Violence, Insufficient Care, and Downloading of Heavy Care Patients:

An evaluation of increasing need and inadequate standards in Ontario's nursing homes

Ontario Health Coalition

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Who We Are

The Ontario Health Coalition is a network of more than 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 more than 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/Older Canadians Network, CareWatch, Concerned Friends, long term care family and residents' councils; 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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Introduction

The Ontario Health Coalition has, in consultation with seniors' groups, nurses' organizations, physicians, community coalitions, unions, members of residents' and families' councils, come to a consensus set of key recommendations regarding quality of life and quality of care in long term care homes. Chief among our concerns is the lack of daily care for residents, and inadequate accountability for the levels of care provided by operators.

Though many aspects of the physical structure of the homes are regulated, the daily care levels have been left without equivalent regulatory and compliance regimes. Yet inadequate nursing and personal support care levels have resulted in significant problems of access, creating a multi-tiered system based on wealth rather than need. Residents with families that can hire in extra help get care, those who do not have families or do not have the money are left with inadequate levels of daily care. This is a violation of the core values of our society: that care should be provided on the basis of need not wealth and that the most vulnerable in our society deserve our protection.

Crushing workloads, stress, inadequate supports, lack of control, a punitive culture, rationing of supplies and inadequate resources have contributed to conditions that are creating harm to residents, stress and undue financial burden on families, and exacerbated staffing shortages across the sector.

Through successive years of significant funding increases to the LTC home sector, we have not found a commensurate increase in daily hands-on care provision. The vast majority of funding increases have gone towards an increase in the size of the sector rather than to improving the amount of daily care for existing residents and addressing the pressing quality of care issues.

There is a need to redirect funding and policy attention to quality of care issues. Care workers regularly report to us that they are unable to meet health and safety and professional standards at current staffing levels. Residents report unsafe or inadequate living conditions, lack of palliative care, and deeply disturbing concerns about quality of care, outcomes and quality of life. Families echo stories of a culture of fear, guilt, stress, and inadequate care. This report matches the research with stories from the front lines.

"It should not be expected that seniors are engaged in the act of dying. Instead, we should be supported in life-giving, loving environments where we can live life to the fullest until life ends." (Resident, Mississauga, 2007)

"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 irreversibly 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." (OHC, Submission to the Standing Committee of the Legislature, January 2007)

"[The staff] have injuries on the job every day. We're up to ten already this year. We have no time. We are run off our feet. Some of us don't even take our breaks because we don't want to leave when we are short staffed, and we're always short staffed. We don't even have time to feed the residents properly." (Personal Support Worker [PSW], Cobourg, ON 2007)

The Need for a Minimum Required Level of Daily Care: Priority recommendation

Based on the evidence from the best practice research and our own comprehensive consultations with stakeholders, we have identified our priority recommendation to improve care standards and outcomes in LTC homes as follows:

A care standard, in regulation under Bill 140 that would set a minimum staffing level of 3.5 hours of hands-on care per resident per day for LTC homes. The minimum would be attached to the average CMM - the average acuity - and therefore correlate to the assessed acuity of each home. As recommended in the research and best practices, the standard would cover direct care staff including RNs, RPNs, and PSWs/HCAs, excluding administrative staff. It would be attached to the Nursing and Personal Care envelope - excluding incontinence supplies. It would reflect worked hours as opposed to paid hours. It would be subject to a compliance and enforcement regime.

Thus, our recommendation suggests that as the CMM ranged from 75.1 to 105.12 in 2006, the average home (CMM 96.33) would be required to provide 3.5 hours per day. A CMM 75.1 home would be required to provide 2.73 worked hours of care per resident per day. A CMM 105.12 home would be required to provide 3.82 worked hours of care per resident per day.* The care standard would cover the classifications within the Nursing and Personal Care envelope (RNs, RPNs, PSWs), excluding Administrative staff. Thus, funding would be aligned to assessed care needs and the required care levels that flow from the assessed needs. This regulated care standard would need to be subject to an effective compliance and enforcement regime.

Most of the girls (staff) have real bad backs. I feel bad for them. They are so tired, most of them.
(Resident, Southeastern Ontario, 2008)

* The formula would be adjusted to work under the new classification system once it is adopted across the sector.

SECTION I: ASSESSING THE STATE OF CARE, REGULATION AND ACCOUNTABILITY IN ONTARIO'S LTC HOMES

Reports from our members

The Ontario Health Coalition has conducted three cross-province consultations on care in LTC homes since 2001. These included one round of broad public hearings, another round of public forums and discussions, and a round of in-depth interviews conducted from 2006 - 2008. More than 1,600 people attended the two rounds of public hearings and forums, and approximately 40 people were interviewed in the latest round of in-depth interviews.

Through our extensive consultation with member groups, residents, family members, volunteers, careworkers and facility operators, a common theme emerged. The care levels in LTC homes are inadequate to ensure the provision of a decent and dignified quality of life. To those who live, help out or work in the homes, this is not "a numbers game" - as it is glibly termed by some policy makers. It is about care and it is an access issue. Inadequate levels of care have led to people hiring in their own care staff, if they can afford it, while residents with few family supports or lower income go without. Perhaps most seriously, we found that current care levels are inadequate to protect both residents and staff from harm.

Everywhere in Ontario we heard from frustrated caregivers, residents and family members who cannot give the care they want or cannot access the care they need. From urban to rural areas, north to south, people are identifying that heavier care residents now live in the homes. Staff feel unequipped to appropriately care for residents with cognitive difficulties and behavioural problems. Careworkers feel alienated from the charting process - terming it "charting for dollars" because they do not see a connection between funding increases and improved staffing. Yet downloading of heavier care patients from mental health facilities and hospitals continues. Across the province, younger people with disabilities are being moved into LTC facilities because of inadequate homecare and community supports. The

"Toileting does not happen on a regular schedule. I don't care who you are or where you work. It happens for those that ring a bell, but not for those that can't. Those that can't ring get checked in the morning and the afternoon. If you have two staff and one is on lunch and someone is a mechanical lift – how do it? Two people are required for a mechanical lift." (PSW, Ottawa area, 2008)

We can't be patient focused. Staff is so task focused they are rushing, they're rushing to get to the next person, there are problems like skin breakdown. It is ridiculous! You wait until it [the diaper] is 90% full, we don't do that to babies. These people have put their time in and given to society, it is not dignity. It is not dignity as these homes profess it is; it doesn't come close. (Registered Nurse [RN], Southeastern Ontario, 2008)

A gentleman said to me yesterday, "My bed hasn't been made in two days." Why hasn't his bed been made? These people pay a lot of money for this. But there isn't enough staff to make his bed. (RN Niagara Region, 2008)

"We have four residents that need to be fed and two that should have help but there isn't enough staff. This does not allow for the times when there is a resident in bed either dying or not feeling well and there is no one to feed or care for that person in a dignified fashion that they should have at this moment in their lives." (PSW, Windsor Region, 2008)

increasing care needs have not been met with a regulatory and compliance regime to support residents and staff.

There are times I can't get a shower because they are working short.... A lot of times the residents might have to wait to be changed or cleaned. Each girl has ten or twelve residents to look after. Residents are woken up by the night staff at 6 o'clock in the morning so they have time to get everyone washed and dressed.
(Resident, Southeastern Ontario, 2008)

On the other hand, we have heard stories of incredible compassion. Careworkers are angry, or they end up in tears, when describing their feelings of guilt and inadequacy for providing less care than they know residents need. Family members tell us of volunteering hours each day, every day, to provide assistance for residents without family support. Personal support workers bring in clothes, work extra hours, do hundreds of extra "little" things to try to improve the quality of life for residents. Residents tell us of advocating for each other, and helping out when possible. The human resources - paid, volunteer, family - overwhelmingly report going "the extra mile" to make the experience of living in LTC homes better.

These findings are not localized. While sound 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 address it.

Increasing acuity

- Resident acuity in Ontario's LTC homes has increased by 29.7% since Classification was implemented in 1992 as a result of the redefinition of complex continuing care, shorter lengths of stay in hospitals, ageing, and the downloading of mental health patients from hospitals. The 2007 Provincial CMM was 98.13, an increase of 1.87% from 96.33 in 2006. (Memorandum to Charitable, Municipal and Nursing Home Operators from Health Data Branch, MOHLTC, December 2007). This increase reflects only the measured needs according to the Alberta Classification system, which, as has been recognized by government, does not adequately recognize the complexities of care required by residents with cognitive, emotional and behavioural problems.
- By 2007, 74% of Ontario's 51,440 LTC residents classified that year were classified as Category F (the second highest acuity category). This represents a substantial increase in acuity over the last decade.
- It is now generally accepted that 60 - 80% of residents have some form of cognitive impairment. In 2005, 140,000 Ontarians had Alzheimer disease or related dementia. The number is expected to double to 307,000 in the next 25 years (Alzheimer Society of Ontario, Position Paper on Casa Verde Recommendations, September 2005.) In an earlier study conducted by PriceWaterhouse Coopers in 2001, 53% of Ontario's LTC residents were diagnosed with Alzheimer/dementia resulting in requirements for improved special training, evaluation and monitoring.
- The same study noted relatively high rates of Alzheimer, stroke, arthritis and significantly higher levels of cognitive impairment, impairment in activities of daily living, depression, and mental health disturbances/problems. (PriceWaterhouse Coopers, Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators. January 11, 2001.)
- Across the province, long-term care workers report that people with serious behavioural problems, psychogeriatric patients, and younger adults with disabilities are being moved into LTC homes with increasing frequency in the last half decade. These residents have complex care needs that result in repeated reports of inadequate training, inadequate staffing levels, improper placement and violence.

Prevalence of Dementia and Alzeimer's Disease, Physical Problems and Other Diagnoses

	Ontario LTC	Sask.	Manitoba	Michigan	Maine	Mississippi	South Dakota	Sweden	Finland	Nether lands
Dementia/ Alzeimer's	53%	62%	41%	47%	50%	57%	44%	19%	65%	34%
Diabetes	19%	12%	17%	24%	20%	22%	18%	9%	6%	9%
CHF	11%	18%	13%	27%	21%	24%	30%	19%	8%	22%
Stroke	22%	18%	16%	24%	22%	25%	21%	4%	23%	13%
Arthritis	30%	32%	28%	32%	26%	34%	39%	7%	4%	17%
End Stage Disease	1%	0.2%	0.2%	1%	1%	0.4%	0.8%	0.6%	22%	0.8%
Parkinson's	6%	6%	7%	6%	7%	6%	7%	5%	3%	4%
Cancer	9%	11%	3%	11%	9%	6%	11%	6%	2%	6%
PVD	4%	3%	2%	12%	10%	9%	6%	2%	1%	3%
Osteoporosis	7%	13%	5%	14%	11%	10%	11%	4%	2%	5%
COPD	1%	4%	2%	19%	19%	14%	13%	3%	3%	7%
AHD	12%	7%	4%	19%	18%	19%	17%	7%	7%	11%

From PriceWaterhouse Coopers 2001 Report.

Ontario Has Second Worst Staffing Levels in Canada
This data covers all hours of care, including non-direct hands on care. Thus, it does not separate out the direct daily care provided under the Nursing and Personal Care envelope by the RN, RPN and PSW staff. But it illustrates, in broad terms, how Ontario is doing relative to the rest of the country.

When the residents are suffering with dementia....I understand where they are at. But they get grabby and they hit. We have one that even the nurses avoid because she grabs you and hangs onto you and she's strong. (Resident, Southeastern Ontario, 2008)

- According to Statistics Canada, total paid hours per resident-day in residential care facilities in Ontario was 3.3 in 1997/98 with a small increase to 3.8 in 2005/06. According to this data, we are second last across the country for total hours per resident day. Only British Columbia has fewer hours per resident-day and the gap between Ontario and the rest of the country is widening significantly. (StatsCan "Accumulated paid hours during year per resident-day in residential care facilities, by principal characteristic of the predominant group of residents and size of facility, Canada, provinces and territories, annual (number))

Total LTC Facility Paid Hours Per Resident Day By Province/Territory (includes all staff)
from lowest to highest (at starting date)

Prov/Terr	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06
BC	3.3	3.5	3.6	3.6	3.6	3.6	3.5	3.5	3.7
Ontario	3.3	3.4	3.4	3.4	3.4	3.5	3.6	3.7	3.8
PEI	3.8	3.7	4.2	4.1	4.1	4.1	4.1	4.0	4.2
NB	3.9	3.9	4.0	4.1	4.2	4.2	4.3	4.2	4.2
NFLD	4.4	4.6	4.2	4.2	4.5	4.6	4.3	4.6	4.8
ALTA	4.6	4.7	4.8	4.9	5.2	5.3	5.0	5.2	5.1
NS	4.7	4.7	5.0	5.2	5.3	5.6	5.6	5.6	5.7
SASK	4.8	4.7	5.1	5.4	5.4	5.6	5.4	5.7	5.7
MAN	4.9	4.7	4.7	5.0	5.0	5.1	5.1	5.1	5.2
QUE	5.2	5.3	5.5	5.8	6.0	6.0	6.0	6.9	6.6
Territories	5.3	5.3	6.1	6.2	6.4	6.8	6.4	6.9	7.5

Actual Levels of Care in Ontario: Below Recommended Standards

- According to MOHLTC figures, average worked hours per resident day for direct care staff categories from 2004 - 2006 shows 2.375 HPRD in 2004 and 2.573 HPRD in 2006.(Letter from Dan Bryant, Program Advisor, Access and Privacy Office MOHLTC to Shelley Martel MPP Nickel Belt, March 14, 2007.) Yet, as described fully in Section II, these levels do not meet minimum thresholds to prevent from harm and are far short of maximum thresholds to improve outcomes.

Hours per resident day (HPRD average):

Phases	**Paid Hours**					**Worked Hours**				
Phases	**1**(Jan-Jun 2004)	**2** (Jun - Dec 2004)	**3** (Jan - Jun 2005)	**4** (Jun - Dec 2005	**5** (Jan-Mar 2006)	**1**	**2**	**3**	**4**	**5**
Nurse Practitioner	0.0002	0.0001	0.0001	0.0001	0.0001	0.0002	0.0001	0.0001	0.0001	0.0001
Clinical Nurse Specialist	0.0003	0.0003	0.0003	0.0003	0.0003	0.0002	0.0002	0.0003	0.0003	0.0003
Infection Control Practitioner	0.0005	0.0005	0.0005	0.0005	0.0007	0.0004	0.0005	0.0005	0.0005	0.0007
Registered Nurse	0.341	0.354	0.363	0.366	0.364	0.312	0.319	0.332	0.331	0.331
Registered Practical Nurse	0.361	0.376	0.380	0.388	0.395	0.329	0.335	0.344	0.345	0.354
Personal Support Workers	1.9	1.972	2.046	2.071	2.081	1.725	1.760	1.852	1.844	1.877
Total	2.611	2.710	2.798	2.836	2.851	2.375	2.421	2.538	2.529	2.573

Note: "worked hours" is defined as including breaks, but excluding vacation, statutory holidays, sick time, education, bereavement, and other paid absences. The phases reflect quarterly reporting by facilities up to the final quarter (#5) ended March 2006.

After these results were released, the Ministry of Health delayed publicly release of any further staffing data, despite repeated requests. Finally in April 2008, in response to a second Access to Information request from the Canadian Auto Workers, updated staffing levels were revealed as follows:

Total Hours Per Resident Day **Source: April 10, 2008 letter in response to Freedom of Information Request from Dan Bryant, Program Advisor, Access and Privacy Office, Ministry of Health and Long Term Care. covers same staff as chart above (paid hours only)**

	Jan - Jun 2004	Jul - Dec 2004	Jan- Jun 2005	Jul- Dec 2005	Jan- Mar 2006	Apr - Dec 2006	Jan-June 2007
LTC Sector-wide	2.61	2.71	2.79	2.83	2.85	2.84	2.85
Municipal (public)	2.713	2.927	3.010	3.039	3.135	3.039	3.098
Charitable (non-profit)	2.728	2.780	2.925	2.910	2.893	2.904	2.918
Nursing Home (non-profit)	2.538	2.637	2.814	2.846	2.840	2.865	2.881
Nursing Home (for-profit)	2.637	2.715	2.752	2.768	2.769	2.773	2.770

This data shows that subsequent to the time period reported initially, care levels actually fell even

as the government announced new funds directed towards hiring new staff and large overall budget increases for the sector, only recovering to early 2006 levels in the last half-year. In addition, the new data reveals:

- Government announcements about funding and staffing increases do not correspond to increased hands-on care for residents.
- Since 2005, for two years, we have not seen any notable improvement in care levels. Thus, the significant budget increases over the last two years have not resulted in any significant increase in daily hands-on care.
- Currently, the lowest levels of care in provided in the for-profit nursing homes, with the highest levels of care provided in the publicly-owned municipal homes.
- Over the period from 2004 - 2007, the largest increases in hours of care occurred in the publicly-owned municipal homes (14.2%), followed by the two types of non-profit homes (10.2%), with a much slower rate of increase in the for-profits (5%).
- The levels of care are not tied to the homes' and the government's measurements of resident need. According to the Ministry of Health's Case Mix Index data, in 2007, the measured acuity of residents in nursing homes (both for- and non-profit) was 5% higher than in municipal homes. The staffing data shows that nursing homes are the lowest in actual hands-on staffing levels. Thus nursing homes not only have the lowest staffing levels but also have the highest acuity residents. (It should be noted that all homes receive funding increases for acuity.)
- Since the new data shows paid hours only, actual worked hours will be lower than indicated here.

Ontario's LTC Homes Are Regularly Working Short-Staffed

In our consultations, staffing shortages were reported as the most significant issue among workers, families and residents. Across Ontario, staff report that it is regular practice not to replace absent careworkers, they are almost always working "short". Residents and families report that they feel bad for overworked staff, hire in their own help if they can afford it, and worry about residents who don't have additional "hired-in" assistance. These findings are supported by evidence from a study done for CUPE by Dr. Pat Armstrong and Dr. Tamara Daly in "There Are Not Enough Hands: Conditions in Ontario's Long Term Care Homes" (2004) who warn that shortages are likely to get worse:

- Like many studies, the survey identifies staff shortages as the central problem and the survey indicates that shortages in every occupational category are critical to care. While shortages in nursing, therapy and personal care staff are vitally important, so too are shortages in laundry, dietary, clerical, recreational, housekeeping and maintenance staff. If the dietary and housekeeping staff are not there, nursing staff end up doing cleaning and feeding.
- The survey found that future shortages result not only from the pay inequities and poor conditions that Monique Smith identified in her report, but also from the aging of the workforce. A majority of the workers surveyed were 45 and older, and one in five have worked in long-term care homes for over 20 years. Inadequacies in formal staffing levels are exacerbated by a failure to replace absent staff members.
- From the report: "We asked workers to indicate whether specified tasks were completed or left undone in the seven-day period prior to responding to the survey. What we found is disturbing and goes far beyond a lack of baths, appropriate food and recreation.... Nearly 60 percent of the time workers don't have the time to provide emotional support (59.8%), while walking and exercising of residents is not done more than half the time (52.3%). More than 40 percent of the time, recording, foot care, and providing support to co-workers is left undone.... More than 20 percent of the time, turning of residents, bed changing, room and bathroom cleaning, learning necessary skills and other unspecified tasks remain to be done. Bathing and building maintenance are left undone nearly 20 percent of the time. Nearly 15 percent of the time (14.7%), workers are unable to attend to clothing changing. Finally, referral to outside medical support is left undone more than 10 percent of the time. Nearly ten percent of the time (8.5%), feeding is left undone...."
- A further study, published in 2007, found that 43.8% of PSWs reported working short-staffed *on a daily basis*. (A.Banarjee et. al. "Out of Control: Violence Against Personal Support Workers in Long Term Care" 2007.)

"When the residents need something, especially to get to a toilet, there is not enough staff to get them on time, so they become incontinent. You have 20 people who have to get to a toilet, everyone has to go, everyone can't be first. Or patients say to you 'I want to go to bed, can you please put me to bed?' but you can't put everyone to bed at once. . . Even dressing them, some of them might be able to dress themselves, but you don't have the time, you have to dress them so they are losing more independence." (RN, Southeastern Ontario 2008)

"All the staff are wonderful, caring individuals, but they are burning out and they are burning out faster then they were ten years ago. . . when I first started working there was more staff. This was before Mike Harris cut back the hours. You could see the difference. On top of that, individuals are coming into the home sicker, frailer, with more complex needs. . . people are staying in their homes longer or are waiting for a bed because there is no bed." (PSW, Ottawa area 2008)

Ontario's LTC Homes Violence, Accident and Injury Rates are Untenable

The evidence of high rates of accident, injury and violence for both staff and residents in Ontario's LTC homes is significant. Though the MOHLTC has recognized and taken steps to alleviate harm and neglect of residents, the data suggest that the MOHLTC needs to recognize LTC homes as unsafe work places also. The research points to a strong link between violence, accident, injury and workload and conditions in the homes, as well as training and special care units which we have expressed support for in addition to regulated staffing standards.

- In their 2004 study, professors Armstrong and Daly found "... Alarming rates of violence among residents and against workers and of both illness and injury. Within the most recent three-month period, almost three-quarters of workers have experienced some form of violence directed at them from one or more individual residents (73.3%). The combination of rising acuity, inadequate staffing and facilities creates conditions that are dangerous for workers's health. A stunning number (96.7%) in our survey reported having been ill or injured as a result of work in the past five years (1999 - 2003). More than 50% report that work caused illness or injury more than 11 times during this time period." (There Are Not Enough Hands: Conditions in Ontario's Long Term Care Facilities, 2004)
- In a 2007 study of personal support workers in Ontario, Manitoba and Nova Scotia these findings were echoed. 89.7% of the personal support workers indicated that they had experienced some form of physical violence from residents and family members. 43% reported that physical violence occurred virtually every day. The physical violence experienced typically includes hitting, punching, biting, grabbing, pulling hair, twisting wrists, poking, spitting, pinching and throwing objects. (Banerjee A, Daly T, Amstrong H, Armstrong P, LaFrance S and Szebehely M. "Out of Control: Violence against Personal Support Workers in Long Term Care" York University & Carleton University, November 20, 2007.
- In 2004 violent residents attacked other residents 864 times and attacked staff 264 times, a ten-fold increase in five years.(CBC News. April 19, 2005.)
- In 1999 there were 101 assaults in the homes. (Ottawa Citizen. October 21, 2006.)
- There have been 11 homicides in Ontario nursing homes since 1999 and 3,000 reported attacks. (Ontario Nurses' Association. Submission to Coroner's Inquest into deaths of Ezz-El-Dine El-Roubi and Pedro Lopez at Casa Verde Health Centre.)
- Ontario health care and social assistance workers reported 5,333 violent incidents between the years 1997 and 2004, out of 12,383 reported by all workers, for an average of 1.21 incidents per 1,000 health and social assistance workers, compared to 0.17 incidents per 1,000 workers in other industries. (CBC News. April 25, 2006.)
- Annually, Ontario health care and social assistance workers lost 24.5 days per 1,000 workers due to violence, compared to 4 lost days per 1,000 workers in all other sectors.(CBC News. April 25, 2006.)
- Neil Boyd, a criminology professor at Simon Fraser University who studied physical abuse in the health care sector, says abuse of workers occurs most frequently in long-term-care facilities, where residents have disabilities such as brain injuries, age-related dementia and chronic progressive diseases. (CMAJ 1998;159:983-5)

Recent research shows that the link between staffing injuries and staffing levels is measurable:

- In a study examining injury and staffing data for three U.S. states: Maryland, West Virginia and Ohio, researchers found that for each additional hour of nursing care provided, injury rates for nurses and nurses' aides fell by nearly 16%. In other words, for every unit increase in staffing, worker injury rates decrease by two injuries per 100 full time workers. (Professors Alison Trinkoff, Meg Johantgen, University of Maryland and Dr. Carlos Muntaner University of Toronto, American Journal of Public Health, July 1,2005)

- Further studies show the correlation between working conditions (including workload) and violence, and the decrease in violence against caregivers as a result of special care units and training interventions:
    - Banarjee A et al. 2007.
    - Guss V, McCann J, eldelman P, Farran CJ. “Job Stress Among Nursing Home Certified Working Assistants: Comparisons of Empowered and Nonempowered Work Environments” Alzheimer’s Care Quarterly. 2004.
    - Morgan DG, Stewart NJ, D’Arcy KC, Werezak LJ. “Evaluating rural nursing home environments: dementia special care units versus integrated facilities” Aging and Mental Health. 2004.
    - Gates D, Fitzwater E, Meyer U. “Violence against caregivers in nursing homes: expected, tolerated, and accepted” Journal of Gerentological Nursing. 1999.
    - Morgan DG, Stewart NJ, D’Arcy KC, Forbes D, Lawson J. “Work stress and physical assault of nursing aides in rural nursing homes with and without dementia special care units” Journal of Psychiatric and Mental Health Nursing. 2005.
    - Gates D, Fitzwater E, Telintelo S, Succop P, Sommers MS. “Preventing Assaults Pilot Study” Journal of American Medical Directors Association. 2002.

Poor Practices in Ontario's LTC Homes On the Record

The ostensible reason for the requirement that residents pay a portion of the costs in nursing homes is that they are paying for accommodation. Government subsidies are supposed to cover the care needs for residents. But over the last decade, media and public reports show a litany of complaints and even scandals in Ontario's long term care facilities. In addition to the coverage of infectious disease outbreaks and the well-publicized deaths in Casa Verde, reports show a consistent pattern of inadequate care, problems with regulation and enforcement, and ineffectual financial accountability. These stories point to a need for improved regulation of care, and accountability for the use of public funds which are supposed to provide care in Ontario's nursing homes. Restoration of public confidence requires improved transparency about actual care levels, such as public posting of staffing levels and strict requirements to provide enough hands-on care.

- In 2000, the Canadian Press reported that documents obtained through a Freedom of Information request revealed that regular inspections had dropped close to 40% between 1996 and 1999. (Canadian Press, October 23, 2000. *'Dangerous' gaps in Ontario nursing home checks*.) In some instances, facilities were not inspected for three years, a clear violation of government policy. Inspectors had been reassigned to work on evaluating bids for new long-term care beds and had no time to carry out inspections. When inspections did actually take place they were not the three- to seven-day examinations mandated by the Ministry. Instead they were quick and often cursory reviews. The government responded quickly to this public embarrassment by hiring new inspectors and returning the old ones to their jobs. However, even after this, and after the requirement to reinstate surprise inspections, workers have reported to us facility "tip offs" about inspections with management bringing in extra staff and major "clean ups" just before inspectors arrive.
- In 2001, *The Toronto Sun* published a 16-page special report on long-term care entitled "Elderly Care Crisis", a moving and disturbing expose of inadequate care, stretched staffing and a non-functioning inspection and compliance regime.
- In 2003, The Ottawa Citizen published an investigative series on Ontario's LTC facilities, finding:
  - Major bankruptcies across several Ontario LTC chains
  - Ontario LTC homes awarded to multinational companies under investigation for poor practices resulting in death in the U.S.
  - Caregivers and family members overstretched in their attempts to provide adequate care
  - Excessive profit taking
- In 2003, The Toronto Star published a series by Moira Welsh on Nursing Homes detailing neglect resulting in the death of resident due to a bedsore. The report painted a disturbing picture of inadequate care, regulation and enforcement and resulted in improvements to the inspection regime. However, the inadequacies in staffing levels persist.

Ontario's LTC Homes Have Inadequate Accountability Mechanisms: 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. The questions raised about funding and accountability are serious. At the time the Toronto Star published its series on nursing homes highlighting the death of a resident due to inadequate care, Extendicare was reporting record profits from its Canadian operations (in Ontario and Alberta) to its shareholders.

In the 2004 auditor's update, improvements to the inspection regime and reporting requirements were reported. However, no substantive action was taken to deal with the lack of accountability regarding whether or not assessed needs of residents were being met. In the minutes of the Standing Committee on Public Accounts, it is reported that the government has been collecting actual staffing data since 1995. However, this information was denied to us on request, and a Freedom of Information request was eventually placed by NDP Health Critic Shelley Martel. In response, the MOHLTC provided staffing information up to March 2006. Despite repeated assurances that up-to-date information would be provided in 2007, there has been no release of the newer numbers. If the auditor's complaint that there is no assessment to determine the adequacy of funding to meet assessed need has been resolved, 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.

"When the minister [of health] talks about quality of life, what does he mean? He is not paying attention to the faces of the people. Instead of experiencing a quality of life, they are experiencing a 'wait for death.'" (Resident, Mississauga—2007)

"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).

"I don't think the people in the higher positions realize what it is that we do. Their goal is to get everyone up for breakfast – whatever looks good – not necessarily the proper care. I'd like them to see what a resistive resident is like. It's like having a wrestling match five times a shift. They think its easy to dress and undress people. It's not."(RPN Niagara Region 2008)

"My mom died in June. I was there every night for four years. I'd get home from work, grab a bite to eat and head to the nursing home. I'd be there from 6:30 to 9:30 to make sure that [mom] was getting care." (Family member, Toronto –2007)

Incongruity between measurements of acuity and outcomes for funding increases

The government mandates homes to use 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. The assessments enable 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, and there is no assessment of outcomes to measure the effectiveness of either the assessment tool or the increased funding. Moreover, though funding is increased as the average acuity has gone up, the funding increase is not tied to actual increased provision of care.

Staff now cynically refer to the documentation required for the assessment tools as "documenting for dollars". Staff attitudes reflect alienation from the documentation process as they see no connection between it and workload. An array of reports and media exposes, and testimony of families and care staff, have shown that there are serious inadequacies in care provision, despite increased reporting on care needs. 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.

We are recommending a care standard that would provide a clear connection between assessments, funding and amount of care. A care standard would be a major step towards closing the loop on measured accountability, funding, and outcomes. It would set an expected level of care, weighted by the assessed acuity of the residents in the home. This would provide one of the most important tools in assessment of appropriate funding, measuring outcomes that result from increases in funding, and provide greatly improved opportunities for accountability.

"We are in the dining room three times a day. I expect some semblance of normalcy. Eating is an emotional event. I expect pleasantness, cheerfulness, background music, quiet, respectful comments from staff. [Instead, it is like] feeding animals on a farm." (Resident, Mississauga—2007)

"The family thought their father was incontentant. I was visiting him when he pressed the call button to ask for help going to the bathroom. A nurse stuck her head in the door and said she would send a PSW. Thirty minutes later, no one had come to help him." (Visiting minister, Ottawa, 2006)

"The staff are so busy . . .there was no time to keep careful notes. There was too much that wasn't written down. I would ask how she got that bruise. If she had been sick, I'd call the next day to find out how she was, and the staff wouldn't know because it wasn't recorded anywhere." (Family member, Toronto –2007)

"I don't think its fair for them to be admitting psychiatric people. Our staff aren't prepared for that. I used to work in a psychiatric hospital and I truly believe that people have a right to be cared for by people who know how to treat or understand their psychiatric problems." (RPN Niagara Region 2008)

SECTION II: THE CASE FOR A REGULATED MINIMUM CARE STANDARD

The Genesis of Regulated Care Standards

The for-profit long term care industry is multinational and many of the chains operating in Ontario also operate in the U.S. The United States has had a robust public discussion about reform in long term care over the last decade and a half. Scandals, lawsuits, and horrific tales of neglect have captured the attention of politicians and have resulted in major research and reform to improve care levels and accountability for public funding. Most states moved to minimum care standards in this period. Efforts to achieve a federal minimum staffing standard were especially pronounced in the final years of the Clinton Administration. This debate and discussion has emerged as a significant piece in long term care reform across Canada.

Even a perfunctory search of the U.S. experience yields a litany of abuses not unlike the bankruptcies, profiteering, stories of neglect, and scandals we have seen in Ontario in the last decade and a half. The US Congress, pressed for ever more funding from the industry, has mandated very intensive research into funding levels and care standards.

Resulting from the escalating reports of poor practices, incessant campaigns for increased funding by operators, Congress mandated the U.S. Health Care Financing Administration to conduct "best practice" research into the staffing and care issues. Over a decade, researchers used rigorous methodology including time motion studies and multivariate analysis to arrive at evidence-based recommendations regarding care requirements. There is no evidence to conclude that this is "a numbers game". Researchers used best practice methodology to measure as accurately as possible the levels of care required to improve outcomes for residents. If the government of Ontario chooses to reject these findings, it cannot do so without full explanation and evidence.

Findings of the Best Practice Research

The report commissioned by Congress found that there were care thresholds below which poor quality of care outcomes were measurably increased and thresholds above which care outcomes do not measurably improve. Our recommendation is based on these findings which are the best practice in research on this issue to date. Notably, study authors found:

1. They were able to demonstrate staffing levels (or thresholds) below which facilities were at substantially greater risk for quality problems (approx. 3 hours per resident per day of RN, RPN and PSW equiv's)

2. They were able to demonstrate staffing levels that were identified as minimum standards for an average acuity at 3. 45 hours per resident per day (RN, RPN, PSW equiv's).

3. They were able to identify thresholds above which additional staffing would not provide demonstrable improvements in outcomes at 4.1- 4.95 hours per resident per day (RN, RPN, PSW equiv's).

4. The minimum staffing levels appeared to be sensitive to case mix, requiring a system to classify all facilities into different categories.

5. They reported that residents in understaffed facilities are at a greater risk of preventable health conditions including pneumonia, urinary tract infection, sepsis, congestive heart failure and dehydration.

(U.S. Health Care Financing Administration "Report to Congress: Appropriateness of Minimum Nursing Staff Ratios in Nursing Homes" Phase I and II reports.)

- 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).

- A recent Canadian literature review found an evidence-based relationship between overall staffing levels and quality of care measured by a number of outcome indicators and concluded that minimum staffing levels are necessary to avoid adverse outcomes. This same review found that the direct care staff, including RN, RPN, and Aides contribute to quality

of care. (Murphy, JM "Residential Care Quality: A review of the literature on nurse and personal care staffing and quality of care" Nursing Directorate of the British Columbia Ministry of Health, November 2006)

- In a study of the experience of dying, researchers found that the most influential factors affecting this experience are: lack of attention to the cultural needs of the residents; cognitive status of the residents; inadequate staffing. (Kayser-Jones J. "The experience of dying: an ethnographic nursing home study" Gerentologist, 2002)

- In her testimony before the U.S. Senate Committee on Finance, Professor Catherine Hawes reported on her findings that 85% of nurse aide registry directors maintain that staffing shortages, too few staff and poor staff-to-resident ratios are the main cause of abuse and neglect in nursing homes. Guilt and stress were found to be significant causes of high turnover. She recommended increased staffing levels and special care units. (Hawes, C, Professor and Director of the Southwest Rural Health Research Centre, School of Rural Public Health, Texas A & M University System Health Science Center. "Testimony before U.S. Senate Committee on Finance, ed. Washington, DC" Senate Committee on Finance, June 18, 2002)

It is based on findings of these reports, and the smaller studies correlating quality, outcomes and care standards of the staff mix in question, that we have made our recommendation to adopt a minimum care standard in Ontario.

Who Should Be Covered in A Care Standard

Though the question of which classifications should be covered in a care standard has been raised repeatedly by Ontario's MOHLTC there is little confusion in the literature regarding care standards. Almost all the literature studies the impact on outcomes of direct care staff - RN, RPN and PSW or equivalent classifications. As outlined in the previous section, the effect on care outcomes has been demonstrated for these classifications. While shortages in all categories affect the ability of direct care staff to provide care, and while all the health professionals and support services are important, the pressing need is for regulation in the daily direct care for residents. It should be recognized, furthermore, that Ontario already has staffing standards for a variety of classifications (see chart below). Thus, our priority recommendation that a regulated care standard cover RN, RPN and PSW classifications in the nursing and personal care envelope, is based on the consensus of a broad coalition of seniors' advocacy organizations, family and resident advocates, workers, unions, health professionals and academics as well as the research outlined above.

Classifications with Existing Minimum Staffing Standards in Ontario's LTC Homes
Administrator
Director of Nursing
Food Services Supervisor
Therapy Services Coordinator
Registered Dietician
Recreation and Leisure Services Staffing

For-Profit Ownership Increases Requirements for Regulation

For-profit nursing homes are required by investors to maximizing the profit and growth potentials of their companies. The investors in 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 Long Term Care Homes homes there are several funding envelopes, including:
- nursing and personal care
- programs and support services
- accommodation
- raw food

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 (in addition to streams of revenue for capital). 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 was recommended that 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. This has not yet been done.

The operators have also conducted public campaigns and lobbying to increase the amount of funding for capital and 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.

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 revealing 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.

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

- 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." (medicalnewstoday.com)

*From the Canadian Medical Association Journal Commentary, January 2, 2007:*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.

For-Profit and Not-For-Profit Ownership: LTC Comparison Across Jurisdictions

Province	**Public/Not-for-profit***	**Private for-profit**
British Columbia	68.3%	31.7%
Saskatchewan	96.2%	5.8%
Manitoba	84%	15%
Ontario	48.4%	51.6%
New Brunswick	100%	0%
Nova Scotia	72%	28%

**Public/not-for-profit include provincial and municipal government LTC facilities and LTC facilities seen by not-for-profit societies.*
(Hospital Employees' Union, April 2002. Statistics collected from the Ministry of Health in British Columbia, Saskatchewan and Manitoba, CUPE in New Brunswick and Nova Scotia, The Seniors Secretariat at the Ministry of Citizenship Culture and Recreation in Ontario.)

Ontario's long-term care lobby has achieved successes in deregulation, only some of which have been reversed. Consider the following:

- ELIMINATED – Requirement to provide a minimum 2.25 hours of care per resident per day in nursing homes. Eliminated by the Harris government. Not reinstated.
- ELIMINATED - Reporting on actual staffing levels to the Ministry of Health. Eliminated by the Harris government. Reinstated starting in 2005 by the McGuinty government. However, information on actual staffing levels has been disclosed publicly only after a Freedom of Information request by NDP Health Critic Shelley Martel in 2007. Following this request, for more than a year updated figures were kept secret. New figures have only been disclosed following a second Freedom of Information Request this year.
- ELIMINATED - Requirement in the Service Agreement to adhere to planned or budgeted levels of staffing. Eliminated by the Harris government.
- ELIMINATED - Requirement to increase the average staffing per resident as a condition for eligibility for new funding. Eliminated by the McGuinty government.
- ELIMINATED – Requirement to have a registered nurse on duty 24 hours per day, seven days per week in nursing homes. Eliminated by the Harris government. Reinstated.
- ELIMINATED – Requirement to return 50% of surcharges for "preferred" accommodation to the Ministry. Eliminated by the Harris government. Not reinstated.
- REVERSED - Proportion of beds required to be held as basic accommodation was initially regulated at 60%, then it was reduced to 50%, then it was further reduced to 40% by the Rae government. This means that 60% of beds are now charged at premium rates, increasing the amount of profit to be taken from the "Accommodation Envelope" into which these user charges for residents go.
- COSTS SHIFTED TO INCREASE PROFITABILITY - The government allowed operators to move costs for incontinence supplies, moving, building cameras and surveillance equipment, and accommodation staff, from the accommodation envelope into the nursing and personal care envelope.

In the U.S. also, it is reported that the for-profit industry has lobbied against care standards. (Devore, E. "Issue Brief: Nursing Home Staffing Standards" Washington DC: Health Policy Tracking Service, June 28, 2002) Yet under the Clinton Administration, the trend was towards more stringent regulation of care standards. It was not until the Bush Administration that this trend has been slowed.

Prior to regulation of care standards, U.S. jurisdictions relied heavily on litigation to accomplish some accountability for harm and neglect in the for-profit homes. The industry has responded by a change in ownership patterns which may carry some lessons for the future in Ontario. Investment firms with Byzantine ownership structures have bought out chains, making the establishment of responsibility in litigation almost impossible. (Duhigg, Charles "More Profit and Less Nursing at Many Homes" New York Times, September 23, 2007) This trend should serve as a warning in Canada and points to a need to create more accountability, transparency, reporting and enforcement, rather than less.

SECTION III: ADDITIONAL HUMAN RESOURCE AND QUALITY OF CARE ISSUES

In our consultations including the two rounds of public hearings and forums, in-depth interviews, and meetings with our member organizations and stakeholder groups, a set of recommendations regarding additional human resource and quality of care issues has been raised. In addition, the family advocates have asked us to identify some clear recommendations pertaining to "quality of life" - a language and focus that is very important to them. The following recommendations are based on these consultations. In addition, we would like to draw your attention to our set of ten priority recommendations in Appendix I: "Key Issues in Long Term Care Homes Policy Statement September 2006" which is based on the consensus of our consultations up to that date.

Priority Consensus Recommendation Impacting Quality of Life, Quality of Care and Human Resources:
A regulated care standard as outlined in the earlier sections of this submission.

Additional Recommendations:

1. Appropriate care settings, special care units, review downloading
The Ontario Health Coalition recognizes the need for long term care homes. In addition, we support the ability of people to choose, whenever possible, the setting for their care. We are concerned about the continued downloading of heavy care patients from mental health facilities into long term care homes which cannot provide appropriately for the complex needs of these residents. We support the re-establishment of public and non-profit long-term homecare to allow seniors the option of aging in place and a range of non-profit and public supportive living environments for the younger persons with chronic care needs or disabilities. The movement of people into long term care homes should not be used as a tool to maximize bed occupancy to maximize funding or profit-taking by operators.

In addition to reviewing the download of heavy care patients from hospitals, the government must fund and set standards for public and non-profit specialty units for persons with cognitive impairment who have been assessed as potentially aggressive and staff them with sufficient numbers of appropriately trained care workers. The movement of patients out of hospitals must be based on an evidence-based assessment of care outcomes and needs, not used as a tool for cost-cutting and for-profit privatization.

2. Development of a Health Human Resource Strategy as a priority policy
Staffing shortages across classifications are impacting quality of care and human resources recruitment and retention. It must be a policy priority to develop a health human resources plan to address the shortages for the long term. Such a plan must address the working conditions that contribute to turnover and recruitment problems in long term care homes, including:

- addressing workload through regulating staffing standards, ensuring replacement for absences, and addressing shortages
- providing training interventions and special care units to reduce violence and injury
- providing wage parity between hospital, long term care facility and homecare sectors
- ensuring adequate supplies
- building an understanding of the team and the importance of the different roles of hands-on care staff
- improving scheduling control and other measures to empower staff

3. Provide time and opportunities for staff to talk with residents for social and rehabilitation purposes, and recognize this activity as vital for quality of life for both residents and staff.

Long term care homes are all-too-frequently referred to as "warehouses" in recognition of the lack of care. The Ontario Health Coalition believes that the goals of care in nursing homes should be to improve the health and social conditions of residents as well as to provide quality end-of-life care. Both of these goals rely on adequate staffing, training, communications, sound management practices, staff empowerment, adequate supplies. But they also rely on recognizing the vital importance of time for gentleness, talking and communications, and human contact between staff, families and residents.

4. Update the findings of the 2001 PriceWaterhouse Cooper's Report into staffing and acuity levels in Ontario's nursing homes as per the Coroner's Jury Recommendations in the Casa Verde homicide. This report should not replace nor delay immediate institution of regulated care standards as per our priority recommendation.

Coroner's Recommendation: That the MOHLTC retain PricewaterhouseCoopers, or a similar consultant, to update the January 2001 *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators*, and to have an evidence based study of the present situation determine the appropriate staffing levels for Ontario Long Term Care facilities given the significant number of Ontario residents with cognitive impairment and complex care needs in LTC facilities.... (Recommendation #28, Office of the Chief Coroner of Ontario, Recommendations of the Coroner's Jury in the deaths of EL ROUBI, Ezzeldine and LOPEZ, Pedro, 2005)

APPENDIX I

Ontario Health Coalition
Key Issues in Long Term Care Homes
September 2006

Adequate funding must be provided for ongoing supportive home and community care to offer seniors, persons with disabilities and those with chronic illnesses the opportunity to live in the community as long as possible.

1) 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.

2) 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 ratio set out in #1 and strong accountability as to how that money is spent.

3) The continuance of the new completely random surprise inspection regime with an adequate number of inspectors to respond to complaints within a reasonable amount of time. Any assessment process must include talking with representatives from residents and family councils where they exist and speaking to nursing and personal care staff.

4) A ratio of 60% of facility beds for non-preferred accommodation and 40% for preferred accommodation should be reinstated. No increase in out-of-pocket fees for beds beyond inflation.

5) All long term care facility beds receive public funding. The legislation must include strong message of support for public and non-profit delivery of care. All new capacity should be built in public and non-profit homes. Operators that transfer their licenses must transfer them to public or non-profit ownership only.

6) Family councils should be recognized in the legislation with official recognition of their right to advocate. Families must be guaranteed access to the information required to hold facilities accountable. Complaints by family members must trigger an automatic inspection within two weeks of receipt of the complaint. In the case of abuse, the inspection must be immediate. Inspectors should be mandated to meet with family and resident councils where they exist. The Ministry should continue to provide funding and support to establish and continue family councils through the office of the elder care ombudsperson. There must be whistle-blower protection for residents, families and staff that speak out about poor practices in the homes.

7) There must be clear and enforced guidelines in the legislation limiting the use of physical, chemical and environmental restraints on residents. Restraints should only be used for the purpose of preventing harm. There must be a clear decision-making process, notification of families, and restraints-as-last-resort policies.

8) Program standards must be reviewed and improved and enforced through the inspection regime set out in #3. 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.

9) The training opportunities for front-line staff, administrators, and Compliance Advisors must be improved to ensure consistency and an understanding of how to provide residents and staff a safe, secure and compassionate environment.

10) Consultation on adequate regulation of retirement homes should be instituted.

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