ONTARIO NURSES' ASSOCIATION

SUBMISSION

ON

2017 PRE-BUDGET CONSULTATIONS

TO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

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Summary of ONA Recommendations for 2017 Ontario Budget

ONA proposes the following recommendations for the 2017 Ontario budget:

1. ONA recommends continued improvements to hospital base operating funding to at least cover the costs of inflation and population growth. This is to ensure our hospitals have the resources to properly maintain staffing for safe, quality care in all our communities.

2. We continue our call for funding and development of a multi-year nursing human resources plan, for implementation and tracking by the Local Health Integration Networks (LHINs), targeted to reduce the significant gap in the Registered Nurse (RN) to population ratio between Ontario and the rest of Canada. Ontario now has the worst RN to population ratio in the country.

3. We, therefore, ask the government to implement a moratorium on any further erosion of RN positions. It is time for the Health Minister to establish a clear vision for RN care in Ontario hospitals. RN care leads to improved patient outcomes and to cost savings for our health care system. The Auditor General reiterates this message in her 2016 Annual Report.

4. We continue our 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. In the interim, ONA will work with the government to ensure continuity of employment and continuity of care as the Community Care Access Centres (CCACs) transition to the LHINs during 2017. The next step is to eliminate the duplication of management of contracts to private home care providers, resulting in cost savings from the elimination of profit from our home care system.

5. We continue our call for funding and enforcement of a daily 4-hour staffing standard to meet the increased care requirements of residents in long-term care homes. We recommend funding and enforcement of a regulated minimum staffing standard in long-term care homes set at an average level of four worked hours of nursing and personal care per resident per day (including 48 minutes of daily RN care out of the 4 hours) to meet increasing resident care needs.

6. We are calling on the government to take action arising out of ONA's recommendations to the Workplace Violence Prevention in Health Care Leadership Table and to fund a health care Action Plan for Workplace Violence Prevention. Key minimum standards will require appropriate enforcement mechanisms, regulation and legislation, to improve the safety of Ontario's nurses by way of safe RN staffing levels, appropriate security staffing, use of best practices for training competent supervisors, accessible panic alarms linked to security, and electronic and visual alert systems for flagging potentially violent patients. We are opposed to accreditation programs that reward employers by eliminating proactive inspections.

I. Introduction

The Ontario Nurses' Association (ONA) is the union representing 62,000 registered nurses (RNs) and allied health professionals, as well as more than 16,000 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 on healthcare priorities for the 2017 Ontario budget.

In November, the Minister of Health and Long-Term Care spoke to 1,000 ONA members at our biennial convention. He reiterated messages that Ontario's nurses have long heard. He also summed up what Ontario nurses are looking for in this budget: respect and empowerment.

First, the Minister thanked Ontario's nurses, "on behalf of Ontario patients, for all that nurses do to help prevent and heal illness and injury, to bring comfort and reassurance to people in need, at the times when they need it most."

The Minister said words like 'care and compassion' describe what nurses do and the staff patients come in contact with most frequently are nurses. The Minister went on to say that for "patient care needs to be met, and for patients to feel that they are heard and confident in the care they are receiving, every nurse they come into contact with has to feel respected and empowered in their workplace. Every minute of every day."

Unfortunately, at the present time, Ontario's nurses do not feel empowered or respected in their workplaces. RNs are the staff that patients see each and every hour, 24 hours a day, every day of the week. RNs are the staff that provide a continuous presence at the patient's bedside. RNs are the staff that play a major role in healthy outcomes for our patients. Yet, the role of RNs in Ontario hospitals is under attack. Instead of using the invaluable skill set of RNs to achieve savings and superior outcomes for patients, funding models are driving hospital decisions to eliminate, replace and erode RN positions. These decisions are not based on respect and empowerment for Ontario's nurses. These decisions are based solely on balancing budgets, not based on the clinical needs of, and outcomes for, our patients.

The 2016 Ontario Budget finally recognized that hospitals were being starved for funding after many years of no increases and provided a welcome additional one percent to the funding already allocated through provincial programs and funding models. This was a modest first step. More recently, arising out of the Finance Minister's Fall Economic Statement, Ontario hospitals have been allocated another one percent in funding to tide them over until April 2017.

Let us be very clear: hospitals need more funding in the 2017 budget just to maintain services for this acute, complex group of patients and to improve RN staffing that provides those services to our patients. As one hospital CEO put it: "we seem to be caring for more patients who are both sicker and older."[1] Health care is Ontarians top priority. 2017 will be an important year to see if Ontario's government also believes hospital funding is a top priority in their budget.

The Health Minister has also embarked on a transformation agenda that will see the Community Care Access Centres (CCACs) merge with the Local Health Integration Networks (LHINs) in 2017. At the same time as funding will be necessary to increase capacity in home care, funding for hospitals must not be lost in the quest to transform the way health care is delivered.

ONA is encouraged by the words and actions of the Health Minister at our biennial convention. First, the Minister said he will take action very soon to ensure that unanticipated technical barriers won't affect student nurses from joining the ranks of practicing nurses. Ontario needs new nurses now more than ever. We salute the Minister for sticking with his commitment to new nurses to bolster the nursing profession in Ontario.

The Minister also announced improvements to the nursing graduate guarantee (NGG) program. Recruitment and retention are essential to build a nursing workforce that Ontario patients can count on. The Minister indicated that the NGG program will be strengthened effective April 1, 2017. Employment stability is crucial not only for new nurses but for all nurses.

The Minister told us that employers will receive 8 weeks of funding to support existing front-line nurses and their professional development, for every new nurse funded through the new NGG program. As well, employers will only be able to receive funding from the program if they intend to hire the nurses into permanent, full-time positions.

Finally, and importantly, the Minister said that, where there have been nursing reductions, or where nursing reductions are anticipated, this **program will not be funded.** We thank the Minister for listening to nurses but there is more to do in this year's budget to ensure hospitals retain the nursing staff essential for healthy outcomes for our patients.

ONA's submission provides an overview of Ontario's current RN workforce, while outlining how funding has not been sufficient to prevent improper nurse staffing decisions being made at the point of care that affect achieving the best outcomes for our patients.

Advocating on behalf of our patients is what nurses do at all times. We can't be there for our patients if funding constraints allow hospitals to make the wrong decision regarding staffing. Every elimination of an RN position is the equivalent loss of 2,000 hours of annual RN care. This loss of RN care affects the care patients receive and adds unnecessary costs to the healthcare system. There is strong and persuasive evidence on the benefits of RN care for healthy outcomes for our patients. This year, Ontario's nurses will be looking for funding in the budget to support action by the Health Minister on the prevention of workplace violence and action to improve employment stability for RNs across Ontario.

II. The RN Workforce in Ontario

The ratio of RNs to 100,000 Ontarians is now the **worst** in Canada.[2] As of 2015, Ontario has 711 RNs per 100,000 compared to 841 RNs for 100,000 people in the rest of Canada. This creates a significant gap in RN care for Ontario. More than **17,920** RNs are now required just to catch up to the ratio in the rest of the country. Ontario now needs an eighteen percent increase in RNs simply to keep up with the rest of the country. This is why we are advocating for the government to develop and maintain a strategic nursing human resources plan for Ontario.

Ontario is also facing a growing segment of RNs in retirement age. In 2015, there were 25,168 RNs aged 55-plus, or 26 per cent of Ontario's employed RN workforce eligible to retire in the coming years.[3] In 2006, for comparison, 20,332 RNs were aged 55-plus or 22 per cent of Ontario's employed workforce. Ontario's RN workforce is aging as evidenced by this 24 percent increase in the number of employed RNs aged 55-plus since 2006.

The current ratio of RNs to Ontario's population must be improved - we are the worst now in the country. Combined with more than a quarter of the RN workforce that is eligible to retire, Ontario's RN overall workforce is cause for concern and action as it has significant implications for patient care.

III. RN Care Means Improved Patient Outcomes and System Cost Savings

The Ontario Auditor General's 2016 Annual Report provides timely evidence for funding in the 2017 budget directed to improve RN staffing in our hospitals.[4] The Auditor General indicates that RN workload is heavier in Ontario than what international best practices recommend. Although Ontario does not have mandated nurse-to-patient ratios as in other jurisdictions, research has established a best practice ratio of 1:4 (one RN for every four patients) in hospital medicine and surgery units.

The Auditor General 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.

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.[5] More RN hours of care positively impact a variety of adverse outcomes for patients *and* reduce costs for our health care system. In short, a large body of literature demonstrates that higher RN ratios result in the provision of high-quality care.

RN staffing is associated with a range of *improved* patient outcomes: *reduced* hospital-based mortality, hospital-acquired pneumonia, unplanned extubation, failure to rescue, nosocomial bloodstream infections, and *shorter* length of stay.[6] This landmark study found an *increased* proportion of RN hours was associated with *decreased* urinary tract infection, a *decreased* rate of pneumonia, a *decreased* incidence of deep vein thrombosis, *decreased* upper gastrointestinal bleeding and *decreased* shock/cardiac arrest. At the end of the day (or overnight shift), patient lives are saved.

Indeed, as the auditor identified, comprehensive research shows "that every extra patient beyond four that is added to a nurse's workload results in a 7% increased risk of death."[7]

Research has also developed costing models related to cost savings realized from interventions and treatments related to avoidable adverse events that would no longer be required. One study, for example, 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.[8] This finding suggests that reductions in readmissions would result in cost savings for the health care system.

The Auditor General has also recommended savings can be found through better decisions by hospitals related to RN staffing. The auditor identified significant increases in the costs of nurse staffing as a result of *higher* usage of high-cost agency nurses, and from *increased* overtime costs and the costs of sick leave.

The auditor identified that the hourly agency rate for RNs is 27% higher than the collective agreement rate. One hospital visited by the auditor reported an increase of 335%, or $2.5 million, in the costs associated with the increased use of agency nurses for its emergency department from 2011/12 to 2014/15. The auditor correctly points out that this hospital could have hired four full-time or seven part-time emergency RNs instead of relying on high-cost agency nurses.[9] As well, as the auditor rightly concludes, the costs are both financial and affect the quality of care as "overreliance on agency nurses creates a lack of continuity that may lead to inconsistencies in care delivered to patients."[10]

Other indicators of the effect of high nursing workloads that the auditor looked at include the use of overtime and sick days for nursing staff. The auditor said that the nursing staff in the hospitals they visited consistently worked significant amounts of overtime. This is not surprising to Ontario's nurses given our lived worklife experience. For example, the auditor identified one hospital where overtime pay totalled $6 million in 2014 in just two wards, money with which the hospital could have hired 31 full-time RNs or 51 part-timers.[11] In addition to the impact on the quality of care for our patients, high patient ratios mean higher overtime costs and higher sick leaves because of the excessive wear and tear on the existing nursing complement.

When you have instances identified by the auditor where one RN in one hospital worked more than 4,000 overtime hours over a four-year period, this indicates hiring an additional 1.5 full-time RNs would have been a more prudent decision. As a result of high patient ratios and high overtime, the auditor identified the emergency and intensive care units as having the most overtime and highest number of nurse sick days in the hospitals visited. Excessive overtime and sick days go hand in hand with high patient ratios.

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 2015. This trend demands immediate attention given the extensive research on the affects of RN staffing on improved patient outcomes. Replacing RNs with lesser trained staff is not cost effective when the impact on patients is taken into consideration.

There are significant cost savings to the system if RN staffing had been employed rather than eliminated. One study by Needleman et al.[12] 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[13] 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.[14]

Further, a study[15] 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.

Increasing the number of RN hours has also been found to be a strategy to reduce medication errors and therefore reduce costs.[16] As RN staffing hours *increased*, medication errors *decreased.*

As the study authors state, administering medications to hospitalized patients requires advanced knowledge and is more appropriately assigned to RNs. In this study, there were 335 errors (dose omission, protocols, and improper dose) with 14 percent requiring additional monitoring and treatment.[17]

The growing body of research evidence clearly shows that patient care is most safely delivered when there are enough RN hours of care. The costs associated with RN care must be balanced against the cost *savings* of preventing adverse events.

How is it that study after study indicates cost savings and improved health outcomes with RN care, while Ontario continues to eliminate, replace and erode the very RN positions that benefit the health of Ontarians? We ask the Health Minister once again to define the role of RNs in his vision for patient-centred care in Ontario. If RN care is central to his vision as he asserts, then it is time to take action to rein in the rogue staffing decisions the hospitals are making. Staffing decisions that Ontario's Auditor General recommends be corrected by hospitals.

IV. Stop the Elimination, Replacement and Erosion of RN Care in Ontario Hospitals

The base hospital operating funding increase for 2008-09 was 2.4 percent, 2.1 percent in 2009-10, 1.5 percent in 2010-11 and in 2011-12, and zero percent frozen hospital base operating funding for 2012-13, 2013-14, 2014-15, 2015-16. In 2016-17, hospitals received a welcome 1 percent increase to base operating funding and a subsequent 1 percent increase that is currently being allocated to hospitals. Other available funding in 2016-17 did not flow to all hospitals as it was directed to specialized programs.

This means hospitals have struggled for at least nine years with insufficient base operating funding to cover the full costs of inflation, population growth and aging. The Ontario population has grown by 8.1 percent in this time period. In addition, the proportion of the population of Ontario aged 65 and over is projected to reach between 23.8 percent and 26.2 percent by 2038 from 15.6 percent in 2014.[18]

The Ontario Consumer Price Index (CPI) increased by 2.3 percent in 2008, 0.4 percent in 2009, 2.5 percent in 2010, 3.1 percent in 2011, 1.4 percent in 2012, 1.0 percent in 2013, and 2.4 percent in 2014. The Ontario Ministry of Finance projects CPI inflation to be 1.2 percent in 2015 and 2.0 percent in 2016 through to 2018.[19]

The Ontario Hospital Association estimates 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.[20]

Obviously, the funding noted above has not met the needs of hospitals to deliver patient care. This has resulted in hospitals adopting short-sighted and risky measures, not based on the research evidence, to balance their budgets, including the elimination of RN positions, not replacing RN positions when they become vacant and substituting RN positions with less-qualified staffing. These measures continue to be approved by the LHINs and condoned by the government without any nursing human resources planning being undertaken.

Continuing to fund hospitals in this manner ignores the research evidence that links RN staffing to improved health outcomes for patients and cost savings to hospitals. Fewer RNs to provide care means that our patients are at risk of higher rates of complications and other adverse events, which add costs from additional length of stays to readmissions.

Ontario has cut the number of hospital beds significantly – 18,500 fewer hospital beds in the period from 1990 to 2010.[21] This has increased the acuity of patients in hospital who require more skilled RN care than ever before.

RN care in Ontario hospitals is being seriously eroded. Four years of frozen base funding combined with a modest increase last year for hospitals has resulted in the elimination of millions of hours of RN care. Since January 1, 2015, more than 1,570 RN positions have been eliminated, which means that more than three million hours of RN care have been eliminated from our communities in this period, completely ignoring the substantive evidence linking RN care to improved patient health outcomes and cost savings to our health care system.

We challenge the government and the Health Minister that now is the time to take action on the continuous reduction of RN positions. We respectfully submit that now is the time to build on last year's budget and to further increase hospital base operating funding.

We also submit that a strategic nursing human resources plan clearly must be developed and maintained. Such planning would consider the value of RN care and would also review the deletion of Nurse Practitioner positions in hospitals and elsewhere, in addition to the substitution of Public Health Nurses with less-qualified staffing.

V. Patient Care at Risk - RN Reductions in Your Community

This year, we are providing further examples to the Standing Committee of RN cuts in Ontario communities.

In southwestern Ontario, a number of communities have been hit hard with excessive RN reductions. In Sarnia, for example, Bluewater Health has reduced their RN complement by 75 positions in the last two years - 30 RN positions cut in 2016. They have cut one Nurse Practitioner position and ten RN reductions in the Intensive Care Unit, seven RNs in emergency, seven RNs cut in the cognitively complex unit with additional positions lost in the geriatric emergency and palliative units, fifteen RN positions in the acute medical floor, eight clinical educator positions, and eliminations in maternal/infant/child and continuing complex care. These units provide essential RN care for the Sarnia community, which is now without nearly 150,000 annual hours of care from Registered Nurses.

The Windsor Regional Hospital has cut 183 RN positions in the last two years - with more than 90 percent of the RN reductions in 2016. The Windsor community has lost the care from sixteen RNs in the critical care unit, twelve RNs in the surgery unit, ten RNs in inpatient oncology, seven RNs in the family birthing centre and four RNs in the neonatal intensive care unit, six RNs in day surgery, fourteen RNs in the intensive care unit, seven RNs in the OR, twelve RNs in the medical unit, and seven Nurse Practitioners.

The Grand River Hospital in Kitchener has cut 62 RN positions, including two Nurse Practitioners, in this period.

These cuts are to essential services for the Kitchener community in oncology, inpatient surgery, mental health, acute care for the elderly, integrated stroke unit, diabetic care and pediatrics.

The Cambridge Hospital has cut twenty-two RN positions. These cuts are removing RN care in inpatient surgery, the medicine unit, in mental health, and in the OR.

The Hamilton area has also experienced RN cuts. Hamilton Health Sciences cut 23 RN positions in adult mental health, nurse clinicians in the heart investigation unit, in rehab geriatric oncology, in nephrology, and in a number of pre-op and cancer clinics.

Joseph Brant has also cut twenty-two RN positions in areas such as surgical, complex care, heart function clinic, OR, acute medicine, rehab/restorative, and the special care nursery.

St. Joseph's Healthcare in Hamilton has cut thirty-seven RN positions. Critical areas include stroke prevention, medicine, rehab, nephrology, day surgery, pre-op assessment, acute mental health, recovery room, neonatal intensive care unit, cardiology, dialysis, complex care, general internal medicine, kidney function, mood disorders, recovery, and geriatric outreach.

In the Toronto area, a number of hospitals have cut RN positions. William Osler Health Centre has cut 16 RN positions in women & children, palliative, endoscopy, emergency, and pediatrics. Trillium Health Partners has cut 46 RN positions in surgery, medicine, community mental health, obstetrics, pediatrics, cardiac, and clinical leaders. Mount Sinai has cut 79 RN positions: cardiac medical unit, critical care unit, medical high acuity unit, 22 positions in the intensive care unit, oncology, emergency, gynecology, and mother/baby unit.

Runnymede Healthcare Centre cut 33 RN positions. Sunnybrook cut 17 RN positions, while University Health Network hospitals cut 77 RN positions. These cuts include cardiology, oncology, thoracic surgery, gastrointestinal, medicine, surgery, and transplant. At Humber River Regional Hospital, 35 RN positions have been eliminated in areas such as dialysis, urgent care, cardiology, geriatric, and a Nurse Practitioner.

In the Greater Toronto Area, Southlake Regional Health Centre in Newmarket has cut 23 RN positions.

The hospitals involved in the mega-merger being planned have seen 494 RN positions cut over the last five years or nearly 1 million hours of RN care, while we expect more cuts as the merger proceeds. Rouge Valley Health System has cut RN positions in surgical, acute medicine, pre-op, birthing, fracture clinic, and two Nurse Practitioners. The Scarborough Hospital has cut in mental health, surgical, medicine, neonatal intensive care, orthopedics, preadmissions, and patient flow.

As we move to eastern Ontario, Northumberland Hills hospital has cut 37 RN positions in emergency, critical care, medical, dialysis, palliative and restorative care, ambulatory care and pre-op, and post-anesthetic care. At Quinte Health Care in Belleville, Trenton and Picton, 101 RN positions have been cut in the last two-year period. These are devastating numbers for the Belleville and area communities. Areas cut include: emergency, continuing complex care/rehab, medical, surgery, endoscopy, behavioural support transition, including a Nurse Practitioner.

The Ottawa area has seen cuts of nearly 100 RN positions at The Ottawa Hospital, the Children's Hospital and the Royal Ottawa Health Care Group, including the Brockville Mental Health site. Areas affected include: obstetrics, maternal fetal medicine, breast feeding, neonatal intensive care, gynecology, dialysis, forensic rehab, inpatient and ambulatory care.

Orillia and Barrie have seen 75 RN positions cut. These cuts cover areas such as dialysis, geriatric care, neonatal care, complex continuing care, obstetrics, day surgery, oncology, and a Nurse Practitioner.

Northern communities in Sudbury, North Bay and the Sault area have been hit hard with 136 RN cuts amongst them and others in Thunder Bay. These cuts are in mental health & addictions, oncology, palliative care, diabetic care, surgical, acute psychiatric care, family & child, chemotherapy, nephrology, dementia care, emergency, birthing, bone health, and dialysis. These hospitals also represent referral centres for a number of smaller northern communities.

Members of the Standing Committee will likely be familiar with some of these RN cuts we have listed as they are occurring in their own ridings of Barrie, Northumberland and Quinte West, Etobicoke, Kitchener and Nipissing. Other cuts are taking place in the ridings of their colleagues across Ontario - urban and rural.

Now is the time to invest in increased levels of RN care as our hospitals struggle to provide appropriate care in their communities. Patients in our hospitals are suffering from higher-acuity conditions and serious illnesses requiring skilled RN care, while RN staffing in our hospitals continues to be eroded when it is needed most.

This is why ONA is calling for an immediate moratorium on further cuts to invaluable RN care. The government must now intervene to ensure that staffing decisions made by hospitals do not negatively affect the care our patients receive. Given the research evidence and the listing of clinical areas being cut across Ontario, it is crystal clear that the erosion of RN care is putting our patients at risk.

VI. Health System Transformation and Restructuring

The Minister of Health is proceeding with a transformation agenda through structural change in the home sector as a result of the implementation of Bill 41 in 2017. The gaps in hospital care as a result of government underfunding have been well documented in previous sections. The government has now shifted some limited funding into home and community care to relieve pressure in hospitals by moving patients receiving care in hospitals that might be able to receive their care in alternative settings. Unfortunately, this is care being moved from a non-profit environment in hospitals to care being delivered in a profit environment in the home care and long-term care sectors.

In previous submissions to the Ministry of Health and Long-Term Care, ONA documented the high costs of care under the current competitive bidding procurement model in the home care sector. We demonstrated the duplication of services and management structures in the delivery of home care services and the lack of continuity of care for patients and their families.

The Auditor General in her 2015 Annual Report similarly documented issues of duplication and omission in the CCACs who administer contracts with about 160 private sector service providers to provide home care services, and commented on the resultant commercial confidentiality in that model so that the true costs are left unsubstantiated. In our submission on the Patients First discussion paper, we proposed an alternative model for the integration of home care delivery into public, non-profit CCACs whereby efficiencies and client quality would be realized.

The government chose to go in a different direction by dismantling the CCACs and transitioning the frontline care staff into the Local Health Integration Networks or LHINs, while maintaining the proliferation of contracts for the delivery of home care services to a multitude of private mainly for-profit home care companies under existing procurement contracts. Bill 41 is the government's operationalization of that decision.

Because of the government's decision, ONA took the position that in order to maintain continuity of care, the transition of staff we represent must maintain existing collective agreements as well as the existing labour relations regime. Bill 41 provides that the labour relations transition will be managed under the sale of business provisions of the Labour Relations Act and the Pay Equity Act to allow for this transition of ONA-represented staff to take place.

We have also been advised regulations will be introduced, if Bill 41 passes, to ensure staff are covered under the existing labour relations regime under which CCAC staff are currently covered.

The primary issue for ONA is gaining a solid understanding of how the structural transition proposed in Bill 41 will actually result in administrative and management savings that can be reinvested in frontline care as the Minister insists is at the core of the transition. Under Bill 41, home care services would continue to be provided by the more than 160 current service providers under contract as noted by the Auditor.

Further, as the Auditor noted, "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."

This proposed model for transition in Bill 41 seems to ignore all of the evidence that has been raised regarding duplication and inadequate home care service provision, while also underestimating the growing demand for home care services requires significant upgrades in resources and capacity. Home care agencies which are not providing adequate service and/or not fulfilling their contract obligations in the current CCAC model will continue to be rewarded with patients being assigned to them under the model transitioned to the LHINs.

This duplication and omission significantly increases the workload and follow up required by the Care Coordinators who seek to ensure patients are receiving timely, consistent quality home care services. Our members tell us about referrals sent by Care Coordinators that are not fulfilled in a timely fashion, often as a result of retention and recruitment issues in the private provider agencies. However, there appear to be no repercussions for the private service providers. How will this transition to the LHINs make change if there is no change to the contracting of service providers under the proposed home care delivery model in Bill 41?

ONA's vision is quite different: we support the delivery of quality home care services in a public non-profit entity. That is why we are generally supportive of the initial transition of home care coordination to the public non-profit LHINs, although we know that the LHINs face issues of capacity as they move to take on home care coordination. The next step to complete our vision is to transition the delivery of home care services to the same public non-profit entity.

Other organizations with interests in building capacity in the primary care sector, have advocated for moving care coordination into some 445 primary care organizations across Ontario, rather than the LHINs. ONA firmly disagrees. Such a move would continue to fragment care and duplicate services between primary care and home care agencies. The services need to be consistent throughout the province regardless of the employer of the Care Coordinator.

This was one of the goals of Bill 41. Care Coordinators working for more, not fewer employers, will not promote consistency. CCACs/LHINs provide good jobs with competitive wages, benefits and pensions that promote retention and recruitment of these valuable health care providers. In the current structure, Care Coordinators who are on leave, vacation or sick have a co-worker who can back them up during absences. Small primary care providers will not have a similar ability. CCACs/LHINs can also provide surge and emergency coverage that cannot be provided by small primary care providers.

In the meantime, under the proposed transition of home care services in Bill 41, the LHINs will be tasked with creating a combined management and administrative structure. It must be noted that the multiple layers and number of CCAC management positions were not reduced with the merger of the 43 CCACs into the current 14, as was expected.

In this new proposed restructuring into the LHINs, we would expect significant reductions in management positions and that savings be reinvested in frontline care. The Deputy Minister has suggested that efficiencies might produce administrative and management savings in the range of 5 to 8 per cent of the management and administration budgets of the former two entities.

However, all indications at the moment in terms of enhancing capacity in the LHINs point to an expectation that the changeover practices may actually increase costs and add administration and management staff. As a result, we are not optimistic that the obvious inefficiencies and wasteful costs will be properly addressed given the continuation of the managed competition model. Simply replacing the CCAC management structure with a new LHIN management structure is not going to reduce this waste of resources from duplication and the siphoning off of profits by private providers.

Our vision in which the LHINs directly employ all of the frontline staff responsible for home care delivery would be a much better use of limited resources and would eliminate the needless and wasteful expenditure of resources on the contracting process. It would also result in much better continuity of care and set consistent standards across the system given the consolidation rather than fragmentation of service delivery.

Further, dispensing with the current fragmentation of services between the CCACs/LHINs and the contracted private service providers 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 simply does not work and tinkering with the structural location from CCACs to LHINs will not lead to the fundamental renewal of home care services for our patients that they deserve.

The government's transformation agenda is now setting out restructuring as the solution to gaps in home and community care. The government starts with the premise that these gaps in care arise because the LHINs are not able to integrate all health services in their communities. In particular, primary care, home and community care and public health are health services planned by separate structures outside of the planning done by the LHINs. Therefore, the government is proposing to expand the role of the Local Health Integration Networks.

LHIN renewal is a first step to a non-profit home care system by bringing care coordination in-house and by increasing capacity. For that reason, while we are generally supportive of Bill 41, structural change alone is not a sufficient precondition for a renewed public home care system where profit and waste are removed.

There is ongoing and mounting evidence being reported in the media of patients being unable to access the home care they require.[22] This situation of rising demands for home care nursing services requires funding to build nurse staffing capacity in the community sector.

The government's proposal appears to incorporate the existing funding shift that began with the 2012 Ontario Budget. It allocates 4 per cent annual average growth for the community care sector over the next three years, which is about half of the past growth rate. The auditor, however, has identified that at least 10,000 people are waiting for community care.[23]

At the same time, it is important to note that the acuity of patients in home and community care is increasing – as a result of shortened length of stay in hospital and renewed efforts to shift alternative level of care patients out of hospital – which requires the skills and knowledge of RNs.[24]

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.[25]

In the transition from CCACs to LHINs, ONA will be working with the government to ensure the stability and continuity of home care services to our patients through continuity of the role of Care Coordinators and other direct care CCAC services such as Rapid Response Nurses, Palliative Nurse Practitioners, and Long-Term Care Placement Coordinators. We will also work together to ensure the continuity of compensation and practice conditions for direct care staff.

We submit that any savings achieved from the reduction in the duplication and fragmentation in the current system must be reinvested into home care services, including savings reinvested into frontline care from the reduction to a minimal management bureaucracy to support the transition and integration of services.

In addition to the coordination of home care services, CCAC staff working as Placement Coordinators ensure appropriate placement into long-term care facilities.

There is an extensive literature[26] 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.[27]

As a result, ONA advocates for funding and enforcement of a staffing standard to meet the increased care requirements of residents in long-term care homes.[28] RN staffing levels have not kept pace with the increasing complexity of resident care and are not keeping residents and nurses safe.[29]

ONA calls on the government to fund and to regulate a minimum staffing standard of an average of four worked hours of nursing and personal care per resident per day, including 48 minutes of RN care per resident per day.

Our proposal addresses increasing resident acuity and is aligned with the RN staffing recommendations for quality resident care in the research literature.[30] RN skills are essential to meet the growing clinical needs of our long-term care residents.

For this reason, we also urge the government to continue to reject the proposal from the for-profit long-term care sector association[31] to eliminate the requirement for 24/7 RN care in long-term care homes. Given the preponderance of evidence on the rising acuity of residents in long-term care, this proposal must be rejected.

Most recently, ONA has raised the alarm about funding and understaffing in the long-term care sector, citing the example of front-line registered nurses working at Hogarth Riverview Manor in thunder Bay. The facility, operated by St. Joseph's Care Group, is currently renovating and is slated to add 128 new beds next year. Yet it employs just 12 full-time, 12 part-time and 10 casual RNs to care for these patients. Under its current staffing model, the home is failing to meet the care needs of its residents, and our dedicated RNs are concerned that understaffing is making it difficult for them to meet the standards of practice, as set out by the College of Nurses of Ontario.

Currently, just one RN is responsible for the care of 128 residents during the day and evening shifts, leaving just 3.25 minutes for each resident per shift. On the night shift, just two RNs are responsible for the care of 416 residents. This is an untenable situation for our residents. ONA is gravely concerned that the conditions for residents will further worsen when the 128 new beds are opened. ONA has presented a staffing proposal to Hogarth Riverview management to increase the number of RNs in each 24-hour period in order to help the facility meet orders laid by the Ministry of Health and Long-Term Care, but overall better funding for the long-term care sector is required in this year's budget to ensure appropriate levels of RN care for our complex residents.

VII. Keep Nurses Safe: Workplace Violence Prevention

The relationship between unsafe patient assignments, understaffing and the lack of safe working conditions leading to nursing injury and illness is now well documented.[32]

Our chart attached provides a comparison of the number of lost-time injuries in Ontario for 2014 and 2015 by sector, and disturbingly shows that the healthcare sector continues to have the highest rates of lost-time injuries for workplace violence and are rising.[33] Lost-time injuries in health care arising from workplace violence rose 6.4 percent in 2014 over the rates in 2013 and rose another 11 percent in 2015 over the rates in 2104.

Key to the work underway by the Workplace Violence Prevention Leadership Table will be the acknowledgment that RN staffing not only improves patient outcomes but RN staffing is a critical feature for improving the safety of nurses themselves.[34]

We are calling on the government to take action arising out of ONA's recommendations to the Workplace Violence Prevention in Health Care Leadership Table and to fund a health care Action Plan for Workplace Violence Prevention. Key minimum standards will require appropriate enforcement mechanisms, regulation and legislation, to improve the safety of Ontario's nurses by way of safe RN staffing levels, appropriate security staffing, use of best practices for training competent supervisors, accessible panic alarms linked to security, and electronic and visual alert systems for flagging potentially violent patients.

We also propose that provincial standards must be implemented that each LHIN and hospital has dedicated experts in occupation health and safety who are mandated to focus on prevention and incident response, including workplace violence.

We know that action on ONA's recommendations coming forth from the joint Minister's of Health and Labour Workplace Violence Prevention Leadership Table will require funding. We also propose that an action plan and implementation strategy be developed to prevent workplace violence in our hospitals and throughout the healthcare sector.

However, we are extremely concerned about the direction the Ministry of Labour is now headed with amendments to the *Occupational Health and Safety Act* contained in Schedule 16 of omnibus Bill 70. We are opposed to accreditation programs that reward employers by eliminating proactive inspections.

Despite the fact that ONA has been in good faith frequently meeting with all levels of the Ministries of Labour and Health and Long-Term Care, and devoting significant resources to the health care violence prevention tables, Bill 70, Schedule 16, was introduced and debated without any communication to, or consultation with, ONA. We are deeply disappointed with Bill 70 (Schedule 16) given the productive, collaborative relationship we thought we were building with both the Ministries of Health and Labour, as well as with health care employers, in our collective violence prevention efforts. Unfortunately, the Minister of Labour is ignoring ONA's request to withdraw Schedule 16 and begin consultations without the structure of the amendments in Schedule 16 already in place.

An important proposal in Schedule 16 is a newly defined Health and Safety Management System (HSMS). The Chief Prevention Officer's powers are broadened to set standards for and accredit the HSMS. There is no mention of worker or union or Joint Health and Safety Committee input or review. The Minister of Labour's office states the outcomes of these proposals: "This program would recognize employers who implement superior occupational health and safety management systems, highlighting the great work they are doing to protect Ontario workers and reduce the **burden of unnecessary processes, such as routine inspections**."

These proposed amendments prevent two of the very aspects Dr. James Ham 1976 raised in his ground-breaking report that prompted the enactment of the *Occupational Health and Safety Act* that he agreed are essential to workplace safety success: objective government oversight by way of inspections and worker participation in their own health and safety. External auditing of workplace safety performance has long been accepted as a cornerstone of health and safety success. In Dr. James Ham's[35] words:

"*Any internal system of direct responsibility will be imperfect and requires audit, not because of any inherent defect in form but because it is a human organization in which conditions of work and concern for the well-being of persons create grounds for tension… External audit can keep the basic internal system alert and responsive."*

Dr. Ham was just as clear about the need for worker participation:

"*The worker as an individual and workers collectively in labour unions or otherwise have been denied effective participation… thus the essential duties of openness and natural justice have not received adequate expression."*

Replacing enforcement with the proposed Health and Safety Management System is controversial and certainly unacceptable to labour for good reason. Research suggests **worker health and safety is better protected and injuries are reduced by "regulatory health and safety inspections that result in a citation or penalty..."** A 2016 study[36] by the non-governmental Institute for Work & Health found "employers do take steps to prevent work-related injuries for employees when there are direct consequences to them." We question why the Minister of Labour insists on carrying forward with proposals to eliminate or reduce those very inspections that are intended to keep workers safe.

The value of proactive monitoring in effecting general and specific deterrence has long been accepted. We value accreditation processes but only as an enhancement of the internal responsibility system, and not as a substitute for the necessary external monitoring that helps keep an internal responsibility system working.

In ONA's experience, accreditation related to health and safety has not worked in the health care environment.

For example, we know of a small hospital that achieved the highest of ratings in its accreditation review, while simultaneously failing a Workplace Safety and Insurance Board Workwell audit of its health and safety system. The most recent salient example of our concern about relying on an accreditation program without benefit of external review is the Centre for Addiction and Mental Health (CAMH). CAMH's webpage proudly displays an "exemplary" standing from its June accreditation, with one of the four areas of their excellence identified as "prioritizing worker…safety." This is the same hospital that in July received its third conviction and fine for health and safety infractions related to serious beatings and critical injuries of workers.

We remain mindful of Justice Campbell's sage advice. Health and safety in health care is doubly important. Justice Campbell said that if workers aren't safe, neither are patients. It's that simple. An action plan with funding related to workforce violence prevention can't come soon enough.

VIII. Conclusion

ONA welcomes the opportunity to provide our priorities to the Standing Committee for the 2017 budget from the perspective of Ontario's front-line registered nurses.

Our first priority covers improved hospital base operating funding to at least cover the costs of inflation and population growth. This is to ensure our hospitals have the resources to properly staff for safe, quality care in all our communities.

Our second recommendation is for funding and development of a multi-year RN human resources plan, for implementation and tracking by the Local Health Integration Networks, targeted to reduce the significant gap in the RN to population ratio between Ontario and the rest of Canada.

Our third recommendation calls on the Minister of Health to establish a vision for RN care in Ontario. To achieve this vision, we are calling for the government to implement a moratorium on any further erosion of RN positions. RN care leads to improved patient outcomes *and results in* cost savings for our health care system.

We are supportive of the government's transformation agenda in the home care sector but only insofar as it leads to a non-profit home system.

Such a non-profit system would eliminate the duplication of management of private contracts and would result in cost savings from the elimination of profit from our home care system. Our fourth priority, therefore, is to see movement toward a fully integrated *public* home care system that integrates the delivery of home care services and care coordination in the non-profit LHINs.

Our fifth priority for the 2017 Ontario budget requires funding and enforcement of a staffing standard to meet the increased care needs of our complex residents in long-term care homes. A regulated minimum staffing standard in long-term care homes must be set at an average level of four worked hours of nursing and personal care per resident per day (including 48 minutes of RN care) to meet the rising acuity of our residents.

Our sixth priority is to fund a health care Action Plan for Workplace Violence Prevention that mandates key standards such as safe RN staffing levels, appropriate security staffing, use of best practices for training competent supervisors, accessible panic alarms linked to security, and electronic and visual alert systems for flagging potentially violent patients. Nurses know that appropriate enforcement mechanisms, regulation and legislation, will be essential to improve the safety of Ontario's nurses and will go a long way to preventing the rising rates of lost-time injuries for healthcare workers arising from incidents of workplace violence.

Nurses know the strong evidence for RN care is compelling. Ontario's healthcare system, however, is falling short. Ontario now has fewer RNs per population than any other province. Nurses know that additional funding will be necessary so that our patients receive the professional RN care they need. We have set out a course of action for the government so that our patients receive the best possible care that they deserve.

Endnotes

[1] Hendry, Luke. "Surge squeezing hospitals." *Trenton Trentonian* December 8, 2016.
[2] Canadian Institute for Health Information (CIHI). *Regulated Nurses, 2015.* ONA calculations based on CIHI data as CIHI no longer reports nurse/population ratios.
[3] College of Nurses of Ontario. *Membership Statistics*, 2015.
[4] See 2016 Annual Report of the Office of the Auditor General of Ontario.
[5] 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.*
[6] 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
[7] Auditor, p. 470.
[8] 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.

[9] Auditor, p. 470.
[10] *Ibid.*
[11] *Ibid*., p. 468.
[12] Needleman, J., et al. "Nurse staffing in hospitals: Is there a business case for quality?" *Health Affairs 25*(1): 204-211, 2006.
[13] Dall, Timothy M. et al. "The Economic Value of Professional Nursing," *Medical Care* 47(1):97-104, 2009.
[14] 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.
[15] 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.
[16] Frith, K., et al. "Nurse Staffing Is an Important Strategy to Prevent Medication Errors in Community Hospitals." *Nursing Economic$* 30(5): 288-294, 2012.
[17] The study estimates the cost of the 47 errors that occurred on the nursing unit at $450,260.
[18] 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.
[19] Ontario Budgets. 2015, 2014, 2011.
[20] See Ontario Hospital Association, Submission to Standing Committee on Finance and Economic Affairs, January 23, 2014, p. 2.
[21] See Ontario Health Coalition.
[22] See, for examples: "Home-care system in free fall after more cuts," Toronto Star, November 19, 2014; "Furor over home care cuts at Champlain Community Care Access Centre", Ottawa SUN, October 21, 2014; "Home-care system let senior down after hip surgery," Toronto Sun, November 10, 2013; "Seniors find little care in provincial strategy," Toronto Star, February 18, 2011; "Home-care services can't keep up, audit finds," Toronto Star, December 6, 2010. Denis Davy. "Private home care on the rise," Hamilton Spectator, November 16, 2010. See also 2010 Annual Report of the Auditor General of Ontario, Chapter 3, "Home Care Services."
[23] Annual Report of the Office of the Auditor General of Ontario, 2010, p. 115.
[24] Health Quality Ontario, *Quality Monitor*, 2012, pp. 12-15.
[25] Williams, A.P. et al. "Reducing Institutional and Community-Based Care," *Healthcare Quarterly* 12(2): 2009.
[26] 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.
[27] 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.*
[28] Examples of increasing acuity in long-term care homes include: 92.8% of new residents have two or more chronic illnesses; 77% require extensive assistance or are totally dependent for help with the activities of daily living; 83% of residents in 2011 had "high" or "very high" care needs compared to 72% in 2007. See materials from Staffing Alliance for Every Resident (SAFER).
[29] 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.
[30] Note that experts suggest 4.55 total hours per resident per day as a minimum (See Harrington et al. "Nursing Home Staffing and Its Relationship to Deficiencies," *Journal of Gerontology: SOCIAL SCIENCES* 55B (5): 2000.
[31] See the Ontario Long Term Care Association, 2015 Pre-budget Submission.

[32] Statistics Canada. *Findings from the 2005 National Survey of the Work and Health of Nurses, December 2006.*
[33] Workplace Safety and Insurance Board EIW Claim Cost analysis Schema, June 2015 and May 2014 data snapshots.
[34] Leigh, Paul. "Higher Nurse-to-Patient Ratio Law Improves Nurse Injury rates by One-third." NIOSH Science Blog, May 6, 2015.
[35] Dr. James Ham, "Royal Commission on the Health and Safety of Workers in Mines" Report. p. 152 and p. 6.
[36] See IWH study: https://www.iwh.on.ca/at-work/81/inspections-with-penalties-linked-to-lower-injuries-iwh-review.