, 68(11), 2462-2466. doi:10.1111/jgs.16787

^{vi} Ibid.

^{vii} Ibid.

^{viii} Harrington C, Dellefield, M.E, Halifax, E, Fleming, M.L., Bakerjian, D. (2020). Appropriate Nurse Staffing Levels for U.S. Nursing Homes. *Health Services Insights* Volume 13: 1–142020 sagepub. DOI: 10.1177/1178632920934785

^{ix} Ibid.

^x Ibid.

^{xi} Spurlock, B., Stack, A., Harrington, C., Ross, L., Senathirajah, M., Yoon, F., Lewis, P., Benevent, R. (2020). Factors Driving COVID-19 Cases & Deaths in California Nursing Homes.

^{xii} Ibid.

^{xiii} Ibid.

^{xiv} Ibid.

^{xv} Ibid.

^{xvi} ONA (2021) Submission on Bill 37, Providing More Care, Protecting Seniors, and Building More Beds Act, 2021. Accessed via <https://www.ona.org/campaigns-actions/read-onas-submissions/>

^{xvii} Government of Ontario (2021). Build Ontario. Accessed via <https://news.ontario.ca/en/release/1001102/build-ontario>

^{xviii} Ministry of Long-Term Care (MOLONG-TERM CARE) (July 30,2020). Long-Term Care Staffing Study. Long-Term Care Staffing Study Advisory Group. Accessed via: <https://www.ontario.ca/page/long-term-care-staffing-study>

^{xix} Ontario's Long-Term Care COVID-19 Commission (2021). Final Report. Accessed via: <http://www.ltccommission-commissionsld.ca/report/index.html>

^{xx} ONA (2021) Final Submission and Recommendations to the LTC Commission. Accessed via: <https://www.ona.org/commission/>

^{xxi} Ibid.

^{xxii} Ontario's Long-Term Care COVID-19 Commission (2021). Final Report. Accessed via: <http://www.ltccommission-commissionsld.ca/report/index.html>

^{xxiii} ONA (2021) Final Submission and Recommendations to the LTC Commission. Accessed via: <https://www.ona.org/commission/>

^{xxiv} Certification Board of Infection Control and Epidemiology, Inc. (2021). Requirements for CIC® Initial Certification and for Lapsed Certificants. Accessed via: <https://www.cbic.org/CBIC/Candidate-Handbook/Updated-CIC-Eligibility-Requirements.htm>

^{xxiv} ONA (2021) Final Submission and Recommendations to the LTC Commission. Accessed via: <https://www.ona.org/commission/>

^{xxiv} ONA (2021) Submission on Bill 37, Providing More Care, Protecting Seniors, and Building More Beds Act, 2021. Accessed via <https://www.ona.org/campaigns-actions/read-onas-submissions/>

^{xxiv} Ibid.