# Ontario Health Coalition
# Response to 2nd Set of Draft Regulations under Bill 140 the Long-Term Care Homes Act, 2007

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**Who We Are**

The Ontario Health Coalition is a network of over 400 grassroots community organizations representing 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 more than 70 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; seniors' groups including the Alliance of Seniors/Older Canadian Network, Ontario Coalition of Senior Citizens Organizations, Canadian Pensioners Concerned, retirees' organizations, low income and homeless peoples' organizations; 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 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 are linked to the Canadian Health Coalition and provide provincial coordination of community-based health coalitions.

# SUMMARY & KEY ISSUES

**General Note:**
We have focused on the sections on care and services and on items that we have identified from our consultations as being significant public interest issues.

**Key Issues Regarding 2nd Set of Draft Regulations As Reviewed to Date:**

1. There is no minimum care standard requiring sufficient staffing to provide for the assessed needs of residents. This is crucial because virtually every activity provided in the homes requires staff to do it. Without a requirement to provide adequate hours of care and enough staff to do this, not enough time is provided to meet the assessed care needs of residents. The OHC has repeatedly recommended, based on best practices, a minimum care standard of 3.5 hours of care per day, contoured to the level of acuity in each home. This is not in the draft regulations.

2. In fact, the former regulation under the Nursing Homes Act (regulation Section 60 (6) stated, "A licensee of a nursing home shall ensure that there is a sufficient number of registered nurses, registered practical nurses and health care aides on duty in the home at all times to provide the nursing care required by the residents of the home." Even this regulation has been removed. All of the references in the Program Manual to ensure enough staff, and evaluation of staffing plans according to this requirement, have been removed. The only regulation pertaining to hands-on daily care levels is so watered-down as to be meaningless. It states that homes' staffing plan plans contain a staffing "mix" that is "consistent" with residents' assessed care and safety needs. Both the use of the term "consistent with" rather than the clear requirement to meet residents' care needs and the use of staff "mix" as opposed to sufficient staffing levels, is less than what has been required to date, and significantly less than what is needed. Further, the regulations set out specific minimum hours for a number of administrative personnel, but nothing to provide a minimum number of hours of actual hands-on care per day, and nothing that would ensure enough front-line hands-on staff time to provide the care that residents need.

3. The new long term care homes legislation provided opportunity for regulations to be passed to provide for standards and criteria and outcome measures for the programs and services of the homes. But there are few standards, only some criteria, and no outcome measures. This is of grave concern. It is not clear how compliance officers (inspectors) can issue orders without these, nor whether these orders could be enforced without these and without a requirement for enough staffing to do so.

4. In the vital areas of Required Programs and Services, former standards that were required (and therefore inspected and subject to compliance regime) have been removed. Required services that were in the Program Manual have been dropped. In these, and other significant areas, these draft regulations are significantly less

than what has been in place to date, despite promises by the McGuinty government for a “revolution” that would improve care in our nursing homes.

5. The legislation requires homes to limit the use of agency (temp) staff. However, the regulations allow wider use of agency staff, and the training requirements do not clearly require that such temporary staff be familiar with the residents’ needs. This is a critical continuity of care and quality of care issue. Further, it seems improper that the regulations can counter the direction of the legislation which has been passed in the legislature.

6. The regulations must clearly prohibit the use of retirement homes as de facto unregulated private for-profit long term care homes. They are not recognized as health facilities under any legislation. They are not regulated. They do not provide any standard of care. It is not in the public interest to create a second tier of unregulated privatized long term care homes that are really retirement homes.

7. Again the process by which consultation is taking place for these draft regulations is undemocratic. Several organizations have had extensive consultations with the Ministry while they were drafting these regulations. Most have not. Entire classes of organizations have been excluded: including many of the senior’s groups, the Ontario Health Coalition, the unions and other workers’ representatives.

   The Ontario ombudsman’s report stemming from his investigation into Ontario’s long term care homes has not been released. The Ombudsman’s office is a formal officewhich provides a vital check and balance in our parliamentary democracy. It is inappropriate for this process to be finalized without full and proper consideration of the Ontario Ombudsman’s findings and recommendations.

   There has been no response from the Ministry of Health and Long Term Care as to what changes, if any, are being proposed for the first set of draft regulations, in response to the input that was given. Since this second set of regulations works together as one package with the first set, it is difficult to provide input without knowing if any changes are being made to the first set of regulations.

8. We asked for an analysis comparing the draft regulations to existing regulations and the standards, criteria and outcome requirements in the Program Manual. We were told that no such comparison is available. It is difficult to understand how these regulations could be drafted without such a comparison having been done. We reiterate our request for any documents containing this information. It is not reasonable to give a very short time period for Ontarians to respond to complex and dense regulatory changes and refuse to provide the information that would facilitate understanding what changes are being made.

**The following items are not dealt with in the second set of draft regulations, and should be:**

1. The Ministry has the power to set minimum care or staffing standards and has not done so. (Section 17)

2. There are few program standards, fewer criteria and no outcomes specified in the regulations. It is not clear how compliance orders can be given without these and without a requirement for sufficient staffing.

3. There is no definition, nor regulations pertaining to secure units and rights advisors.

4. There is no regulation setting out how the residents' Bill of Rights will be promoted and respected by home owners and operators. (Section 3 (4))

5. There is no regulation pertaining to the Office of the Long Term Care Advisor.

6. There appears to be no mention of service accountability agreements (SEA) in either the Bill or the draft regulations other than Section 79(3)(g.1) of the Bill which requires that the licensee make available a copy of the agreement. All the other references are just a more general one to "agreements".
   The following are references to this subject in the Nursing Homes Act:
   i. Section 2 which requires that the SEA be interpreted in a way to meet the residents' rights in the Bill of Rights
   ii. Section 4(2)(a) which requires that a licensee be party to an SEA
   iii. Section 4(2)(b) which requires that the SEA comply with this Act and the Commitment to the Future of Medicare Act
   iv. Section 13(a.1) which empowers the Director to revoke or refuse to renew a license if the licensee breaches the SEA
   v. Section 21.17 which empowers the Director to prohibit new admissions if the licensee breaches the SEA
   vi. Section 20.13(3)(b) which empowers the Minister to withhold funding if the licensee breaches the SEA
   The following are references to this subject in the Nursing Homes Regulation
   i. Section 107(2) which prescribes that funding for a home shall be in accordance with the SEA (the regulation uses the previous term " service agreement")

# PART I

## Definitions

**Facility Design Manuals**
This set of draft regulations includes definitions of the facility design manuals from 1999 and 2009 and the retrofit design manual. We asked for this in our response to the last set of regulations. The Ministry informed us that, although they are withdrawing the facilites' Program Manual, the Design Manuals will still be in effect and that the regulations would contain an expectation to maintain the homes according to those design standards.

*Recommendation: It is important that the Design Manuals will still be in effect. This is important to preserve the safety and quality of the built environment and we want to ensure that is, in fact, the case.*

**Staff**
There are definitions for dieticians, food service workers, registered nursing staff (RNs and RPNs), health professionals, but not PSWs/aides.

*Recommendations: There is no definition for PSW/aides, though there is for other staff. It is not clear whether this is an oversight or if the training criteria for PSW/aides covers both Health Care Aides and Personal Support Workers. The definitions for registered nursing staff should exclude Directors of Care who do not provide hands-on care.*

**Secure Units and Rights Advisors**
There is still no definition of secure units nor for rights advisors.

*Recommendation: This must be rectified. Anyone who is prevented from leaving a long term care home should be deemed to be in a "Secure Unit" and to have the right to a rights advisor and their services. Otherwise, the legislation allows the continuation of a system in which vulnerable people can be essentially detained without any rights. Perhaps protections for individuals such as those under mental health legislation should be considered here.*

**Basic and Preferred Accommodation**
In our response to the last set of draft regulations, we asked for clarification of basic versus private and semi private accommodation. The problem is that residents are being charged two different rates for the same type of rooms. In the definitions under this second set of draft regulations, the definition of private and semi private rooms refers to rooms so designated in the 1999 facility design manual or, if not covered by the 1999 manual, a room with one bed or two beds respectively, unless the licensee designates them as standard rooms. Standard rooms are defined as those designated in the 1999 or 2009 manual, and those designated by the licensee as a standard room. Thus, it appears that the designation of some rooms is left to the licensee.

*Recommendation: All homes should be clearly covered by the requirements of the Design Manuals.*

Also, in the definition for basic accommodation, the definition includes lodging in the room and a few services (but not all of the services homes are supposed to provide). In the definition for preferred accommodation, the definition does not list any services.

*Recommendation: Either all services or no services should be included in the definitions, and those services, if listed, should be equal for both preferred and basic accommodation. All items deleted from the list of services included in the charge for basic accommodation in the Program Manual should be included here.*

In the current Long Term Care Homes Program Manual, there is a list of services included in the basic accommodation charge as copied and pasted into the following pages:

Residents of Long-Term Care facilities are expected to pay the basic accommodation charge. This charge is for the cost of food and for basic accommodation. This section outlines which services are to be included in charge for basic accommodation.

The following is a list of the basic services that residents can expect to receive without additional charge, other than the charge to the resident for basic accommodation

- Nursing and personal care on a 24-hour basis, including care given by or under the supervision of a registered nurse or a registered nursing assistant, the administration of medication and assistance with the activities of daily living

- Medical care that is available in the facility

  ***Note***: *Residents may continue to have their personal physician provide care to them in the facility. These physicians will be expected to meet the standards and criteria for attending physicians. (Refer to Medical Services)*

- Medical supplies and nursing equipment necessary for the care of residents, including the prevention or care of skin disorders, continence care, infection control, and sterile procedures

- Medical devices, such as catheters and colostomy and ileostomy devices

- Supplies and equipment for personal hygiene and grooming, including skin care lotions and powders, shampoos, soaps and deodorant, toothpaste, toothbrushes, denture cups and cleansers, toilette tissue, facial tissue, hairbrushes, combs, razors/shavers, shaving cream, feminine hygiene products
- Equipment for the general use of residents, including wheelchairs, geriatric chairs, canes and walkers, toilet aids and other self-help aids for the activities of daily living
- Meal service and meals, including three meals daily, snacks between meals and at bedtime, special and therapeutic diets, dietary supplements and devices enabling residents to feed themselves
- Social, recreational and physical activities and programs, including the related supplies, equipment and staff
- Laundry, including labelling, machine washing and drying of personal clothes
- Bedding and linen, including firm comfortable mattresses with waterproof covers, pillows, bed linen, washcloths and towels
- Bedroom furnishings, such as beds, adjustable bed rails, bedside tables, comfortable easy chairs, and where a resident is confined to bed, a bed with an adjustable head and foot

- Standard ward accommodation
- The cleaning and upkeep of accommodations
- Suitable accommodation and seating for meetings of the residents' family councils
- Use of the infirmary room, if available

This has been deleted from the current draft regulations.

## PART II

## RESIDENTS: RIGHTS, CARE AND SERVICES

**Plan of Care**

*OHC Response & Recommendations re. Plans of Care Draft Regulations:*

*The requirements for initial plans of care exclude key items that are currently in the Program Manual. They should be included. Requirement for communication of both initial plans of care and comprehensive plans of care should be included. The recommendations of the Casa Verde Inquest regarding assessment, admission, and communication of care needs upon admission – as inserted below – should be included.*

*The legislation does refer to "Development of an initial plan of care" Section 6 (6) but does not differentiate between a "comprehensive" and an "initial" plan of care. Nor does it refer to two separate definitions for these to be put in the regulations. Though it may be reasonable to build upon an initial assessment to create a comprehensive care plan, the problem with the approach in the draft regulations is that the list of assessments provided under the initial plans of care – to be created within 24 hours - is too open-ended and fails to list key elements that are critical for the resident's health, safety, physical comfort and psychological well-being. This is the only care plan required for almost a month after the resident is admitted, since the regulations allow homes to take 21 days to develop the comprehensive plan of care. This timeline may be more convenient to the licensees, but it is an unduly long period of time for a resident to go without a proper care plan.*

- *The draft regulation for the initial plans of care exclude 19 specific items and other information that are listed as required under "comprehensive plans of care" as follows: resident's demographic information; all the persons who participated in the development of the plan of care; customary routines; cognition ability; communication abilities; vision; mood and behaviour patterns; psychological well-being; continence; disease diagnosis; health conditions; seasonal risk relating to heat; dental and oral status; nutritional status including weight; hydration; foot conditions; activity patterns and pursuits; special treatments and interventions; nausea; fatigue; shortness of breath; sleep patterns and preferences; cultural, spiritual and religious preferences; potential for discharge.*

- *The described assessments for the initial plans of care are very open-ended and are missing key elements that are critical for a a resident's health – including hydration, specific food restrictions, continence, foot conditions, communication abilities, cognition ability, mood and behaviour patterns, special treatments and interventions, shortness of breath, sleep preferences, cultural needs etc.*

- *There is no deadline contained in the regulations for ensuring that direct care staff have received communication of the comprehensive plan of care, only the initial plan of care.*

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- *There appears to be nothing in the regulations for the comprehensive plan of care to specifically assess for restorative care, though the Act requires homes to include restorative care in their plan of care.*

- *In the Casa Verde Inquest recommendations, the Coronor's Jury specifically recommends measures to provide for improvements to care planning prior to admission and upon admission as follows:*

Recommendation 20:

Where behaviours have been identified as presenting a risk to self or others, admission to any facility should be delayed until the behaviours have been appropriately assessed and a care plan has been developed. In such cases, the MOHLTC should ensure that there are interim alternatives to placement in the long-term care facility until the individual has been assessed and an appropriate plan of care has been developed such as:

i) appropriate support in their homes up to 24 hours a day to assist the family;
ii) beds available at an appropriate alternative facility (hospital, mental health facility or specialized facility)

Recommendation 73:

All LTC facilities must have a set "admissions team" which consist of:
(i) LTC facility's Administrator,
(ii) The LTC facility's Director of Care,
(iii) The LCT facility's Chief Medical Administrator, and
(iv) One PIECES-trained staff RN.

All members of this "admissions team" must be present on the day the patient is admitted into their respective LTC facility.

Recommendation 74:

Long-term care homes ensure that when a resident is admitted to a long-term care home, all staff who may have direct contact with a resident are provided with all necessary information about that resident.

*The Long Term Care Facility Program Manual, which is being withdrawn and replaced with these regulations, required medical and nursing assessments to be done within 7 days of admission. It appears that these are now to be done within 14 days of admission with the comprehensive care plan to be developed within 21 days of admission.*

*The Manual also requires that weight be taken on admission and that it be evaluated at least monthly thereafter. This last provision – that weight be taken on admission and monthly thereafter – is now included in the second set of draft regulations.*

**Safe and Secure Homes**
In this set of draft regulations there are provisions for doors, elevators, privacy curtains and screens, shower grab bars, bed-rails, windows, communication and response system, lighting, generators, cooling requirements, compliance with manufacturers' instructions.

It is not clear if this covers everything in the old regulations, nor that the Design Manuals apply to all homes. We were assured on the phone with MOHLTC staff that the Design Manuals will still be in effect, but without a comprehensive comparison of both the design manual and the old legislation with the new regulations, it is impossible to tell what changes to the regulation of the safety of the built environment have been made. In addition, the Program Manual referred to the Fire Code and the Building Code, but the new draft regulations do not.

*Recommendation: either a reference to the Design Manuals and their requirements for the built environment should be included in the regulations, or the regulations need to include these requirements directly.*

**General Requirements Re Organized Programs**
The Long Term Care Facilities Program Manual will be withdrawn and replaced by the new Act and these draft regulations, once finalized. This Manual sets out standards and criteria for these programs and requires homes to take all reasonable steps to meet these standards and criteria and to be responsible to the Ministry for he standards and criteria contained in the Manual.

The changes that the Ministry is proposing to make are as follows:
Sections 8 to 16 of the Act set out programs that homes must offer, including: Nursing and Personal Support; 24-RN on duty, Restorative Care (including therapies); Recreational and Social Activities; Dietary Services and Hydration; Medical Services; Information and Referral Assistance; Religious and Spiritual Practices; Accommodation Services and a Volunteer Program. Section 18 calls for these programs to comply with standards and requirements and outcome measures specified in the regulations (equivalent to the general requirement in the Manual).

The changes, in general, comprise significant deregulation of standards, criteria and outcome measures. They include:

1. We noted in our response to the first set of regulations that there were no standards and requirements and no outcome measures for the required programs. In this set of draft regulations, there are still very few standards and requirements and no outcome measures for the organized programs that the homes are supposed to have. Almost all of the former standards and criteria (too lengthy to include in full here relating to the programs set out in Sections 8 to 16) have been removed. Notably: requirements for enough nursing staff to meet needs; requirements for recreation programs to be age-appropriate; requirements for therapies to meet assessed needs; much clearer and stronger requirements for RN on duty 24 hours per day; requirement that this RN is not the Director of Care; requirements to reduce use of agency staff and require agency staff to be familiar with the residents' needs etc. In this set of draft regs, the homes simply have to have their own written description of the program, identify any changes annually based on

an internal evaluation of the program, and implement these. There are very few provincial standards and requirements, and no outcome measures.

2. The Facility Program Manual provides criteria for homes to provide emotional, social and cultural observances, practices and affiliations; language; sensory function and communication; cognitive and intellectual supports; safety and security; elimination; skin and nail care; comfort, rest and sleep; hygiene and grooming; the promotion of independence in activities of daily living. These are not provided for in the draft regulations.
3. The requirement to have enough direct care staff to meet residents' assessed needs is removed and not replaced by anything.

*Recommendation: The standards and criteria from the Programs Manual regarding the Required Programs, and the items listed in numbers 2 & 3 above, must be included in the regulations.*

**General Requirements Re. Organized Programs**

17. Simply requires homes to have their own written description of the program, annual evaluation, and records kept by the homes.

**Nursing and Personal Support Services**

18. There are no standards or outcome measures here. The only requirement is that home owners and operators have a written staffing plan for the programs (no standards, requirements or outcome measures for this), that changes to it are written, and that the staffing plan contains a staffing "mix" that is "consistent" with residents' assessed care and safety needs. This is not a staffing or care standard. It is much less than even the former requirement in the regulations in Section 60(6) of Regulation 832 that required sufficient staff on duty to meet the care needs of the residents of the home.

*Recommendation: a minimum standard of care – requiring 3.5 hours of care on average, contoured to the relative acuity of the homes, must be in the new regulations. In addition, regulation 832 under Section 60 (6) of the Nursing Homes Act, requiring sufficient staff on duty to meet the care needs of the residents of the home, must be included in the new regulations.*

In addition, the current language is "Nursing and Personal Care" and "Program Support Services". It is not clear why this is changed here.

*Recommendation: The language should be the same as the language used in the funding envelopes. If a change from the envelope funding system that does not allow for-profit homes to take profit from the Nursing and Personal Care envelope is contemplated, we would like to register extreme concern.*

There is no standard to evaluate the staffing plan. All of the processes for evaluation that were clearly set out in the Program Manual are removed, including the non-acceptance of staffing plans that do not provide enough staff to meet residents' needs. This is of great concern.

*Recommendation: The processes for evaluation and non-acceptance of inadequate staffing plans from the Program Manual must be included in the new regulations. The Ministry must retain this means of holding homes accountable for providing enough staffing to meet residents' assessed needs.*

**Personal Care**
19. Simply requires that every resident gets personal care, including hygiene care and grooming, on a daily basis.

*Recommendations: Resident's ability to be admitted into a home relies upon assessments that show they need support with these activities. Thus, it is vital that homes be required to provide personal care to meet the resident's assessed needs. There needs to be specific language requiring toileting of residents who are capable and desirous of such, as opposed to use of continence products.*

**Bathing**
20. Requires that homes bathe every resident by a method of their choice (tub baths, showers, full body sponge baths) at minimum twice a week.

**Oral Care**
21. Requires homes to provide mouth care in morning and evening, physical assistance for residents who cannot brush their own teeth, annual dental assessment, assistance to insert dentures prior to meals and at any other time requested by resident.

*Recommendations: The dental assessment should be every six months. Residents should have assistance to insert their dentures more frequently – presumably as part of their morning routine and upon request - rather than only at meal times. All details omitted from the Program Manual should be included here.*

**Foot Care**
22. Requires home to provide unspecified basic and preventative foot care.

*Recommendations: There is no definition of what basic and preventive foot care is. In our consultation with nurses, PSWs, family and residents' councils, there was confusion over what is and is not included in this. Currently some residents are being charged for this, when they should not be. This needs to be made clearer. There is more detail in the Program Manual on this, which should be included here.*

**Transferring and Positioning**
23. Homes must ensure that safe transferring and positioning techniques are used by staff, and that residents' weight bearing capability, endurance, and range of motion are maintained or improved whenever possible.

*Recommendation: There needs to be specific requirement for turning and skin care as often as required.*

**End-Of-Life Care**

28. Homes must provide this "in a holistic manner" when required, and must ensure that it responds to the "immediate needs" of the family members, other residents and staff.

*Recommendation: There is no requirement for prompt notification when a resident dies, which has been a reported problem. No requirement for spiritual counseling or equivalent if the family or resident asks for it. This has been raised as a complaint in our public consultations.*

**24-hour Nursing Care**

30. In homes with less than 64 beds: contract RNs may be used; RPNs from the regular staff or contract RPNs may be used. In homes with more than 64 beds, contract RNs may be used in the case of extended leave of absence by regular staff. This is a lower standard than is currently required.

*Recommendation: This draft regulation contradicts the new legislation's requirement to minimize use of contract staff and to ensure that contract staff are familiar with the residents' needs. The requirement that homes show proof of attempts to hire permanent staff in the Program Manual have been removed. The sanctioned use of agency staff raises serious continuity and quality of care issues. The arms-length requirements later in the draft regulations are not sufficient to prevent related companies from using this loophole to double-dip.*

**Qualifications for PSWs**

31. After March 31, 2011, all must have completed a PSW program that meets the government's standards (set out in specifics in these draft regs.)

*Recommendations: The standards set out in the regulations should only support at minimum the level of training provided in the public colleges, not the private association. Further, it should be noted that once this system is in place, PSWs who move from one facility to another will have to complete the PSW program to do so, except in the case of the for-profit facility chains where they can be transferred from one facility to another and thus not be considered a new hire. Is this going to aggravate shortages? Perhaps an approach similar to that taken for the Administrators (see 111.) – which allow for a shorter training program for those already working in the system – might prove more viable and equitable.*

## RESTORATIVE CARE

36. Requires homes to have a program to ensure that residents are able to maintain or improve functional and cognitive abilities in all aspects of daily living.

*Recommendations: This is less than the current requirements in the Program Manual and the missing details from the Program Manual should be reinserted here.*

**Therapy Services**

37. & 38. Homes must ensure on-site physiotherapy to meet assessed needs. OT and speech-language therapy (no requirement to meet assessed needs) and other therapies (no requirement to meet assessed needs), and that there is safe space and equipment for this, and that the therapists are certified and support staff are trained.

*Recommendation: This is less than the requirement in the current Program Manual that requires all therapies to meet assessed needs. The requirements from the current Program Manual should be included here*.

## RECREATIONAL AND SOCIAL ACTIVITIES

43. Homes have to provide a range of activities "at a frequency and type to benefit all residents of the home" . These must be communicated to residents, there must be opportunities for resident and family input, and assistance for residents to participate.

*Recommendation: Because many homes are taking in residents who are diverse in age, culture and other needs, this regulation should specify that there has to be programming to meet <u>each</u> resident's needs.*

## NUTRITION CARE AND HYDRATION PROGRAMS

46. Weight must be taken on admission and monthly thereafter. Body mass index and height on admission and annually thereafter.

Also an unspecific nutrition care and hydration program, but with specifics about menus and food choices, provision for individualized diets for residents whose needs cannot be met in the regular menu, choice, adequate nutrients, fresh seasonal foods, variety, three meals daily and snacks etc.

There should be an emphasis on fresh foods that allows prepared food to be brought in only when special dietary purposes require it.

51. Homes must ensure that no more than two residents who require total assistance with eating to one staff, no meal served until staff can aide resident to eat if they need it. Residents can eat at their own pace and are given time to do so.

*Recommendation: There are not enough staff to do this. Homes must be required to provide enough staff to meet these requirements.*

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## RELIGIOUS AND SPIRITUAL PRACTICES

62. Homes must give reasonable opportunity to practice religious and spiritual beliefs, provide non-denominational spiritual counseling and worship services based on availability within the community.

*Recommendations: There is no clear requirement to provide this at end of life upon request. This is an issue about which we have received complaints in our public consultations.*

## ACCOMMODATION SERVICES

**Housekeeping**

64. Homes must provide it 7 days per week.

*Recommendation: It should be clearly stated that homes are required to reduce rates of institutional-acquired infection.*

**Laundry Services**

66. Linen changed once per week, and more often as needed; soiled clothes are removed, cleaned and returned to residents within 48 hours; sufficient clean linen, face cloths and bath towels in good state of repair.

*Recommendation: this does not specify availability of disposable towels, soap, continence care products etc. We believe that there is clearer language in the Program Manual regarding these.*

## REPORTING AND COMPLAINTS

*Recommendations: There is still no definition of zero-tolerance, no protection from discipline for staff whistle-blowers (see our recommendation from the first set of draft regulations), and no clear access to documents for residents/family, no notification of councils.*

*There should be access to the report from the investigation for the residents and family. There should be some sort of reporting about complaints – that protects privacy issues – but gives a sense of the number and type of complaints to the councils.*

# PART III

## ADMISSION OF RESIDENTS

## INTERIM BED SHORT-STAY PROGRAM

Specifies who can be admitted, criteria for waiting lists, authorization of admission, removal from waiting lists.

*Recommendations: Since this section will be used to move patients out of ALC beds in hospitals, there must be consent. People should not be forced into homes far away from their home community. All of our recommendations pertaining to general admissions from the first set of draft regulations also apply here, including the findings of the Coronor's Jury in the Casa Verde Inquest pertaining to admissions.*

## SPECIALIZED UNITS

101. Upon the recommendation of the appropriate LHIN, the Ministry may designate a specified number of beds as a specialized unit, subject to any terms and conditions the Ministry may specify. The Ministry must be satisfied with the home's record of compliance.

*Recommendation: There is no clear criteria setting out when a Specialized Unit is required.*

102. The operation of the specialized unit shall be subject to terms and conditions in an agreement with the LHIN.

*Recommendation: It is not clear how this works with the CCACs.*

# PART IV

## COUNCILS

110. Councils have right to detailed allocation (audited annual reconciliation report) of the home.

*Recommendation: Councils should have the right to detailed staffing levels, including actual worked daily hours of care by hands-on care staff (RN, RPN, PSW/Aide).*

# PART V

## OPERATION OF HOMES

111. Sets out minimum hours for Administrator, also education and training requirements.

112. Sets out minimum hours for Director of Nursing and Personal Care, and education and training requirements.

113. Sets out requirements for responsibilities of Medical Director, excludes those who hold home licenses or are members of the board or have controlling interest in the corporation.

## TRAINING

114. Sets out requirements for a training program that covers:

- cleaning and sanitization of equipment
- dealing with complaints
- safe use of equipment including mechanical lifts

118. Sets out requirements for training program for direct-care staff that covers:

- Fall prevention and management

- Skin and wound care
- Continence care and bowel management
- Pain management
- Responsive behaviours
- Safe use of therapeutic equipment and adaptive aids
- Application, use and dangers of physical restraints, PASDs.

*Recommendations: The most common complaint we receive from staff is that there are increasing numbers of residents with psychogeriatric issues and they do not feel adequately trained to deal with this. It is not clear that the requirements in the Act for mental health training and the requirement in the regulations for training in responsive behaviours specifically addresses this.*

*In the case of Secure Units, or for residents who should be deemed to be in a Secure Unit because they are prevented from leaving, staff need specialized training. This is not included here.*

*It should be made clear that contract staff have to have these training requirements. This must be in the contract with the agency.*

119. Sets out requirements for orientation of volunteers.

**INFORMATION**

120. Residents obligations to pay must be included in information package, also list of prohibited charges from homes.

*Recommendations: All requirements from the Program Manual should be including here, including those regarding displaying of information in the homes.*

121. Homes must post licence, most recent audited report, complaints hotline.

**REPORTS**

165. *Recommendation: It is vital that reports (quarterly or more frequent) be sent to the Ministry on actual staffing levels for hands-on care staff (RN, RPN, PSW), and that information must be available to the public.*

**RETIREMENT HOMES**

192. *Recommendation: Retirement homes are private for-profit and unregulated entities. They are not health care facilities. They should not be used to take interim beds, those assessed as needing care in a long term care home, n or hospital patients. Retirement homes should not be exempt from the license requirement. There must be a clear right to refuse consent by patients. If retirement homes are to operate as long term care homes, they must be regulated as long term care homes, and the government must stop the for-profit privatization of these services.*