# Submission to the Standing Committee on Social Policy Regarding Bill 140: An Act Respecting Long-term Care Homes

Ontario Health Coalition

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January 16, 2007

The Ontario Health Coalition is a network of over 400 grassroots community organizations representing virtually all areas of Ontario. Our primary goal is to empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to health care and healthy communities. To this end, we seek to provide to member organizations and the broader public ongoing information about their health care system and its programs and services. Through public education and support for public debate, we contribute to the maintenance and extension of a system of checks and balances that is essential to good decision-making. We are an extremely collaborative organization, actively working with others to share resources and information. We are a non-partisan group committed to maintaining and enhancing our publicly-funded, publicly-administered health care system. We work to honour and strengthen the principles of the Canada Health Act.

Our members include over 50 local health coalitions in communities across the province; local health action committees; health professionals' organizations; physicians that support medicare such as the Medical Reform Group; medical students' groups that support medicare; non-profit service providers; health sector unions; women's groups such as the National Action Committee on the Status of Women, the Older Women's Network, Canadian Pensioners Concerned, Immigrant Women's Health Centre, Voices of Positive Women; seniors' groups including the Ontario Coalition of Senior Citizens Organizations, CAW retirees, Alliance of Seniors to Protect Social Programs; low income and homeless peoples' organizations including Low Income Families Together, Food Share of Metro Toronto, Ontario Coalition Against Poverty; social service organizations; workers' advocacy organizations; ethnic and multiracial minorities; the Ontario Federation of Labour; and other organizations such as the Canadian Council of South Asian Seniors (Ont.), the Association of Neurologically Disabled, Ontario Coalition for Social Justice, Social Planning Council of Metro Toronto, Native Women's Resource Centre, Aids Action Now, Birth Control and Venereal Disease Centre, the Canadian Federation of Students (Ontario division), Oxfam Canada and the Injured Workers Resource Centre, among others.

We work in partnership with the Canadian Health Coalition and provide provincial coordination of community-based health coalitions.

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## The Impact of the New Act

There are 75,282 long term care beds in Ontario. In these homes tens of thousands of vulnerable and dependent adults live, thousands of volunteers help out, and additional tens of thousands of Ontarians work. The new act respecting conditions and standards for these homes will impact millions of Ontarians in intimate and life-altering ways: the amount of time a staff person has to bathe a resident, or feed her; the quality of food, whether a resident has activities, stimulation and supportive surroundings; safety of all involved the homes from violence, illness and injury; the ability to access timely medical help; the gentleness of care; and whether residents thrive or deteriorate. These issues are of critical importance for all residents, for their families, and for caregivers, paid and unpaid.

## Appropriate Consultation

While we believe that the process adopted by Monique Smith involving consultation prior to the drafting of the act was a good first step, we are very concerned that the decision to set a deadline during the holiday season for requests for standing at committee hearings, and the inadequate number of hearings, has meant that many people who care deeply about what happens in long term care homes will not be heard. We urge that the committee extend the hearings and make proactive efforts to ensure that residents, families, concerned community members and caregivers are invited to have input.

## The Key Issues

Through our extensive consultation with member groups, residents, family members, volunteers, careworkers and facility operators one common theme emerged. The care levels in the facilities are inadequate to protect from harm, and to ensure the provision of a decent and dignified quality of life. Everywhere in Ontario we have heard from frustrated caregivers, residents and family members who cannot give the care they want to give or cannot access the care they need. Families are forced to hire in extra help if they can afford it. If they cannot, residents go without. Everywhere, people are identifying that heavier care residents now live in the homes. Staff feel inequipped to appropriately care for residents with cognitive difficulties and behavioural problems. Yet downloading of heavier care patients from mental health facilities and hospitals continues.

These findings are not localized. While good facility management and lots of volunteers can compensate to some extent for the inadequacies, they cannot provide the levels of care across the province that are a minimum requirement to protect from harm. The evidence is that the lack of care is so widespread as to be a systemic problem that requires a change in public policy to adequately address it.

The evidence is that the heavier care needs will continue and deepen in coming years. It is now generally accepted that 60 - 80% of facility residents have some form of cognitive impairment. In 2005 - 140,000 Ontarians had Alzheimer Disease or related dementia. This number is expected to double to 307,000 in the next 25 years.(Alzheimer Society Ontario. Position Paper on Casa Verde Recommendations, September 2005).

This new legislation must ensure that the care needs of residents are soundly measured and reported, that a minimum care standard - weighted to these assessed needs- be established, that the government fund to a level that is adequate to provide care to the assessed levels and standards, and that the facilities be held to account for providing the care for which they are funded. In its current form, the proposed legislation does not accomplish these things. In this brief, we have made recommendations to ensure that these minimal requirements be met.

## Improvements in the Proposed Legislation as it Stands

Many of the provisions in the proposed legislation reflect existing provisions and regulations under the former Acts, relying heavily on the Nursing Homes Act. We support several of the new initiatives including:

- the increased ability of residents to promote their rights contained in the Bill of Rights
- written sign-off of facility operators to confirm their review of admission documents
- the proposed intent to limit casual and agency staff to be included in the regulations is a good first step, however the limitations must be strengthened
- the inclusion of an RN on site 24/7
- increased powers of inspectors and continuation of regular unannounced inspections

## Prevention of Harm

The health minister promised a "revolution" to ensure that we will never allow the repeat of such preventable tragedies such as the sad and painful death of Natalie Babineau from a bed sore, or the deaths of Ezz-El-Dine El Roubi and Pedro Lopez who were beaten by a cognitively-impaired resident at Casa Verde, and the many other attacks and inadequate care that have irreverseably damaged peoples' lives. But if the new act is to succeed in this, it must provide the legislative and regulatory standards that will protect residents, staff, families and visitors from harm.

**Our recommendations for amendment are:**

- **The Bill must be amended so that the zero-tolerance and reporting policies conform to a minimum standard across the province, with allowance for additions to fit the context of the particular home.** ***(Section 18)***
- **Neglect should be defined so that facility operators and the government, who bear the majority of the responsibility for funding and assessment and for spending decisions which are critical to preventing neglect, are held accountable for these decisions.** ***(Section 2 definitions, and Section 17)***
- **Staff that whistle-blow can still lose their jobs and will have to grieve or go to the Labour Board to get them back. There are already cases of staff firings due to whistle-blowing in Ontario. This is a significant financial barrier to whistle-blowing. At minimum, this section should be amended to ensure that financial barriers to whistle-blowing are removed.** ***(Section 24)***
- **There should be a pro-active duty of operators to provide a living and working environment that is respectful and free of fear. The Bill should be amended so that gag orders and other such clauses in employment contracts must be unlawful, and this must be enforceable.** ***(Section 24)***

- **Proactive public and mandatory staff education similar to models used to prevent workplace harassment, discrimination and family abuse should be instituted. *(Section 24)***
- **In addition to protections for residents, the Act must also ensure that facilities are safe for staff who have alarmingly high rates of illness, accident and injury in this sector.*(Section 5)***
- **This section needs to include clear assurances of staff coverage for care during absences for training, a strong commitment to fund continuing education for direct care staff including sensitivity training around equity issues, standards and a provincial tripartite structure to oversee training and skills development. We have received many complaints about inadequate training for staff working with people moved from mental health facilities into ltc homes. Special training to address the care needs and safety concerns regarding residents with psychogeriatric issues must be included here. *(Section 74)***

## A Minimum Care Standard

We are insisting that the key component is the re-institution of a minimum care standard. We recommend a province-wide minimum staffing standard that ensures sufficient hands-on staff to provide a minimum of 3.5 hours per day of nursing and personal care per day per resident. This is to reach the goal of prevention of risk, it is not an optimum. Increases in staffing should be shared proportionately among all members of the health care team. The government must fund and set standards for specialty units or facilities for persons with cognitive impairment who have been assessed as potentially aggressive, and staff them with sufficient numbers of appropriately trained workers.

- **The Bill should be amended to require cabinet to set a minimum staffing standard in the regulations. *(Section 36)* The regulations should require the minimum care standard described above.**
- **The staffing standard should be required to meet the assessed needs of the residents. Government must provide funds, in the nursing and personal care envelope, to meet the required staffing standard. *(Section 36)***

**What is a Minimum Care Standard?**
This is a defined number of hours of care that is attached to a particular level of assessed need. We are proposing that Ontario adopt a 3.5 hour minimum care standard of hands-on care. This means that a facility with the average case mix (or an average level of need) would receive resources for nursing and personal care specifically to provide 3.5 hours of care per resident. Those facilities with lower acuity levels (less needy residents) would receive less. Those with higher acuity would receive more.

**Ontario used to have a Minimum Care Standard**
In 1996 the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. We are insisting that the government re-instate a care standard to improve quality of life in long-term care homes. Since the level of acuity has increased with the downloading of heavier care patients from hospitals and mental health facilities and with the aging of residents, the standard must be modernized to meet today's care needs. Based on our research of standards in other jurisdictions across Canada and the US, we believe that 3.5 hours of care would be the minimum required to reach the goal of

prevention of risk. This should be adopted as an interim measure while the government undertakes the research necessary to define the care levels associated with the current assessed levels of need.

**Inaction on the provincial auditor's recommendations**

The provincial auditor in 1995 and 2002 noted that inaction on issues such as the staffing mix and appropriate levels of funding meant that there was no basis to assess whether funding in the sector is appropriate to meet the assessed needs of residents. In addition, the auditor criticized the government for inadequate financial reporting, inadequate inspections, the lack of action to address the findings of the 2001 PriceWaterhouse Coopers Report, and inadequate tracking of contagious disease outbreaks. In the 2004 auditor's update, improvements to the inspection regime and reporting requirements were reported. In the minutes of the Standing Committee on Public Accounts, it is reported that the government has been collecting actual staffing data for several years. However, we have not been able to obtain this data. If the auditor's complaint that there is no assessment to determine the adequacy of funding to meet assessed need has been met, that report is not available publicly. No staffing standards have been created. The Ministry has never updated nor has it addressed the findings of the 2001 PriceWaterhouse Coopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs including depression, cognitive impairment and behavioural problems.

**How does our proposed minimum standard work?**

The government uses an assessment tool to figure out how much care residents need. The current tool is recognized as flawed, and the government is piloting a new assessment tool in 70 long-term care homes. The tool allows facilities and the government to determine the "case mix". The average case mix across the province is then calculated. Those with lighter care needs than the average are deemed to have lower acuity, those with heavier care needs are deemed to have higher acuity. The funding the home receives for nursing and personal support care (feeding, bathing, nursing etc.) is based on the level of acuity in the home.

However, there is no expected amount of care that is attached to the average level of acuity. An array of reports and media exposes, and testimony of families and care staff, have shown that there are serious inadequacies in care provision. There are not enough staff to provide the needed care. Staff are unable to get their care work done to expected standards within the time they have on their shifts. Bathing, repositioning, referrals to medical care, even feeding, are left undone because there is not enough care time. This shortfall has serious health and quality of life implications for residents and staff.

A care standard would set an expected level of care, weighted by the assessed acuity of the resident. This would provide one of the most important tools in assessment of appropriate funding and provide greatly improved opportunities for accountability.

**What does the research show about Minimum Care Standards?**

- The Province of Alberta has set a policy direction to bring care to 3.6 hours. As of the latest budget, Public Interest Alberta and the Capital Health Authority report that funding is at 3.6 hours, as of the latest budget.

- The Liberal Party of New Brunswick recently won an election with a pledge to phase in a minimum standard of 3.5 hours by 2008.

- Nova Scotia is increasing their previous 2.25 hour guideline to 3.25 hours.

- PriceWaterhouse Coopers found that Saskatchewan was at 3.1 hours in 2001.

- 37 U.S. States have established minimum staffing standards either in statute or in regulation. While Ontario axed its care standard, 13 U.S. states increased their staffing standards (between 1999 and 2001).(Harrington, 2001).

- The US Health Care Financing Administration conducted major research to deliver two phases in its "Report to Congress: Appropriateness of Minimum Nursing Staff Ratios in Nursing Homes". They used multivariate analysis and time motion studies to assess the impact of levels of care. Their findings yielded a strong link between staffing and quality. They found that preferred minimum levels existed above which quality was improved across the board. The total preferred minimum level was 3.45 hours of care, with a staffing mix of aides, RPNs (or equivalent) and RNs. They also found that residents in understaffed homes are at a greater risk of preventable health conditions including pneumonia, urinary tract infection, sepsis, congestive heart failure and dehydration.

- The Institute of Medicine (IOM) report Improving the Quality of Long-term Care (2001) recommended the development of minimum care levels integrated with case mix adjusted standards. It found increasing acuity of nursing home residents and recommended "[F]ederal staffing levels must be made more specific and that the minimum level of staffing has to be raised and adjusted in accord with the case-mix of residents. The objective should be to bring those facilities with low staffing levels up to an acceptable level and to have all facilities adjust staffing levels appropriately to meet the needs of their residents, by taking case-mix into account."

- The Coroner's Jury in the Casa Verde inquest recommended increased staffing and regulation, including a minimum staffing standard.

- A recent study published in the Amercian Journal of Public Health (July 1, 2005) by researchers from the University of Toronto and University of Maryland found that for each hour of care, injury rates for nurses and nurses' aides fall by nearly 16%. For every unit increase in staffing, worker injury rates decrease by two injuries per 100 full time workers. Study authors concluded that more hours of care provided per patient, the fewer the workplace caregiver injuries, which leads to better care. (Medical News Today (medicalnewstoday.com).

**The Bill should be amended to require cabinet to re-instate a minimum staffing standard by regulation. The regulation should require a minimum standard of 3.5 hours of hands-on nursing and personal care per day. There should be clear standards, special care units, and improved training requirements and opportunities to provide appropriate care for residents with behavioural problems or cognitive impairment, and especially those with a history of aggression.**

- **The Ministry of Health and Long Term Care must immediately update to the comparative work done by PriceWaterhouse Coopers in 2001. The review must include at minimum the current levels of acuity and the current actual levels of care. The review must also include an assessment of an evidence-based appropriate minimum staffing standard, to be weighted by assessed need, that is required. This information must be made public.**
- **In addition to the requirement for cabinet to set a minimum staffing standard, there should be a process to require a regular 3 year review by the standing committee covering the same information to ensure care needs and standards are being met. This**

**information must be made public.**

- **There must be a clear requirement for a provincial funding model that is based on a uniform assessment tool across the province to ensure that there are uniform provincial standards and funding assessment tools across all LHINs. The funding model must provide adequate funding for the required staffing standard and strong accountability as to how that money is spent. *(Section 88)***
- **There needs to be a clear standard to prevent the offloading of patients from acute-care facilities to long term care homes that are inadequately staffed to provide appropriate care. *(Section 41)***

## Support for public and non-profit care

### Profit Taking

For-profit nursing homes are required by investors to maximizing the profit and growth potentials of their companies. The investors in Diversicare, Extendicare, Chartwell or the others, seek to maximize the rate of return on their investment and to pursue a growth strategy that maximizes return down the road. That means profit has to be found from the mix of government (public) funding and private fees that residents pay.

In Ontario's nursing homes there are several funding envelopes, including:

- nursing and personal care

- programs and support services

- accommodation

Only in the accommodation envelope do the facilities keep funding if they do not spend it all. In the nursing & personal care and programs & services envelopes the homes must return funding received from the government if it exceeds what they spend. In the for-profit facilities this means that the accommodation envelope is the one from which they can take profits. This is the envelope also into which premiums charged for private and semi-private beds go.

Over the years, the operators have done a number of things to shift costs from the accommodation envelope into the nursing and personal support envelope, including moving incontinence supplies, moving costs for building cameras and surveillance equipment, and shifting the work of accommodation staff to personal support staff. The fewer the costs in the accommodation envelope, the more room for profit-taking. In recent years, it has been reported that the government is directing the operators move incontinence supplies and surveillance and security costs back into the accommodation envelope so that nursing and personal care funds are not siphoned off into these other items. We are now hearing reports that this has not yet been done.

The operators have also conducted public campaigns and lobbying to increase the amount of funding in the accommodation envelope. The fee increases for residents adopted by the Harris-Eves Conservative government go into the accommodation envelope.

The for-profit homes have an interest in increasing fees for seniors and in shifting costs out of the accommodation envelope, even if it lowers care staff levels, because it fits their requirement to maximize rates of return for their investors. Thus the profit and growth requirements of the for-profit nursing home industry are in direct conflict with the public interest in accessible and affordable care.

**Beds for Care or Revenue Streams for Investors?**
Ontario's non-profit and public facilities have always had "approved beds" which means that the number of beds they operate is approved by the provincial government. The for-profits have bed "licensed beds" which have a value on the open market. Thus, the for-profits can buy and sell bed licenses as revenue streams for their companies. Nursing home beds are places of care for vulnerable seniors. Most Ontarians would be appalled to realize that the for-profits see them as commodities to be bought and sold for investor revenue streams.

**Mission and Mandate**
The mission of a non-profit or public long term care home is to provide care. This is incorporated into the agency's by law and letters patent as the reason the home exists. The mission of a for-profit nursing home is to maximize profit and growth for its shareholders. So a non-profit is founded on the principle of putting the most it can into the home. The for-profit requirement to deliver maximum rate of return and growth means it must take the most it can out of the home.

To a for-profit, long term care homes are an investment. They move from jurisdiction to jurisdiction depending on the market conditions. For example, after Extendicare was sued in Florida for deaths in their homes due to dehydration and bed sores, which the court ruled as neglect, they sold off their facilities in the state and moved shop. Ironically, while Extendicare was given the largest penalty in a civil suit in history in Florida for the deaths of residents in its nursing homes, Ontario was awarding the company with the single largest share of our new beds. While we think of nursing homes as places to live for our aging parents, or spouses, or friends, Extendicare Canada sees these homes as one part of its "portfolio" providing a revenue stream to investors as follows:

"Today, the Company is focused on growing its business in both the assisted living and nursing home sectors of senior care. The Company expects to continue making selective acquisitions to increase the size and scale of its portfolio." **http://www.extendicare.com/aboutus/history.html** (Dec. 19, 2006)

Research from well-over a decade of experience in the United States shows that care in non-profit and public long term care homes is superior to that of for-profit homes. When releasing his recent study showing better performance in non-profit versus for-profit nursing homes, University of Toronto PhD candidate Michael Hillmer noted that the difference, "could be as simple as them being required to put any profits back into the homes." His study found non-profits performed better, especially in measures of patient care, than for-profits. Findings in the for-profits included higher rates of pressure ulcers (bed sores) and use of psychoactive medications to subdue patients and more use of restraints.[1] His conclusions were echoed in the June 2005 release of the University of Toronto, University of Maryland study on caregiver injuries and staffing levels in nursing homes. Lead researcher Dr. Carles Muntaner state, "Reductions in staffing ratios and numbers of staff hours lead to lower quality of care. At the end of the day, it's a policy option, but the consequences are clear. If you try to squeeze the budget to maximize profits, it creates the dangerous situation we see in the United States."[2]

In his investigative report on Ontario's long-term care homes, Ottawa Citizen reporter Paul Mackay reports on the claims of the for-profit lobby group the Ontario Long Term Care Association as follows, "Karen Sullivan contends her members make no profit on the provincial subsidies. Instead, she says, they earn their profits by charging higher fees to wealthier residents who can afford private rooms, and by buying food and other supplies in bulk and setting lower wage scales for staff."[3] Despite the spin, even the for-profit association admits that cutting on food and staff costs, and charging higher fees is the practice to maximize profit taking from the homes.

Conversely, municipalities are pouring funding into the operational budgets of the facilities to improve care. Non-profits fundraise to provide activities and amenities. They act to levy additional

resources to *put into* the homes.

Most recently, the Canadian Medical Association Journal Commentary from January 2, 2007 included the following review of the evidence from Canada noting, "There is now increasing evidence that the for-profit and not-for-profit sectors in Canada make different spending decisions.

- In an Ontario study, government-operated facilities were found to provide more hours of direct patient care per resident than for-profit facilities, although the public-sector facilities also care for residents with greater health needs. Berta W, LaPorte A, Valdemanis V. Observations on institutional long-term care in Ontario: 1996–2002. Can J Aging 2005;24:70-84.

- In British Columbia, not-for-profit facilities were also found to provide more hours of direct patient care per resident than for-profit facilities. McGregor MJ, Cohen M, McGrail KM, et al. Staffing levels in not-for-profit and for-profit long-term care facilities: Does type of ownership matter? CMAJ 2005;172:645-9.

- Although this was not the primary question under study, Shapiro and Tate found that, in Manitoba, for-profit long-term care facilities had higher rates of acute care hospital admission of residents because of several quality-of-care related diagnoses than did not-for-profit facilities. Shapiro E, Tate RB. Monitoring the outcomes of quality of care in nursing homes using administrative data. Can J Aging 1995;14:755-68.

Section 103 (9) of the proposed legislation allows non-profits to transfer to for-profits as per regulations (unspecified). There is no requirement that homes be rolled back into non-profit or public control. We have expressly oppose non-to-for-profit transfers. Later in the Transition section it is specified that non-profits with licenses will continue to have licenses, those with approved beds will continue as such. (Currently there is a mix of approved and licensed non-profits). In the fall of 2006, the government put out to tender new beds in Southeastern Ontario, following the tender process established by the Harris-Eves Conservative government which is weighted towards the large for-profit chains with their superior access to capital. These policies, combined, mean that the current majority of for-profit beds will continue, with provision that new beds can be tendered to the for-profit sector, and more of the non-profit beds could be transferred to for-profits. We called for a strong message in support of public and non-profit provision of long term care. The legislation does not provide this and enables for further for-profit privatization. The process of licensing and selling beds on the market should be stopped: beds are places of care, not commodities.

- **The Bill must be amended to require the government to increase the proportion of non-profit and public facilities.** ***(Sections 95 & 96)***
- **All new homes should be built in the non-profit and public sector.** ***(Sections 95 & 96)***
- **Transfers from non-profits to for-profits should be disallowed.** ***(Section 103)***

## Access to Care

In the old acts as in the proposed legislation, the Fundamental Principle is to be used in interpretation. Included in the Fundamental Principle of the former acts, was a provision that the physical, psychological, spiritual, cultural and social needs of the homes' residents are adequately met. This is now removed. There is no fundamental principle that people have the right to access the care that they need. There is no obligation of the Ministry to fund to assessed level of need. All obligations listed here are for the licensee.

It is not clear if the geographic areas referred to in the new Act might be the LHINs. Given the size of the LHINs, we want to ensure that people can access the care they need close to their home

communities. In our response to the Ministry's discussion paper, we have also called for the following: "Greater dignity and discretion is required for people seeking placement in long term care facilities. Freedom of choice is an essential principle in all settings. Homecare should be an accessible choice."

In addition to care levels in the facilities and the geographic location of the beds, cost is another major aspect of accessibility. Ward accommodation is the most affordable type of bed, and has been where the wait lists have occurred. Over the years, the government has reduced the ratio of beds that facilities must hold for basic ward accommodation and the balance is now shifted in favour of the higher-cost "preferred" (private and semi-private) beds. While this increases the funding in the accommodation envelope from which facilities can take profit, it is not in the interests of the majority of Ontarians.

**Our recommendations to protect and promote accessibility:**

- **The Bill should be amended to re-instate the Fundamental Principle that the physical, psychological, spiritual, cultural and social needs of the homes' residents are adequately met. *(Section 1)***
- **The Ministry must be required to analyse the level of funding required to meet to assessed level of need and to establish a plan to achieve the required level of funding. *(Section 88)***
- **A ratio of 60% of facility beds for non-preferred accommodation and 40% for preferred accommodation should be reinstated. *(Section 92)***
- **Charges to residents for basic accommodation should not exceed CPP/OAS benefit increases. *(Section 89)***

## Advocacy Structures

The rights given to family and residents' councils and to advocacy structures that will help to ensure that facilities meet the needs of residents must be more robust. Though the facilities are obliged not to interfere, there is no right for the councils have a voice at appeals, obtain necessary information, speak to inspectors etc. It is also a problem that the setting up of the councils rests with the facility operators themselves. It is imperative that the independence of the councils from the facility operators be established and maintained. An arms-length third party must receive funding to be able to effectively establish and assist in maintaining the councils. In our response to the Minister's consultation paper we called for funding and support to flow through an elder care ombudsperson's office and/or through Concerned Friends or the Advocacy Centre for the Elderly. Furthermore, we have received reports that volunteers in facilities, who represent the facilities rather than the families or residents, are on the family councils. The proposed legislation allows for this to continue.

In addition, there should be a complaints process that allows residents, staff, family and advocates to complain to a third party that is not the facility operator. In this bill there is a provision for very serious complaints to go directly to the Director (in the Ministry) but others go to the facilities. We have called for the institution of an elder-care ombudsperson who can receive and process complaints. Simply instituting a 1-800 number for complaints is not a good model since few know about it and we have received complaints that calls are not answered. The provision of an Office of the Long Term Care Homes Resident and Family Advisor in Section 35 is significantly weaker than the creation of an elder-care ombudsperson who would be mandated to receive and process complaints and it will not accomplish the needed support for advocacy.

**In order to provide the needed advocacy structures, we propose that the Bill be amended as follows:**

- **Inspectors should be mandated to talk to residents, families and staff at the homes, not**

**just administrators.** ***(Section 144)***

- **It should be clear that family members or residents' designated advocates are the only people on these councils and attending meetings, unless expressly invited.** ***(Section 57)***
- **The legislation must provide for public access to information that would allow Family Councils and others to effectively hold operators accountable. Information that must be made available should include but not be limited to: financial reports on income and expenditure from all funding envelopes, including the amount of profit taken; reports on complaints regarding standards; level of care needs; Ministry or LHIN directives; facility funding & licensing agreements; inspection and compliance reports.** ***(Sections 55 and 58)***

## Enforcement and Compliance

We support the increased powers of inspectors and the continuation of regular unannounced inspections. However, there are some inadequacies regarding powers to inspect contracted out work, the lack of recognition of residents, staff and families in this section, and lack of requirement for the government to ensure compliance. Program standards must be reviewed and improved and enforced through the inspection regime. More attention must be paid to homes that are non-compliant and strong and effective sanctions must be imposed on homes that are consistently non-compliant with significant care standards including non-renewal of the license to operate. Given the history of lack of action from government on enforcement and compliance, as outlined by the provincial auditor, newspaper reports, advocacy groups and Concerned Friends among others, there is plenty of evidence that it is necessary to ensure that adequate enforcement is followed.

Further, the government must fund to ensure inspection and compliance staff are adequate for tasks outlined in this Bill. We note that in the proposed legislation inspectors can inspect facilities of contracted-out services, but there appears to be no requirement to do so. This is an unequal playing field as homes that do not contract out services will have these services inspected in the regular inspections.

**We recommend the following amendments to strengthen this section:**

- **Residents, staff, families and councils should be added to the "parties" with access to appeal or means of challenging action.** ***(Section 164)*** **There should be a right for residents, staff, families and councils to appeal or challenge inaction by the Ministry.** ***(Section 160)***
- **There is no actual requirement for the Director to pursue sanctions in Sections 150 - 154, even in cases of consistent non-compliance. The Ministry should have a clear obligation to enforce standards.** ***(Sections 150 - 154)***
- **In corporations that are chains or own more than one facility, corporate penalty should be $200,000 per facility where the offense occurs.** ***(Section 177)***
- **If significant non-compliance is found in one home that is part of a chain, it should trigger inspections in all the homes of that chain.** ***(Sections 150 - 154)***

## Access to Information and Democratic Protections

The long term care sector budget is now over $2.8 billion in government funding, plus fees collected from residents. Yet the experience of lack of enforcement, tip-offs regarding inspections, exchanges of personnel between the for-profit sector and government, and de-regulation, point to the urgent need to improve public accountability and democratic control over this sector. There are a number of outrageous recent stories of fraud, neglect and abuse occurring in chains of for-profit nursing homes. There is no clear ability for the public to gain access to information about

how much money is received by the facility in each funding envelope and how much is spent. The reports on actual staffing levels that are collected by government are not available to the public. This situation must be addressed.

**It is critical that the following additions to the Bill be made to improve access to information and democratic protections:**

- **Nursing home operators should not be allowed to fund political parties and politicians, nor to give gifts to them. (To be added in a new section on accountability and democracy)**
- **There should be a "sunset clause" included in the legislation aimed at preventing a revolving door between the Ministry, LHINs, any body that is created to form recommendations for health restructuring and long term care reform on one hand, and the nursing home industry on the other. (To be added in a new section on accountability and democracy)**
- **The Ministry must be required to make public any past criminal or civil offenses for fraud, neglect and abuse by nursing home operators applying to be awarded beds in Ontario. (Section 104)**
- **The requirement for public consultation on licensing must be accompanied by disclosure and access for the public to information regarding the proposal and the proponent. (Section 104)**
- **Public consultation re. licenses under Section 104 does not require any public notice of the consultation to anyone in any format. The public must be notified of the consultations.**
- **The government must provide public access to information it collects regarding actual staffing and care levels and assessed need. It must make public the funding formula. (To be added in a new section on accountability and democracy)**
- **The public must be given access to clear information delineating how much money each facility receives in each funding envelope and how much money is spent in each envelope. (Could be under Sections relating to access to information for family and residents' councils - Sections 55 and 58, also to be added in a new section on accountability and democracy)**
- **Currently salary disclosure legislation applies to Homes for the Aged. This is unequal. Executive salaries across all long-term care facilities and profit levels must be made public. (Could be under Sections relating to access to information for family and residents' councils - Sections 55 and 58, also to be added in a new section on accountability and democracy)**

## Consultation on Regulations

There are potential regulations under many sections of the legislation. However, there is no process required for consultation on the regulations as there is in Bill 36, for example. The government should balance its powers to regulate with an obligation to consult on regulations.

- **The Bill must be amended to include a consultation process for the regulations, such as that contained in Bill 36.**

1. Hillmer, Michael et al. Study is published in Medical Care Research and Review, April 2005.

2. Medical News Today, June 29, 2005.

3. "Ontario's Nursing Home Crisis - Part 1: Cut-Rate Care", Ottawa Citizen, April 26, 2003

## APPENDIX:

### Recommended Amendments In Order:

- **The Bill should be amended to re-instate the Fundamental Principle that the physical, psychological, spiritual, cultural and social needs of the homes' residents are adequately met.** ***(Section 1)***

- **In addition to protections for residents, the Act must also ensure that facilities are safe for staff who have alarmingly high rates of illness, accident and injury in this sector.*****(Section 5)***

- **Neglect should be defined so that facility operators and the government, who bear the majority of the responsibility for funding and assessment and for spending decisions which are critical to preventing neglect, are held accountable for these decisions.** ***(Section 2 definitions, and Section 17)***

- **The Bill must be amended so that the zero-tolerance and reporting policies conform to a minimum standard across the province, with allowance for additions to fit the context of the particular home.** ***(Section 18)***

- **Staff that whistle-blow can still lose their jobs and will have to grieve or go to the Labour Board to get them back. There are already cases of staff firings due to whistle-blowing in Ontario. This is a significant financial barrier to whistle-blowing. At minimum, this section should be amended to ensure that financial barriers to whistle-blowing are removed.** ***(Section 24)***

- **There should be a pro-active duty of operators to provide a living and working environment that is respectful and free of fear. The Bill should be amended so that gag orders and other such clauses in employment contracts must be unlawful, and this must be enforceable.** ***(Section 24)***

- **Proactive public and mandatory staff education similar to models used to prevent workplace harassment, discrimination and family abuse should be instituted.** ***(Section 24)***

- **The Bill should be amended to require cabinet to set a minimum staffing standard in the regulations.** ***(Section 36)*** **The regulations should require the minimum care standard described in the brief and below at the asterisk*.**

- **The staffing standard should be required to meet the assessed needs of the residents. Government must provide funds, in the nursing and personal care envelope, to meet the required staffing standard.** ***(Section 36)***

- **There needs to be a clear standard to prevent the offloading of patients from acute-care facilities to long term care homes that are inadequately staffed to provide appropriate care.** ***(Section 41)***

- **The legislation must provide for public access to information that would allow Family Councils and others to effectively hold operators accountable. Information that must be made available should include but not be limited to: financial reports on income and expenditure from all funding envelopes, including the amount of profit taken; reports on complaints regarding standards; level of care needs; Ministry or LHIN directives; facility funding & licensing agreements; inspection and compliance reports.** ***(Sections 55 and 58)***

- **It should be clear that family members or residents' designated advocates are the only people on these councils and attending meetings, unless expressly invited.** ***(Section 57)***

- **This section needs to include clear assurances of staff coverage for care during absences for training, a strong commitment to fund continuing education for direct care staff including sensitivity training around equity issues, standards and a provincial tripartite structure to oversee training and skills development. We have received many complaints about inadequate training for staff working with people moved from mental health facilities into ltc homes. Special training to address the care needs and safety concerns regarding residents with psychogeriatric issues must be included here.** ***(Section 74)***

- **There must be a clear requirement for a provincial funding model that is based on a uniform assessment tool across the province to ensure that there are uniform provincial standards and funding assessment tools across all LHINs. The funding model must provide adequate funding for the required staffing standard and strong accountability as to how that money is spent.** ***(Section 88)***

- **The Ministry must be required to analyse the level of funding required to meet to assessed level of need and to establish a plan to achieve the required level of funding.** ***(Section 88)***

- **Charges to residents for basic accommodation should not exceed CPP/OAS benefit increases.** ***(Section 89)***

- **A ratio of 60% of facility beds for non-preferred accommodation and 40% for preferred accommodation should be reinstated.** ***(Section 92)***

- **The Bill must be amended to require the government to increase the proportion of non-profit and public facilities.** ***(Sections 95 & 96)***

- **All new homes should be built in the non-profit and public sector.** ***(Sections 95 & 96)***

- **Transfers from non-profits to for-profits should be disallowed.** ***(Section 103)***

- **The Ministry must be required to make public any past criminal or civil offenses for fraud, neglect and abuse by nursing home operators applying to be awarded beds in Ontario.** ***(Section 104)***

- **The requirement for public consultation on licensing must be accompanied by disclosure and access for the public to information regarding the proposal and the proponent.** ***(Section 104)***

- **Public consultation re. licenses under Section 104 does not require any public notice of the consultation to anyone in any format. The public must be notified of the consultations.** ***(Section 104)***

- **Inspectors should be mandated to talk to residents, families and staff at the homes, not just administrators.** ***(Section 144)***

- **There is no actual requirement for the Director to pursue sanctions in Sections 150 - 154, even in cases of consistent non-compliance. The Ministry should have a clear obligation to enforce standards.** ***(Sections 150 - 154)***

- **If significant non-compliance is found in one home that is part of a chain, it should trigger inspections in all the homes of that chain.** ***(Sections 150 - 154)***

- **There should be a right for residents, staff, families and councils to appeal or challenge inaction by the Ministry.** ***(Section 160)***

- **Residents, staff, families and councils should be added to the "parties" with access to appeal or means of challenging action.** ***(Section 164)***

- **In corporations that are chains or own more than one facility, corporate penalty should be $200,000 per facility where the offense occurs.** ***(Section 177)***

**Accountability, Access to Information and Democratic Protections - new section to be added**

- **Nursing home operators should not be allowed to fund political parties and politicians, nor to give gifts to them. (To be added in a new section on accountability and democracy)**
- **There should be a "sunset clause" included in the legislation aimed at preventing a revolving door between the Ministry, LHINs, any body that is created to form recommendations for health restructuring and long term care reform on one hand, and the nursing home industry on the other. (To be added in a new section on accountability and democracy)**
- **The government must provide public access to information it collects regarding actual staffing and care levels and assessed need. It must make public the funding formula. (To be added in a new section on accountability and democracy)**
- **The public must be given access to clear information delineating how much money each facility receives in each funding envelope and how much money is spent in each envelope. (Could be under Sections relating to access to information for family and residents' councils - Sections 55 and 58, also to be added in a new section on accountability and democracy)**
- **Currently salary disclosure legislation applies to Homes for the Aged. This is unequal. Executive salaries across all long-term care facilities and profit levels must be made public. (Could be under Sections relating to access to information for family and residents' councils - Sections 55 and 58, also to be added in a new section on accountability and democracy)**

**Consultation on Regulations - new section to be added**

- **The Bill must be amended to include a consultation process for the regulations, such as that contained in Bill 36.**

*** Regulations regarding minimum staffing:**

**The Bill should be amended to require cabinet to re-instate a minimum staffing standard by regulation. The regulation should require a minimum standard of 3.5 hours of hands-on nursing and personal care per day. There should be clear standards, special care units, and improved training requirements and opportunities to provide appropriate care for residents with behavioural problems or cognitive impairment, and especially those with a history of aggression.**

- **The Ministry of Health and Long Term Care must immediately update to the comparative work done by PriceWaterhouse Coopers in 2001. The review must include at minimum the current levels of acuity and the current actual levels of care. The review must also include an assessment of an evidence-based appropriate minimum staffing standard, to be weighted by assessed need, that is required. This information must be made public.**
- **In addition to the requirement for cabinet to set a minimum staffing standard, there should be a process to require a regular 3 year review by the standing committee covering the same information to ensure care needs and standards are being met. This information must be made public.**