Ontario Health Coalition
Submission to the Standing Committee on Social Policy

Regarding Bill 21
An Act to Regulate Retirement Homes

May 10, 2010

Ontario Health Coalition
15 Gervais Drive, Suite 305
Toronto, Ontario M3C 1Y8
Tel: 416-441-2502
Fax: 416-441-4073
Email: ohc@sympatico.ca
Web: www.ontariohealthcoalition.ca

Who We Are

The Ontario Health Coalition is comprised of a Board of Directors, committees of the Board as approved in the Coalition's annual Action Plan, Local Coalitions, member organizations and individual members. Currently the Ontario Health Coalition represents more than 400 member organizations and a network of Local Health Coalitions and individual members. Our members include: seniors' groups; patients' organizations; unions; nurses and health professionals' organizations; physicians and physician organizations that support the public health system; non-profit community agencies; ethnic and cultural organizations; residents' and family councils; retirees; poverty and equality-seeking groups; women's organizations, and others.

Mission and Mandate

Our primary goal is to protect and improve our public health care system. We work to honour and strengthen the principles of the Canada Health Act. We are led by our shared commitment to core values of equality, democracy, social inclusion and social justice; and by the five principles of the Act: universality; comprehensiveness; portability; accessibility and public administration. We are a non-partisan public interest activist coalition and network.

To this end, we empower the members of our constituent organizations to become actively engaged in the making of public policy on matters related to our public health care system and healthy communities. We seek to provide to member organizations and the broader public ongoing information about our health care system and its programs and services, and to protect our public health system from threats such as cuts, delisting and privatization. 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.

PART I.

A. The legislation should be amended to provide a clear definition of the role of Retirement Homes with firm limitations.

Retirement Homes must not be allowed to become a second-tier of lesser-regulated long term care homes. The results will be worse wait times for appropriate long term care beds as chains close down the more expensive beds to open the cheaper retirement homes beds, worse levels of care, preventable death and poorer health outcomes, and more hardship for seniors.

In Section 2 (1) the Bill defines a retirement home as a place where a number of persons, unrelated to the home operator and primarily over the age of 65 live, and where the operator of the home makes available at least two care services. The regulations will specify the number of people. The regulations will also define the care services.

The Bill needs to be amended to clearly define what care services retirement homes can and cannot do within the legislation itself, not in the regulations. This definition is an important government policy decision. The scope of the function of these homes holds serious policy implications for long term care homes and hospitals and potentially affects the lives of thousands of seniors. Short-termism and the desire to close down hospital beds must not pre-empt the public interest and due process on this question.

It is our opinion that the role of retirement homes should be limited so that they cannot become de facto long term care homes or chronic care hospitals that are privately owned and operated and subject to much less legislation and regulation. This would entail clear limitations on the types of health care services that retirement homes provide. Allowing retirement homes to become a second-tier of lesser regulated long term care homes not only flies in the face of decades of work to improve conditions in the long term care sector, it also carries significant dangers for worsening bed shortages, liability, worse care, poorer health outcomes or preventable deaths, and increasing hardship for seniors.

- Everything about the regulatory regime set out in this Bill is less than long term care homes' requirements.
- There are no provisions for adequate staffing, including directors of care, physicians and medical leadership positions, access to health professionals, nor the nurses and personal support to meet the needs of the residents. There is no requirement to assess appropriately and meet assessed needs.
- There is no facility design manual to ensure that the built environment is safe and appropriate.
- There is no requirement for programs and services to provide stimulation and meet the care needs of the residents.
- Because retirement homes have many fewer legal requirements and because they pay their staff less, they are cheaper to operate. The for-profit chains, in particular, may well close their long term care beds, making wait times for appropriate beds worse, in favour of opening high-cost privately funded, owned and operated (and, according to this legislation, self-regulating) retirement homes.

- Retirement homes could even, under this legislation the way it stands, operate as de facto private chronic care hospitals.

Currently, hospital patients deemed "ALC" (Alternate Level of Care) or "Ready for Discharge" are being placed into retirement homes, publicly-funded through agreements with the LHINs and CCACs. This recent muddying of waters regarding the roles of supportive housing (retirement homes) and health care facilities (long term care homes) reverses 20 years of policy-making in Ontario geared to clarify the role and legislative and regulatory requirements of long term care homes. It does not serve patients well. It encourages hospitals such as Cobourg's or St. Catharines' to cut their ALC beds without appropriate places for patients to go, without clear consent, and without clear policy requiring disclosure about the type of care setting they are being moved into. Are patients warned of the fact that the retirement home care setting is run for-profit – not for the public good – that it has no required staffing levels, no requirement to be accredited, no experienced and trained staff and no programs to deal with the care requirements of the patients being moved in? Are the proper consents, with full information, afforded to patients? It appears that the answer to all these questions is no.

In their "Nineteenth Annual Report of the Geriatric and Long Term Care Review Committee to the Chief Coroner for the Province of Ontario", September 2009, the Committee included a case study of a 92 year old woman transferred from an Ottawa hospital to a retirement home. She was readmitted to the hospital with severe dehydration and died shortly thereafter. Her daughter was described as very unsure that the home could provide for her mother's needs, and she documented serious failures to provide adequate care. The committee concluded,

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

Recently the provincial government has claimed that retirement homes taking hospital patients are meeting the regulatory requirements of long term care homes. That claim is implausible since the

homes are not built to the standards in the long term care homes regulations, nor do they have the staffing structures, programming, and the training.

B. The legislation should be amended to clarify which Ministry has carriage of this legislation.

To further clarify that retirement homes are not hospitals or alternate long term care homes, consideration should be given to placing these homes under the oversight of a ministry that has experience dealing with housing, such as Municipal Affairs and Housing.

We are concerned that the Seniors' Secretariat is not really a ministry with the capacity to oversee retirement homes. To further clarify that retirement homes are not de facto chronic care hospitals or long term care facilities, in addition to limits on their ability to provide health care services, they should be under a Ministry that deals with other forms of housing and supportive housing.

PART II.

C. The legislation should be amended to provide for clear governance and oversight by a ministry that has the capacity to inspect and provide protections for residents in a large sector that is dominated by multinational for-profit chains.

If there is an authority designated by the Minister, it should have a board that is appointed by cabinet and that represents the public interest not the industry. The mandate of the board or the Ministry with regard to retirement homes should be clarified to ensure that the board/Ministry provides oversight and stewardship in the interests of residents and the public.

In this Bill, a Retirement Homes Regulatory Authority is established. The board is to be comprised of 9 board members, the minority of whom would be appointed by cabinet. There are no term limits for board members and no membership. There are no clear requirements to prevent conflicts of interest. There is a suggestion in the legislation that the board include licensees and representatives of business.

The provisions in this Act create a board that could easily be dominated by (or entirely made up of) the retirement homes industry itself. A quick review of other legislation pertaining to care homes seems to indicate that most homes are under the Residential Tenancies Act and some are covered by the Homes for Special Care Act. Both are under the authority of a Ministry (Municipal Affairs and Housing, and Health and Long Term Care, respectively).[1]

[1] The Homes for Special Care Act (1990) does not set up a separate authority, it gives authority to the Minister of Health and Long Term Care to do a number of things and to regulate. Even the Residential Tenancies Act sets up a board that is entirely appointed by cabinet and subject to conflict of interest rules. (To contain those who own rental properties and therefore have a profit-interest).

Self-regulation is not appropriate to this industry. Many of these homes are owned by multinational real estate chains. This industry is sophisticated and develops profit-maximizing behaviours across multiple jurisdictions. Their track record in long term care has been poor, to say the least. Their residents are vulnerable. Moreover, we could find no precedent in Ontario's supportive housing or housing legislation for such self-regulation. It appears that the precedent for the approach in this Bill - including a Registrar and the authority to investigate complaints, issue licences, impose orders and terms and conditions, inspect and cancel licenses - follows more along the lines of the self- regulating colleges model. The difference is that the allied health professionals, nurses and physicians covered by the colleges are not generally large for-profit multinational corporations with all of the context and sophistication of approach to deregulation and profit-taking that this entails.

The objects of the Authority are to administer and enforce this Act and the regulations, educate about matters relating to the Act and regulations, provide information about retirement homes, advise the Minister on policy matters relating to retirement homes, carry other any other duties prescribed by the Minister. This mixed mandate gives the Authority powers that are akin to a self-regulating College and also a lobby group for the industry. Is this supposed to be an oversight group or a lobby group for policy matters? The mandate of any authority created by this legislation and of the Ministry with regards to this legislation, should be to provide oversight for the protection of residents' rights and the aims and objectives of the legislation (which we are assuming is the fundamental principle) and the public interest.

D. Public access to information should not be delayed by months or even a year.
Public access to information such as annual reports and reports from the Risk Officer should not be delayed by six months or even a year.

In the bill, reports from the Risk Officer to the board only need to be publicly-accessible after the next AGM. Reports from the Risk Officer to the Minister only need to be made public after one year. This is indefensible. They should be available to the public immediately. The three month provision for the Minister to get annual reports should apply to the public also.

PART III.

E. It should be made clear that in the case of chain ownership, the license applies to one individual premises only and is not transferable within the chain.

F. The legislation should be amended to require public notice of application for license and provide a public process for response and input.
The public should have the right to make a submission or an appeal in the licensing process.

G. There should be a requirement that these homes must be accredited in order to obtain a license.

PART IV.

H. The legislation should be amended to strengthen the enforcement of the Bill of Rights.

The Bill of Rights should be enforceable by order of the Registrar and homes should be inspected for compliance with the Bill of Rights.

I. The requirements for the built environment, particularly for exits, fire and emergency safety and for outbreaks of infectious disease should be clear and placed in the legislation.

Retirement homes have a history of fires in which people have lost their lives. These requirements are among the most important in this legislation and should be clearly specified.

J. The legislation should be amended to remove the exceptions to the limits on restraints and secure units.

Long term restraining should not be a function of these homes.

These homes are not built, equipped, staffed and regulated adequately to provide services for persons with the heavy care needs that seem to be anticipated in this section of the Bill. Secure units and restraints that the resident cannot undo or get out of by themselves should only be allowed in accordance with the common law duty to protect against immediate risk of harm to that person or others. There must be a higher authority (such as the Consent Capacity Board) involved in the approval to place any person into a secure unit. Rights advisors must always be provided – without the requirement that the person ask for one and without the requirement that the person disagree with their confinement. The limitations on restraining are inadequate and must be strengthened to protect the basic rights of residents.

PART V.

K. The legislation should be amended to improve the responsiveness of the system for complainants and to ensure that critical incidents are reported to the Minister.

There are no timelines in which the Registrar is required to respond to complaints. There is no duty to report certain types of serious complaints to the Ministry. The limitations on appeal for complainants are much less than the rights for licensees to appeal. It appears that a complainant can only appeal to the Complaints Review Officer if the Registrar has determined not to take action. It is not clear that they can complain if inadequate action is taken. Whereas licensees can appeal decisions to the Tribunal and then to Divisional Court, complainants have no such ability.

The Bill should be amended to clearly provide the ability to appeal to the Complaints Review Officer if the Registrar does too little. They should then have the same rights to appeal to the Tribunal and courts as the licensees. The registrar should be required to answer complaints within specified timelines. Certain serious incidents should require a report to the Minister.

PART VII.

L. The legislation should be amended to provide redress for staff that are fired or harassed as a result of whistle-blowing.

Section 115 defines whistle-blowing protection as no person shall retaliate or threaten to retaliate by action or omission because any person has disclosed anything to the Registrar or inspector or in any proceeding under this Act, in the regulations or under the Coroner's Act. If this is violated it is considered an offense and the offender may face fines or imprisonment. But while staff are required to report serious incidents or face significant fines, the whistle-blowing protection does not provide any redress for that staff person if they are fired and there is no process set out for the staff person to appeal, get back-pay, have their job reinstated or receive compensation. This must be rectified. Similarly, if families or residents are harassed as a result of whistle-blowing, there should be some arrangement made to ensure that they are compensated and that if they need to move to another home, they are afforded support and their costs are taken care of.

M. The legislation should be amended to review it in two years with public input.

Section 120 calls for a five year review of this legislation. That period is too long. The initial review, at least, should take place within two years.

N. The legislation should be amended so that the Health Care Consent Act applies.
Section 121 (21) specifies that certain provisions of the Health Care Consent Act that don't apply. It is not clear why this is. This should be taken out and the Health Care Consent Act should apply.