

SITUATION CRITICAL

Planning, Access, Levels of Care and Violence in Ontario's Long-Term Care

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Introduction & Summary

On November 2, 2016, Keith Wood, a 79-year old resident in a long-term care home in Mississauga, was struck on the head and killed by fellow resident, 82-year old Arnold Kendall. The legal case is ongoing but the shock of the homicide, involving two elderly and vulnerable residents in a care facility where they were supposed to be safe and supervised, spawned media headlines across the province. The sad facts are that Keith Wood's death is not the first resident-on-resident homicide in Ontario's long-term care homes and the shocking rate of homicides in Ontario's long-term care is the extreme end of a spectrum of violence that has reached levels beyond any that can be deemed acceptable. In fact, repeated reports from the Ontario Coroner's Office reveal a homicide rate in this province's long-term care homes that is higher than those of our province's largest cities. In many cases, elderly residents with dementia are both the victims and the perpetrators. The twin issues of violence and insufficient levels of care in Ontario's long-term care homes are a matter of policy choices, not necessities. They are also a matter of fundamental human rights and a measure of our humanity, and on both counts we are failing.

Planning, care levels, regulation and resourcing of long-term care have not kept pace with population aging and patient offloading. This is not the norm. In fact, Ontario's long-term care homes have extraordinary levels of occupancy and

acuity... Levels of care are too low to meet needs... Levels of fatal violence in the homes are higher than virtually anywhere else in our society.

In this report, we look more closely at the evidence of increased need and inadequate levels of care in Ontario's long-term care homes in which nearly 80,000 people live and their consequences for caregivers and residents, including escalating violence. Our research shows that the increased complexity of residents is partly a function of offloading of more complex patients from hospitals to facilities with insufficient levels of care in order to save money and partly a function of the aging population. We also found that planning, care levels, regulation, and resourcing of long-term care have not kept pace with population aging and patient offloading. This is not the norm. In fact, Ontario's long-term care homes have extraordinary levels of occupancy and acuity. Access to care is gravely inadequate: waitlists are longer than the entire population of a medium-sized town in Ontario. Levels of fatal violence in the homes are higher than virtually anywhere else in our society. Levels of care are too low to meet need and basic safety requirements and have been falling further behind year after year. For equity-seeking groups, this experience of inadequate planning, resourcing and poor access to care is even more severe, leaving people waiting for years for a bed. While population aging is unavoidable, the evidence shows that the situation that we are seeing in Ontario's long-term care homes results, to a great extent, from policy choices that can and must be changed.

The failure to plan and resource Ontario's long-term care system has been the key cause of the current situation. Population aging is upon us but, despite its predictability, government planning lags far behind. The first baby boomers turned 65 years old in 2011. In 2015 Statistics Canada reported that, for the first time in Canadian history, seniors outnumbered children. By 2035, a quarter of Canadians will be aged 65 and older¹ and the size of the oldest cohorts are increasing fastest. While some have invoked imagery such as a grey "tsunami" to evade responsibility for planning to provide adequate care -- or, in the case of pro-privatization forces to undermine confidence in the sustainability of public health care² -- in truth, the data shows that rate of health spending growth for non-seniors has actually increased faster in recent decades than the rate for seniors.³ Evidence-based models that project health care costs in coming decades show that the investments in health care needed for the aging population are incremental and manageable.⁴ Further, despite overwhelming rhetoric to the contrary, the fact is that health spending declined significantly as a percent of the Ontario budget over the last decade and a half (see Figure 1). The evidence lays waste to any rhetorical attempts to paint health care as an insatiable 'Pac-Man' eating up the budget; an image created by pro-privatization forces for their own benefit. While there is not the unbridled crisis that the public has been led to believe, nevertheless, our health care system urgently needs to catch up on

¹ Canadian Institute for Health Information, *Health Care in Canada 2011: A Focus on Seniors and Aging*, page ix.

² See for example Fraser Institute Op Ed in New Brunswick Telegraph Journal *Health-care spending increases in Canada point to unsustainable future* June 2, 2016. Also see for example, the self-described "apocalyptic language" used in this article by Maclean's Magazine: Kirby, Jason *The most important*

planning for the greying of our population.

In fact, Ontario ranks second-last in Canada in the number of long-term care beds per capita. As a result, Ontario's long-term care wait list has totalled 18,000⁵ – 33,000⁶ or more people since the 1990s and wait lists for racialized groups seeking culturally appropriate long-term care are far longer than that of the general population. In effect, the plan has been to allow the unregulated and privatized seniors' health and service market grow to take up the unmet demand for the growing elderly population.

While the demand for long-term care homes is increasing as the population ages and as public hospitals cut beds and services, the supply of placements in long-term care homes has fallen far behind. As acuity has soared, that is, the complexity and heaviness of the care needs for residents, care levels have not increased in tandem. In fact, daily hands-on care

economic charts to watch in 2018 Macleans, December 5, 2017.

³ CIHI 2011, page ix.

⁴ CIHI 2011, page ix.

⁵ Ontario Health Coalition, 1999: Fact Sheet <http://www.ontariohealthcoalition.ca/wp-content/uploads/Fact-Sheet-May-1999.pdf>

⁶ AdvantAge Ontario (Trade association representing non-profit and public long-term care homes) 2018: *Making Good On Promises*.

levels have decreased. Rather than planning to meet population need for care and having a democratic discussion with Ontarians about how to pay for that care, Ontarians have been subject to repeated broken promises and fiscal (budgetary) policies in which they have never been given an informed choice. Instead governments have simply rationed care levels and limited access to care. In fact, Ontario ranks second-last in Canada in the number of long-term care beds per capita. As a result, Ontario’s long-term care wait list has totalled 18,000⁷ – 33,000⁸ or more people since the 1990s and wait lists for racialized groups seeking culturally appropriate long-term care are far longer than that of the general population. In effect, the plan has been to allow the unregulated and privatized seniors’ health and service market grow to take up the unmet demand for the growing elderly population.

The bottom line? Those who can pay get care, though it is often unregulated and extremely expensive. Those who cannot afford to pay are left to suffer.

The elderly are left on their own to navigate a “market” of expensive, self-policing, residential options, many of which charge exorbitant fees, including fees for services that the person is entitled to receive through publicly-funded services. The bottom line? Those who can pay get care, though it is often unregulated and extremely expensive. Those who cannot afford to pay are left to suffer.

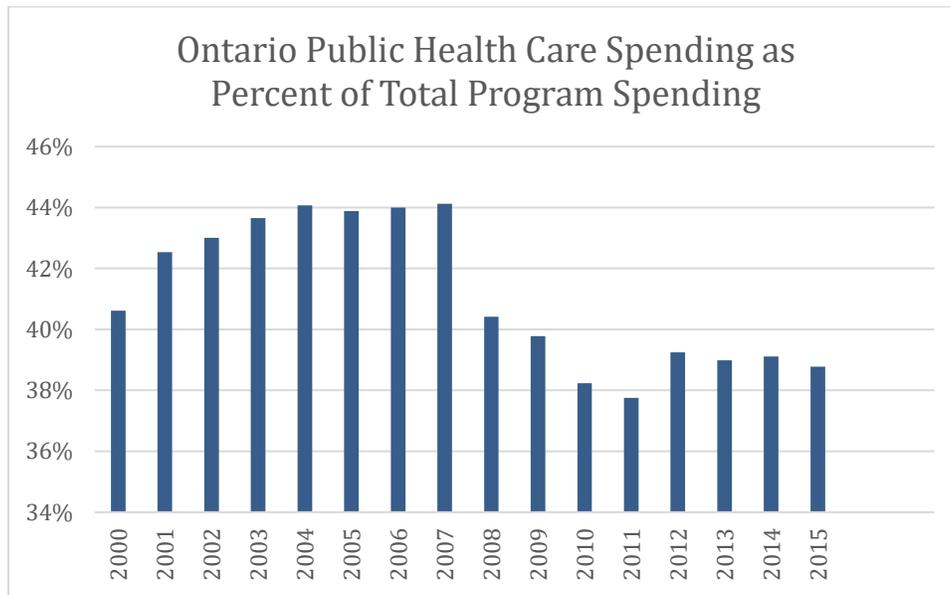


Figure 1: Ontario Public Health Care Spending as Percent of Total Program Spending⁹

⁷ Ontario Health Coalition, 1999: Fact Sheet <http://www.ontariohealthcoalition.ca/wp-content/uploads/Fact-Sheet-May-1999.pdf>

⁸ AdvantAge Ontario (Trade association representing non-profit and public long-term care homes) 2018: *Making Good On Promises*.

⁹ Author’s calculation using *CIHI National Health Expenditures 2017*.

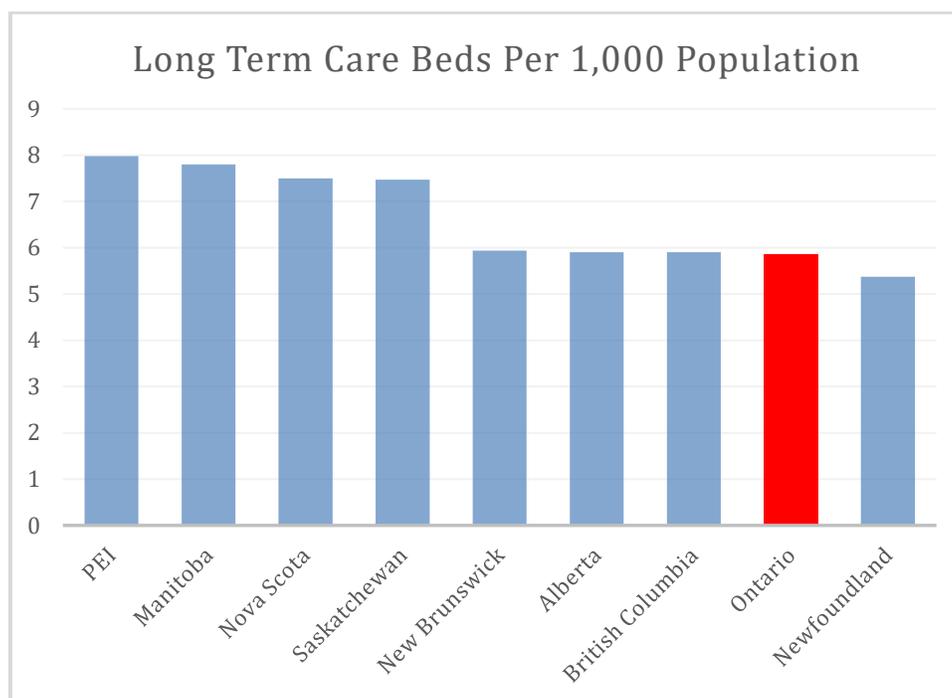


Figure 2: Long Term Care Beds Per 1,000 Population¹⁰

There is not only a problem of access to care in the sense of gaining access to long-term care placements. For those who have been able to obtain a placement within long-term care homes, there is a grievous shortfall of care. As the complexity and heaviness of the care needs of the residents in long-term care homes have risen dramatically, government data shows that the amounts of care provided have actually declined. Again, rationing of care is the unspoken order of the day. Those who can afford to

hire in private caregivers for their family members in long-term care do so. Those without family or resources have to go without. Across Ontario we are seeing the results of this approach in high rates of accidents, injury and violence both against residents and staff in our province's long-term care homes and in the suffering of people who are waiting for placements that can range from months for those in crisis to half-a-decade or even longer.¹¹

¹⁰ Author's calculations based on data gathered from provincial websites and Statistics Canada 2016 Population Census data.

¹¹ For LTC Waitlist by LHIN see for example:
<http://healthcareathome.ca/torontocentral/en/care/Documents/Toronto%20Central%20LTC%20Wait%20List%20APR%202018.pdf>,
<http://healthcareathome.ca/champlain/en/care/Documents/Long%20Term%20Care%20Wait%20Times%20ENG.pdf>,
<http://healthcareathome.ca/northeast/en/care/Documents/LTC%20Wait%20Times/2018/June/NBMay2018.pdf>,
<http://healthcareathome.ca/hnhb/en/care/Documents/Long-term%20care%20wait%20time%20reporting%20May%202018%20-%20Niagara%20En.pdf>

As the complexity and heaviness of the care needs of the residents in long-term care homes have risen dramatically, government data shows that the amounts of care provided have actually declined. Again, rationing of care is the unspoken order of the day. Those who can afford to hire in private caregivers for their family members in long-term care do so.

There are three broad trends we have identified as contributing to this urgent situation in Ontario's long-term care:

- I. Ontario has cut more hospital beds than anywhere in the "developed" world.¹² Compared to every other Canadian province and peer jurisdictions around the world, Ontario has dropped to the bottom of the rankings in the number of hospital beds per population. Ontario's stock of chronic care hospital beds has been cut in half and psychogeriatric beds have been cut significantly. Thus, patients with very high and complex needs, including patients with aggressive behaviours, have been offloaded from hospitals into long-term care homes. But Ontario's long-term care homes have not been resourced to

increase care levels commensurate with the offloading of significantly more complex patients. Our research shows that long-term care beds are funded at approximately one-third the rate of chronic/complex care hospital beds, and lesser still than psychogeriatric beds, meaning that patients with the same levels of need are now being shifted to long-term care homes that are somehow supposed to provide for them at a fraction of the previous funding.

- II. Ontario's population is aging. This would be manageable over time with incremental funding increases, but given the failure to plan for their needs, we now need significant resources to catch up and a concrete commitment to appropriate forward planning. Unfortunately, Ontario pursued fiscal policies of austerity for the decade of 2006 – 2016 and once again the new Ontario government is proposing fiscal austerity. Ontario's long-term care homes have not been resourced to expand access to meet the needs of the aging population.
- III. As government policy forces public hospitals to move more and more patients from the chronic care hospitals to long-term care and as access to long-term care is rationed, levels of violence have escalated. The vast majority (84%) of those currently admitted to long-term care homes are assessed as

¹² See Appendix I for sources and data charts comparing Ontario's hospital beds per population with other jurisdictions.

having high and very high needs.¹³ Those who need residential long-term care, but whose needs are not ranked at the highest levels are simply not getting in. As the long-term care sector takes on more and more complex patients, serious problems regarding the appropriateness of long-term care placement, staff training and care levels continue to emerge. At the same time, successive Ontario governments have waffled on regulatory regimes that would ensure funding goes to care and is not taken away for profit. Without question, today's long-term care homes are the chronic and psychogeriatric hospitals of previous decades, but without the corresponding resources and care levels. This leads to poor resident outcomes and poor quality of life. As a result, we are seeing a deeply disturbing rise in violence, insufficient care, injury, and in the extreme, homicides.

As this report has been written, the incoming PC government promised in the election that it will build 30,000 new long-term care spaces with 15,000 of these to be completed over the next five years. If this comes to pass, it will be the first significant increase in long-term care placements since approximately 2003. There are already 33, 000 Ontarians on wait lists for long-term care home

placements¹⁴ so a plan to attach capacity-building to population need is urgently needed. We argue that the capacity plan should favour building public not-for-profit long-term care homes over for-profit homes. In addition, there is an urgent need to build culturally appropriate homes for racialized groups, safe spaces for LGBTQ2S identified people and other equity seeking groups. These services are mainly provided in public and non-profit long-term care homes. For-profit facilities provide fewer hours of care per resident¹⁵ leading to poor outcomes.¹⁶

There are already 33, 000 Ontarians on wait lists for long-term care home placements so a plan to attach capacity-building to population need is urgently needed.

Further, once placed in long-term care, residents require actual hands-on care to meet their real needs and to keep residents, staff, volunteers and family members safe. The legislative and regulatory regimes for long term care must require all long term care homes to direct funding increases to actually improving hands-on care levels. Based on the best available evidence and given the high acuity of Ontario's long term care residents, this regulated and enforced care standard should require a minimum

¹³ Ontario Long Term Care Association (Industry association representing for-profit long-term homes): *This is Long Term Care 2018*.

¹⁴ AdvantAge Ontario 2018: *Making Good On Promises*.
http://www.advantageontario.ca/AAO/Content/Resources/Advantage_Ontario/Spending_Priorities.aspx

¹⁵ Hsu, A, et al. 2016: *Staffing in Ontario's Long-Term Care Homes: Differences by Profit Status and Chain Ownership*, Canadian Journal of Aging.

¹⁶ Tanuseputro, P, et al. *Journal of Post-Acute and Long-Term Care Medicine*, 2015: *Hospitalization and Mortality Rates in Long-Term Care Facilities: Does For-Profit Status Matter?*, vol. 16.

average of 4-hours per day of hands-on nursing care and personal support. The evidence shows that this would prevent harm and improve health outcomes.¹⁷ These requirements -- to improve access to long-term care, and to plan and resource them appropriately -- cannot continue to be considered dispensable promises made before an election and then abandoned. Ontarians cannot continue to tolerate a level of violence and suffering among the elderly who have, all their lives, contributed to our society when they are vulnerable and in need of our protection and compassion.

¹⁷ U.S. Centers for Medicare and Medicaid Services, Abt Associates Inc. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing*

Homes. Report to Congress: Phase II Final. Volumes I-III. Baltimore, MD: CMS; 2001.

I. Population Aging, Increased Incidence of Dementia and the Need for Long-Term Care Capacity Planning

For the first time in our history, there are more Canadians over the age of 65 than children under the age of 15 years¹⁸ and this demographic shift is projected to continue for the next half century. In 2014/2015 the growth rate of the population aged 65 years and older was 3.5 per cent, approximately four-times the growth rate of the total population¹⁹. By 2024, 20.1 per cent of the population will be 65 years and older²⁰. In Ontario, it is projected that the number of seniors over the age of 65 will double from about 2.2 million or 16 per cent in 2015 to 4.5 million or 25.3 per cent by 2041. Further, among the aging, the older age cohorts are growing fastest. By 2041, the number of Ontarians aged 90-plus will almost quadruple from 109,000 to 413,000.²¹

The association representing Ontario's non-profit long-term care homes has distilled population aging statistics to reveal a stark picture of the real needs arising over the next few years, as follows:

Over the five year period from 2017 – 2021 the Ontario Ministry of Finance projects that the 65-plus population in Ontario will increase by about 383,000 individuals. Individuals 75 and over will increase by about 167,000 and the number

of individuals over 90 will increase by approximately 30,000. *“The seniors’ care sector does not have the capacity to provide the care required now, let alone over the next five years.”*²²

Along with the aging population there is a growth in diseases of aging, such as dementia. The Alzheimer Society of Ontario predicts that the number of Ontarians with dementia will almost double within the next 15 years. There are currently 228,000 Ontarians living with dementia. By 2038, that number will be almost a half million (430,000)²³.

The seniors’ care sector does not have the capacity to provide the care required now, let alone over the next five years.

The aging of the population, the increase in the oldest age cohorts, and the rising incidence of dementia require sound health care planning to address the changing needs for our health care and social safety nets. The data shows that there are far too few long-term care beds to meet current population need. Not only is there a crisis in access to care and

¹⁸ Statistics Canada, 2017: *Population by sex and age group*.

¹⁹ Statistics Canada, 2015.

²⁰ Statistics Canada, 2015.

²¹ Ontario Population Projections Update 2016-2041.

²² OAHNSS (now AdvantAge), 2017: *Meeting Seniors’ Needs Now, Provincial Spending Priorities*.

²³ Ministry of Health and Long-Term Care 2016: *Developing Ontario’s Dementia Strategy: A Discussion Paper*.

dangerous privatization of needed care, but also, as care is more severely rationed, those that are able access it have higher acuity – that is higher complexity and more care needs.

The number of Canadians over the age of 65 has risen by 3 per cent from 2005 to 2015 but health spending only increased 1.7 per cent in the same time period.²⁴ Without any plan either to build capacity to meet population need or to provide adequate care, the risks for those affected include:

- growing inequities in access to care
- a shifting of the cost burden for care from government onto families and individuals
- inhumane living conditions for those who cannot access care
- suffering for both elderly people in need of care and family caregivers who cannot meet the overwhelming care needs of their ailing and elderly spouses or parents
- unsafe conditions for residents and staff in long-term care homes that are understaffed and inappropriately staffed for the care needs of the residents
- higher mortality rates, including preventable homicides.

²⁴ CIHI, 2017: *Has the share of health spending on seniors changed?*

II. Hospital Offloading and Increasing Complexity in Long-Term Care

Ontario hospitals are reassessing chronic care patients and are discharging patients at a faster rate than long-term care homes can admit

Ontario's public hospitals have faced two periods of significant funding constraint over the last three decades: the Harris/Eves government hospital restructuring of 1995-97, and the McGuinty/Wynne hospital restructuring of 2006-2016. All across Canada during this period, the numbers of days that inpatients spend in acute care hospitals has declined significantly.²⁵ But the cuts to inpatient stays in hospital have been even sharper in Ontario, where in 1995-1996 the total number of acute inpatient hospitalizations was 1,149,929 declining to 996,884 by 2010-11, a 13.3 per cent negative change, even as the population has grown significantly.²⁶ As a result, more than half of Ontario's chronic care hospital beds (also called complex continuing care)²⁷ and almost half of our province's acute care hospital beds have been closed.²⁸ These are the most radical hospital cuts in the developed world, leaving Ontario with the fewest hospital beds per population of any province in the country and of any peer country.²⁹

The consequence of this extreme downsizing of public hospital capacity has been profound. According to hospital unions, violence and injury in hospitals has joined workload as the most frequent complaint by hands-on care workers and professionals.³⁰ In virtually all medium and large hospitals, crowding rates have soared to dangerous levels, unheard of in developed nations, and this has become Ontario's new norm. From 2006 - 2016, despite evidence that the cuts have gone too far, hospital global budgets were constrained, with increases below the rate of inflation, meaning year-over-year real-dollar cuts, forcing hospitals to shed services and to ration access to care.³¹ Thrown into a crisis of under-capacity, hospitals systematically redefined chronic care hospital patients as requiring lesser-funded long-term care in a bid to move those patients out of hospitals. As a result, hospitals are discharging more and more complex patients who require ongoing care, and they are trying to offload them at a faster rate than long-term care facilities can accept. Patients are now routinely sent home to wait for long-term care placement without proper informed consent and often without adequate care in place.³² At the same time, long-term

²⁵ Statistics Canada, 2015

²⁶ CIHI, 2012: *Highlights of 2010- 2011 Inpatient Hospitalization and Emergency Department visits.*

²⁷ Ontario MOHLTC, 2018: *What is chronic care/complex continuing care (CCC).*

²⁸ Globe and Mail: *Beds in Ontario Public Hospitals 1990 to 2014* ("snapshot" as of March 31st each year).

²⁹ See Appendix II.

³⁰ CUPE, 2018: *Unique Alliance of 75,000 hospital workers formed in Ontario;*

ONA, 2018: *The Endless List of Workplace Violence Incidents That Are Happening in Ontario Health Care Settings Is Nothing Less Than Horrifying;*

Unifor, 2018: *Hospital staff join Ontario-wide workplace action;*

OPSEU, 2017: *Help end workplace violence in mental health care;*

³¹ Data from Ontario Budget 2006-2015.

³² Toronto Star, 2014: *Beware of hospital 'discharge planners': Goar.*

care homes are under pressure to accept residents with higher and higher levels of acuity.

Long-term care homes are under pressure to accept residents with higher and higher levels of acuity.

Today, fully 84 percent of long-term care admissions are categorized at the highest two levels of acuity.³³ Almost everyone waiting for long-term care is left with impossible wait times, but the situation is even worse for high-moderate and less acute seniors who are left suffering and sometimes pass away while waiting. There are numerous patients who should be in chronic/complex care, but because there is no space, the only option is placement into long-term care. Long-term care homes refuse a number of these patients because they do not have the resources. Sometimes the patient has needs such as mechanical ventilators that are not truly manageable in long-term care without appropriate levels of RN and Respiratory Therapist staffing. Sometimes they have multiple needs, each of which could be managed, but altogether they are more than a home can manage. These patients are stuck in an unfortunate limbo, unwelcome in hospital and under constant pressure to leave, yet unable to be admitted into long-term care. Recently, there is an increase in pressure for these patients not only to go to long-term care, but advocates report that patients are often told that they have to go to a retirement home or other type of unregulated accommodation where there is even less or no care, though their care

needs are too much even for long-term care.

Hospital Downloading: Complex Continuing Care/Chronic Care Cuts

There have been draconian cuts to complex continuing care, also called chronic care, which is defined as ongoing specialized medical services for patients with complex health needs. Chronic or continuing care is a type of hospital care because of the resource intensity of the care needs of patients. These patients require a level of resourcing and staffing that is greater than long-term care. Over the last 30 years we have seen more than half of all complex continuing care beds eliminated. In 1990 Ontario had 11,435 complex continuing care beds. By 2014 there were only 5,329 beds, a 53.4 per cent decrease.³⁴

Today, fully 84 percent of long-term care admissions are categorized at the highest two levels of acuity.

The average complex continuing care bed is funded by the Ontario Government at \$450-500 per day.³⁵ Due to lack of available beds, patients who require more care are being shifted to long-term care homes that receive significantly less funding: an average of only \$170.14 per day.³⁶ Patients are being shifted to cut costs, compromising their health and safety and that of all long-term care residents. The evidence in Ontario shows that the levels of violence in long-term care have risen as staffing levels have fallen behind need. Further, complex residents require more hours of care per

³³ OANHSS, 2016: *Pre-Budget Submission: Ensuring the Care Is There.*

³⁴ The Globe and Mail: *Beds in Ontario Public Hospitals 1990 to 2014.*

³⁵ Rehab Care Alliance, 2015: *Financial and Clinical Implications of Re-Classification.*

³⁶ RNAO: *Transforming long-term care to keep residents healthy and safe.*

day, taking already inadequate hours of care time away from residents with lesser needs.

In addition to the problems created by rising acuity, downloading of patients from complex continuing care to long-term care increases the number of people waiting for long-term care beds. Since the Harris government of the 1990s, the vast majority of long-term care beds that have been added to the system have been for-profit beds, meaning that the closing of complex continuing beds has shifted care that was formerly under public non-profit ownership to the for-profit sector. For-profit long-term care beds have historically underperformed non-profit long term care in terms of safety, health and happiness of the residents.³⁷ They also provide less culturally diverse services.

Hospital Downloading: Psychogeriatric cuts

Psychogeriatric care is a branch of health care concerned with the diagnosis and treatment of mental health in elders. Over decades, hospitals have been eliminating psychogeriatric beds, leaving the growing numbers of elderly residents with mental health disorders to be treated in highly-occupied long-term care homes. This is the cause of frequent complaints from staff who say that they are not adequately

trained and resourced to provide care to this population in long-term care homes.

Following the dramatic cuts of the 1990s and early 2000s in mental health hospital capacity, the number of psychogeriatric beds in Ontario has continued to be downsized. In 2007, there were 4,740 psychiatric beds in Ontario³⁸. In 2016 number dropped to 4,578 mental health and addiction beds³⁹ which is a reduction of 162 beds in less than 10-years while population has increased significantly. Out of the 1,389 mental health beds left in specialty psychiatric hospitals only 167 are geriatric psychiatric inpatient beds.⁴⁰ While the Mental Health Commission of Canada established a guideline of 3.3 specialized geriatric psychiatry beds per 10,000 elderly⁴¹, in 2011, at the time the guideline was published, no province had met that benchmark⁴² and psychogeriatric beds have been cut in the years since the guideline was established.⁴³

In recent years we have seen additional cuts to mental health bed capacity including psychogeriatric beds. Lakehead Psychiatric Hospital in Thunder Bay cut 28 psychogeriatric unit beds in 2012 before finally shuttering their doors completely in May 2018.⁴⁴ The number of psychiatric beds in London, Ontario was cut from 364 to 156. 138 beds were moved to Windsor, Kitchener, St. Thomas

³⁷ McGregor MJ, et al, 2011, *Complaints in for-profit and public nursing homes in two Canadian provinces*. Open Medicine.

³⁷ Hsu, A, et al. 2016, *Canadian Journal on Aging: Staffing in Ontario's Long-Term Care Homes: Differences by Profit Status and Chain Ownership*.

³⁸ CIHI, 2007-2008: *Beds Staffed and in Operation*.

³⁹ CIHI, 2015/16: *Beds Staffed and in Operation*.

⁴⁰ Auditor General Report, 2016: *Special Psychiatric Hospitals Services*.

⁴¹ Mental Health Commission of Canada, 2011: *Guidelines for comprehensive mental health services for older Adults in Canada*.

⁴² CMAJ, 2011: *National benchmarks for treatment of seniors' mental health recommended*.

⁴³ Ontario Health Coalition, 2012-2106: *Beyond Limits: List of Hospital Cuts & Closures across Ontario*.

⁴⁴ Thunder Bay News, 2012: *Supporters continue fight for long-term care facility* and Thunder Bay News Watch, 2018: *St. Joseph's Care Group preparing to vacate Lakehead Psychiatric Hospital*.

and Hamilton while the remaining 70 beds were eliminated.⁴⁵ The Brockville Mental Health Centre also closed 90 mental health beds.⁴⁶

⁴⁵ The London Press, 2014: *Is London Going to Be Short on Beds.*

⁴⁶ OPSEU, 2009: *Bed closures at Brockville mental health facility 'outrageous' says OPSEU.*

III. Long-Term Care Wait Times

The long-term care occupancy rate is defined as a ratio between vacant and occupied beds in long term care homes. The number of available spaces is counted in terms of available “beds”. A bed refers to a placement: a funded and staffed bed with the support and daily services each resident needs; from support services like bathing to eating, to programs and activation, to nursing care. As the length of stay for patients in hospitals has shortened while the population has grown and is aging, and without commensurate increase in long-term care bed capacity, it should come as no surprise that the occupancy rate of long term care homes has soared. From 2012 to 2013 alone, Ontario’s long-term care occupancy rate rose 4.6 per cent from 92.8 per cent to 97.4 per cent.⁴⁷ By 2017 the occupancy rate further increased to 98.9 per cent, a 6.1% increase from 2012.⁴⁸

As of February 2018 there were 627 long-term care homes in Ontario housing more 77, 574 long-term care beds⁴⁹ and 33, 080 on the wait list.⁵⁰ The median wait time is currently 160 days: over 5 months.

There is no question that Ontario lacks capacity to meet the population’s current need for long-term care home placements. As of February 2018 there were 627 long-term care homes in Ontario housing more 77, 574 long-term care beds⁵¹ and 33, 080 on the wait list.⁵² The median wait time is currently 160 days: over 5 months. It has been steadily increasing since June 2015 after a temporary dip in wait times when many individuals were removed because they were disqualified from the long-term care wait-list after the government changed the criteria.

The length of the wait time ranges widely depending on the patient’s acuity and is much worse for some equity seeking groups. For instance a crisis referral can take an estimated 67 days⁵³ while a lower priority person who requests long-term care, or those with specific religious or ethnocultural needs can wait several years to find a home⁵⁴. Due to the limited space and growing responsibilities of long-term care homes, many people with real need for long-term care remain at home until they are in crisis and end up in a hospital.

Long-term care home waits may vary based on type of accommodation. Basic beds cost the resident (as of July 1, 2018) \$1,848.73 per month and are eligible for subsidy through the Long-Term Care Home Rate Reduction Program.⁵⁵ Long-

⁴⁷ CIHI: Residential Long-Term Care Financial Data Tables 2012 and CIHI: Residential Long-Term Care Financial Data Tables 2013.

⁴⁸ OANHSS 2015: *Need is Now: Addressing Understaffing in Long Term Care.*

⁴⁹ Ontario Long-term Care Association, 2018: *About Long-term Care in Ontario: Facts and Figures.*

⁵⁰ Ibid.

⁵¹ Ontario Long-term Care Association, 2018: *About Long-term Care in Ontario: Facts and Figures.*

⁵² Ibid.

⁵³ OANHSS, 2016: *Pre-Budget Submission: Ensuring the Care Is There.*

⁵⁴ TVO, 2016: *Why Ontario needs more culturally sensitive long term care*

⁵⁵ Government of Ontario, 2018: *Long-term Care Accommodation Costs and Subsidy.*

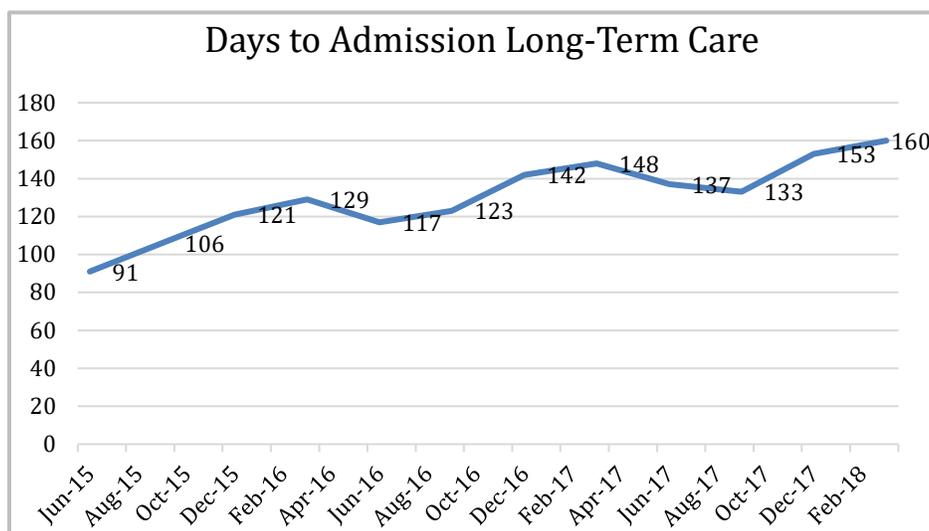


Figure 3: Median Days to Admission to Long Term Care ⁵⁶

term care homes are required to have 40 per cent of beds offered at the Basic/Standard bed rate.⁵⁷ They are allowed to hold 60 per cent of beds for higher priced Semi-Private or Private accommodation. The data shows that 56 per cent of the people on the wait list for long-term care are waiting for a basic bed. This means that 44 per cent of people on the wait-list have access to 60 per cent of the available beds (the ones for which premium rates are charged). The mean wait time for a basic bed is 689 days and the mean wait time for a private or semi-private bed is 440 days⁵⁸, meaning that there is almost an 8 month difference between mean wait times for those who can afford to pay over \$2,000 a month out of pocket and those who cannot. This creates a significant gap in access based on socio-economic status. There is a \$792.08 price differential between Basic accommodations and Private accommodations and that gap is further widened because only individuals who are in Basic accommodations have

access to the Long-Term Care Home Rate Reduction Program which can further reduce cost by up to \$1,848.73 a month, depending on income and assets. People who can afford to pay more for long-term care are therefore able to access long-term care considerably more quickly than those who can only pay for basic rooms or need a subsidized rate.⁵⁹

In our research, we also found that wait times and long-term care access vary based on location. The most densely populated urbanized areas have longer mean wait times which may, in part, reflect the extremely long wait lists for ethno cultural homes that are primarily found in urban areas.

⁵⁶ OLTCA Dashboard as of November 2018
⁵⁷ Advocacy Centre Elderly, 2014: Issues with Long-Term Care Rate Reductions.
⁵⁸ Author's calculations based on 'Long-Term Care Wait Times and Waitlists' posted by

LHINs based on data from September – November 2018.
⁵⁹ Government of Ontario, 2018: *Long-term care accommodation costs and subsidy*.

Accommodation Rates as of July 2018		
Type of Accommodation	Daily Rate	Monthly Rate
Long-stay Basic¹	\$60.78 (a)	\$1,848.73 (b)
Long-stay Semi-private²	\$73.27 (Basic plus a maximum of \$12.49)	\$2,228.63
Long-stay Private²	\$86.82 (Basic plus a maximum of \$26.04)	\$2,640.78
Short-stay	\$39.34	N/A

Figure 4: Accommodation Rates⁶⁰

Mean Days to Placement for 9/10 People on Long-Term Care Waitlist		
LHIN	Basic	Private/Semi-Private
Erie St. Clair	473	217
South West	350	212
Waterloo-Wellington	641	456
HNHB	380 (incomplete data)	346
Central West	933	446
Mississauga Halton	734	738
Toronto Central	996	710
Central East	999	616
South East	553	397
Champlain	824	411
North Simcoe - Muskoka	641 (incomplete data)	739
North East	520	457
North West	634	426
Central	No data	No data

Figure 5: Days to Placement Long-Term Care by Region⁶¹

⁶⁰ Ibid.

⁶¹ Author's calculations based on 'Long-Term Care Wait Times and Waitlists' posted by LHINs based on data from September – November 2018.

IIIa. A Diversity Lens on Wait Times & Access Issues

Ethno-Cultural Needs and Long-Term Care Waits

The population of Ontario is exceptionally multicultural and diverse with almost 30 per cent of Ontarians identifying as members of a visible minority population, a number that has been rapidly increasing.⁶² There are 56 ethno-specific long-term care homes across the provinces. These serve faiths such as Catholicism and Confucianism and ethnicities from Finnish to Portuguese to Filipino.⁶³ Ethno-specific homes include Yee Hong and Mon Sheong for the Chinese population, Suomi-Koti for those of Finnish heritage, Baycrest Centre for the Jewish community, Hellenic Home for the Greek community, and Villa Colombo for the Italian community. Finding a home that meets language needs and ethno-specific criteria is challenging since demand is far greater than availability⁶⁴.

Ethno-specific care and communication in the residents' languages are essential to both mental and physical health and wellness.⁶⁵ Homes that are culturally sensitive and that can appropriately address the challenges faced by different ethnicities and cultures are critical in preventing social isolation and depression in residents of long-term care.⁶⁶ Language barriers are a significant concern. They can create an isolating environment when the resident is unable to communicate

and socialize with staff and other residents. Language barriers may also decrease the ability to receive appropriate medical care for residents, as misdiagnosis and inability to communicate pain are common when language barriers are in place. Language barriers often mean that informed consent to treatment is not obtained from competent residents or the substitute decision-makers of incapable residents, as homes neither speak their language nor hire qualified interpreters for this purpose. Language barriers may worsen as residents develop dementia, at which time they may forget any language but their mother tongue. Inability to accommodate specific dietary needs or preferences can also contribute to decline. Nourishment is essential for wellness and residents may not eat if the food is unfamiliar or does not meet their religious requirements.⁶⁷

In February 2018 the median wait time for a bed in a long-term care facility in Ontario was 160 days; however, those waiting for a place in an ethno-culturally specific care home are faced with an average wait up to

⁶² Ontario Ministry of Finance, 2016: Ethnic Origins and Visible Minorities.

⁶³ TVO, 2016: Why Ontario needs more culturally sensitive long-term care homes.

⁶⁴ Toronto Star 2012: Toronto's Ethnic Nursing Homes Have Long Waiting Lists.

⁶⁵ Ontario CLRI-LTC Initiative, 2018: Supporting Diversity and Indigenous Culture in Long-Term Care 2017.

⁶⁶ Peel Long Term Care: Cultural diversity - A Handbook for Long Term Care Staff.

⁶⁷ Supporting Cultural Diversity in Long-Term Care 2017.

six months longer than the mainstream wait times.

The wait time for seniors looking for a bed in any Ontario nursing home is long, but those requiring culturally specific homes often experience even longer wait times, putting stress on patients and their families. As an example, in February 2018 the median wait time for a bed in a long-term care facility in Ontario was 160 days; however, those waiting for a place in an ethno-culturally specific care home are faced with an average wait up to six months longer than the mainstream wait times. For some homes such as Mon Sheong Centre, Hellenic Home for the Aged and Yee Hong Centre for Geriatric Care, applicants may have waits upwards of 2,400 days. That calculates to a period greater than six years.⁶⁸ The long-term care homes operated by Mon Sheong and Yee Hong have over 4,000 residents on their wait lists. The demand for quality long-term care for elders, especially visible minorities, will only continue to rise with the aging of the baby boomers.⁶⁹

Long wait times may incentivize seniors to omit their first choice of home which would have been the most appropriate and comfortable. With staffing shortages and rising stress levels due to understaffing and high turnover, there are additional barriers in place that impede culturally competent care. The rising acuity levels add to the challenge of finding time to meet the cultural needs of residents when achieving even the bare minimum of care is a daily struggle.⁷⁰

⁶⁸ TVO, 2016: *Why Ontario needs more culturally sensitive long-term care homes.*

⁶⁹ TVO, 2016: *Why Ontario needs more culturally sensitive long-term care homes.*

⁷⁰ Ontario CLRI-LTC Initiative, 2018: *Supporting Diversity and Indigenous Culture in Long-Term Care 2017.*

⁷¹ Sussman, T, et al., *Canadian Journal on Aging*, 2018: *Supporting Lesbian, Gay, Bisexual*

Long-term care system planning should include ensuring that there are homes that are welcoming and provide optimal care for older residents of our multicultural province.

LGBTQ2S-Inclusive Long-Term Care

LGBTQ2S older adults report that discrimination against them in long-term care is common.⁷¹ Those who are considering entering long-term care express a fear of bullying and aggression from other residents. As a result, some feel the need to “go back in the closet” when they enter long-term care out of fear of being vulnerable to residents and care staff.⁷² That fear may be precipitated by anxiety due to lack of control over whether they are sharing a room with someone who may have been part of their historic persecution.⁷³ The onset of dementia may also decrease the ability to hold back prejudices.⁷⁴ Creating an environment that is inclusive, supportive and safe for LGBTQ2S individuals in Ontario’s long-term care homes should be a priority.

There are currently only two homes in Ontario that are known to be specifically LGBTQ2S inclusive. They are both Toronto publicly-owned long-term care homes, one of which is feared in the community to be decommissioned within the next 10-years. None of the other long-term care homes in the province of Ontario have mandated LGBTQ2S allied training although they may choose to implement training at will.

& Transgender Inclusivity in Long-Term Care Homes: A Canadian Perspective.

⁷² Ibid.

⁷³ SAGE & MAP, 2010: *Improving the lives of LGBT Older Adults.*

⁷⁴ The Globe and Mail, 2018: *LGBTQ seniors fear renewed discrimination in long-term care.*

Indigenous Peoples' Access to Long-term Care

Indigenous elders and those requiring long-term care face barriers far greater than the general Ontario population in both accessing care and in accessing culturally appropriate, safe, competent and responsive services. One study of Indigenous communities found that ninety-five percent of Indigenous people would prefer long-term care in their own community but current services are not sufficient to meet need.⁷⁵ A 1999 study of Indigenous access to long-term care revealed that 85 per cent of community members were forced to leave their homes and families to reside in long-term care homes away from their community.⁷⁶ Elderly Indigenous people from remote northern communities are admitted to long-term care homes in Thunder Bay, thus being separated from tight-knit communities in which they have lived for their entire lives, and far enough away that it is challenging to visit, especially in winter when access to Thunder Bay is limited.⁷⁷ The lack of long-term care in Indigenous communities is exacerbated by an inadequate number of hospital beds in Northern communities.⁷⁸ Impediments to accessing services such as the lack of roads and transportation, high cost of medical supply transport, inability to access rehab services, long travel to health professionals, and lengthy waits

are all contributing impediments to access.⁷⁹

Relocation by itself can be devastating. This stress and grief is compounded by the failure to provide access to culturally appropriate practices and care. Indigenous elders in long-term care face a culture that is entirely different from what they have experienced. The food, language and activities do not meet cultural needs.⁸⁰ In addition, Indigenous residents have reported experiencing racism and degrading treatment which violates their rights to obtain respectful and adequate care, and removes feelings of safety, affecting health and well-being.⁸¹

In May, the provincial government announced that 500 of the new long-term care beds would be allocated for Indigenous community members or located in First Nations Territories.⁸² While this is a start, it does not address the current shortfall, nor does it provide for coming needs. In 2013, Indigenous elders appealed for redress to protect the cultural rights for people to stay in their home communities as they age and require long-term care.⁸³ It is beyond time that this urgent need be met. Respect for treaty rights and jurisdictional issues must also be considered when planning care and supporting culture for Indigenous populations.

⁷⁵ Ibid.

⁷⁶ Sue Cragg Consulting and the CLRI Program, 2017: *Supporting Indigenous Culture in Ontario's Long-Term Care Homes*.

⁷⁷ CBC, 2013: *Aboriginal Long-Term Care Experts Call of Beds, Housing*.

⁷⁸ CBC, 2013: *Aboriginal Long-Term Care Experts Call of Beds, Housing*.

⁷⁹ Sue Cragg Consulting and the CLRI Program, 2017: *Supporting Indigenous Culture in Ontario's Long-Term Care Homes*.

⁸⁰ Ibid.

⁸¹ Ibid.

⁸² Ontario Ministry of Health and Long-Term Care, News Release May 4, 2018: *Nearly 500 More Long-Term Care Beds for Seniors in Indigenous Communities*.

⁸³ CBC 2013: *First Nation Elders Appeal for Long-Term Care Home*.

iv. Increase in the Acuity of Residents

It is irrefutable that the acuity – that is the complexity and heaviness of care needs of long-term care residents -- has dramatically increased, while actual care levels have not kept pace, and we argue that this policy of planned offloading of patients to lesser-funded levels of care despite their need is unsafe and inhumane. By all measures, levels of acuity have steadily risen and continue to escalate in Ontario's long-term care homes. Recent public testimony has emerged at the Long-Term Care Inquiry following the serial murders of eight residents in long-term care homes by Elizabeth Wettlaufer, a nurse who was responsible for the victims' care.⁸⁴ It puts a real human face on the most severe consequences of rising acuity without appropriate resourcing. The staff called to the stand from the long-term care homes at which Elizabeth Wettlaufer worked testified repeatedly that the heightened acuity of long-term care residents has increased the workload of the nursing staff.⁸⁵ This compromises the quality of care and safety of all of the residents and may have contributed to Elizabeth Wettlaufer's behaviour going unchecked in the long-term care homes where she was employed. Ontario government data supports the testimony of the staff regarding increased care loads.

By all measures, levels of acuity have steadily risen and continue to escalate in

Ontario's long-term care homes.

Today, long-term care residents (really patients) are medically complex and frail – they require many medications, they have comorbidities, they require complex nursing care. For example, residents today require peritoneal dialysis, wound treatments, palliative care, post-operative care, pain management, suctioning, and so on. This care is being provided in environments that are not physically designed for such care nor staffed with appropriate nursing staff and personal support staff in insufficient numbers for the setting.

Today, long-term care residents (really patients) are medically complex and frail – they require many medications, they have comorbidities, they require complex nursing care... This care is being provided in environments that are not physically designed for such care nor staffed with appropriate nursing staff and personal support staff in

⁸⁴ Elizabeth Wettlaufer murdered 8 residents in 2 Ontario long-term care homes from 2007 to 2014. She was also charged with assaults and attempted murders of other long-term care residents, a resident in a retirement home and a person for whom she was

providing care in the community. This is the subject of an ongoing public inquiry.

⁸⁵ Long-Term Care Homes Public Inquiry: Robert Ventrack – Meadow Park, June 5, 2018; Brenda Van Quaethem and Helen Crombez, Caressant Care, June 7, 2018; Deanne Beauregard – Telfer Place, June 26, 2018

insufficient numbers for the setting.

Measures of Acuity

The Case Mix Index is used to assign a relative value of acuity to patients in long term care. Patients are classified into groups based on condition, complexity and needs. A relative value is then calculated to indicate the amount of resources that the resident needs. In 2009 the province of Ontario shifted from using CMM to CMI to calculate funding for long-term care homes. No tool was developed to enable researchers to create a consistent data set to compare rising

acuity as the resident assessment systems changed. However, the data that does exist is very clear and it tells an irrefutable story that corroborates the accounts of those who work in long-term care who content that rising acuity levels have created an impossible workload for front-line care staff.

Provincial government data shows that the CMM increased by 12.2% overall from 2004 – 2009 and the CMI increased by 7.63% from 2009 – 2016. These are measures on two different scales but they both reveal dramatic increases in levels of acuity.

Case Mix Measure 2004 – 2009							
	2004	2005	2006	2007	2008	2009	% increase
Provincial CMM	91.58	93.39	96.33	98.13	100.4	102.74	12.20%
Municipal	88.75	90.14	92.39	94.96	97.74	99.99	12.70%
Charitable	89.3	91.34	94.77	95.56	97.15	99.38	11.30%
For-Profit	93.09	94.84	97.77	99.55	101.16	103.49	11.20%

Figure 4: Annual Provincial Case Mix Measures; By Subsector; 2004-2009⁸⁶

The Case Mix Index (CMI) is a calculation based on the home’s Case Mix Measure (CMM) in relation to the provincial CMM.⁸⁷ The province began using CMI instead of CMM to allocate long-term care funding in 2009.

Case Mix Index 2009 - 2016									
Year	2009	2010	2011	2012	2013	2014	2015	2016	% increase
CMI	0.9999	1.0188	1.0318	1.0388	1.0470	1.0572	1.0644	1.0762	7.63%

Figure 5: Case Mix Index 2009 - 2012⁸⁸⁸⁹

⁸⁶ Statistics Canada, Residential Care Facilities, Table 5.7

⁸⁷ Health Data branch. Ontario Ministry of Health and Long-Term Care: *Levels of care classification*.

⁸⁸ Health Data branch. Ontario Ministry of Health and Long-Term Care: *LTC Homes Case Mix Index 2009-2012. Assessment Fiscal SR Ltd.*

⁸⁹ LTC Home Level Master Sheet 2015 – 16, 2017 – 18, 2018 – 19 reporting from 2013 – 2016. Reported as fiscal year, SR Limited CMI

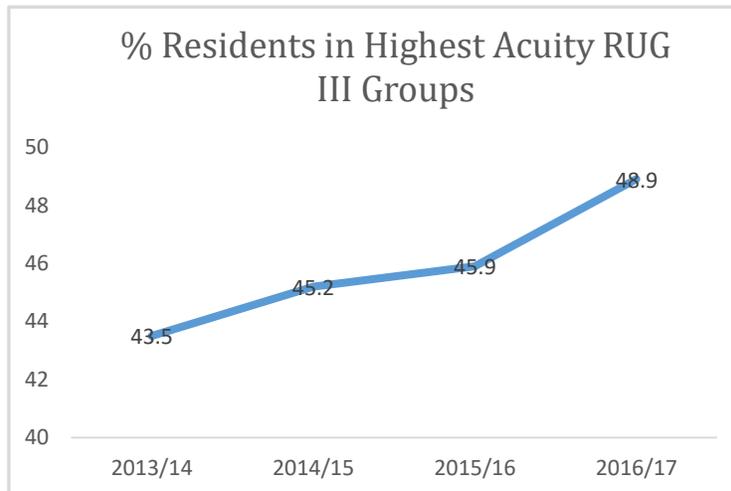


Figure 6: % Residents in Highest Acuity RUG III Groups⁹⁰

Only Those with Higher Needs are Admitted

The data also shows that acuity has increased at the point of admission, meaning that residents are entering long-term care with greater needs. The MAPLe score (Method for Assigning Priority Levels) is used by care coordinators to classify clients according to their level of care needs. The MAPLe score of residents was 76% in 2010. By 2016 it had increased by 8% to 84%, a very significant leap in 6 years alone.⁹¹ Today, the vast majority (84%) of those currently admitted to long-term care homes are assessed as having high and very high needs.⁹² People with significant care needs who are not ranked as highly are unable to access long-term care.

Total Care Needs Escalating

The Continuing Care Reporting System (CCRS) contains data on individuals who

receive continuing care services in long-term care homes in Ontario, shows an increase in residents of long term care who have care needs from “extensive” to “total” dependence on staff in order to perform activities of daily living such as bathing, dressing, toileting or eating. This data also shows a dramatic escalation of the percentage of residents whose care needs rate at the highest levels.

Incidence of Dementia Escalating

The majority of residents in long-term care homes have a diagnosis of dementia. Dementia is associated with a decline in memory and other thinking skills.⁹³ Government data reveals that 81 per cent of individuals in long term care have some form of cognitive impairment with nearly 1/3 displaying severe cognitive impairment.⁹⁴ The number of residents with dementia has been increasing at a steady rate of 1 per cent per year in recent years (see Figure 8).

⁹⁰ CIHI: Continuing Care Reporting System Data 2013 - 2017

⁹¹ OANHSS, 2016: *Pre-Budget Submission: Ensuring the Care Is There*.

⁹² Ibid.

⁹³ Alzheimer’s Association, 2018: *What is Dementia?*

⁹⁴ CIHI: Continuing Care Reporting System Data 2016 - 2017

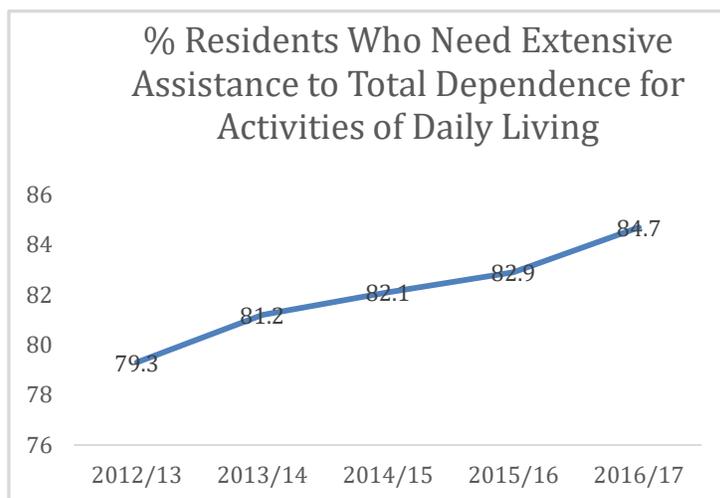


Figure 7: Residents Who Need Extensive Assistance to Total Dependence for Activities of Daily Living⁹⁵

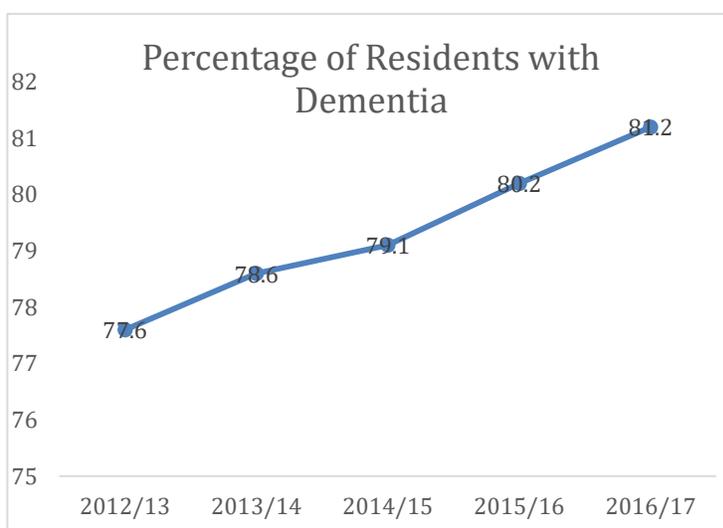


Figure 8: Percentage of Residents with Dementia⁹⁶

As many as 86 per cent of individuals diagnosed with dementia will experience displays of aggression as the disease progresses.⁹⁷ Nearly half of residents in long-term care display aggressive behaviours, and as the proportion of patients with dementia in long-term care

continues to rise we can expect to see increased levels of aggressive behaviour. As psychogeriatric services are cut, aggressive behaviours are at risk of increasing due to low staffing levels and staff who are not trained or equipped to manage psychogeriatric crises.

⁹⁵ CIHI: Continuing Care Reporting System Data 2012 - 2017

⁹⁶ CIHI: Continuing Care Reporting System Data 2012 - 2017

⁹⁷ Talerico, K, Evans, L, & Strumpf, N, 2002, *The Gerontologist: Mental Health Correlates of Aggression in Nursing Home Residents with Dementia*.

Almost Half of Residents in Long Term Care Exhibit Some Form of Aggressive Behaviour

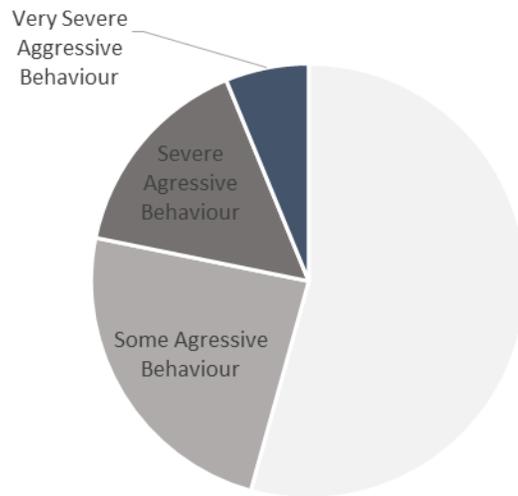


Figure 9: Proportion of Residents with Aggressive Behaviour⁹⁸

⁹⁸ CIHI: Continuing Care Reporting System Data 2016 - 2017

v. Inadequate Care Levels

A regulated minimum care standard for long-term care was identified, by the U.S. Centers for Medicare and Medicaid Services in 2001, 17 years ago.⁹⁹ Subsequently, there has been a struggle, largely between the for-profit chain companies who want deregulation and more money for their profit margins and their assets on hand, versus consumer, union, and public interest groups advocating for a strong regulated care standard and more resources to care, on the other. In 2008, to address the controversy, the Ontario government commissioned an expert opinion. Known as the Sharkey Report, it acknowledged that care levels were inadequate but it did not recommend a regulated minimum standard for hours of care. Instead it muddied the waters, appearing to recommend 4 hours of care per day, but included in the care calculation allied health professionals in addition to daily hands-on nursing and personal care staff. The report recommended *up to* 3.5 hours of care by personal support worker, registered practical nurse or registered nurse per resident per day and did not provide the needed accountability to ensure this would actually happen. With current levels of acuity in long-term care, and based on the best available evidence, a regulated minimum average of 4 hours of daily hands-on direct care staffing is required to prevent harm and improve outcomes.

With current levels of acuity in long-term care, and based on the best available

evidence, a regulated minimum average of 4 hours of daily hands-on direct care staffing is required to prevent harm and improve outcomes.

At the time the Sharkey Report was written, Ontario's long-term care staffing was an average of 2.84 worked hours per resident per day. Current levels of staffing have dropped to 2.71 worked hours per resident per day.¹⁰⁰ This is a significant decrease in hands-on care in the face of growing acuity. Sharkey's approach of a voluntary – not regulated – and watered-down target has clearly failed. We can learn from past experience that without a mandatory requirement and resources to support it, levels of care will not rise to meet resident's needs. This is supported by the 2015 Report of the Ontario Auditor General in which it was noted that Ontario does not require a minimum front-line staff-to-resident ratio and that inadequate staffing was the primary reason reported by long-term care homes' administrators for inability to achieve compliance in inspections and meet government requirements.¹⁰¹

In fact, as shown in Figure 10, the actual hours of care provided to residents by hands-on care staff (RNs, RPNs and PSWs) is declining. After a slight improvement from 2006 – 2012, care levels have dropped to their lowest levels of the decade shown, despite the increases in levels of resident acuity. Overall, the trend line tracks downward

⁹⁹ U.S. Centers for Medicare and Medicaid Services, 2001, Abt Associates Inc . *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes*. Report to Congress: Phase II Final. Volumes I–III.

¹⁰⁰ Figure 10: Worked Staffing Hours Per Resident Per Day Based on MOHLTC

¹⁰¹ Office of the Auditor General of Ontario, 2015: *Annual Report 2015*.

indicating that Ministry of Health funded staffing levels have actually declined since 2006.

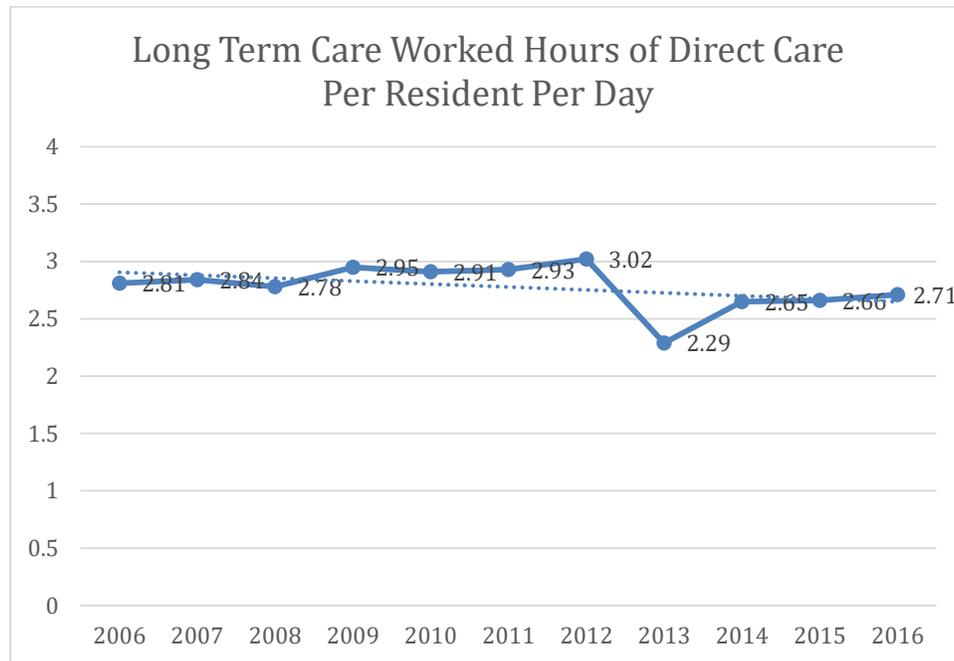


Figure 10: Worked Staffing Hours Per Resident Per Day¹⁰²

During the Wettlaufer Inquiry the former Director of Nursing at Meadow Park London owned by Jarlette reported that she wished they had more staff, including PSWs and nurses because there were more things for staff to do than they had time to complete. There was a focus on filling out all the RAI MDS data so that they could try to get to 100 per cent funding.¹⁰³ There were multiple complaints by witnesses about the difficulties finding and retaining registered staff due to low salaries and long grueling hours.¹⁰⁴

Not enough care means residents are fed too quickly, cannot get enough food down, and lose weight, becoming frail and risking dehydration or starvation. It means no time for bathing or repositioning to prevent bed sores. It means no friendly visits or socialization for lonely or depressed residents.

Not enough care means residents are fed too quickly, cannot get enough food down, and lose weight,

¹⁰² Author's calculation based on Ministry of Health and Long-Term Care Staffing Database: *Ontario Long-Term Care Homes Staffing Data 2009-2016*.

¹⁰³ Long-Term Care Inquiry: June 19, 2018 Heather Nicholas (Meadow Park- London).

¹⁰⁴ Long-Term Care Inquiry: June 5, 2018 Robert VanderHayden (Meadow Park-London) & June 7 – Brenda Van Quaethem (Carresant Care- Woodstock).

becoming frail and risking dehydration or starvation. It means no time for bathing or repositioning to prevent bed sores. It means no friendly visits or socialization for lonely or depressed residents.

This inadequacy of care was described by Brenda Black, a personal support worker, who reported to the Long-Term Care Inquiry about her time in Caressant Care Woodstock during a “cease admit” order in 2017. She testified that because resident numbers were down, staff finally had time to adequately care for residents. They were able to take them to the bathroom on time, and attend to their needs, and even sit and talk with them:

“Yes, we could get to residents’ needs a lot quicker. There was less of them, and so we were able to get to them quicker and catch them and get them on the toilet before they had their – you know, like, an accident. And, you know, we were just able to spend more quality time with them and at least even just sit down and talk. Like, usually, it is in and out, gotta go, gotta go. We can’t sit and spend five minutes, and then they would talk, and we kind of keep walking, and they would still keep talking because we had ten other things we had to do. But with less residents, we had more time to spend with them, so it was nice.”¹⁰⁵

¹⁰⁵ The Long-Term Care Inquiry: Sept 24, 2018 Brenda Black as quoted by Mr. Van Kralingen

¹⁰⁶ Behavioural Supports Ontario accessed at: <http://www.behaviouralsupportsontario.ca/29/Background/>

¹⁰⁷ Ontario Long Term Care Association, 2017: *Building Better Long-Term Care*.

Behavioural Supports Ontario (BSO)

Behavioural Supports Ontario (BSO) was designed to help long-term care homes manage individuals with responsive behaviour due to dementia, substance use, mental health and neurological conditions.¹⁰⁶ Responsive behaviours include grabbing, screaming, making strange noises, trying to go somewhere, verbal aggression, agitation, wandering and other actions. BSO provides behavioural support outreach teams that can support professional and family caregivers. They advise of strategies to manage responsive behaviours that can be considered negative in a way that is helpful and not harmful to the resident. BSO has been proven to reduce violence in long-term care without using medication and physical restraints¹⁰⁷. The 2015-16 Ontario Budget invested \$10 million over 3-years to implement BSO but there are obstacles to implementation due to understaffing.

Mobile BSO teams are dispatched when responsive behaviours become problematic. They have been used as a strategy rather than in-house teams in order to save money. In-house BSO teams are 2- to 4-times more likely to help reduce challenging behaviours than mobile BSO teams. Since mobile teams are not “in-house” they are not always there when needed.¹⁰⁸ Half of Ontario’s long-term care homes have no in house BSO resources.¹⁰⁹

¹⁰⁸ Grouchy, M, Cooper, N, and Wong, T, Healthcare Quarterly, 2017, *Implementation of Behavioural Supports Ontario (BSO): An evaluation of Three Models of Care*.

¹⁰⁹ *Building Better Long-Term Care*.

VI. Escalating Violence

The violence in Ontario's long-term care homes has reached a scale that can no longer continue to be swept aside. In its most extreme, violence takes the form of homicides¹¹⁰, and in comparing the rate of homicide in this province's long-term care homes we calculated that it is higher than any of the province's largest urban centres. This is unacceptable and we have chosen to use strong language to underline the priority with which this issue must be addressed. We are not alone. In fact, in recent years, the Ontario Coroner's Geriatric and Long-Term Care Review Committee has repeatedly flagged this issue as one that must be addressed urgently. In addition to the appalling rates of resident-on-resident homicide, we also found that resident-on-resident abuse is rising, and measures of injury among staff and reported violence against staff were intolerably high.

The evidence shows that the violence in the homes is systemic and is escalating as acuity increases and care levels decline.

The evidence shows that the violence in the homes is systemic and is escalating as acuity increases and care levels decline. While causes of increased violence and injury may be multifaceted, there can be little doubt that the inadequacy of care levels is a central contributing factor. This is a policy choice, not a necessity, and this data should raise a serious question for policy makers. How much longer can we tolerate a situation in which living or

working in a long-term care home is more dangerous than working or residing virtually anywhere else in our society?

While causes of increased violence and injury may be multifaceted, there can be little doubt that the inadequacy of care levels is a central contributing factor. This is a policy choice, not a necessity, and this data should raise a serious question for policy makers.

Resident-on-Resident Homicides in Long-Term Care

According to the Ontario Coroner, there were 27 known resident-on-resident homicides in Ontario's long-term care homes over the most recently measured 5-year period. We know the total number of homicides is actually higher because the Coroner's reports do not include the victims of Elizabeth Wettlaufer which were not considered suspicious deaths until her confession.

¹¹⁰ The Ontario's coroner's office definition of homicide differs from the criminal definition as it does not imply criminal culpability.

The following lists the homicides by year as reported by the Ontario Coroner:

2012 – 3 definite homicides, 2 possible homicides¹¹¹

2013 – 5 homicides¹¹²

2014 – 8 homicides¹¹³

2015 – 7 homicides¹¹⁴

2016 – 4 homicides¹¹⁵

Using the Coroner's reporting, we can calculate that the average rate of homicides in Ontario's long-term care homes is approximately 7 per 100,000 people over the 5-year period ending in 2016.¹¹⁶ Comparably, the 2016 rate of homicides per 100,000 people was 1.69 in all of Canada¹¹⁷ and 1.47 in Ontario.¹¹⁸ In Toronto, the homicide rate per 100,000 was 1.55 that year.¹¹⁹ Sarnia, Ontario which has a similar sized population as the total long-term care population at 73,981 residents had 2 homicides in 2016 putting its homicide rate at 2.7 per 100,000.¹²⁰ Sault Ste. Marie with a population of 75,937 saw no homicides in 2016 and has a 0 per 100,000 homicide rate.¹²¹ Thus, the long-term care homicide rate is more than four times that of our country's largest city and 4- to 8- times that of an average large town in Ontario. Homicide

is the extreme end of a spectrum of violence in long-term care. Reports also hold that the number of resident-on-resident assaults is increasing significantly. A CBC report found that there has been a 129% increase in resident-on-resident abuse reported between 2011 and 2016¹²².

Violence Against Long-Term Care Staff

Violence is constant for long-term care staff. This is a systemic issue in Ontario's long-term care homes and it is also a gender issue. In a study of workforce violence, the vast majority of Personal Support Workers (more than 95 per cent) working in long-term care homes in Ontario, Manitoba and Nova Scotia were women.¹²³ Almost all of these Personal Support Workers in long-term care homes report that they have experienced violence in either physical, verbal or sexual capacity, and almost half report that they violence they experienced occurred daily.¹²⁴ They report that racism is also common.¹²⁵ The numbers of nurses, both RNs and RPNs, who report violence is also extremely high.¹²⁶ Most of the violence goes unreported unless medical attention is necessary.

¹¹¹ Office of the Chief Coroner for Ontario, 2013: *2012 Annual Report of the Geriatric and Long-Term Care Review Committee*.

¹¹² Office of the Chief Coroner for Ontario, 2015: *Geriatric and Long-Term Care Review Committee 2013-14*.

¹¹³ Ibid.

¹¹⁴ Office of the Chief Coroner Province of Ontario, 2016: *Geriatric and Long Term Care Review Committee 2015 Annual Report*.

¹¹⁵ Office of the Chief Coroner Province of Ontario, 2017: *Geriatric and Long Term Care Review Committee 2016 Annual Report*.

¹¹⁶ Author's calculation using definite homicide numbers from Coroner's Report and 2016 total number of long-term care beds (76,982).

¹¹⁷ Statistics Canada, Table 35-10-0068-01 *Homicide victims, number and rates (per 100,000 population)*

¹¹⁸ Statistics Canada, *The Daily - Homicide in Canada 2016*.

¹¹⁹ Statistics Canada, *The Daily - Table 2 Homicides by Census Metropolitan Area 2016*.

¹²⁰ MacLean's: *Canada's Most Dangerous Places 2018*.

¹²¹ Ibid.

¹²² CBC News, 2018: *Reports of staff abusing residents up nearly 80% in GTA long-term care homes*.

¹²³ Banerjee, A, et al., 2008: *"Out of Control": Violence against Personal Support Workers in Long-Term Care*.

¹²⁴ Ibid.

¹²⁵ Ibid.

¹²⁶ Ibid.

The study described the violence in graphic terms:

“The verbal violence experienced by care workers often includes threats, screaming, cursing, racial insults, and demeaning remarks. It can also include excessive demands and complaints. The physical violence experienced by care workers typically includes being slapped or hit with an object. It frequently involves being pinched, bitten, having one’s hair pulled, being poked or spit on. Having one’s wrists painfully twisted is also very common. Sexual harassment and violence has been noted, though far less studied.”¹²⁷

Violence is often blamed on the staff¹²⁸ despite inadequate staffing and BSO implementation which would help reduce violence in long-term care. In fact, the extent to which levels of violence may be a result of policy choices is evidenced in comparative data. Study authors found that Nordic countries have dramatically lower levels of violence.¹²⁹ Authors noted the correlation between inadequate staffing and levels of violence, noting that almost half of Canadian Personal Support Workers reported working short-staffed nearly every day. Comparatively many fewer (15 per cent) of their Nordic counterparts reported working short-staffed daily.¹³⁰

Long-Term Care Injury Statistics

¹²⁷ Ibid, page 4.

¹²⁸ Ibid.

¹²⁹ Ibid.

¹³⁰ Ibid.

Further evidence of the rates of violence in long-term care can be found in the statistics measuring rates of workforce lost time due to injury. Health care ranks second-highest among all industries in the numbers of lost time injury (LTI). The average rate of LTI in health care in general is 1.27 but in long-term care the LTI injury rate is 2.24, nearly double the LTI rate in other health jobs and higher than other industries.¹³¹ In 2016, there were 1,746 allowed Schedule 1 LTI counts in long-term care out of a total of 6,902 LTI in all of health care.¹³² The number of unreported incidents is likely higher.

Public Inquiry into the Safety of Residents in the Long-Term Care Homes System and Elizabeth Wettlaufer

As this report has been written, testimony has been given in the Long-Term Care Inquiry into the murder of eight long-term care residents, and additional attempted murders and assaults in long-term care homes, a retirement home and in the community, by nurse Elizabeth Wettlaufer. The behaviour of Elizabeth Wettlaufer is her own responsibility, but salient questions have been raised about whether the deaths and harm suffered by those in her care could have been prevented, and about why she was able to carry on for so long without being stopped. In our opinion, the revelations from nursing, administrative and personal care staff in the long-term care homes fully support the data and findings of this report. The testimony provided in the Inquiry shows that the homes in which Elizabeth Wettlaufer worked suffered from chronic understaffing and

¹³¹ Government of Ontario, 2017: *Health care sector plan 2017-18: Health care sector injury statistics.*

¹³² WSIB Ontario: 2016 *WSIB Statistical Report – By the Numbers.*

rising acuity, contributing to the creation of an unsafe environment for the frail and vulnerable residents.

With extremely low staffing rates it can be impossible for staff to notice and prevent acts of abuse, and with a frail and vulnerable population one instance of violence can lead to death. Elizabeth Wettlaufer was responsible for almost 100 residents during the night shift when she harmed residents with the other nurse on shift being responsible for 60 residents.¹³³ In the Inquiry, the lack of qualified staff and low staffing levels were reported over and over.¹³⁴ Staff who worked with Ms. Wettlaufer in long-term

care homes raised this as a constant issue and a possible reason why she was hired and remained on staff despite having other employment-related issues.¹³⁵

¹³³ Long-Term Care Inquiry: Barbara Van Quaethem - Caressent Care, June 6, 2018.

¹³⁴ Long-Term Care Inquiry: Barbara Van Quaethem - Caressent Care, June 6 & 7, 2018; Heather Nicholas – Meadow Park, June 9,

2018; Heather Wilmot Smith – Lifeguard Carehome, June 14, 2018.

¹³⁵ Long-Term Care Inquiry: Barbara Van Quaethem - Caressent Care, June 6, 2018.

VII. For-Profit Privatization: Impact on Care

Small locally-owned long-term care homes have a long history in Ontario. But as the sector has been expanded, ownership on the for-profit homes has consolidated and homes have gotten larger. A few very large chain corporations have taken ownership of significant segments of the “market” and have brought with them a corporate approach to maximizing profits and lobbying for their own interests. In addition, the proportion of long term care homes owned by for-profit interests has grown. A minority of homes were for-profit prior to Ontario’s Harris government. The expansion of for-profit long-term care and contraction of public hospitals in the late 1990s amounted to a significant transfer of public non-profit assets and serves private for-profit corporations. By the end of the Harris government’s tenure in 2002, for-profit long-term care homes had taken over the majority of the long term care sector. Under the Liberal governments of McGuinty and Wynne the proportion of for-profits continued to increase. Today 59 per cent of Ontario’s long-term care homes are owned and operated by for-profit corporations.

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Ownership matters. Non-profit long-term care homes use surplus dollars to expand services and operations so extra revenue

is put back into improving quality of care. Public and not-for profit homes have accountability for dollars spent to elected representatives and to their community Boards of Directors. In for-profit homes there is incentive to siphon funds away from care and increase profit margins. Non-profits and for-profit long-term care homes are both funded by the same system and all profits that are channelled away from care are taken at the expense of tax payers and residents.¹³⁶

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Poorer Quality in For-profit Long-Term Care

The evidence shows that for-profit homes have poorer quality. A study looking at one year follow-up post admission to Ontario long-term care facilities found residents in for-profit homes have a 10 per cent higher risk of mortality and a 25 per cent higher risk of hospitalization. In the three months after admission, rates were even higher. At that point, the risks of mortality was 20 per cent higher and the risk of hospitalization was 36 per cent higher in the for-profit long-term care homes when compared to non-profits.¹³⁷

¹³⁶ AdvantAge Ontario, 2018: *The Not for Profit Difference in Services for Seniors*.

¹³⁷ Tanuseputro, P, et al., *Journal of Post-Acute and Long-Term Care Medicine*, 2015: *Hospitalization and Mortality Rates in Long-*

It is likely that the poor outcomes found in for-profit long-term care homes are because of lower staffing levels.¹³⁸ For-profit chains also have higher rates of resident complaints compared with non-profit and public facilities.¹³⁹

For-profit long-term care homes have lower staffing levels in Ontario even when adjusting for different acuity levels and the worst offenders are long-term care homes with chain affiliation.¹⁴⁰ The lower staffing numbers can clearly be seen in the financial data.¹⁴¹ For-profit facilities only spend 49 per cent of their operating revenue on staffing while not-for profits spend 75 per cent of revenue on staffing.¹⁴²

The public also overwhelmingly supports and prefers non-profit and publicly owned long-term care. The data shows that 58 per cent of long-term care homes are in the for-profit sector yet they make up 32 per cent of the waitlist while non-profit and municipal homes comprise 42 per cent of long-term care homes but carry 68 per cent of the waitlist.

The homes that Elizabeth Wettlaufer worked in were for-profit long-term care homes. In the Long-Term Care Inquiry, staff testified that accountants would look

at CMI each month to ensure that nurses were charting to reach optimal CMI to ensure maximum funding levels. Staff were pressured if maximum funding for nursing and personal care was not achieved.¹⁴³ Staff also testified that it was challenging to find and retain nursing staff because of the low wages offered in for-profit long-term care homes.¹⁴⁴

Big Chain For-Profits

The largest five chain companies control 23.8 per cent of beds and 18.9 per cent of nursing homes in Canada. In Ontario almost half of all long-term care beds are owned by for-profit chain companies.¹⁴⁵ A number of these companies have extensive track records including allegations of fraudulent billing practices and poor quality of care or neglect. In the United States, Extencicare sold 90 homes with more than 12,000 beds in 2015 after they paid \$38 million to the US Department of Justice and eight state governments to settle allegations of billing Medicare and Medicaid for substandard nursing services and billing for medically unreasonable and unnecessary therapy.¹⁴⁶ A mass tort claim is being started in Ontario against Revera¹⁴⁷, Extencicare Inc. and Sienna Senior Living Inc. alleging the companies

Term Care Facilities: Does For-Profit Status Matter?

¹³⁸ IRPP, 2011: *Residential Long-Term Care for Canada's Seniors*.

¹³⁹ McGregor MJ, et al, *Open Medicine*, 2011: *Complaints in for-profit and public nursing homes in two Canadian provinces*.

¹⁴⁰ Hsu, A, et al. *Canadian Journal of Aging*, 2016: *Staffing in Ontario's Long-Term Care Homes: Differences by Profit Status and Chain Ownership*.

¹⁴¹ Calculation based on Nursing and Residential Care Facilities Statistics Canada (Provisional Estimate) 2015

¹⁴² Calculation based on Nursing and Residential Care Facilities Statistics Canada (Provisional Estimate) 2015

¹⁴³ Long-Term Care Inquiry: Heather Nicholas – Meadow Park, June 19, 2018

¹⁴⁴ Long-Term Care Inquiry: Brenda Van Quaethem, June 7, 2018

¹⁴⁵ *Staffing in Ontario's Long-Term Care Homes: Differences by Profit Status and Chain Ownership*.

¹⁴⁶ Harrington, C, et al., *Health Service Insights* 2017: *Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains*.

¹⁴⁷ CTV News 2018: *Class Action Lawsuit Against Nursing-home Giant to be Halted in Favour of Mass Tort*.

did not operate in accordance to their fiduciary and contractual responsibilities to their patients. It cites cases of extreme neglect of residents.¹⁴⁸ Across the biggest Canadian for-profit long-term care chains revenues ranged from Canadian \$509 million to \$980 million. From 2007 to 2012 Extencicare reported an average annual profit margin of 9.6 per cent (\$86 million) Chartwell reported a 12.6 per cent (191.6 million) profit margin and Sienna Senior Living Inc. (Leisureworld) reported an 11.8 per cent (\$67 million) profit margin.¹⁴⁹

The new Ontario government under Premier Doug Ford has proposed a significant expansion of the long-term care sector. Thirty-thousand new long-term care beds are to be created over the next decade with 15,000 to be created in the next 5 years. It is in the public interest that this welcome expansion in long-term care capacity be built under public and non-profit ownership so that the homes are run for the public interest, not as a tool for revenue streams for private for-profit corporations.

Long-Term Care Homes Ownership Status		
Long Term Care Homes Ontario		
For-Profit	355	58.8%
Not For-Profit	249	41.2%
Total	604	

Figure 10: Long-Term Care Homes Profit Status¹⁵⁰

¹⁴⁸ CBC News, 2018: 'We want justice for our mom': Lawsuit against long-term care providers alleging serious neglect.

¹⁴⁹ Harrington, C, et al., *Health Service Insights 2017: Marketization in Long-Term Care: A*

Cross-Country Comparison of Large For-Profit Nursing Home Chains.

¹⁵⁰ 2016 Ontario Long-Term Care Homes Staffing Database.

VIII. Conclusion

Long-term care in Ontario houses almost 80,000 people who are elderly, have chronic disease, disability or mental health issues. Ontario's long-term care system is their home: the place that they rely upon to provide for the necessities of life; for their safety; for their comfort, and hopefully their enjoyment; and the place in which they receive the needed care that is fundamental to every human life. For many residents of long-term care, it is their final home. Conditions of care in long-term care are also the conditions of work for the tens of thousands of nurses, allied health professionals, personal support workers and other staff who provide care and programs for the residents. Poor access to long-term care impacts not only the 80,000 residents and tens of thousands of long-term care staff, but also at least 33,000 more Ontarians waiting for placements and all of their families.

Poor access to long-term care impacts not only the 80,000 residents and tens of thousands of long-term care staff, but also at least 33,000 more Ontarians waiting for placements and all of their families.

There have been warning signs for many years that Ontario's long-term care system is failing. There have been numerous individual reports of neglect, and insufficient care, and violence, and homicide; and even, as in the Ontario Coroner's reports, aggregations of mounting incidents that point to serious systemic issues. In this report we have tried to build upon the work that has been

done; to bring together all of the most recent data that is available pertaining to population need, the measured needs for care of long-term care residents and the level of actual care provided. We think we have created a thorough and, hopefully, compelling argument for a system that urgently needs healing.

The most critical factor in improving conditions of care and work in long-term care is enough staff. Care workers in Ontario report working short staffed virtually every single day. The data shows that daily hands on care levels for Ontario long-term care residents are far too low and has actually declined as levels of acuity have increased.

We have found that there has been a failure to plan for the long term care needs of Ontario's population. But this understates the reality of the policy decisions that have been made. In fact there has been a purposeful policy of planned rationing of access to- and levels of- care far below demonstrated population need. These policy choices are just that: choices. They are not necessities. We have shown that other provinces and other jurisdictions do far better than Ontario in a number of crucial measures.

By any measure of morality and humanity, the situation in Ontario's long-term care sector has become intolerable. The consequences of planned under resourcing of long-term care and the

offloading of increasingly complex hospital patients has seen levels of violence and harm that would not be countenanced virtually anywhere else in our society. We can no longer permit these conditions to continue in long-term care.

There is almost total consensus that the most critical factor in improving conditions of care and work in long-term care is enough staff. Care workers in Ontario report working short staffed virtually every single day. The data shows that daily hands on care levels for Ontario long-term care residents are far too low and have actually declined as levels of acuity have increased. The testimony at the Long-Term Care Inquiry was rife with accounts of levels of inadequate staff and inability to provide sufficient care and safety. Administrators report that they are unable to meet existing standards for safety and care because of insufficient staffing. Numerous reports, budget submissions, public exposes, and lawsuits have recounted the inadequacies of staffing and care levels in Ontario's long-term care.

It was Mahatama Gandhi who said "A nation's greatness is measure by how it treats its weakest members". We believe that the research we have compiled in this report will contribute to amplify a call for policy change to address the serious shortfall in care. It is time to heal long-term care.

IX. Recommendations

- I. Levels of care in Ontario's long-term care homes must be improved and this improvement must be mandatory and enforceable. Increased funding must go to improving care. The Ontario government must institute a regulated minimum care standard of an average of 4-hours of daily hands-on direct nursing and personal support per resident to provide care and protect from harm.

- II. A plan must be developed and implemented to build capacity to meet the need for long-term care beds now, not a decade down the road, and this capacity should be built in public and non-profit homes that are operated for the public good. Long-term care capacity planning must meet the ethno-cultural needs of all Ontario residents, and special attention and urgency must be given to redress the disproportionate wait times and differential access issues experienced by equity-seeking communities.

- III. Public hospital downsizing must be stopped and public hospital capacity restored rebuilt to meet population need, according to the evidence. The offloading of complex patients into long-term care must stop.

- IV. Long-term care homes must be resourced with trained staff able to deal with the increasing responsive behaviours in the homes. Homes should have in-house Behavioural Support Ontario (BSO) teams in addition to the 4-hour minimum care standard (above).

Appendix I

Ontario Has Fewer Hospital Beds Than Almost All OECD Countries

OECD Hospital Beds Per 1000 Population 2015	
Country	Number of beds per 1000
Japan	13.17
Korea	11.53
Germany	8.13
Austria	7.55
Hungary	6.99
Poland	6.63
Czech Republic	6.49
Belgium	6.18
France	6.13
Slovak Republic	5.75
Latvia	5.69
Estonia	4.96
Luxembourg	4.82
Switzerland	4.58
Slovenia	4.51
Finland	4.35
Greece	4.25
Norway	3.76
Portugal	3.4
Italy	3.2
Iceland	3.11
Israel	3.03
Ireland	3.01
Spain	2.98
New Zealand	2.71
Turkey	2.68
Canada	2.61
United Kingdom	2.61
Denmark	2.53
Sweden	2.44
Ontario	2.24
Chile	2.14
Mexico	1.52

Source: OECD Health Statistics 2017;
Health Resources; Hospital Beds

Appendix II

Ontario Has Fewer Hospital Beds Than All Other Provinces

Hospital Beds Per 1000 Population 2015-16	
Newfoundland	4.48
P.E.I.	3.32
Nova Scotia	3.34
New Brunswick	3.76
Ontario	2.24
Manitoba	3.35
Saskatchewan	2.65
Alberta	2.73
British Columbia	2.62
Average of other provinces	3.28

Sources: Calculated from: Canadian Institute for Health Information Hospital Beds Staffed and in Operation 2015-16; Population data from Canadian Institute for Health Information National Health Expenditures Database 2017.

Ontario has a total population of 13.8 million. Therefore, a shortfall of 1 hospital bed per thousand is equivalent to an aggregate shortfall of 13.8 thousand beds to meet the average of other provinces.