

**Ontario Health Coalition**  
**Response to Draft Regulation under**  
**Bill 140 the Long-Term Care Homes Act, 2007**  
*May 28, 2009*

**DRAFT**

**Background**

The Long-Term Care Homes Act, 2007, rolls into one and replaces the former acts governing public, non-profit and for-profit long term care facilities (*Nursing Homes Act, Charitable Institutions Act, Homes for the Aged and Rest Homes Act*). This new act has been largely taken from the former Nursing Homes Act. Though it has been passed, the Act is not in force until regulations are passed under it.

On May 5, 2009, the government released the first set of regulation for a mandatory 30-day public consultation. The regulation that has been released for public input covers most of Parts I, II and III of the Act. Thus, these draft regulations are some – but not all - of the regulations the Ministry intends to introduce to cover the Parts of the Act pertaining to: Fundamental Principle and Interpretation; Residents’ Rights, Care and Services (including abuse and neglect policies and restraints); and Admission of Residents. We have confirmed with the Ministry that the sections on restraints, care plans, abuse and neglect, and admissions are complete and they intend no further regulations under these sections.

A second set of regulations covering Parts IV –X and additional regulations under Parts I, II and III will be released for consultation at some unspecified date in the future. The final decision on the regulations rests with Cabinet.

Together these two sets of draft regulations will replace both the existing regulations under the three former Acts and they will also replace the LTC Facility Program Manual. This is significant because the Program Manual is a large document containing principles, standards and criteria to guide long-term care home operators and protect residents. Many of the provisions in the Manual are not yet in the new regulations.

The reason that the Ontario Health Coalition is working to be particularly vigilant regarding these regulations is that there is potential for de-regulation in this process. Regulations for long-term care facilities were created for a reason – there was, at the time they were created, and continues to be need for standards, inspection and enforcement regimes to protect those impacted by conditions in the homes. Ontario has the most privatized long term care sector in the country, with the majority of homes now owned and operated by for-profit companies, many of them multinational chains. The for-profit industry has created a powerful and aggressive lobby for more funding with less strings attached. Over the last decade, there has been a series of de-regulation that has not been in the interests of residents nor the public. This deregulation has occurred despite regular reports of unnecessary deaths, homicides, infectious disease

outbreaks, poor conditions, lack of transparency, inadequate inspection and enforcement, rationing of supplies and inadequate staffing in the homes. It is not in the public interest, nor in the interests of residents, caregivers and staff in long-term care homes to remove needed regulations governing the practices and standards required in Ontario's long term care homes. For 75,000 Ontarians, mainly vulnerable seniors and persons with disabilities live in Ontario's long term care homes. They need and deserve the protection afforded by a robust regulatory and enforcement regime, and public access to information.

## Key Issues

**As they have been provided at this point, the draft regulations do not provide an improved regulatory regime for the long term care homes sector. The stated goals of the Ministry to provide effective whistle-blower protection, zero-tolerance of abuse and neglect and improve important care and quality of life issues are not met in these draft regulations. The draft regulations released to date fail to provide requirements or standards for most care and programs (though there are apparently more draft regulations coming re. these) and it is not clear if existing criteria and standards will be included in the next set of draft regulations. There is no care or staffing standard regulation and the existing regulation will be eliminated with the passage of the new regulations. There are no regulations at all in this first set of draft regulations pertaining to reporting and complaints of abuse, neglect and harm or suspected incidents. We have identified these as key issues in an attempt to ensure that they are remedied in the second set of draft regulations.**

1. Given that the entire Facility Manual is to be withdrawn once these regulations are put into effect, there is not sufficient time provided in the 30-day consultation period for those wishing to provide input to ensure the adequacy of the proposed regulation. We are requesting an extension of the time period so that stakeholders can provide meaningful input.
2. Further, regarding the timelines: the Ontario Ombudsman has not yet released the results of his investigation into Ontario Long Term Care Homes. It is inappropriate to finalize the regulations prior to the release of the ombudsman's report and recommendations. The extension for input should provide for 30 days for stakeholders to review and prepare our input from the date of the release of the ombudsman's findings. Indeed, this process should be started from scratch with the Ministry issuing a consultation paper indicating which of the recommendations from the Ombudsman's report it is prepared to adopt and setting out the reasons with supporting facts for any recommendations it is not prepared to adopt. This should be followed by open meetings in which stakeholders can interact with the Ministry senior officials to give feedback as to whether the proposed Ministry response is adequate.
3. Virtually all of our input, and that of our member organizations has been ignored in the draft regulations released so far (see chart below).
4. The draft regulations do not comply with the recommendations of the Casa Verde Inquest (2005) into the deaths of two residents at a North York long term care home at the hands of another resident with dementia who had just been admitted (see chart under Part III: Admissions).

5. There is no minimum care standard in the regulation. This is the key regulation that would improve care, safety and quality of life for all residents and for staff. All of the care requirements in the draft regulation, even as it stands, require adequate staffing to provide the care. Facilities are required to only accept residents whose care needs can be met in the homes, yet there is no clarity about what care needs and what level of care is required to be provided in the homes. Failure to include this minimum care standard – long promised by both the premier and the health minister – is unacceptable.
6. There are no regulations under most of the sections on care and programs.
7. In general, the approach of identifying key risk indicators (falls, skin tissue breakdown, incontinence, pain, responsive behaviours, altercations) and reporting on them is a reactive rather than a proactive approach. There is little or nothing in the regulations provided to date that would actually prevent these things from happening, and reporting on them once they have happened is too late. It means that inadequate care and therefore neglect that borders on abuse will only be discovered after the indicator reports have been prepared, forwarded to the Ministry and analysed with no indication as to when and how corrections will be made.
8. There are few regulations under the Sections on Abuse and Neglect, and nothing that would comprise a clear Ontario-wide standard for policies and procedures relating to these. There are no regulations setting out criteria for procedures to deal with neglect and abuse perpetrated by facility owners and operators.
9. There are no regulations setting standards, requirements or criteria for complaints and reporting.
10. Whistleblower protection is inadequate, particularly for staff.
11. There are no regulations pertaining to the use of chemical restraints.
12. The initial assessments for residents, upon being admitted to the homes, are inadequate.
13. The admissions section does not provide protection against downloading of patients into long term care homes with complex care requirements that are too heavy for the homes to provide adequately. Nor does it provide adequate protections and rights to appeal in the case of homes discriminating against certain types or classes of people who are seeking admission.

COMPARISON OF DRAFT REGULATION WITH OHC INPUT INTO MINISTRY OF HEALTH REGULATION CONSULTATION		
OHC Recommendation	Is it in Draft MOH Regulation?	
	Yes	No
<b><u>Part I, FUNDAMENTAL PRINCIPLE AND INTERPRETATION</u></b>		
The regulations should specify that the fundamental principle be interpreted such that the Fundamental Principle recognizes that the physical, psychological, spiritual, cultural and social needs of the homes' residents are adequately met. (Section 1)	X- this was adopted in the amendments to the Act itself	
In addition to protections for residents, the regulations must recognize in principle that the homes are also workplaces that should be operated and maintains so that they are safe for staff who have alarmingly high rates of illness, accident and injury in this sector.(Section 5)		X
<b><u>Part II, RESIDENTS: RIGHTS, CARE AND SERVICES</u></b>		
Neglect should be defined so that facility operators and the government, who bear the majority of the responsibility for funding and assessment and for spending decisions which are critical to preventing neglect, are held accountable for these decisions. (Section 2 definitions, and Section 17)		X
The regulation requiring facilities to report of staffing levels to the government was eliminated by the Harris government and re-instated in 2005. However, these reports have been shielded from public scrutiny. A Freedom of Information request in 2007 yielded disclosure of staffing levels up to March 2006. But, current figures are still hidden from the public. The regulations should specify that staffing levels, by facility and province-wide aggregates, must be made available to the public upon request.		X
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, that would set a minimum		X

<p>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.</p>		
<p>The regulations must 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.</p>		X
<p>While we are generally supportive of the improvement in assessment that will likely result from the pilot projects using the RAI MDS 2.0 classification system, the regulations should require consultation of residents, public interest and advocacy groups and unions for input and changes before it is fully adopted. Moreover, the change in assessment is insufficient to deal with the problem of assessing adequate staffing and funding.</p>		X
<p>The Nursing and Personal Care envelope has been used to fund a variety of items that should be considered part of the accommodation envelope, including incontinence supplies, staff and security systems, among others. The regulations should specify that these items cannot be charged to the Nursing and Personal Care envelope.</p>		X
<p>The regulations should specify that incontinence products must be provided, based on need, not rationing. Facility operators should not be allowed to set arbitrary targets for use of incontinence supplies, the principle that care be provided based on the need, safety and comfort of the residents should be set out in a clear regulation regarding this issue.</p>		X
<p>Acuity should be an additional determining factor when regulating staffing standards. For instance, special care units for residents with cognitive impairment may require a different range of training and skills among staff.</p>		X

<b>Part III, ADMISSION OF RESIDENTS</b>		
<p>The regulations need to specify clear assessments of care requirements and levels above which patients cannot be admitted to ltc facilities to prevent the inappropriate downloading of patients from acute-care facilities and mental health facilities to long term care homes that are inadequately staffed to provide appropriate care. <i>(This applies to Section 41)</i></p>		X
<p>The recommendations from the Casa Verde Coronor's Inquest regarding admissions, including the requirement that homes receive full information on patients prior to admission to reduce violence should be implemented. There must be clear guidelines for admission of residents with dementia and cognitive impairment and aggressive tendencies and establishment of care plans for those with a history of violence prior to admission.</p>		X
<p>The regulations must provide for access to and standards for special care units or facilities for patients with behavioural problems and aggression.</p>		X

# Review and Analysis of the Draft Regulations Released by the Ministry of Health and Long-Term Care:

## PART I

*Note: this section deals only with definitions. There are further comments about abuse, neglect, zero-tolerance policies, complaints procedures and whistle-blower protection under Part II below.*

### **Definitions**

**Abuse** – The regulations contain definitions for emotional, financial, physical and sexual abuse.

### ***OHC response to draft regulation definitions of abuse:***

*It appears that the wording of these definitions is fairly broad and serve the public interest, with the exceptions as follows:*

- *In the draft Ontario regulations, misuse of restraints is not explicitly listed as abuse. Other jurisdictions include use of restraints without a physician's order to be physical abuse (see for example Manitoba, various U.S. jurisdictions).*
- *Other jurisdictions include neglect as abuse.*
- *The Ontario Network for the Prevention of Elder Abuse also lists unreasonable confinement as abuse. See their full definitions of abuse at: <http://www.onpea.org/english/elderabuse/formsofelderabuse.html>*
- *Financial Abuse -- The most recent amendments to legislation and regulation in other jurisdictions specifically include forgery, fraud and identity theft in definition of financial abuse. Upon a quick review of the literature, we found that law firms working in the public interest recommend a definition broad enough to include fraud, constructive fraud, conversion and unfair business practices. In September 2008, California expanded legislation to protect from elder abuse to include using undue influence to obtain the elder's property or real assets. Certainly, given the dependence of residents on the licensees, charging residents for items that are not allowed should constitute financial abuse. It is not clear whether the proposed definition in the regulations: "Financial abuse means any misappropriation or misuse of a resident's money or property" covers all of these.*

**Neglect** – defined in the draft regulations as the failure to provide a resident with the care and assistance required for health, safety or well being, and includes inaction or a pattern of inaction that jeopardizes the health or safety of one or more of the residents.

***OHC response to draft regulation defining neglect:***

- *This definition of neglect does not clearly include emotional neglect, isolation, a pattern of ignoring the resident or their substitute decision-maker when they are describing unmet needs, nor withholding of supplies (such as incontinence products, for example).*
- *The definition should be expanded to include inaction or a pattern of inaction that jeopardizes not only health and safety, but also specifically physical comfort and psychological well-being.*
- *Since long term care homes require staff to ration care and the government has failed to provide any regulation to ensure that homes provide enough staff and enough care time to meet resident’s assessed needs let alone provide for residents’ physical comfort and psychological well-being, a serious attempt to reduce neglect needs to provide for a specific understanding and definition that captures systemic neglect both in the definition and in the regulations.*
- *Decisions, made by home operators and the government, to routinely understaff the homes or to allow routine understaffing result in neglect. The definition needs to specifically address this situation. Staff and their unions have expressed that neglect should be defined broadly as recommended here, to protect residents, and that this improved definition needs to be accompanied by clear staffing and care standards (which are not in the draft regulations though the Act specifies that the regulations should contain them) and real whistle-blower protection (which is insufficient in the Act and in the regulations) so that staff can safely report neglect and systemic conditions of routine staff shortages and inadequate time to provide needed care such as bathing, feeding, repositioning etc., and rationing of supplies that create situations of neglect.*
- *Advocates for the elderly and in other sectors such as child welfare agencies have much more robust definitions of neglect. See for example: Child and Family Services Act, 2001; Ontario Association of Children’s Aid Societies Eligibility Spectrum; BOOST. For example: the definition of neglect from the Ontario Network for the Prevention of Elder Abuse is:*

**“Neglect**

Neglect can be intentional (active) or unintentional (passive) and occurs when a person who has care or custody of a dependent senior fails to meet his/her needs. Forms of neglect include: withholding or inadequate provision of physical requirements, such as food, housing, medicine, clothing or physical aids; inadequate hygiene; inadequate supervision/safety precautions; withholding

medical services, including medications; overmedicating; allowing a senior to live in unsanitary or poorly heated conditions; denying access to necessary services (e.g. homemaking, nursing, social work, etc.) or denial of a senior's basic rights.”

### **Other definitions:**

**Placement Coordinator** - The Act gives the Minister the ability to describe persons or entities as ineligible to be placement coordinators in the regulations. But the definition of “appropriate placement coordinator” in the regulations does not actually provide a definition, nor does it describe any person or entity who/that should not be a placement coordinator. Instead it refers one back to the section of the legislation that gives the Minister the power to set such a regulation. Section 44 (2).

### ***OHC response:***

- *Currently, placement coordinators are employed by the CCACs (and there are some discharge planners in hospitals). It is not clear why the definition does not simply state this.*
- *It appears that the Ministry has chosen not to deem any person or entity ineligible to be placement coordinators. Anyone with a vested interest (ie. a financial interest in a long term care facility or a chain, or in a retirement home or chain, or any other for-profit entity to which placement planners provide referrals) ought not to be a placement coordinator.*

**Casual absence** – same definition as in Nursing Homes Act.

**Comprehensive Plan of Care** – *The draft regulations have created two types of care plans – an initial care plan and a comprehensive care plan. In the Act, there is reference to an initial plan of care, but no distinction between an initial and a comprehensive plan of care. In the draft regulation, there is no definition of “initial plan of care” and the definition of “comprehensive plan of care” simply describes the comprehensive care plan as the contents of Section 6 (1) of the Act as follows (see more on comprehensive versus initial plans of care under Part II):*

#### **PLAN OF CARE**

##### **Plan of care**

6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

- (a) the planned care for the resident;
- (b) the goals the care is intended to achieve; and
- (c) clear directions to staff and others who provide direct care to the resident.

**Continuum of care applicant/Continuum of Care Facilities Table/Continuum of care home** – same definitions as in Nursing Homes Act.

**Long Stay Program, Partner** – these did not exist in the Nursing Homes Act.

**Long-stay resident, medical absence, nursing care, private accommodation, psychiatric absence, registered dietician, registered nursing staff, related temporary long-term care home, re-opened ltc home, replacement ltc home, semi-private accommodation, short-stay program, sort-stay resident, vacation absence, veteran’s priority access bed** – same definitions as in Nursing Homes Act.

**Physical device** – is defined as “without restricting the generality of that term, includes a bed rail”

**Red circled** – has been removed from the definitions.

**Responsive behaviours** – was not included in Nursing Homes Act. They are defined here as:

“responsive behaviours” mean behaviours that often indicate,

- (a) an unmet need in a person, whether physical, psychological, emotional, social, environmental or other, or
- (b) a response to circumstances within the social or physical environment that may be frustrating, frightening or confusing to a person”

**Definitions missing or eliminated:**

*All references to and a definition of the **Facility Design Manual** that were in the Nursing Homes Act have been eliminated in the draft regulations provided to date, along with specific required items and definitions relating to building standards and equipment such as **fire extinguishers, egress, ratings, noncombustible materials, exits etc.** Similarly the building specifications and references to the Design Manual have been removed from the definitions when describing **private, semi-private rooms.***

*In Section I of the Act, there are two additional items to be defined in the regulations. But they are not defined in the regulations. The reference to these in the Act follows here:*

“rights adviser” means a person designated by or in accordance with the regulations as a rights adviser; (“conseiller en matière de droits”)

“secure unit” means an area within a long-term care home that is designated as a secure unit by or in accordance with the regulations; (“unité de sécurité”)

## PART II Residents: Rights, Care and Services

### **Plan of Care (Part II, Section 6 of the Act):**

Under the Act, homes must ensure that there is a written plan of care for the resident, based on an assessment of the needs and preferences of the resident, and the home must ensure the plan of care covers all aspects of care including medical, nursing, personal support, nutritional, dietary, recreational, social, restorative, religious and spiritual care. The resident or substitute decision-maker are required to be given the opportunity to participate fully in the development and implementation of this plan of care. The Act provides for the regulations to set out the timelines for the initial plan of care to be developed.

In the draft regulations, there are *two* different types of care plans as follows:

**Initial plans of care** must contain assessments under seven items of information and must be completed and communicated to the direct care staff within 24 hours.

**Comprehensive plans of care** must include assessments under 26 items and must be developed within 21 days of admission.

### *OHC Response to Plans of Care Draft Regulations:*

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

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

*and preferences; cultural, spiritual and religious preferences; potential for discharge.*

- *The described assessments for the initial plans of care are very open-ended and are missing key elements that are critical for a resident's health – including weight, hydration, specific food restrictions, continence, foot conditions, communication abilities, cognition ability, mood and behaviour patterns, special treatments and interventions, shortness of breath, sleep preferences, cultural needs etc.*
- *There is no deadline contained in the regulations for ensuring that direct care staff have received communication of the comprehensive plan of care, only the initial plan of care.*
- *There appears to be nothing in the regulations for the comprehensive plan of care to specifically assess for restorative care, though the Act requires homes to include restorative care in their plan of care.*
- *In the Casa Verde Inquest recommendations, the Coronor's Jury specifically recommends measures to provide for improvements to care planning prior to admission and upon admission as follows:*

Recommendation 20:

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

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

Recommendation 73:

All LTC facilities must have a set "admissions team" which consist of:

- (i) LTC facility's Administrator,
- (ii) The LTC facility's Director of Care,
- (iii) The LTC facility's Chief Medical Administrator, and
- (iv) One PIECES-trained staff RN.

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

Recommendation 74:

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

- *In the Long Term Care Facility Program Manual, which is being withdrawn and replaced with these regulations, required medical and nursing assessments to be done within 7 days of admission (see section on Standards: Resident Care, Section B. Resident Care and Services, Standards and Criteria, page 4.). The Manual also requires that weight be taken on admission and that it be evaluated at least monthly thereafter. (same section, page 9).*

### **Care and Services (Part II, Sections 8 – 18 of the Act):**

Part II, Sections 8 – 18 of the Act set out various programs and services that homes are required to provide, including:

- Nursing and personal support
- 24-hour RN on duty
- Restorative care
- Recreational and social activities
- Dietary services and hydration
- Medical services
- Information and referral assistance
- Religious and spiritual practices
- Accommodation services
- Volunteer program

These programs and services are listed in the Act and the Act provides for regulations under these Sections as follows:

#### **Staffing and care standards**

17. Every licensee of a long-term care home shall ensure that the home meets the staffing and care standards provided for in the regulations.

#### **Standards for programs and services**

18. (1) Every licensee shall ensure that the programs required under sections 8 to 16, the services provided under those programs and anything else required under those sections comply with any standards or requirements, including outcome measures, provided for in the regulations.

However, there are no standards and requirements, including outcome measures for any of these services in the regulations provided in the draft regulations to date.

All former regulations providing details about what these services must include under the previous Nursing Homes, Municipal Homes and Charitable Homes Acts are not included in the draft regulations provided to date.

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

*OHC Response to the Sections on Care and Services:*

- **Re. Regulations referred to in Section 17** -- the draft regulations provide no staffing and care standards and the former regulations pertaining to ensuring sufficient staffing have been eliminated here. This is unacceptable.
- The OHC, based on our research of best practices, recommended a minimum care standard that would provide an average of 3.5 hours per day of hands-on nursing and personal support care as a minimum requirement to provide needed care and protect from harm or neglect. The government amended the legislation to include Section 17 to provide for a minimum care standard in the regulations and promised to do so repeatedly in the lead-up to the last election. It has failed to provide this regulation here. This minimum care standard is crucial to ensure that there is enough time allocated for each resident to provide their needed nursing and personal support services. Without it, residents will continue to go without needed daily care and support.
- The former Nursing Homes Act contained a regulation Section 60 (6) “A licensee of a nursing homes shall ensure that there is a sufficient number of registered nurses, registered practical nurses and health care aides on duty in the home at all times to provide the nursing care required by the residents of the home.” This has not been included in the new draft regulations provided to date.
- In other jurisdictions the approach has been that the homes must provide “sufficient nursing staff to attain or maintain the highest practicable well-being of each resident” – with this general principle supported by regulated staffing and care standards. (see Report to Congress on Appropriateness of Minimum Care Standards, Phase I, pp 7)
- **Re. Regulations referred to in Section 18** -- Section 18 allows for regulations to set standards, requirements and outcome measures for the following programs: Nursing and Personal Support, 24-hour RN on duty, Restorative Care (including therapies), Recreational and Social Activities, Dietary Services and Hydration, Medical Services, Information and Referral Assistance, Religious and Spiritual Practices, Accommodation Services and a Volunteer Program. The draft regulations provided to date do not provide any standards, requirements or outcome measures for any of these.
- There are regulations under the three former Acts governing for-profit, non-profit and municipal homes that set standards and requirements for these programs have been eliminated. There are also standards and criteria for the above-listed services in the LTC Facility Programs Manual. (See Standards: Resident Care, Section B. Resident Care and Services, Subject: Standards and Criteria; Section C. Nursing Services; Section E. Recreation and Leisure Services; Section F. Social Work Services; Section G. Spiritual and Religious Program; Section H. Therapy Services; Section I. Volunteer Services; Section J.

*Dental Services; Section K. Foot Care Services; Section L. Other Approved Programs.*

- *The Facility Program Manual provides criteria for homes to provide emotional, social and cultural observances, practices and affiliations; language; sensory function and communication; cognitive and intellectual supports; safety and security; elimination; oral and dental care; skin and nail care; comfort, rest and sleep; hygiene and grooming; the promotion of independence in activities of daily living. These are not listed in the Act and are not provided for in the draft regulations that have been released to date.*
- *A fuller analysis of what has been eliminated from the regulations under each of the former Acts and from the Program Manual has not been possible to date, given the very short time allowed to provide input to these draft regulations. We will build on this section of our analysis in the final version of the OHC submission.*
- *Specific nursing and personal support is required by all residents whether or not they have fallen, have skin tears, are incontinent or are in pain. But there are no regulated standards, requirements nor outcome measures specified for these in the draft regulations provided to date. In addition, there are no standards, criteria nor outcome measures to protect against weight loss & dehydration; no provision for any clear standards regarding access to culturally appropriate services; no standards, criteria or outcome measures for infection management and a host of other items that should be included. There are no requirements or standards for accommodation services – including laundry; nor for dietary services and medical services. Indeed, there should be clear standards, requirements and outcome measures for all of the programs listed in Section 18 (see list in bullet point that is titled “Re. Regulations referred to in Section 18 – bottom of previous page). We expect this to be addressed in the next set of draft regulations.*
- *Actual levels of care (ie. hours of nursing and personal support provided by hands-on RN, RPN and PSW/Aides for each home and province-wide aggregates should be public information that is available in each home and through the Ministry of Health and Long Term Care without the need to resort to Freedom of Information requests.*

The only required programs under the current draft regulation are the following:

1. Falls management
2. Skin and wound care
3. Continence care and bowel management
4. Pain management

There are additional sections in the draft regulations in this Part on responsive behaviours and altercations.

In each of these sections there are criteria that homes are required to follow.

*OHC Response:*

*Aside from the need to advocate strongly for regulations pertaining to all care, staffing and program standards and criteria to be included in the next set of draft regulations:*

- There is no requirement that continence supplies not be rationed as they are currently. In the draft regulations 12 e) states that there must be sufficient changes of continence care products to remain clean, dry and comfortable – but the facilities claim that until the incontinence products are 75% full, there is no need to change them. They will likely claim that this meets the criteria in 12 e). The language in this section needs to be changed to clearly prohibit rationing of incontinence supplies and to provide changes to incontinence products upon request if the resident is able to make such a request.*
- 12 f) states that the use of continence care products is not solely for the convenience of staff. But the staff and their unions have led the campaign to stop the rationing of supplies. More importantly, this should refer to the convenience of the licensees (home owners and operators) who have required staff to ration products against their will and who are responsible for short-staffing decisions.*

*In addition to the need for regulated standards and criteria for all of the listed programs and those that are listed in the Facility Program Manual but do not appear in the draft regulations to date, the following changes are needed to the language in the draft regulations regarding these required programs (see highlighted additions and crossed out text inserted into the language of the draft regulations below):*

- **Section 9 – Required programs***
- Interdisciplinary programs would be developed and implemented for falls prevention and management, skin and wound care, continence care and bowel management and pain management. Each program would include relevant written policies, procedures and protocols and would be developed, implemented, evaluated and updated using appropriate evidence-based practices or in accordance with prevailing **best** practices. Each program would require the use of clinically appropriate assessment instruments and establish protocols for the referral of residents to specialized services. Programs would provide for methods to reduce risk and monitor 6 outcomes and would be evaluated annually by the licensee to identify changes required for improvement. The changes identified would be implemented.*
- **Section 10 - Falls Prevention and Management***

- *This program would provide for screening protocols and assessment instruments as well as strategies to reduce or mitigate falls, including the monitoring of residents and the use of pharmaceuticals, equipment, supplies, devices and assistive aids. Residents who fall would be assessed and ~~when~~ unless the condition or circumstances clearly do not require, a post-fall assessment would be conducted using a clinically appropriate assessment instrument designed for falls. The equipment, supplies, devices and assistive aids would be readily available at the home at all times.*
- **Section 11 - Skin and Wound care**
- *This program would provide for screening protocols and assessment instruments, strategies to maintain skin integrity and reduce and prevent skin breakdown and wounds, routine skin care and treatments. Routine skin care would include care of nails, feet and mouth as well as safe and effective techniques for care, repositioning and transferring residents. A resident at risk of altered skin integrity would receive an assessment by a member of the registered nursing staff within 24 hours of admission, upon return from hospital, and upon return from an absence of greater than 24 hours. A resident exhibiting skin breakdown, pressure ulcers, wounds, or skin tears would receive a skin assessment by a member of the registered nursing staff, immediate treatment and would be reassessed at least weekly, if unless clinically contra-indicated. Residents dependent upon staff for repositioning would be repositioned every two hours or more frequently depending on their condition and tolerance of tissue load. However, residents would only be repositioned while asleep if clinically indicated.*
- **Section 12 – Continence care and bowel management**
- *This program would include screening protocols and assessment instruments and treatments and interventions to promote continence, toileting programs, including protocols for bowel management and strategies to maximize residents' independence, comfort and dignity. Individualized plans for residents would be based on their assessments. Toileting and where necessary, continence training should be provided to all residents who so request unless it is clear that the resident is incapable of benefitting from such assistance. Residents who use continence products would have sufficient changes to remain clean, dry and comfortable and there would be appropriate numbers and types of products available to do so. Rationing of continence products is not allowed. In particular residents whose continence products are wet or soiled should be changed upon request. Continence products would be evaluated annually by residents, family members, substitute decision-makers and staff to determine residents' satisfaction and the evaluation would inform purchasing decisions.*

- **Section 14 – Responsive Behaviours**
- *The needs of residents with responsive behaviours would be met by assessment and reassessment, identification of triggers for the behaviour and proactive measures to reduce risk, strategies and interventions designed to minimize as much as possible and if possible ~~or~~ prevent the behaviours, resident monitoring and establishing protocols for the referral of residents to specialized resources. All approaches to care would be designed to meet the needs of residents with responsive behaviours and staff would be advised of the residents who require monitoring. The use of pharmaceuticals as a remedial measure, should only be used as a last resort where no other intervention will assist and only where there are likely to be achieved on the basis of evidence positive outcomes which clearly outweigh any potential negative outcomes.*
- **Section 15 - Altercations**
- *The risk of altercations between residents would be reduced by identifying factors that could trigger the altercations and identifying and implementing interventions. The use of pharmaceuticals as an intervention, should only be used as a last resort where no other intervention will assist and only where there are likely to be achieved on the basis of evidence positive outcomes which clearly outweigh any potential negative outcomes.*
- **Section 67 - Infection prevention and control program**
- *Every licensee would ensure that there is an interdisciplinary team approach in the co-ordination and implementation of the program and that the team meets regularly. The licensee would be required to designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices. The staff member so designated shall not be a member of the management of the home. All staff would participate in the implementation of the program. Daily monitoring, recording and analysis of the presence of infection in residents would be required. Licensees would be required to implement any surveillance protocol provided by the Ministry. The section includes provisions related to the availability of personal protective equipment, hand hygiene programs, training, pets, and immunization and screening measures.*

**Abuse and Neglect (Part II, Sections 19 & 20 of the Act):**

The Act provides for regulations to set requirements for a zero-tolerance of abuse and neglect policy. But under this section, the draft regulations are minimal, and none pertain to neglect by the licensee (facility owner).

- The draft regulations require procedures and interventions (unspecified) to assist and support residents who have been abused or neglected, and procedures and interventions (unspecified) to deal with staff members who have abused or neglected residents.
- The draft regulations require the resident's substitute decision maker or any other person specified by the resident to be notified within 24 hours of any alleged, suspected or witnessed incident of abuse or neglect and of the results of the investigation of the incident.
- The draft regulations require notification of the police if the home suspects the incident may constitute a criminal offence.

*OHC Response to the sections on "zero-tolerance" policies:*

*There is no regulation pertaining to abuse or neglect perpetrated by the home owner or operator, or any party except for staff. Any zero-tolerance policy that pertains to abuse and neglect must include those who have decision-making powers to ration care, operate a facility with inadequate staffing, ration or deny access to needed supplies, provide inadequate food, etc. There is need for a regulation that sets out who investigates incidents of abuse or neglect perpetrated by the home owner or operator (do they investigate themselves?) or any others that may perpetrate abuse or neglect as described in Part II, Section 19 of the Act, and other associated criteria for this.*

*There is nothing in the Act or the regulations to protect volunteers, visitors and staff from abuse or violence, despite studies showing alarming rates of injury and violence in Ontario's long term care homes.*

*The regulations do not set criteria for investigating incidents, nor for informing all parties of the method and timelines for the investigation.*

*Although the Act provides for each home to have a program that complies with the regulations for preventing abuse and neglect (Part II, Section 20 (c)), there are no draft regulations pertaining to prevention.*

*There is not much in the draft regulations that actually sets a provincial standard for zero-tolerance. Each home will have its own policy based on minimal requirements in the regulations, but these will not be consistent across the province, and there is no requirement for the Ministry to approve the homes' zero-tolerance policies.*

*See notes in Part I pertaining to the definitions of abuse and neglect.*

*In addition to addressing these problems, the language of the draft regulations in this section should be amended as follows (see highlighted additions below):*

- **Section 16 – Policy to promote zero tolerance**
- *In addition to section 20 of the Act, the licensee’s policy to promote zero tolerance would comply with the Act, contain procedures and interventions to assist and support residents who have been or have allegedly been abused or neglected and contain procedures and interventions to deal with staff members and “other persons connected to the Home” who have neglected or abused residents or have allegedly done so. “Other persons connected to the Home” include employees of the corporate entity owning or managing the home, their officers, Board members and shareholders. “Other persons connected to the Home” also include officials of the Ministry of Health and Long Term Care responsible for taking any actions under the Act and regulation, their immediate supervisors and persons higher in the Ministry ladder of responsibility up to and including the Minister. Finally “Other persons connected to the Home” also include officials of the Local Health Integration Network with any responsibility for decisions on the funding or operation of the home, their immediate supervisors and persons higher in the LHIN ladder of responsibility up to and including the members of the Board of the LHIN.*
- *The licensee’s policy shall provide effective whistleblower protection for persons who report suspected abuse or neglect. The policy shall include provisions addressing the process for discipline of employees by the licensee or any of its supervisory staff for misconduct where the employee has made reports of suspected abuse or neglect. No discipline may be imposed until the licensee or its officials have first satisfied the Ontario Labour Relations Board (or grievance arbitration board where the employee is covered by a collective agreement), that the discipline was not in any way connected to the report of abuse or neglect, that there was misconduct on the part of the employee and that the misconduct warrants the proposed discipline to be imposed.*

### **Reporting and Complaints (Part II, Sections 21 – 28 of the Act):**

The Act requires the home to have written procedures to deal with complaints. Homes are required to forward complaints to the Ministry along with documentation, and the home is required to investigate and respond to complaints according to criteria set out in the regulations. But there are no draft regulations provided under this section. The Act also requires reporting and considers it an offence to fail to report and to suppress reporting of suspected incidents of abuse, neglect, unlawful conduct, misappropriation or misuse of a residents' money or funding from the government, and harm. Under the Act, the Ministry shall have an inspector investigate if abuse, neglect, harm, unlawful conduct, a violation of whistle-blowing protection or any other matter provided for in the regulations has occurred. (Again, there are no regulations for this section). The Ministry can also send in an investigator if they have reasonable grounds to believe that there may be a risk of harm to a resident.

In Part II, Section 26, the Act sets out Whistle-blowing protection that forbids retaliation against any person that has disclosed anything to an inspector, the Ministry, in a proceeding or in an inquest. Retaliation includes dismissal or discipline of a staff person; discharging, threatening, discrimination against residents, their family, and substitute decision-makers; penalties, intimidation, coercion or harassment of anyone. The home is not allowed to discourage reporting. However, the staff person may still lose their job and have to go to the Labour Board or seek binding arbitration under their collective agreement to get it back. Under Section 28, it is an offense to obstruct any person from providing information to the inspector or the Ministry where the provision of the information is required or permitted in the Act or in the regulations (again there are no regulations under this section).

Under this Part, the Sections of the Act that specifically refer to criteria to be provided in the regulations follow (sections referring to regulations underlined):

#### **Complaints procedure – licensee**

21. Every licensee of a long-term care home shall ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints. 2007, c. 8, s. 21.

#### **Licensee to forward complaints**

22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

#### **Other documentation**

(2) A licensee who is required to forward a complaint under subsection (1) shall also provide the Director with any documentation provided for in the regulations, in a manner that complies with the regulations. 2007, c. 8, s. 22 (2).

#### **Licensee must investigate, respond and act**

23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

25. (1) The Director shall have an inspector conduct an inspection or make inquiries for the purpose of ensuring compliance with the requirements under this Act if the Director receives information from any source indicating that any of the following may have occurred:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. A violation of section 26.
5. Misuse or misappropriation of a resident's money.
6. Misuse or misappropriation of funding provided to a licensee under this Act.
7. A failure to comply with a requirement under this Act.
8. Any other matter provided for in the regulations. 2007, c. 8, s. 25 (1).

(2) The inspector acting under subsection (1) shall immediately visit the long-term care home concerned if the information indicates that any of the following may have occurred:

1. Anything described in paragraph 1, 2 or 3 of subsection (1) that resulted in serious harm or a risk of serious harm to a resident.
2. Anything described in paragraph 4 of subsection (1).
3. Any other matter provided for in the regulations. 2007, c. 8, s. 25 (2).

28. Every person is guilty of an offence who attempts, by any means, to prevent another person from providing information to an inspector or the Director where the provision of the information is required or permitted by this Act or the regulations. 2007, c. 8, s. 28.

*OHC Response to the Section on Reporting and Complaints:*

*Regulations must be included in the next set of draft regulations covering this section.*

*There are no criteria for procedures for initiating or dealing with complaints.*

*There are no criteria for documentation that must be provided regarding complaints.*

*There are no criteria for investigating nor for responding to suspected incidents, and there is no clarification of what suspected incidents should be reported.*

*As noted in the section on 'zero-tolerance' policies, in order to provide effective whistleblower protection for staff who report suspected abuse or neglect, the regulations should include a requirement that where an employee has made a report of suspected abuse or neglect, no discipline may be imposed until the licensee (home*

*owner/operator) have first satisfied the Ontario Labour Board (or grievance arbitration board where the employee is covered by a collective agreement), that the discipline was not in any way connected to the report of abuse or neglect, that there was misconduct on the part of the employee and that the misconduct warrants the proposed discipline to be imposed.*

*Because timelines to produce our analysis and response are too tight, we are still working to check to ensure that the provisions in the Act are sufficient to protect residents, volunteers, family members and visitors who report suspected abuse, neglect or harm. As noted, there are no regulations stipulating any additional criteria or requirements for the homes regarding this. Feedback from our member organizations as soon as possible would be appreciated.*

## **Minimizing Restraining (Sections 29 – 36 of the Act)**

The Act provides for each home to create a written policy on minimizing restraining and to ensure that restraining is necessary and is done in accordance with the regulations.

The regulations set out prohibited devices, requirements for ordering and approving physical devices, monitoring, documentation, requirements for the use of PASDs, barriers, locks and other devices.

### *OHC Response:*

*The tight timelines provided for input, and our need to consult with clinical experts limit our ability to fully assess this section. What is notable is that the regulations do not refer to the use of chemical restraints (drugs) at all. In the Act, any use of drugs that is in the plan of care is not considered a restraint (even if it is a restraint). We welcome input as soon as possible on this section and this issue in particular. We will include a fuller assessment of this section in the final version of this document.*

**Office of the Long Term Care Homes Resident and Family Advisor (Section 37 of the Act):**

The Act provides for this function as follows:

**37.** The Minister may establish an Office of the Long-Term Care Homes Resident and Family Adviser to,

- (a) assist and provide information to residents and their families and others;
- (b) advise the Minister on matters and issues concerning the interests of residents; and
- (c) perform any other functions provided for in the regulations or assigned by the Minister. 2007, c. 8, s. 37.

*OHC Response:*

*There are no regulations under this Section, and the Act states that the Minister may (but is not required to) establish this office. As such, this is a toothless and unresourced office. The Ontario Ombudsman should have the mandate to investigate and report on long term care facilities unless or until an equivalent service to that provided by the Ontario Ombudsman is provided through this office or another.*

## **Regulations (Section 38 of the Act):**

Under the Act, the Ministry may set additional regulations as follows:

### **Regulations**

**38. (1)** The Lieutenant Governor in Council may make regulations for carrying out the purposes and provisions of this Part. 2007, c. 8, s. 38 (1).

### **Specific inclusions**

**(2)** Without restricting the generality of subsection (1), the Lieutenant Governor in Council may make regulations,

- (a) governing anything that a licensee is required to do, ensure or provide under this Part, including establishing standards or outcomes that must be met;
- (b) governing temperature requirements for long-term care homes;
- (c) requiring and governing the assessment and classification of residents for the purpose of determining care requirements and other needs of residents;
- (d) governing the mission statements provided for in section 4 and the requirements under that section;
- (e) governing plans of care, including governing their development and implementation and setting requirements in addition to what is required under section 6;
- (f) defining “regular nursing staff” for the purposes of subsection 8 (3);
- (g) requiring certain classes of long-term care homes to have more registered nurses on duty than are required by subsection 8 (3) and providing for rules governing such a requirement;
- (h) specifying, for the purposes of paragraph 4 of subsection 24 (1) and paragraph 5 of subsection 25 (1), what constitutes misuse or misappropriation of a resident’s money;
- (i) specifying, for the purposes of paragraph 5 of subsection 24 (1) and paragraph 6 of subsection 25 (1), what constitutes misuse or misappropriation of funding provided to a licensee;
- (j) providing for anything that under this Part may or must be provided for in regulations, or that is to be done in compliance with or in accordance with the regulations.

There are no additional regulations pertaining to any of these provided in the draft regulations.

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**PART III**  
**Admission of Residents**

<b>COMPARISON OF DRAFT REGULATION WITH RECOMMENDATIONS OF THE CORONOR'S JURY IN THE CASA VERDE INQUEST</b>		
<b>Casa Verde Inquest Recommendation</b>	<b>Is it in the MOH draft regulation?</b>	
	<b>Yes</b>	<b>No</b>
<p>Recommendation 11: The MOHLTC, in consultation with CCAC's should revise the Health Assessment Form to ensure the health professional completing the form has a clear understanding of the purpose of the form and the importance of including a detailed diagnosis, prognosis, specialist reports, psychiatric or psychological assessments, behavioural concerns, and all information that would have an impact on the client's ability to be cared for in a long-term care facility in a manner that ensures the safety of both the client and other residents. The structure of the form itself should also be changed in order to accommodate the above noted recommendation.</p> <p>Recommendation 12: The Health Assessment Form should be amended to include a "drug profile" which analyzes the side effects of prescribed drugs on LTC applicant.</p> <p>Recommendation 13: The Health Assessment Form should be amended to include a separate section that seeks information about incidents of aggressive or violent behaviour of the applicant that have occurred in the applicants past. Rationale: Report from the Geriatric and Long Term Care Review Committee on the Deaths of Mr. El-Roubi and Mr. Lopez.</p> <p>Recommendation 17: The MOHLTC in consultation with health care professionals should take immediate steps to issue standardized monitoring forms for all LTC facilities (i.e. wanderers record, daily flow sheet, medication administration record, screening tools for placement of residents, placement criteria score sheet, residential functional profile, behavioural/aggressive behaviour checklist, etc.) Rationale: Uniformity will ensure a "continuity of care" across all long-term care facilities throughout Ontario (Report –Commitment to Care: A Plan for Long-Term Care In Ontario – Prepared by Monique Smith, Parliamentary Assistant, Ministry of Health and Long-Term Care – Spring 2004).</p>	<p>The recommendations pertaining to improved forms are not in the regulations. Obviously the forms themselves would not be in the regulations, but the references to ensuring that the health professionals completing the forms understand the importance of including certain information, and the types of information that must be included in the assessments could and should be included in the regulations. We are following up to see if the forms referred to in these recommendations have been improved as per the recommendations.</p>	
<p>Recommendation 58: CCAC's should include with the assessment package sent to long-term care facilities a social assessment that would include the client's interests, wishes, family dynamics, and ethnic, cultural and</p>		X

religious considerations.		
<p>Recommendation 18: It is recommended that the MOHLTC, after appropriate consultation, review eligibility and admissions regulations and policies to ensure that individuals exhibiting or prone to aggression be assessed prior to the eligibility decision and only be placed in specialized facilities or LTC facilities with appropriate specialty units. It is further recommended that if the decision is made to continue to place such individuals in LTC facilities, that the MOHLTC must set standards for these facilities and units to ensure that they are sufficiently staffed with appropriate skilled regulated health care professionals who have expertise in managing these behaviours and at a staffing level that these behaviours can be managed without risk of harm to self and others. If unregulated staff are assisting the regulated health professional on these specialty units/facilities they must be U-FIRST trained. Rationale: Report from the Geriatric/Long Term Care Review Committee on the deaths of Mr. El Roubi and Mr. Lopez.</p>		X
<p>Recommendation 19: It is recommended that the MOHLTC and all CCAC's change their policies to ensure that in cases of potential residents with cognitive impairment, with actual or potential aggressive behaviours, that the Community Care Access Centre health professionals should ensure that a comprehensive medical assessment has been completed by a specialist in geriatric medicine and/or geriatric psychiatry.</p>		X
<p>Recommendation 20: Where behaviours have been identified as presenting a risk to self or others, admission to any facility should be delayed until the behaviours have been appropriately assessed and a care plan has been developed. In such cases, the MOHLTC should ensure that there are interim alternatives to placement in the long-term care facility until the individual has been assessed and an appropriate plan of care has been developed such as: i) appropriate support in their homes up to 24 hours a day to assist the family; ii) beds available at an appropriate alternative facility (hospital, mental health facility or specialized facility)</p>		X
<p>Recommendation 22: The MOHLTC should fund specialized facilities to care for demented or cognitively impaired residents exhibiting aggressive behaviour as an alternative to LTC facilities. Funding for these facilities should be based on a formula that accounts for the complex high-care needs of these residents in order that the facility be staffed by regulated Health Care Professionals (RN's and RPN's) who are trained in PIECES, and in sufficient numbers to care for these complex and</p>		X <sup>1</sup>

<sup>1</sup> The regulations for the funding section have not yet been released for public consultation. However, in the draft regulations pertaining to Part III of the Act that should contain definitions and regulations regarding secure and specialized units, there are no definitions, criteria, standards and no regulations for specialized and secure units.

behaviourally difficult residents.		
<p>Recommendation 23: The facilities, in consultation with experts in the field, should be designed using the model of the Dorothy Macham Home at Sunnybrook and Women's College Health Science Centre to meet the physical and staffing requirements of these high needs residents.</p> <p>Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors (Exhibit 67, p.4) Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report March, 2001 – (Exhibit 40, p.1)</p>		X
<p>Recommendation 24: The MOHLTC should ensure that these facilities are accessible for the individuals who are not appropriate for placement in long term care facilities. This means that there should be sufficient beds for the region's needs, in all regions that there is no barriers to admission for the individuals who require this specialized care (eg. no requirements that the resident be "stable" to be transferred there from long term care facility, no requirement to be a war veteran or only referred by institutions).</p>		X
<p>Recommendation 25: The MOHLTC should immediately mandate and fund specialized units in sufficient numbers in each region to care for residents with behavioural problems. The MOHLTC should consult with healthcare professionals and experts working in the field in setting standards for these units.</p> <p>These units should be regulated by the MOHLTC rather than based on the LTC facility's definition of a "specialty unit". The units should include:</p> <ul style="list-style-type: none"> <li>i) beds in appropriate physical spaces (ie. Private rooms located close to nursing stations, etc.) in which residents stay for a short period of time while they are assessed and an appropriate care plan is developed.</li> <li>ii) If appropriate, the resident, once they are assessed and a care plan developed may be transferred to other units where the care plan will then be implemented. Attention must be paid to ensuring that the care plan is transferred completely, and that follow up resources are available to the unit caring for the resident.</li> <li>iii) Some of these units may also be set up based on a long term residential model where residents would live in these units for the entire duration of their behavioural complications.</li> </ul> <p>Rationale: Report on Mental Health Issues and Long-Term Care from the Ontario Association of Non-Profit Homes and Services for Seniors Report on Individuals who Present Challenges to Placement in a Long-Term Care Facility, Interim Report - March, 2001 Review of Homicides in Long Term Care Facilities by the GLTCRC.</p>		X
<p>Recommendation 33: Pending the remodeling of the future system and implementation of training for all staff, additional funding must be provided and tracked to ensure that a PIECES trained Registered Nurse at each</p>		X

<p>facility is designated for those residents on each shift, due to the unpredictability of behaviours and level of risk associated with these residents. Rationale: Service Provisions Manual – Ministry of Health and Ministry of Community and Social Services – Service Provision – Objectives and Functions (1994-1997)</p>		
<p>Recommendation 38: That MOHLTC immediately review and revise their “High Intensity Needs Program” to ensure that every LTC facility has access to additional funding for immediate staffing increases to care for <i>existing</i> cognitively impaired residents safely. The revised programme should ensure the funding is used by LTC facilities to provide RN care for all such residents who are prone to or assessed with potential aggressive behaviours. The program should ensure that the funding is available for an appropriate period of time and, at a minimum until the resident has been appropriately assessed, an appropriate nursing care plan is developed, and in the opinion of a psychogeriatric resource person, the resident is stable enough that he/she does not provide a risk to self or others if not closely monitored. Rationale: OANHSS, “Mental Health Issues and Long Term Care”</p>		<p>X – there is funding for high needs residents but it is not tied to any clear care requirements and the other provisions in this recommendation. The regulations pertaining to training are not yet released for public consultation.</p>
<p>Recommendation 39: The MOHLTC should review its High Intensity Needs Program to ensure that transitional beds in long-term care facilities are available for <i>newly assessed</i> high risk residents while waiting assessment and/or to ease their transition into a long-term care setting. The Ministry should expand the program to ensure: i) It is available on admission where aggressive behaviours have been identified; ii) It is available for residents being admitted directly from the community; iii) It is available on an on-going basis until a psychogeriatric assessment can be completed and a safe care plan can be implemented; iv) Funds are available to provide the resident with a private room at the basic ward rate, if necessary; v) There are sufficient funds to provide one on one care by a PIECES trained RN.</p>		<p>See above.</p>
<p>Recommendation 40: The MOHLTC should set mandatory standards and provide designated funding to ensure that all staff interacting with cognitively impaired residents in LTC are PIECES/U-First trained. This includes those individuals who make decisions regarding admission and placement, as well as those managing the individual’s care. Rationale: PIECES Manual Report - Commitment to Care: A Plan for Long-Term Care In Ontario – prepared by Monique Smith – Spring 2004</p>		<p>Regulations pertaining to training are not yet released for public consultation.</p>
<p>Recommendation 41: More specifically, it is recommended, that the MOHLTC create and enforce standards requiring all RN’s working in LTC to be PIECES trained as a priority. Such standards should set out timelines such as ensuring that all RN’s presently on staff are PIECES trained within one year, and shall include PIECES training</p>		<p>See above.</p>

as part of the orientation for new staff. The MOHLTC shall ensure that there are adequate classes in each region to address the waiting lists and have all RN's trained within one year.		
Recommendation 42: That the MOHLTC create and enforce standards requiring all administrative and management staff who are involved in admission decisions and staffing decisions to be trained in either the full PIECES course or the ENABLER course.		See above.
Recommendation 43: The Ministry of Health and Long-Term Care, in order to support PIECES trained staff, require that physicians providing services in long-term care homes be knowledgeable about the programme.		See above.
Recommendation 44: Health Care Aids should have a college or governing body which regulates them. As part of their education they should be trained in psycho-geriatric, aggressive behaviours.		See above.
Recommendation 45: That the MOHLTC create and enforce similar standards requiring that all other staff (RPN's and HCA's) be PIECES/U-FIRST trained in a timely way and that there be adequate classes without waiting lists to facilitate this training.		See above.
Recommendation 46: The MOHLTC set standards, monitor and enforce such standards, to ensure that all facilities have at least one Registered Nurses' with PIECES training on staff on all shifts and available to do PIECES assessments.		X – this could be included in Admissions or in regulations pertaining to training. It is not in the draft regulations to date.
Recommendation 47: That the MOHLTC reinstate funding for all expenses associated with PIECES/U-FIRST training, including travel expenses and wages to backfill for equivalent staff to ensure that all LTC facilities have their staff appropriately trained and continue to have new staff trained.		The regulations pertaining to training have not yet been released for public consultation.
Recommendation 48: That the MOHLTC immediately review and address any institutional barriers that may exist that prevent RN's and LTC facilities from accessing PIECES training (ie. Preconditions for administrators, funding issues, waiting lists or being, under-resourced in certain regions).		See above.
Recommendation 49: The MOHLTC, in consultation with psychogeriatric health care professionals, should ensure that Psycho-Geriatric Assessment Teams with established referral patterns are available to all Ontario communities. These teams must be accessible on an urgent basis for CCAC case managers, LTC admissions staff, and PIECES-trained Registered Nurses and other health care providers in order to ensure that all applicants with complex and/or aggressive behavioural concerns can be thoroughly assessed		X

<p>prior to admission to a long-term care facility.  Specific funding and legislation should be put into place by the MOHLTC to develop and maintain these Psycho-Geriatric Assessment Teams.  Rationale: Through the inquest testimony, we the jury believe that in order to properly care for the ever increasing complex care elderly patients, all health care professionals must be properly trained in order to care for their needs.  Ten-Point Plan for Improving Quality of Life and Decreasing the Burden of Illness of Residents in Long-Term Care In Ontario</p>		
<p>Recommendation 50:  That the MOHLTC increase the number of fully funded, full-time Psychogeriatric Resource Consultants and Psychogeriatric Assessors doing assessments through the Geriatric Outreach teams and monitor delays. MOHLTC should ensure that there are sufficient "PRC's" (Psychogeriatric Resource Consultants) and Psychogeriatric Assessors available in a timely way to assist the Psychogeriatric Resource persons and other Registered Nurses in managing cognitively impaired residents in LTC facilities (and other facilities where these residents may be placed).</p>		X
<p>Recommendation 59:  The MOHLTC, in consultation with the CCAC sector, should consider including a provision in legislation and Ministry policy that limits the choice of clients who have been assessed as posing a risk to others due to physically aggressive or violent behaviour. Clients who are assessed as posing this risk, should be required to choose a LTC home with a specialized behavioural unit designed to deal with the clients behavioural concerns.</p>		X
<p>Recommendation 60:  That the Regulations, including the PCS Manual be revised by the MOHLTC to ensure that there is a requirement that an assessment of risk to self and others is done by the CCAC <i>prior</i> to placing the individual in any LTC facility. This revised regulation and the accompanying policy, would require the CCAC to consider a full assessment of the applicant's mental health status and behavioral problems prior to the determination of eligibility. It would also require the CCAC to consider the particular LTC facility and assess its resident population (the frailty of other residents, the competing high needs of other residents, the level of staffing, the numbers of Registered Nurses available, the presence of an appropriate specialty unit etc.) as part of the CCAC process and the determination of whether the resident is eligible for admission to LTC and should be placed in that particular LTC facility.  Rationale: Placement Coordination Service Manual</p>		X
<p>Recommendation 61:  That the MOHLTC review their regulations and policies to clarify the crisis admission process. At a minimum, standards must be set to ensure that complete and accurate information is obtained prior to decision making about an applicant's eligibility and admission, despite the fact that the family is in crisis. The policy should ensure that no decisions regarding eligibility and placement are made without all relevant information. This information must include, but is not necessarily limited to, information from the entire</p>		X

<p>health care team such as, information from all relevant family members, family physicians, and specialists. Information from other community resources such as psychogeriatric assessments and, where appropriate the police, should also be obtained. If the information is inadequate at the time of the application, the family should be notified and the CCAC should not make the placement arrangements until all relevant information is obtained and should ensure alternative resources are made available to the family in the interim.</p>		
<p>Recommendation 62: That the legislation, regulations and policies be reviewed to ensure that there is a mechanism for the conditional placement of residents in LTC facilities. If, after admission, a resident is found to have a complexity of care such as aggressive behaviors that cannot be safely managed, or to have requirements beyond the staffing ratios and staff expertise of the LTC facility, the CCAC shall be responsible for overseeing the immediate removal of the resident and their placement in a more appropriate setting. The LTC facility should not be left with the responsibility of finding alternative services, such as an acute care hospital, a specialized Centre or another LTC facility with a more appropriate unit.</p>		X
<p>Recommendation 63: That the LTC facility, through its Director of Care or delegate, when reviewing the CCAC materials to determine if the facility has the physical and nursing expertise to safely admit the individual, should be given sufficient time, resources and mechanisms to make this determination. This may include the LTC facility meeting with the resident and family prior to the decision to admit being made, and the facility having the means to accept the resident on a conditional basis.</p>		X
<p>Recommendation 73: All LTC facilities must have a set “admissions team” which consist of: (i) LTC facility’s Administrator, (ii) The LTC facility’s Director of Care, (iii) The LCT facility’s Chief Medical Administrator, and (iv) One PIECES-trained staff RN. All members of this “admissions team” must be present on the day the patient is admitted into their respective LTC facility.</p>		X
<p>Recommendation 74: Long-term care homes ensure that when a resident is admitted to a long-term care home, all staff who may have direct contact with a resident are provided with all necessary information about that resident.</p>		X

## **Admission of Residents (Sections 39 – 55 of the Act):**

### **What the Act says:**

This part of the Act applies to the admission of a resident to a long-term care home and any transfers of residents to a specialized unit. Specialized units are to be defined further in the regulations. Secure units are not “specialized units” unless the regulations so designate. The draft regulations provided to date do not define nor do they set criteria for specialized units and secure units.

The Act sets out stages of application as follows:

1. Placement coordinators in the Community Care Access Centres (CCACs) collect assessments and determine eligibility (discharge planners in hospitals are not mentioned)
2. The person or substitute decision-maker chooses a long-term care home
3. They apply for authorization of admission
4. The long-term care home determines if they are authorized
5. The applicant can appeal a placement coordinator’s decision to deem them ineligible, but there is no specific provision in the Act to appeal a decision of a home to refuse authorization for admission. In the latter case, the person is given the contact information for the Director (in the Ministry) to whom, presumably, they can complain.

According to the Act, the regulations are to specify:

- Definition of a specialized unit
- Definition of a secure unit
- Who is ineligible to be a placement coordinator
- Criteria for eligibility for admission into a ltc home
- How the application is made
- Assessment information for applications for admission
- Who may make assessments of functional capacity, requirements for personal care, current behaviour, and behaviour during the year preceding the assessment
- What comprises an application for authorization of admission
- Grounds for home owners/operators withholding approval for admission into the selected long term care home
- Requirements for notification of a rights advisor in cases where a person is admitted to a secure unit on consent of a substitute decision-maker
- Requirements for what the rights advisor must explain to the substitute decision-maker in these cases
- Requirements for what the placement coordinator must provide in written notification to substitute decision-makers in these cases
- Any requirements for the legal advisor to assist the person in making an application to the Consent and Capacity Board and in obtaining legal services re. admission to a secure unit

And (note Lieutenant Governor in Council means Cabinet);

**55. (1)** The Lieutenant Governor in Council may make regulations for carrying out the purposes and provisions of this Part. 2007, c. 8, s. 55 (1).

### **Specific inclusions**

**(2)** Without restricting the generality of subsection (1), the Lieutenant Governor in Council may make regulations,

- (a) governing determinations of eligibility for long-term care home admission;
- (b) governing authorizations of admission to long-term care homes, including, without limiting the generality of the foregoing,
  - (i) providing for priorities for persons in circumstances specified in the regulations or for classes of persons specified in the regulations,
  - (ii) governing the notices to be given by licensees under subsections 44 (8) and (9);
- (c) governing placement co-ordinators, including, without limiting the generality of the foregoing,
  - (i) providing for classes of persons or entities that are ineligible to be designated as placement co-ordinators,
  - (ii) providing for how placement co-ordinators shall co-ordinate with each other,
  - (iii) governing the transfer of responsibility for applications between placement co-ordinators under section 48;
- (d) requiring placement co-ordinators to ensure that persons seeking admission to long-term care homes receive information about their rights and assistance in exercising their rights;
- (e) providing for exemptions from provisions of this Part, subject to any conditions that may be set out in the regulations;
- (f) modifying the application of this Part for emergencies or other special circumstances specified in the regulations;
- (g) providing for applications under section 44 for admission to a long-term care home to be made before the home is licensed or approved;
- (h) defining “veteran” for the purposes of section 51;
- (i) providing for anything that under this Part may or must be provided for in regulations, or that is to be done in compliance with or in accordance with the regulations. 2007, c. 8, s. 55 (2).

### **Different requirements for programs, groups**

**(3)** The regulations may provide for different requirements for programs or groups specified in the regulations. 2007, c. 8, s. 55 (3).

### **What is in the draft regulations:**

Only CCACs are placement coordinators (presumably this covers all staff in a CCAC that do parts of the job of placement coordination), any other entity is not eligible. However, since the placement coordinator is supposed to provide information on alternatives to placement in a long term care home, and place in a long term care home, those with vested interests should be prohibited.

The regulations specify information to be given to applicants by placement coordinators, including alternatives to long-term care home placements, maximum fees for accommodation in long-term care homes and – notably – information about homes that have short wait lists or vacancies. They are not required to provide a list of all homes in the area close to the applicant’s home.

The regulations specify criteria and conditions for eligibility for admission to a long-term care home. The person must be 18 or older, be covered by OHIP, their needs can be met in a long-term care home, and they must meet at least one of the conditions and at least one of the criteria in the regulations:

Criteria:

- Applicant requires nursing care to be available on-site 24 hours/day
- Applicant requires assistance with daily living at frequent intervals throughout the day, or
- Applicant requires on-site supervision/monitoring to ensure safety and well-being at frequent intervals throughout the day

Conditions:

- None of the publicly-funded community-based services and other support arrangements are sufficient to meet the applicant’s requirements

There are provisions for eligibility for short-stay respite care and convalescent programs if the person meets the criteria above and will be returning to their own residence within 60 days for respite care and 90 days for convalescent care.

There are provisions for eligibility for spouses and partners of residents or those deemed eligible to be a long-stay resident.

The regulations require that the eligibility assessments for physical and mental health be signed by a physician or registered nurse. The regulations allow the assessments of functional capacity, personal care requirements, current behaviour and behaviour in the year preceding to be done by a registered nurse, social worker, physiotherapist, occupational therapist or speech-language pathologist. There are no further requirements for assessments, particularly for those with behavioural issues and aggression as per the Casa Verde Inquest recommendations.

The regulations do not specify additional details re. eligibility assessments beyond what is in the Act.

Upon receiving the application for authorization, the regulations specify that the long term care home owner/operator will respond within 5 days (excluding weekends and holidays).

The applicant can apply to only five homes at once.

The CCACs are to keep wait lists for each home in its area and for each specialized unit.

Applicants will be removed from waiting lists for every home to which they have applied if they refuse consent to admission for one home, if they refuse to enter into the agreement to pay for the availability of the bed from the date that they are informed they can move in, and if they don't move in. This applies unless the applicant has a health condition or illness or injury that prevents them from moving in within 5 days of being informed the bed is available. They will be removed from the wait list for 12 weeks minimum and have to re-apply for eligibility unless their condition has deteriorated.

The regulations set out categories for the wait list:

- Short stay
- Long stay
- Crisis category – the applicant is put at the top of the list (category 1) if the applicant is in a hospital, mental health facility or other specific types of facilities; if there will be no bed in the hospital or facility; they are a long-stay resident at another long term care home and the beds are closing; if they are ALC patient and there are severe capacity pressures at the hospital verified by the LHIN.
- Spouse/partner reunification – the applicant is put in category 2 on the wait list if their partner or spouse is a resident of the long term care home and they meet the eligibility criteria
- Religious, ethnic or linguistic origin – the applicant is put in category 3a or 3b on the wait list if the home provides services for the particular religion, ethnic origin or linguistic origin of the applicant
- Category 4a and 4b – these are categories on the wait list for applicants who are receiving high service levels under homecare, or in a public hospital and require an alternative level of care or in a long term care home and are seeking a transfer to their first choice of long term care home.
- Veteran category – for homes with veteran's priority access beds, if the applicant has applied for authorization to a veteran's priority access bed and is eligible.
- Exchange category
- Readmission category – for those who have been on medical or psychiatric absence for a longer time than permitted, or those who have been discharged because of an emergency in the long term care home
- Related temporary long term care home category
- Re-opened long term care home category
- Replacement long term care home category

The regulations provide tables ranking the various categories of the wait list with rules associated with the rankings.

The regulations require the homes to alternate between accepting transfers from those in preferred accommodation in the home waiting to move into basic accommodation and those who are on the waiting list to get into the home. (This is to ensure that residents that take private or semi-private beds because they are available, but cannot afford the higher fees for these beds in the long-term, are able to transfer within the home to basic accommodation with lower fees.)

Every March 31, the owner/operator of the home must report to the Ministry all those who were admitted to the home in the preceding calendar year, with verification that their admission was authorized by the appropriate placement coordinator.

**Under the current Nursing Homes Act regulations (which will be replaced by the new regulations):**

Many of the draft regulations under this Part are taken directly from the current Nursing Homes Act. There is very little that has been removed, except as follows, and there are some requirements that have been added in the new draft regulations.

- The same conditions and criteria for eligibility are the same, except the Nursing Homes Act regulations also included conditions such that a resident is eligible for placement in a nursing home: if they are at risk financially, emotionally or physically in their own residence; or the applicant may harm someone else if they live in their own residence; or there is some environmental condition that cannot be resolved if the applicant lives in their own residence. These conditions are removed in the new draft regulations.
- Short-stay eligibility and duration same or very similar.
- Requirements for information to be given to the placement coordinator by the applicant is the same or very similar.
- 5-day timeline for owner/operator of home to provide authorization or refuse it, same.
- The number of homes the resident can apply to for authorization at the same time was three under the Nursing Homes Act. This has been increased to five in the new draft regulations.
- Under the Nursing Homes Act regulations, the placement coordinators are required to keep a waiting list, and also to keep a refusal list. (The latter is useful to determine patterns of discriminatory behaviour on the part of particular owner/operators.) In the new draft regulations they are not required to keep a refusal list.

- The regulations pertaining to removing applicants from the waiting lists for all homes if they do not consent, move in within 5 days etc. are the same or very similar.
- The Wait List categories are similar. We have not done a detailed comparison of the rankings of the categories and the rankings within categories.

**What is in the LTC Facility Program Manual (to be replaced by the new regulations):**

Much of what is contained in the Manual under this section has been removed in the draft regulations as follows:

- List of objectives of the placement coordination service (see Tab 5, pp. 1 -3)
- List of functions of the placement coordination service (same Tab, pp. 3 – 7)

***OHC Response to the Sections on Admissions:***

*The regulations should specify that anyone with a vested interest in a long term care facility or a retirement home, or in a chain corporation that owns and operates long-term care facilities and retirements homes in Ontario, or with a vested interest in any other for-profit entity to which placement coordinators provide referrals or about which they provide information, is ineligible to be a placement coordinator.*

*All of the recommendations from the Casa Verde Inquest are not included in the draft regulations provided to date (see chart at beginning of this section). This must be addressed and those recommendations must be followed in the regulations.*

*The placement coordinators should provide information on all long-term care homes in the geographic region if the applicant requests this, not only the ones with vacancies or short wait lists.*

*One of the problems with admissions is that because of bed shortages both in hospitals and in long-term care homes, people are forced to move to long-term care homes that are far away from their home communities, families and support systems. The regulations for admissions and wait lists do not in any way recognize the need for people to be as close to home as possible, if they or their substitute-decision maker requests it. This situation is worse for those who require specialty units or secure units. There should be regulations recognizing the need for residents to be placed in homes close to their home communities, and requiring placement coordinators to keep data and identify service gaps and trends that result in people being placed far from home. The Ministry should operate under a goal of providing service as close to home as possible.*

*Another problem is that there is continued downloading of complex continuing care patients with high medical needs and psychogeriatric patients with complex needs into long term care homes. This is one of the most common complaints we receive from staff*

*in every geographic area of the province. It is a serious problem that is not adequately addressed in the draft regulations.*

- The Casa Verde recommendations were clear about the need for care plans to be instituted prior to admission for those with behavioural problems and aggression that may pose a threat to themselves or others. They were also clear about the need for appropriate and full assessments prior to admission, for conditional placement opportunities, for the need to take into full consideration the needs of residents and the levels of staffing, for the need for specialized and secure units with appropriate training and care levels, and for the need for other alternatives to placement in long term care homes. None of these recommendations are implemented in the draft regulations.*
- In addition, the regulations do not provide for any clear level of nursing and personal support care, so that a clear determination can be made about whether or not a long-term care home can provide for the applicant's needs. There needs to be a clear regulation setting out a provincial standard for the level of hands-on nursing and personal support care (we have recommended an average of 3.5 hours per resident per day), and a requirement that eligibility and authorization for admission be provided only if that care level is sufficient to meet the resident's assessed needs.*
- Not all Alternate Level of Care patients in hospitals are the same and the drive to move patients out of hospitals because of bed closures is resulting in inappropriate downloading of patients into long term care homes. There needs to be a clear definition in the Ministry of patients that require complex continuing care in hospitals and clear prevention of downloading of heavy or complex patients into long term care homes that do not have adequate staffing, specialized or secure units and adequately trained staff to meet their needs. All of this is too loose in the draft regulations, and a recognition that to date it has not been enforced adequately to protect residents, visitors, family and staff from harm.*

*There are no regulations pertaining to the definitions for secure units or specialized units, and criteria or requirements for these.*

*A further problem is posed by homes refusing admission to certain classes of persons whose behaviour does not pose a threat and who require access to long term care homes, (for example those with Huntington's). Thus, there needs to be a balance achieved between ensuring access for those who require long term care homes and preventing discrimination against certain types or classes of people, and ensuring that homes are not used as downloading grounds in order to cut needed hospital beds. The draft regulations do not require placement coordinators to keep refusal lists, which the regulations under the Nursing Homes Act do require. In order to address this:*

- An applicant who is denied authorization for admission should have the ability to appeal to the Health Services Review Board.*
- The placement coordinators should keep refusal lists and the data required to assess if there is a pattern of discrimination.*

- *There should be a systematic review process to weed out discrimination in authorization for admissions.*

*The Health Care Consent Act requires consent of a patient or their substitute decision-maker for treatment, including the use of restraints. However, patients do not know their rights under this Act, and consent is not always obtained. In recognition of this, the patient's rights to consent under this Act should be provided in the package of information provided to residents upon admission.*

*The recommendations of the Coronor's Jury in the Casa Verde inquest should be implemented and added into the regulations under this Part.*

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