AdvantAge Ontario

Advancing Senior Care

Proposed Amendments to the *Long-Term Care Homes Act, 2007*

Submission to the Ministry of Long-Term Care

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Introduction and Context

AdvantAge Ontario is the provincial association representing community-based not-for-profit providers of long-term care (LTC), community services and housing for seniors. Our members include not-for-profit (NFP) LTC homes (municipal, charitable and non-profit homes), seniors' housing, supportive housing, and community service agencies serving seniors. Member organizations serve over 36,000 long-term care residents annually and operate over 8,000 seniors' housing units across the province.

We want to recognize the Ministry of Long-Term Care (MLTC) and the Government of Ontario's recent investments in the sector, such as the funding for four hours of care, PSW and nursing training, and covering the costs of the pandemic. However, we must acknowledge that seniors' care in Ontario is at a pivotal crossroads at this moment, given the impacts of the devastating COVID-19 pandemic on our sector layered on top of pre-existing under-funding and over-regulation. The sector as a whole sorely needs significant reform to transform into a properly resourced, people-centred provider of care to seniors and vulnerable adults. Public expectations for change in the sector are at an all-time high, as evidenced by the recent Angus Reid poll where 75% of respondents said LTC needed either significant changes or a total overhaul.[1] While our member organizations have demonstrated considerable leadership, resiliency and expertise throughout the pandemic, this has been in spite of a chronic lack of resources and a byzantine regulatory structure.

We strongly believe that changes to the *Long-Term Care Homes Act, 2007* (LTCHA, or the *Act*) and its regulations are not only warranted, but also imperative, to achieve transformational change in LTC and sustain its leadership and front-line staff, which are on the brink of collapse.

Change cannot occur without a substantive overhaul of the *Act*.

The Problem

For years, the sector has been under-funded, and successive governments have tried to address issues by layering on more and more regulation. This has resulted in a no-win situation in which homes cannot meet targets, and much of the staff time is spent addressing regulatory requirements that go well beyond anywhere else in the healthcare sector, including hospitals and retirement homes, and approaches levels in the nuclear industry. This is in addition to the rising acuity in residents in LTC over time and lack of coincident investment in higher levels of care for residents. For over a decade, many experts and reports have been calling for four hours of care, and we are pleased that the government is finally moving forward in this area and working on incentives for health human resources (HHR). However, investments alone will not be enough to transform LTC. Significant change is needed to the *Act*.

In her series called "The Fix",[2] *Toronto Star* journalist Moira Welsh describes the current LTC system as controlled by "300 provincial regulations that keep staff focused on the tasks of feeding, scheduling and cleaning, all documented for government collection. It's a detached, antiseptic end to life."

A common concern with LTC homes is that the current regime forces the emphasis to be on things other than resident-focused and emotion-focused care. With over 80 per cent of LTC residents experiencing some form of dementia, emotion-focused care is equally important to physical care. In our July 2021 submission to the MLTC in response to the Final Report of Ontario's LTC COVID-19 Commission, we outlined our responses to the Commission's recommendations in detail and echoed the Commission's call to move forward on helping homes deliver emotion-focused models of care.[3]

These models of care put residents at the centre and enable staff to more holistically address residents' needs. While the funding of four hours of care will support the achievement of these models, there are currently major barriers in the LTCHA and its regulations that prevent homes from embedding these care models into their work. One of their major tenets is allowing homes to use their creativity and flexibility to provide care to residents. This does not match the strict rules required by the LTCHA. Outcomes such as laughter, joy, and fun are crucial to anyone's life, and yet they are not prioritized at all in the Ministry's regime, despite the tenet of a "home-like environment" being a fundamental principle in the LTCHA.

Transformation is possible, but not without major legislative changes. With our current oversight mechanisms, the rigidity with which care needs to be delivered in order to follow all of the requirements of the *Act* means that staff have to choose between spending most of their shift documenting care – which amounts to mostly transactional exchanges with residents – rather than focusing on residents as people in need of caring and love. Unfortunately, with the current punitive inspections regime and the public shaming exercise that accompanies it, the only choice that homes and staff are able to make is the one that serves residents the least.

No amount of funding or incremental changes to the *Act* will fix this. We need substantive, systemic change – not only to the compliance regime but also to the principles that underpin the whole *Act*. Adding in additional language to the Preamble of the *Act* which speaks to major transformative changes, such as Coaching for Quality Care and recognizing the special role of the NFP LTC sector, would signal a commitment to the desperately needed changes in the sector.

The LTCHA is written from the perspective of assuming homes are not interested or willing to provide the best possible care, and therefore must be strictly overseen, chastised and written up. This dynamic does not exist in any other healthcare setting in Ontario, and has major detrimental effects to recruiting and retaining staff into the LTC sector. Why work in a setting which, in addition to being understaffed and under-funded, makes you responsible to follow regulations in a similar volume to the nuclear industry, when you signed up for a career of helping people? This undermines creating a just culture in LTC, which is a critical element of delivering quality care: staff need the space and flexibility to do their jobs. We propose changes to the *Act* and its regulations to reduce duplication, enhance streamlining which would help to address the current staffing crisis, and make LTC a desirable place for healthcare professionals to work.

We also comment on overhauling the admissions process in this submission, so that homes are spending time more efficiently when reviewing resident applications, as well as strengthening campus of care and cultural home admissions guidelines.

In addition, the COVID-19 LTC Commission made a number of recommendations for amendments to the Act and its regulations. Throughout the submission, we offer our commentary on those proposed measures as well as a number of considerations for government when implementing those changes.

In order to truly transform care, change needs to come from the sector's very foundations – from the *Act*. Our goal is to move the LTCHA and its regulations from a punitive regime to a system that is focused on achieving excellence in order to enhance resident-centred care.

The Proposal

The good news is that both the Ministry and Minister of Long-Term Care have signaled their commitment to positive, implementable changes in opening up the LTCHA. AdvantAge Ontario is pleased to assist and is uniquely situated as the voice for NFP and municipal homes, which research has shown to provide better quality of care, and to have fared comparatively well in the face of COVID-19. Throughout this submission, we provide simple solutions to change the delivery and experience of LTC in Ontario, and in some cases, technical suggestions for amending the *Act*.

AdvantAge Ontario is pleased to offer our proactive submission to the MLTC with respect to potential reforms to the LTCHA. We have grouped our comments and recommendations under the following priorities:

1. Preamble – Adding to the Goals of the *Act*, and Highlighting the Special Role of Not-for-Profit and Municipal Homes
    - Recognizing the better quality of care for residents of NFP and municipal homes due to their ties to local communities, and focus on reinvesting funding directly into care, to the benefit of residents.

2. Embracing and Enabling Resident-Centred Care including Emotion-Focused Models of Care
    - Creating an enabling regulatory and legislative environment for enhanced adoption of these models, rather than impeding them.

3. *Coaching for Quality Care* – A New Compliance Regime
    - Reinforcing continuous quality improvement through compliance coaching, which we call "Coaching for Quality Care" – leverage homes' expertise and see the Ministry develop tools for both homes and residents/substitute decision makers (SDMs) and the public, as well as create Communities of Practice.

4. Overhauling the Admissions Process
    - Recommending greater efficiency for homes when reviewing potential resident applications, and strengthening campus of care and cultural home admissions guidelines.

5. Streamlining Reporting

- Addressing the current reporting burden on homes that takes time away from providing care to residents.

6. Staffing – Four Hours of Care and Additional Allied Staff
   - Legislative and regulatory amendments that reflect appropriate staffing needs and expertise, including among RNs/RPNs/PSWs and allied health (such as OT/PTs and recreational staff).

7. IPAC Recommendations from the LTC COVID-19 Commission
   - Providing input on recommendations related to IPAC, and advice to government on their implementation.

8. Additional Housekeeping Amendments
   - Addressing several outstanding issues in the LTC sector that could be resolved with regulatory or legislative changes.

1. Preamble – Adding to the Goals of the *Act*, and Highlighting the Special Role of Not-for-Profit and Municipal Homes

The preamble to the LTCHA is foundational, as it outlines the principles in which the *Act* should operate. Given the reform agenda of the MLTC, amendments to this area would do a great deal to signal the future priorities for LTC in Ontario. Overall, the most important piece is that the principles in the Preamble must actually be implementable in the LTC sector, and homes must be given the funding required to make them happen.

Below are our recommendations for additions to the Preamble of the LTCHA. Specific wording recommendations can be found in Appendix 1:

Special Role for Non-Profit and Municipal Homes

Not-for-profit and municipal LTC homes in Ontario hold a special stature in the health system. (Please note that throughout this submission, we will use NFP to refer to not-for-profit, charitable and municipal homes.) Many studies have demonstrated the higher quality of care in NFP homes. These homes have also been cited as having better outcomes through the pandemic, they have no overriding financial interest to gain in the care they deliver, they are strongly linked to local communities, and they reinvest all of their profits back into care. The province should recognize this difference and expand on its ongoing support and preference for NFP homes by adding additional language in the Preamble to the *Act*.

Respect for LTC

The COVID-19 pandemic highlighted the resiliency and deep skill of the sector's staff and leaders, who were working understaffed, in an overly punitive system, with ever-changing rules and guidance sent from multiple areas of the healthcare system, and with little to no coordination between them all. However, in many situations, there was a power imbalance between LTC homes, hospitals and public health units. In many instances, the advice and expertise of the homes' leaders were disregarded. And the system rarely turned to LTC leaders to ask them to assist other homes.

The introduction of Ontario Health Teams (OHTs) provides a great opportunity to attain this much-needed system and regional coordination, and LTC is eager to be part of that work. However, those who have been working in LTC for years have specific and deep expertise, which should be respected and taken as a first consideration with respect to all matters related to LTC and the operations of homes. This respect should be explicitly articulated in the *Act* in recognition of the thousands who work diligently every day to deliver the best quality care possible for their residents.

Coaching for Quality Care

Later in this submission and in keeping with the Commission's recommendations, we propose that a new compliance system be enshrined in legislation, called *Coaching for Quality Care*. This new system would replace the current punitive regime with an enabling environment that allows homes to learn from one another, and would reorient the current inspections regime to focus on the homes that most need support, while allowing the remaining homes to focus on delivering high quality care.

The principles of this new regime should be in the LTCHA Preamble to set the tone for the culture change it would enact in the LTC sector.

Emotion-Focused Models of Care

Overall, what the *Act* is trying to achieve is the best possible care for residents and a working environment that is attractive for staff so that the system can sustain itself for years to come. Emotion-focused models of care have been cited by many, including the LTC COVID-19 Commission, as a way to change the culture of care in the sector, and the signal in the Preamble to the Ministry's commitment to these models would reinforce that this culture change is needed and is underway.

COVID-19 LTC Commission Recommendation 29 – *Recognizing Residents' Complex Health Needs*

Residents in LTC have increasingly complex care needs. We support the LTC COVID-19 Commission's *Recommendation 29* that calls for amendments to the fundamental principle in section one of the LTCHA to explicitly acknowledge that LTC residents have complex physical and mental health needs, including cognitive impairments.

2. Embracing and Enabling Resident-Centred Care including Emotion-Focused Models of Care

The overriding priority of this legislative and regulatory change should be to enshrine the principles of resident-centred care in such a way that homes can implement them. LTC is not acute care; these buildings are people's homes. Truly embracing resident-centred care and a home-like environment requires a paradigm shift. There have been many successes with emotion-focused models of care, often spear-headed by NFP and municipal homes which have been pioneers in this area. Many of our members are keen to be given the resources and the regulatory environment to be able to implement and incorporate the values and principles from these models into their own homes. While some members are already doing this, they have cited the time and effort it takes to find workarounds to the rules so that they can deliver these

models within the current structure. The LTCHA should be enabling these models, not impeding their adoption.

There are two actions required to achieve resident-centred care from a legislative/regulatory perspective: (1) establish appropriate parameters for staff to be able to meet resident needs, and (2) provide enough flexibility to enable the provision of emotion-focused models of care.

One simple example of how the current *Act* contradicts the concept of resident-centred care is around mealtimes. Right now, a licensee has restrictions on when they can serve food. However, residents usually prefer more dining options and flexible times. Removing restrictions around mealtimes and allowing the licensee to determine the appropriate schedule based on resident needs and desires would allow residents to feel less constricted in their homes. It would reduce responsive behaviours and lower staff stress.

Another issue related to mealtimes is the requirement for all residents to be monitored during meals, regardless of if they are capable of eating independently without supervision. Allowing capable residents to eat on their own if they wish to do so would give them more autonomy and choice, without impacting the safety of the quality of their care.

There are countless other examples of how current regulations impede resident-centred care. While the health system was built on a medical model (which is typical in hospital and physician environments), Ontario's health system has evolved considerably over the years. A pure medical model imposed on people's "homes" is inconsistent with the way residents should live, and staff should work, in an LTC home. Perceptions in the healthcare sector about how LTC should be medicalized need to change or else this will become an increasingly misunderstood and contentious issue as LTC homes join OHTs and health system partners work together more closely.

Another concern raised is that the current compliance model, with its hundreds of licensee obligations between the *Act* and its regulations, creates a climate of fear and mistrust as opposed to a just culture. For instance, using the mealtimes example above, staff may be fearful of meeting a resident's dining request where it deviates from the regulations, because the home could be written up for "breaking the rules." Empowering staff to make choices (or the choices of residents' SDMs) that are aligned with residents' needs would go a long way to improve the culture of the workplace by giving staff the space they need to do their job. Truly, the time has come for LTC oversight that enables resident-centred care, rather than a punitive focus on meeting what may appear as sometimes obscure parts of a very lengthy *Act*.

The Ministry should be viewing the *Act* and its regulations through the lens of enabling culture change, not perpetuating the status quo. Even if millions more in funding was given to the sector, the barriers that currently exist in the *Act* would continue to prevent homes from delivering these care models.

> **Recommendation:** That the MLTC, in partnership with LTC associations and others, do a line-by-line regulatory review of the LTCHA, with the aim of amending all of the regulations that conflict with implementing emotion-focused models of care.

COVID-19 LTC Commission Recommendations: Residents' Bill of Rights

The COVID-19 LTC Commission made a number of recommendations as it relates to the Residents' Bill of Rights. We offer our commentary on those recommendations here:

Recommendation 34 highlights legislative amendments to the Residents' Bill of Rights and Ontario Regulation 79/10 around the right to technology for residents, and the requirements of LTC home licensees to provide reliable Wi-Fi and consistent, frequent access to technology.

AdvantAge Ontario does not agree that this should be a legislative measure; however, these would be excellent best practices for the sector. If this was to be included in legislation, there is a need for resources to support access to technology. In some parts of the province, infrastructure does not exist, and therefore access to reliable Wi-Fi may not be an attainable or realistic requirement of LTC homes.

Recommendation 37 states that the Residents' Bill of Rights should be amended to align more closely with the prohibited grounds of discrimination in the Ontario Human Rights Code. AdvantAge Ontario agrees with this recommendation. The Association believes that the protected grounds of the Ontario Human Rights Code are fulsome and represent the diversity of residents in LTC homes. Additionally, this would position LTC homes to continue driving towards diversity, inclusion, and cultural safety. We also recommend that the Ministry provide funding for education on these matters for staff and leadership.

3. Coaching for Quality Care – A New Compliance Regime

The Current System

Successive governments have layered on increasing compliance requirements on LTC to try and fix the issues in the system instead of providing adequate funding and human resources. The current system has reached the point where LTC homes in Ontario are rarely able to meet all the regulations in the *Act*, which is demoralizing. In addition, many of the regulations focus on matters that do not truly impact resident quality of care and safety. Homes are therefore excessively penalized for trivial matters. A culture change is needed in inspections. The *Act* must be streamlined to focus on what counts, and homes need assistance and guidance on how to not only meet but also exceed expectations in the regulations.

The current compliance model is rooted in an over-emphasis on documentation, and a "gotcha" culture that presumes that homes will be caught in the act of disobeying rules. This is not the best focus for existing LTC resources, including the inspections resources of the MLTC. When all homes are treated the same, those with the gravest concerns get the same level of oversight as homes who are performing satisfactorily. This serves no one well, least of all residents.

The current inspection and enforcement program does not set up homes to succeed, and in fact our members often feel it expects homes to fail. Inspectors have no authority to enable and support performance improvements – they simply judge whether homes meet the regulations or not. With the complexity of LTC home regulations, there is a substantive need for guidance, advice, and best practices for home operators on how to pass inspections and meet expectations. Inspectors should be able to point out best practices of other homes so that homes can learn from one another.

Other systems, such as Ontario's retirement homes regime, offers this much-needed support. Before the current LTCHA was put in place, LTC homes inspectors were advisers who provided advice and guidance. While we recognize that mechanisms must be put in place to address serious issues of non-compliance, this should not be mutually exclusive from assisting homes in reaching their full potential to provide safe care.

This criticism of the compliance system has been echoed throughout the course of the global pandemic, including by the Ministry,[4] in LTC sector reports (and AdvantAge Ontario submissions), and most recently in the Auditor General[5] and LTC COVID-19 Commission Final Report.[6] Resident well-being, safety and quality of care are of utmost importance to AdvantAge Ontario and our members, and the need for an overhaul should not be seen as competing with this stated purpose.

Below we set out recommendations for a *Coaching for Quality Care* system and other suggestions for an improved inspections process.

Coaching for Quality Care

AdvantAge Ontario is recommending that the MLTC amend the LTCHA by introducing a *Coaching for Quality Care* regime, in keeping with the following LTC COVID-19 Commission recommendation:

> *Recommendation 73*: To support long-term care homes in their compliance and quality improvement efforts, the Ministry of Long-Term Care should establish a dedicated Ministry compliance support unit as recommended by Justice Gillese in the Long-Term Care Homes public inquiry. The compliance unit should encourage and assist with compliance training tools, compliance coaching, sharing best practices, and tracking and reporting on improvements.

We have long advocated for this. Our envisioned approach is two-pronged:

- Take a supportive and enabling (rather than punitive) approach to compliance and inspections, with Ministry inspectors providing support, guidance and tools
- Leverage the expertise of many of the NFP LTC homes who are willing to share their expertise and best practices with their peers.

With this approach, the Ministry would provide support to homes to allow them to reach their full potential and meet the complex requirements of the LTCHA. The power of allowing homes to learn and share among each other cannot be overstated, and could include the MLTC issuing interpretive bulletins, sharing key analytics, developing plain language and practical guidance documents, and disseminating best practices within the sector. Additionally, dedicated Ministry resources should be available 24/7 for support and liaison.

Homes sharing best practices with one another would create a community of practice model, which would transform the LTC sector and its regulatory framework by giving opportunities to homes to identify issues about a home's practices and care and give them the space to address them outside of the punitive inspections process. This Ministry support unit would allow for leading practices and innovative solutions to be shared among homes, so they could be models of continuous quality improvement.

This is in contrast to the current approach, where homes are written up for minor issues, yet Ministry investigators are already challenged to handle the volume and scope of the issues in their purview. If homes are struggling to comply, document and respond to complaints and inspections, and inspectors are struggling to deal with the workload that these complaints create for them, then this system is working for neither party and needs to change.

The LTCHA's oversight mechanisms must be streamlined significantly to first focus on the highest risk and/or most common issues that have a significant impact on residents' quality of care and/or quality of life. Those that impact both must be given highest priority. Additionally, any system of oversight must be able to respond swiftly to the rare scenario where resident care or quality of life is being seriously threatened/endangered in a home, or where a consistent pattern of less serious issues also impacts quality or care.

This approach ties into the LTC COVID-19 Commission's *Recommendation 78(a)* which calls for proportionate and escalating consequences for non-compliance.

While critics may feel that any change of this type would undermine the quality of care, we would argue the opposite. By having inspections and regulations focus on the most critical matters, quality of care will improve. Inspectors and home staff alike will be able to put their full attention on what matters most instead of being distracted by less important matters.

We appreciate that residents (and where incapable, their SDMs), family members and the general public also have an expectation that seniors will live in a safe environment while in a LTC home, and benefit from robust protections as well as opportunities to live well in their later years and as their health needs change. They must also be empowered to make choices in how they live.

> **Recommendation:** That the Ministry work with the sector and stakeholders to develop and implement a *Coaching for Quality Care* program. We recommend that it be operational within 12 months of the passage of legislation.

Inspections Judgement Matrix

Currently, MLTC inspectors use the MLTC *Inspections Judgement Matrix* when measuring compliance to the legislation in relation to the severity and scope of the non-compliance of an issue. They also take into account the home's compliance history. This document is important to the inspections process and needs to be overhauled when the *Coaching for Quality Care* regime is brought in, so the system works together in a coherent way. This overhaul should be done in collaboration with homes, and there should be transparency on the new Matrix and education provided before it is introduced.

> **Recommendation:** MLTC should overhaul the *Inspections Judgement Matrix* while introducing *Coaching for Quality Care*, in collaboration with the sector on any changes made, and should ensure education for the sector on the changes is included.

AMPs

We also want to voice our concerns regarding Administrative Monetary Penalties (AMPs), which were established by the previous government but not implemented. These have the

potential to create an additional, punitive measure to a system that is not set up adequately to help homes succeed.

Additionally, NFP LTC homes reinvest all their profits back into resident care. Municipal homes also receive funding from their tax base, and charitable homes may obtain funding from voluntary contributions. In both instances, the implementation of AMPs would mean that money would be taken out of the care for residents to pay for these fees – and communities would be on the hook to reinvest more. This is a self-defeating measure, and we therefore do not agree that AMPs should be implemented in NFP and municipal LTC.

> **Recommendation:** Do not implement AMPs in NFP and municipal LTC.

Inspector Identity and Conflict of Interest

Inspectors do not immediately identify themselves and are not subject to the same identification procedures as everyone else who enters the home. (s. 146 LTCHA). This is an issue because it undermines the safety of residents if operators are unsure of who is on their premises. As inspectors currently wear no identification, this could lead to unauthorized individuals using the inspector excuse as a way to access the building and residents for harmful purposes.

A more transparent relationship between staff and inspectors will encourage them to work more collaboratively to improve care for residents.

> **Recommendation:** MLTC should add a requirement in section 146(3) of the LTCHA that when entering a LTC home, inspectors must wear identification that is visible and identifies them as inspectors.

We are also aware of inspectors who are former employees of homes that they inspect, which is a clear conflict of interest. These are important considerations as they impact the inspections process and may even impact consistency of report findings among various inspectors.

> **Recommendation:** Inspectors should not be assigned to work in homes where they previously were employed.

Powers on Inspection

Currently, an inspector has the right to demand any record or other items to be produced within timeframes set by the inspector. This places significant pressure on homes as they often have to take immediate time away from resident care to meet an inspector's requirements (s. 147(3) LTCHA). Staff in LTC homes are not always available to immediately furnish documents demanded for inspection purposes when they are required to attend to resident care or operational issues, or if they are not scheduled to work at that time.

The reduction of administrative burden will allow staff to focus on providing care to residents. Ongoing communication during the Resident Quality Inspection (RQI) will allow for more timely provision of information requested, while not adversely affecting managers' schedules in the home or negatively impacting on staff's ability to provide care.

Recommendation: Revise this provision to include the principle of reasonableness, and provide staff with sufficient time to provide records during staff working hours.

COVID-19 Commission Recommendation: Coordinated Inspections

Recommendation 75 highlights that the MLTC should develop a coordinated, comprehensive LTC home inspection regime involving the Ministry of Labour, Training and Skills Development and the public health units. It goes on to discuss the need for gathering information from a variety of sources, and communication between the ministries and public health units.

AdvantAge Ontario agrees with this recommendation and would like to see more coordination between the ministries and public health units. It would also be important to develop an integrated reporting system to reduce administrative burden for LTC staff. We discuss this further in section five in this report, Streamlining Reporting.

New Proposed Category for Inspections: Minor Issues

Currently in the LTC inspections system, there is little nuance in the range of duties imposed on a licensee: everything requires write up, no matter how large or small the infractions are.

With over 300 regulations that staff and licensees need to follow, it is nearly impossible for an inspector to leave a home without writing up the home for some infraction, which then gets publicized on a website that has zero context on the severity of the issue. The public only sees that a home has a write-up, which makes the home look like they are faring worse than they actually are.

We are proposing that the Ministry makes changes to the LTCHA to allow a subset of the most minor regulations to be carved out and treated separately during the inspections process.

If issues are found in homes regarding this grouping, inspectors should consider them "Minor Infractions of the *Act*" and, in the spirit of *Coaching for Quality Care*, give homes the opportunity to address the concern before being given a written notice or an order.

If issues are not resolved in the agreed upon timeframe, this repeated non-compliance would lead to a write-up that could be publicly posted.

Recommendation: We recommend that MLTC look at all the regulations and, in consultation with LTC associations, dedicate a grouping of them to be treated as "minor infractions."

We propose a short list of examples of regulations that could meet the "Minor Infraction" category in Appendix 2.

More Targeted Public Posting of Findings

The visibility of a home's compliance history online is problematic, because as stated previously, there is no indication of the severity of the issues on the Ministry's portal. This means that for minor infractions, it would seem to a potential resident or their family or existing/prospective staff that a home is doing worse than they actually are. Secondly, it does

not incorporate anything a home does well and/or is compliant around, which makes the report skewed to the negative aspects of the home without celebrating its successes.

Only the serious findings tied to mandatory reporting or a critical incident should stay permanently posted online, as that is pertinent information to a resident and/or loved one's decision-making process. For the minor infractions outlined in the previous section, these findings should be posted for a limited amount of time, unless and until they become chronic. The suggested time period of this posting would be four weeks.

This change would improve not only public perception of the LTC sector but also assist in facilitating positive culture change, as LTC homes would be trusted to make any needed minor changes within a set timeframe without having the infraction listed online in perpetuity.

We would be supportive of a home having minor infraction findings permanently posted online after a period of repeated non-compliance.

> **Recommendation:** Amend the *Act* to allow for a four week time limited public posting of findings related to 'Minor Infractions of the *Act*', unless and until there is repeated non-compliance.

Revamp Online Compliance Reporting

The entire online compliance reporting environment should be revamped to be a more user-friendly, one-stop shop for the public. This process should include input from a variety of stakeholders in LTC, including homes themselves, families and residents.

> **Recommendation:** The MLTC should work with LTC organizations as well as entities with digital expertise to revamp the online compliance reporting environment to be user-friendly and a one-stop shop for the public.

Multiple Orders/Notices for Same Issue

Similar to the issue outlined above regarding findings, homes are currently being issued multiple orders and/or notices for the same issue. Online, this makes it look like a home has multiple issues when in reality there is only one, and yet separate reports are issued. This needs to change as it again makes homes look like they're doing worse than they are, which can unduly alarm families, residents and others.

> **Recommendation**: To reduce confusion, direct inspectors to issue one order and/or notice only for each finding.

Complaints Management

Currently, all email concerns and complaints must be reported to the Director; however, concerns indicated verbally or in person are not required to be reported (s. 22 LTCHA, s. 101(4) O. Reg. 79/10). Now that electronic communication has become one of the primary ways to contact the home, families find email very convenient. However, not all email concerns or complaints are serious enough to be reportable, while some verbal concerns are serious. The focus should be on the issue, and not the medium by which it is conveyed. This regulation places a significant administrative burden on homes, and in many cases is unnecessary.

Recommendation: Repeal the provision that requires a LTC home licensee who receives a written complaint concerning the care of a resident or the operation of the home to immediately forward it to the Director and revise it in order to stipulate that s.22(1) would only apply to written complaints that are not resolved within 24 hours.

- Revise s.101(4) in O.Reg.79/10 related to resolution of verbal complaints to include written complaints that are resolved within 24 hours, so that they are treated the same way as verbal complaints.
- In addition, the regulation should clearly distinguish between concerns and complaints.

Vexatious Complaints

Once a resident is admitted to a LTC home, the matter of how to address complaints (either theirs, or if incapable, those of their SDMs or family members) can be difficult. AdvantAge Ontario acknowledges the important role of SDMs and family members as the eyes and ears of the resident, and that abuse in any form is unacceptable.

The reasons for these complaints vary, and in some cases are from loved ones who do not understand the LTC context or limitations that homes have regarding staffing and resources. The situation outlined in this section put homes and the Ministry in a challenging position. It is without question that abuse must be reported, and complaints addressed. However, in a number of cases, a SDM or family member regularly makes frequent complaints, often on a daily basis. Each must be filed with the Ministry as a formal complaint. The sheer volume of complaints in these cases, and the lack of a mechanism within the compliance framework to weigh them in a prompt and measured manner or to determine whether they are indeed abuse (despite the definitions in section two of O.Reg. 79/10 which defines the various types of abuse), must be addressed.

In a few cases, the complainant turns to social media and is unchecked in that forum. Privacy laws (Ontario's *Personal Health Information Protection Act, 2004)* prevent any public response by the LTC home to correct the record.

In law, there is a concept of a vexatious litigant; we urge the Ministry to adopt a mechanism such that both the home and the Ministry are able to identify the point at which such complaints fall under this category.

Recommendations: The Ministry should consider preparing and issuing guidance for the sector on how to address these difficult situations as part of the *Coaching for Quality Care* program:

- The Ministry provide supports (e.g., to homes/to the Ontario Association of Residents' Councils (OARC) and to Family Councils Ontario (FCO) to help residents and loved ones better understand the LTC setting and LTCHA context as well as practical strategies to work with homes to resolve situations.
- The MLTC adopt mechanism to determine whether a complaint is vexatious and change the expectations of the operator in responding to them.

Timeliness of Complaints

In some cases, LTC homes have not been made aware of complaints made to the Ministry, and these complaints are only investigated during the annual RQI, often months after the issue occurred and sometimes long after it has been resolved (s. 24 (1) LTCHA). Sometimes, corrective measures are easy for homes to implement and avoid non-compliance, but they cannot do this without adequate and timely information about the issue.

By addressing this issue, LTC homes will be able to more quickly rectify and prevent similar complaint situations from occurring, thereby improving resident care as well as resident and family satisfaction.

> **Recommendation:** The Ministry should communicate all complaints to the home, when received, so that homes have an opportunity to resolve them, and record actions and outcomes.
> - Inspectors would then only check that these complaints have not been resolved, during the RQI.

Discharge Complaints

At present, the discharge provisions of the LTCHA and its regulations [i] limit the ability of a home to discharge a resident. They can only do so where a home can no longer meet the care needs of the resident. We suggest that there be a mechanism to reinforce that, while residing in a LTC home is the choice of a resident/SDM, there are limits to the complaints processes such that in the rare but vexatious cases described, the home and/or the Ministry can initiate discharge.

> **Recommendation**: That there be a mechanism to reinforce the limits of the complaints process and in what circumstances a home and/or Ministry can initiate discharge.

AdvantAge Ontario acknowledges that a better alternative may be to expand the powers of the Consent and Capacity Board, an arm's length tribunal established under the *Health Care Consent Act* (HCCA). Under Ontario law, the HCCA governs admission to, but not discharge from, a LTC home. A discharge by a LTC home under the circumstances (or all circumstances) described above could reasonably be placed before the Consent and Capacity Board, given that the Board already exercises authority over admission to LTC.

> **Recommendation**: That MLTC explore expanding the powers of the Consent and Capacity Board to govern discharges from an LTC home.

4. Overhauling the Admissions Process

Currently, the admissions process is too slow and complicated. It needs to be streamlined to reduce the administrative burden on homes and to get people into homes more quickly. We understand that the MLTC has committed to reviewing the admissions process; however, there are a number of areas that could be addressed immediately as part of the amendments to the LTCHA.

[i] LTCHA, O.Reg. 79/10, sections 144-151.

Assessments

Currently, homes can receive upwards of 100 applications a month, with a mandated five-day turnaround to review and either accept or decline. Staff can usually only review about 10 to 12 applications in a seven-hour day for general applications, and more complex ones can often take double that time due to the back and forth with Home and Community Care Support Services (HCCSS).

One example representative of the experience of many of our members is that one home's most recent analysis from last year (pre COVID) was that 97% of their admissions were "crisis" admissions, so they would be accepted in advance of all of those applications already reviewed on the wait list. This makes the wait list review a waste of time for staff who could be using their skills supporting existing admissions and residents, as the non-crisis waitlist residents would have no spot. However, if the home does not meet the review and turnaround times, they can be cited by the Ministry for non-compliance, as has happened to this particular home.

Oftentimes, a prospective resident's package is incomplete, and it takes the home more than five days to receive the additional required information from other healthcare system partners. This is something that homes cannot control yet they might be cited for non-compliance nonetheless.

There are other, much more efficient admissions models that could be used. For example, in Saskatchewan, applicants sit on a central list until a spot becomes available, and their name is put forward for admission. The home reviews the resident's application at that time, instead of when they appear on the central waitlist.[7]

Changes to the admissions process is sorely needed, and they should not have to all wait for the Ministry's full review. The following would go a long way to help ease this process:

Recommendations:

- Remove the legislative requirements of five days for review of an application; it is not reasonable and takes time/resources away from reviewing and supporting residents who are being admitted now.
- Give all homes access to CHRIS (the admissions program used by Home and Community Care), which could help with the application review as it negates the requirement to liaise in detail with HCCSS on each application.
- Review the process for transfer between facilities – people may accept a home thinking that they will transfer to their home of choice, which rarely occurs due to the high rate of crisis admissions. Prospective residents should be informed of this.
- Review the admissions system as a whole for equity, fairness and transparency and consider other admission processes, such as in Saskatchewan.

Risk-Based Admissions

LTC homes must provide a safe and secure home for all residents, but they have very limited ability to refuse a high-risk admission and/or discharge a resident even if the applicant/resident presents a grave risk of harm to and jeopardizes the safety of other residents. Currently, homes can only withhold approval of applications on the basis of a lack of physical facilities, nursing expertise, and/or other circumstances provided for in the regulations.

Bilateral agreements may be developed as a condition of admission that specify the sending facility (usually a hospital psychiatric ward) will guarantee readmission if the placement does not work out. Some of our members have chosen to refuse admission of high-risk individuals as they would prefer to have an order from the Ministry than an assault or homicide in their home.

Risk-based admissions would reduce resident-upon-resident and resident-upon-staff violence, thus resulting in a safer environment. Residents will be able to be placed in the appropriate care settings more efficiently, and receive the care they need, while homes will be able to assess and determine whether they have the resources and capacity to provide person-centred care to all seniors, including those requiring high levels of care.

> **Recommendation:** That the grounds for refusal in LTCHA s. 44(7) be revised such that LTC homes may refuse residents where there are reasonable grounds to believe that the applicant poses a significant risk to the health, well-being and safety of other residents and staff (e.g., enabling homes to rely on section 19 of the Act, "Duty to Protect," as a reason for refusal of an applicant).
> - "Significant or high risk" in terms of refusal of admission would need to be defined.
> - That a provision be added to the LTCHA and/or its Regulation which will allow LTC homes to admit a high-risk resident on a trial basis to determine if the placement is appropriate.

Risk-Based Discharge

Currently, the discharge provisions in the Regulation limit the conditions under which LTC homes may discharge a resident (e.g., if they leave the home under the conditions defined in the Regulation, if a residents' requirements for care have changed and the home cannot provide a secure environment to ensure the safety of the resident or the safety of persons who come into contact with the resident). They also detail a lengthy process for discharging severely aggressive or violent residents, which greatly increases the risk of harm to other residents and staff.

> **Recommendation:** That the discharge provisions under s.145 or 146 in the Regulation be amended to provide LTC homes with the ability to discharge a resident where a resident assessment shows reasonable grounds to believe that the safety of other residents is in jeopardy due to a risk of harm. ("Reasonable grounds" could be replaced with "high probability".)
> - Alternatively or in addition to the recommendation directly above, that the law be revised to provide homes with the option of an automatic discharge provision where there is a demonstrated risk to the safety of other residents.
> - "Significant or high risk" would need to be defined.
> - That more reasonable and timely provisions be given for discharging inappropriately placed and/or unsafe residents from LTC.

Resident Criminal/Predatory History

Currently, an applicant's eligibility for LTC is determined based on assessments outlined in s.43 (4) of the LTCHA and required documentation in s.160 (1) of O. Reg. 79/10. A resident's non-medical history, such as criminal history, is not required. A lack of disclosure or communication about a resident's history, including criminal history, creates a challenge for LTC homes to implement the appropriate means to provide a safe home for all residents and a safe workplace for staff and volunteers.

For example, it makes it difficult for homes to distinguish between predatory and responsive behaviours that are associated with dementia, mental health, or other neurological conditions, and therefore provide the appropriate care or offer the tools to address the behaviours. While LTC staff mobilize BSO and other dementia care approaches, these are not adequate to address predatory behaviours stemming from a pre-existing criminal pattern. Full information is required so that homes can develop appropriate care plans.

> **Recommendation:** That a policy be developed for placement coordinators to communicate to homes, where possible, information about a resident's medical and non-medical history, for the purposes of determining comprehensive care needs beyond medical care and evaluating the home's capacity to provide that care.
> - That the Ministry work with stakeholders to develop a process and procedure for finding non-LTC alternatives for care upon learning that a resident has predatory behaviours, whether they stem from pre-existing convicted or non-convicted criminal activity.

Campuses of Care

Seniors living on a campus in retirement or supportive housing do not currently get priority to the LTC home on that campus, and therefore often need to move to a LTC home not on the campus. This defeats one of the main benefits and purposes of a campus which is to provide a continuum of care. For example, a couple might be living in a supportive housing building on a campus. If one spouse becomes ill, she or he must move off campus to a LTC home, even though there is one right on their current site. As a result, individuals often end up being placed in a home that is much further away.

There should be a target for referrals of residents who are currently living in a campus of care to move to a LTC home within their campus. Some hospitals are currently allowed to have a certain percentage of their ALC patients go to their LTC home and the same should be true for LTC campus of care referrals.

Allowing residents to move within their campus would ensure that spouses and family members living on the same campus are not separated when one's care needs change. This legislative change would support a person-centred approach to care and recognize the value of relationships to the health and wellness of residents.

> **Recommendation**: That 20 per cent of LTC beds opened up in an LTC home on a campus of care in a given year be for their campus referrals.

Cultural Homes

During the pandemic and as a result of crisis admissions from hospitals, a number of cultural homes had their percentages of appropriate placements erode to the point where less than 70 per cent of the home's residents were of that designated culture and/or religion. While provisions can be made during a health crisis, there should be a minimum admissions threshold for residents of that homes' cultural and/or religious background. We recommend creating a threshold of 75 per cent for waitlists for homes that are primarily engaged in serving the interests of persons of a particular religion, ethnic origin or linguistic origin. Specific amendments are suggested in Appendix 4.

Recommendation: That a threshold of 75 per cent be created for waitlists for homes that are primarily engaged in serving the interests of persons of a particular religion, or ethnic and/or linguistic origin. Once a home falls below this threshold, cultural admissions would take higher priority than crisis admissions.

5. Streamlining Reporting

There are various processes and requirements in LTC homes that are administrative in nature and do not impact on the safety and well-being of residents or improve care. These tasks require a significant amount of time to complete, often due to the level of detail required. By streamlining and reducing some of these tasks and processes, LTC home staff can focus their attention on the individual needs of residents, thus increasing the time spent with residents and improving care and outcomes.

Operators understand the need for information sharing with government and support transparency in the LTC sector. However, as has been noted earlier in this submission, the LTCHA and its regulations are overly onerous and have a major impact on preventing staff from providing more hands-on care. No other sector in Ontario, other than the nuclear industry, has such a complicated and exacting system, which is accompanied by reporting burdens. The excessive requirements on staff for documentation has greatly impacted the ability of homes to recruit and retain staff at all levels, in a system that is already understaffed.

Despite this, we expect the amount of reporting has gone up over the years, and we expect that the government will increase this reporting further post pandemic. In order to address this issue, there are a number of measures that can be taken.

Right now, homes have to report to multiple areas of government, in a variety of different ways. A single, digital platform that would replace all of the discreet reporting layers with consistent and streamlined requirements would save an immense amount of time for homes that could be better spent providing quality care for residents.

It is important to note that the implementation of such a system should not include additional items to report, without MLTC looking at whether the current reporting requirements are necessary and serving their purpose. We want to reverse the trend of excessive reporting, not add additional layers to it.

Just like every other part of the healthcare sector has dedicated staff for reporting, the LTC sector needs funding for dedicated staff to ensure these responsibilities are being carried out properly and satisfactorily, and that resident care is not impacted by staff having to fulfill reporting requirements.

Recommendation: Implement one fully digital reporting system, which would replace the multiple information sharing systems that exist between LTC and their many reporting partners.

- The MLTC should provide funding for dedicated staff to onboard and manage this system, as well as funding any and all technology
- The MLTC should streamline existing reporting requirements before adding any additional reporting requirements onto homes.

6. Staffing – Four Hours of Care and Additional Allied Staff

Four Hours of Care

The government's commitment to four hours of care is long awaited and much appreciated. Given how important this commitment is to the sector's future, it should be enshrined in legislation.

> **Recommendation**: Amend the LTCHA to include the four hours of direct care commitment.

We have suggested specific amendments related to this in Appendix 3.

Flexible Staffing Mix

In implementing the four hours of care, government should empower homes to staff appropriately according to resident needs, both with the right roles as well as the right mix of staff. We do not recommend prescribing ratios in legislation or regulation as it would be too rigid a system for homes to address their needs properly. Staffing availability also varies regionally, which means that any prescriptive staffing mix could be difficult for certain homes to follow, depending on where they're located.

> **Recommendation**: The MLTC include ranges for the staffing mix related to the four hours of direct care commitment, and not hard ratios.

We have suggested specific amendments related to this in Appendix 3.

PSWs

The LTCHA, as it exists, currently specifies qualifications for PSWs that are extremely difficult for many homes to achieve, particularly in rural and remote areas where staff recruitment and retention are a constant challenge. These issues have been magnified and intensified throughout the pandemic as many staff have left the sector and continue to do so. For example, in one home, 13 staff went on mental-health-related leave in the final two weeks of July. The result is that, despite their considerable efforts to recruit, some homes will be non-compliant. This has an impact on public trust as well as on the morale of existing staff, which the sector is trying to retain.

We recognize that staff must have a baseline degree of training and qualifications; however, given the ongoing HHR challenges that LTC homes face, a more creative yet robust solution is required.

> **Recommendation**: Expand the exceptions to the general rule related to the hiring of PSWs so that LTC homes may hire the following individuals as a PSW:
> - A person who has graduated from an educational program for registered nurses or registered practical nurses who, in the opinion of the home's Director of Nursing and Personal Care or equivalent, has adequate skills and knowledge to perform the duties of a personal support worker (with proof of graduation).
> - A person who has graduated from an educational program for developmental support workers who, in the opinion of the home's Director of Nursing and

Personal Care or equivalent, has adequate skills and knowledge to perform the duties of a personal support worker (with proof of graduation).

- As a conditional hire, a person who is enrolled in the PSW program described in s. 47(1) even where they are not currently completing the practicum component but will be provided training and education about, as well as orientation to, LTC and resident care at the home (hours to count towards the practicum component).

Specific wording is proposed in Appendix 3.

24/7 Nursing

s.8 (3) of the LTCHA requires 24/7 nursing in LTC homes to be provided by a registered nurse. While there are exceptions to this rule for medium and small homes (i.e., this requirement may be met by a registered practical nurse), they do not apply to large homes (e.g., 129 beds or more) (O.Reg. 79/10, s.45). However, large homes have the same challenge of meeting the 24/7 nursing requirement. Compounded by the HHR crisis in the LTC sector, large homes need options to address staffing shortages and emergency situations where there is no RN available. The labour market for all direct care staff has changed dramatically since 2010 and even more so over the last year and half. Homes are struggling to ensure that, 365 days of the year, there is an RN in the building.

Recommendation: That the Ministry work with the Association and key sector stakeholders to develop and incorporate strategic changes to the legislative/regulatory framework related to the current exceptions for the purposes of enhancing the role of registered practical nurses (RPNs). This would include specific provisions to ensure that RPNs are connected to RNs and would need to apply to small, medium and large homes.

- That small- and medium-sized homes be able to utilize a RPN with a RN on call where the requirement for 24/7 cannot be met even where there is no "emergency" (revise s. 45(1)1 at i;s.45(2) at i) and a home has shown it has explored all possible avenues to hire a RN.
- Create exceptions that can be relied on by large homes with some consideration being given to appropriate coverage for units/floors within the home by an RPN with access to an RN, if the home has explored all possible avenues to hire an RN.
- Where a home (regardless of size) has exhausted its ability to retain adequate RNs to fulfill the requirement (evidence to be provided to Compliance), the home may staff on nightshift with RPN staff and provide the RPN with on-call access to an RN for emergencies.
- Allow for OTN consultation between a RPN and a RN. OTN is available widely in the province. This can be utilized for the on-duty staff to obtain clinical consulting support from an RN located anywhere.
- Any other type of support for the regular operations of the home may be provided by the administrator or managers.

Residents will receive better and timely care, thereby improving resident and family satisfaction. If there was an on-call provision for all homes, there would be less burnout from other RNs that would need to work double shifts or from administrative RNs that normally don't work on the floor. This would decrease the risk of compromising delivery of care.

Staffing Flexibilities

Ontario Regulation 95/20 under the *Reopening Ontario Act, 2020,* provides for certain staffing flexibilities that were essential to enabling homes to respond to the COVID-19 pandemic. The continuation of this emergency order is helpful in the current staffing crisis that our sector is experiencing. If it is lifted prematurely without consultation with LTC associations, LTC homes, unions, and other relevant stakeholders, it could further destabilize a sector that is already in a staffing crisis.

> **Recommendation**: Retain the staffing flexibilities under Ontario Regulation 95/20 until the staffing situation in LTC stabilizes.

> **Recommendation**: That the Ministry consults with LTC associations, LTC homes, unions, and other relevant stakeholders before making any changes to the staffing flexibilities in Ontario Regulation 95/20.

Bill 283

We are also mindful that the Ontario government has taken additional significant steps regarding oversight of PSWs with the introduction of Bill 283, *Advancing Oversight and Planning Ontario's Health System Act, 2021,* which received Royal Assent on June 3, 2021. Schedule two of the *Act* (*Health and Supportive Care Providers Oversight Authority Act, 2021)* opens the door to create practical standards for education and training of PSWs. We welcome any changes this might bring to address the HHR issues facing LTC homes today.

> **Recommendation**: Given the significance of this oversight, we recommend the government consult with AdvantAge Ontario ahead of implementing the regulations of the *Advancing Oversight and Planning Ontario's Health System Act*.

Allied Staff

Allied staff are critical to the resident care in LTC, and are particularly vital to the successful implementation of emotion-focused models of care. Recreation staff, as an example, connect residents to loved ones via technology, and provide social activities which are crucial for psychological and emotional well being.

While we understand the Ministry has committed to providing 20 per cent funding for an additional allied health provider for homes, this is not enough. A minimum level of care per resident on a per home average for allied staff, such as one hour per day, should be fully funded and added to the legislation, separate from the four hours of care. It is these staff that make the homes a place where residents can come together and enjoy their lives, and allied staff should be recognized and have their impact enshrined in legislation.

> **Recommendation:** Introduce a minimum level of care of one hour per resident, on a per home average, for allied staff and add this requirement to the LTCHA.

Designated Lead: Housekeeping, laundry, maintenance

Currently, the LTCHA regulation stipulates that the lead on these functions must have a post-secondary degree or diploma to be the designated lead. There is a requirement for two years of experience in a managerial or supervisor capacity. The educational requirement restricts the hiring of individuals who have other attributes, including knowledge, interest and practical life experience-based skills. Furthermore, there is no specific or related degree or diploma that addresses these programs (housekeeping/laundry). The minimum experience requirement restricts persons from entering the sector who have interest and reduces career opportunities for a position that may not require this degree of qualification.

> **Recommendation:** That the Regulation be revised to reflect that a post-secondary education is an asset as opposed to a requirement for the Designated Lead – Housekeeping, Laundry, and Maintenance.

The cost of hiring delays would be reduced, and these costs could instead be spent on providing care to residents. Staff will be more satisfied with their employer and more likely to be retained if there are opportunities for them to advance in their career in the LTC sector.

Dietitians

The way the LTCHA regulation is worded requires unnecessary referrals to dietitians for skin and wound care. Altered skin integrity is defined as potential disruption of epidermal or dermal tissue. The interpretation that these include bruises can result in unnecessary referrals re: nutrition needs to support bruise healing, especially for those residents who are on blood thinners and bruise easily. (s. 50(2)(b)(iii) O. Reg. 79/10) Homes may only expense 30 minutes per resident, per month of registered dietitian time from the Program and Support Services envelope to carry out clinical and nutritional care duties. Expenditures beyond the 30 minutes need to be expensed to the Other Accommodations envelope.

By allowing RNs to determine when a referral to a dietitian is necessary, this would allow registered dietitians to focus on the residents with the highest needs. Residents will have timely access to the care they need, which improves their health outcomes and satisfaction. Homes would be able to use dietitians' time effectively and save costs coming out of the OA envelope that they can use for other needs.

> **Recommendation:** Amend the requirement for assessment by a registered dietitian.
> - Allow registered staff to determine when this assessment is necessary and make the appropriate referral.

Vulnerable Sector Screens for Staff

The regulation requires police record checks/vulnerable sector screens for prospective LTC staff/volunteers within six months of hire, but does not apply to those who do not provide direct care to residents (s.75 LTCHA, s.215 O.Reg 79/10). Because staff (e.g., housekeeping, maintenance) may be in contact with residents and are often trained in care approaches to reduce responsive and aggressive behaviours, the legislation should require vulnerable sector screens for all staff who may be in contact with residents. In addition, police departments are inconsistent in the provision of checks and may not align with the LTCHA. Some police departments are more lenient with requests for police checks; the individual simply has to

request and pay for it. However, some require more documentation that places more administrative burden on homes. For example, while the LTCHA requires a police record check to be completed up to six months in advance of hire, police departments are often requiring prospective staff to produce hiring contracts or agreements to be able to carry out the police record check.

> **Recommendation:** Require any staff who may come into contact with residents to obtain vulnerable sector screens.
> - Police services policies should be aligned with the requirements of the LTC home sector and the LTCHA.

COVID-19 Commission Recommendation – Staff Training

Recommendation 52 proposes amendments to Ontario Regulation 79/10 to define ongoing training requirements for LTC health care professionals in key areas responsive to resident needs. It also highlights the elimination of training exemptions which is consistent with Justice Gillese's recommendations. AdvantAge Ontario supports these amendments and appreciates the government's commitment of $10 million in funding for this purpose.

Some members have also shared that it is difficult to have medical directors involved in education, and this may be something that requires attention at the MLTC level. There is also general agreement that the preparation of physicians for the LTC sector is lacking, and there should be a requirement for education that includes the LTC setting for these health care professionals. Accordingly, AdvantAge Ontario believes that medical students must have LTC placements to better understand the sector and the clinical needs of LTC residents.

> **Recommendation:** We support the Commission *Recommendation 52* that Ontario Regulation 79/10 be amended to define ongoing training opportunities for LTC health care professionals in key areas responsive to resident needs, provided there is funding for the training and backfilling made available.

7. IPAC Recommendations from the LTC COVID-19 Commission

Ontario's LTC COVID-19 Commission made a number of recommendations for legislative and regulatory amendments related to IPAC in their report. We outline our responses to those recommendations below.

Recommendation 5 suggests amendments to Ontario Regulation 79/10 to provide specific requirements for LTC homes' mandatory written infectious disease outbreak plans. AdvantAge Ontario does not agree with including these amendments in the regulations, as outbreaks can vary dramatically, and plans could be outdated depending on the nature of the virus.

However, it would be appropriate to develop a policy around infectious disease outbreak plans, or alternatively to include these requirements into the pandemic plan. The answer for pandemic preparedness for the LTC sector in the future is having a plan in place that is robust, but also being able to respond nimbly and quickly to the best of the home's abilities. The COVID-19 pandemic was unpredictable; therefore, the response will require flexibility as opposed to regulation.

> **Recommendation**: That the MLTC not embed pandemic plans in regulation. Instead, pandemic plans should be developed and implemented through policy guidance.

Recommendation 21 states that the province should make any legislative amendments necessary to designate the Chief Medical Officer of Health as responsible for the management of the pandemic stockpile. AdvantAge Ontario agrees with this recommendation and believes that this is a reasonable approach for the future.

Recommendation 24 highlights the need for IPAC expertise in LTC homes through making amendments to Ontario Regulation 79/10. This includes an IPAC practitioner for each LTC home with minimum training requirements, and for this role to take on the duties formerly assigned to the staff IPAC coordinator.

AdvantAge Ontario supports this recommendation but believes that this will be a difficult recommendation to operationalize, as IPAC practitioners are a scarce resource in the province. Prior to the COVID-19 pandemic, many homes could not hire IPAC Practitioners externally, and therefore had to add these additional requirements to the roles of their existing staff. Alternatively, it would be useful to develop a Community of Practice around IPAC, and leverage this for smaller organizations.

> **Recommendation**: MLTC should not regulate the requirement for IPAC Practitioners until there is an increased supply of them.

> **Recommendation**: Before IPAC capacity is regulated, MLTC should provide funding to each LTC home to pay for full-time IPAC professional, and further train/formally train an existing regulated health professional staff member (i.e., funding to "grow their own" IPAC Practitioner).

Recommendation 25 suggests that the MLTC and the Ministry of Health should amend the Institutional/Facility Outbreak Management Protocol, 2018, to explicitly provide for the involvement of local hospitals to support LTC homes in their IPAC practices, up to and including a related management agreement if and as necessary, along with any other legislative amendments necessary to facilitate the IPAC program. LTC homes should be helping other LTC homes in the event of an outbreak as the first option, as they are the experts in LTC delivery.

> **Recommendation:** MLTC, MOH, and Public Health should work to ensure that LTC homes are able to support LTC homes as a first option in the event of an outbreak, as community-based LTC expertise is a specific attribute that is not available from a hospital perspective.

Recommendation 30 suggests the MLTC should amend Ontario Regulation 79/10 to include a presumption against prohibiting all visitors to LTC homes experiencing an outbreak. It also mentions that any changes to visiting rules during an infectious disease outbreak must seek to place the minimum possible restrictions on visits to LTC residents.

AdvantAge Ontario disagrees with this recommendation but recognizes the importance of visitors on the quality of life for LTC residents. This amendment should not take place until there are enough staff to support visiting during outbreak situations, and until systems can be put in place to support visitors in the homes. This would go hand-in-hand with the LTC Staffing

Plan, as having more staff in the homes will allow for safe and supported visiting with residents.

> **Recommendation**: That the MLTC should not regulate the requirement to permit visitors to LTC homes experiencing an outbreak until there is adequate staff and effective systems in place to support safe visiting.

Recommendation 31 proposes amendments to Ontario Regulation 79/10 to recognize the role of an "essential caregiver" in order to avoid the separation of residents from their families and loved ones in future infectious disease outbreaks. It also discusses the need for mandatory annual training for essential caregivers around the areas of IPAC and appropriate use of PPE.

AdvantAge Ontario is supportive of explicitly recognizing the essential caregiver role in regulation. However, in order to enact this amendment, there is a need for a dedicated IPAC resource in homes and PPE availability in outbreak situations, and there must be decision-making ability at the facility level to determine who is an essential caregiver.

> **Recommendation**: That MLTC ensures dedicated IPAC resources and consistent/sufficient PPE availability before amending Ontario Regulation 79/10 to recognize the essential caregiver role.

8. Additional Housekeeping Amendments

The following amendments should be added to the LTCHA reform to address longstanding issues in the sector. In some cases, specific amendments are suggested in Appendix 4.

Addressing Failure to Pay

It is important that a regulatory mechanism be established to deal with residents/SDMs who do not pay their fees. This is a long-standing issue in the sector. LTC homes have few mechanisms to pursue a resident (or their legal representative such as an attorney for property), short of going to court or sending files to collections. Our proposed amendment would require that, in the information package that residents/SDMs received upon admission, they would have to input who would have the responsibility to pay, which would need to be signed before the resident enters the home. This would give homes a name to pursue in issues around non-payment, should that occur.

> **Recommendation:** Amend the *Act* to require that, in the information package residents/SDMs received upon admission, homes would require the name of the person who would be responsible to pay the residents' fees.

Family Council Term Limit

A number of our member homes have voiced concerns, including those brought to them by their Family Councils, that even after a Family Council member's loved one dies, there is no mechanism for a family council member's term to expire. In a few cases, these family council members who no longer represent a resident have harassed homes. The purpose of Family Council is to support the home's existing residents. A term process for Family Council members would better support this, including a term limit for a member where the resident associated with the member has died or been discharged from a LTC home.

Recommendation: Amend the LTCHA to create a term limit for members of Family Councils once a resident has died or been discharged from a LTC home.

Duty to Protect Provisions

Resident care and safety are top priorities for our members. However, LTC homes that have taken all necessary steps to prevent neglect and abuse are still found to be in non-compliance with this section of the *Act*, when an incident occurs (s. 19(1) LTCHA). It is not possible to watch every resident every moment of the day, and unfortunately incidents do occur.

Recommendation: Provide flexibility in legislation so that only homes that have not taken ALL necessary steps to prevent abuse and neglected are penalized.

Duties of Directors and Officers

Prior to 2017, the LTCHA already imposed harsher offence provisions on directors and officers of LTC homes than those serving on boards of hospitals. In 2017, Bill 160 brought in legislation that exacerbated this by removing the due diligence standard for governors and amending the legislation to read as follows:

> "Where a licensee is a corporation, every director and every officer of the corporation shall ensure that the corporation complies with all requirements under this Act" (s.69(1)).

It further added a draconian measure that stipulates corporate prosecution or conviction would not be necessary for a director or officer to be prosecuted or convicted (s. 69(4)). The current legislation is a disincentive for volunteers from the community to become board members of a LTC home.

Recommendation: That the *Act* is amended to mirror the language from Regulation 965 under the *Public Hospitals Act* such that "every director and every officer shall take such measures as the board considers necessary to ensure compliance with the Act and Regulation."

> As an alternative, we recommend that a due diligence standard be reinstated in the *Act*, that mirrors Regulation 965 such that s. 69(1) reads as follows: "Where a licensee is a corporation, every director and every officer shall (a) exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances; and (b) take such measures as the board of the corporation considers necessary to ensure that the corporation complies with all requirements under this Act."

The amendment would ensure that LTC home board members are protected and are not susceptible to individual prosecution or conviction. Board members provide LTC home oversight and ensure that Ontario's LTC home residents are receiving safe and high quality care.

This amendment would increase the probability of obtaining more volunteers as board members at LTC homes, ensuring oversight and accountability for LTC homes.

Regulation 965 under the *Public Hospitals Act* requires a hospital board to take such measures as it considers necessary to ensure compliance with the provisions of the Act

and its regulations and by-laws of a hospital. Further, the *Public Hospitals Act* does not create a specific offence provision for directors and officers for failing to take measures to ensure compliance. Instead of specific offence provisions or any other draconian measures, the *Public Hospitals Act* has a general offence provision relating to a contravention of the Act and Regulation, and the penalty on conviction is minor (a fine of not less than $50 and not more than $1,000).

Conclusion

We applaud the Ministry's desire to effect reform in LTC, which is most welcome at this juncture. AdvantAge Ontario, as the definitive voice representing not-for-profit seniors' care, is focused squarely on the quality of care of residents. We urge the Ministry to consider the above amendments to the LTCHA to make it less punitive, provide a system for "coaching for quality care," attend to the long-standing staffing restrictions, and ultimately create the groundwork for resident-centred care. The time is now for transformative change in LTC, and that needs to include major changes to the *Act*, as it has huge implications on the way that homes function on a daily basis.

We stand ready to work with the Ministry of Long-Term Care and appreciate their consideration of our proposal.

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Appendix 1: Preamble Amendments

Note: Highlighted and bolded text flag our suggested wording changes.

Preamble

The people of Ontario and their Government:

Believe in resident-centred care **and support long-term care homes in providing emotion-focused models of care;**

Remain committed to the health and well-being of Ontarians living in long-term care homes now and in the future **by placing greater focus, attention and support on non-profit, charitable and municipal homes.**

Strongly support collaboration and mutual respect amongst residents, their families and friends, long-term care home providers, service providers, caregivers, volunteers, the community and governments to ensure that the care and services provided meet the **physical and emotional** needs of the resident and the safety needs of all residents;

Recognize the principle of access to long-term care homes that is based on assessed need;

Recognize the expertise of the long-term care sector;

Firmly believe in public accountability and transparency to demonstrate that long-term care homes are governed and operated in a way that reflects the interest of the public, and promotes effective and efficient delivery of high-quality services to all residents;

Firmly believe in clear and consistent standards of care and services, **with** inspection and enforcement **targeted to priority areas of safety and resident quality;**

Recognize that a home average of four hours of PSW and nursing care a day, and one hour of allied health a day, with flexible staffing for each resident, is critical to support optimal care and support for residents

Recognize the responsibility **to take prompt and measured** action where standards or requirements under this Act are not being met, or where the care, safety, security and rights of residents might be compromised;

Preamble Continued…

Affirm our commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of long-term

Preamble Continued…

care homes, **balancing the requirements of infection prevention and control and other safety measures with the ability of residents to enjoy their homes;**

Recognize that long-term care services must respect diversity in communities;

Respect the requirements of the French Language Services Act in serving Ontario's Francophone community;

Recognize the importance of fostering the delivery of care and services to residents in an environment that supports continuous quality improvement**, grounded in communities of practice and coaching for quality care;**

Are committed to the promotion **and capital funding** of the delivery of long-term care home services by not-for-profit organizations **given their proven high quality of care and quality of life for residents.**

Therefore, Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

PART I

FUNDAMENTAL PRINCIPLE AND INTERPRETATION

Home: the fundamental principle
1 The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met, **in an environment supported by adequate staffing where alternate, person-centred models of care are promoted and funded.**

Appendix 2: Examples of Regulations Under New Category "Minor Infractions"

Licensee shall ensure that the notice [of a public meeting] is promptly posted in a prominent place in the home	Reg 79/10 s. 273(4)
Licensee shall ensure that there is an organized interdisciplinary program with a restorative care philosophy; program shall include services for residents with cognitive impairments and residents who are unable to leave their rooms	s. 9(1)(2)
Licensee shall maintain, and keep for at least seven years, records that specify for each week, (a) the number of meals prepared for persons who are not residents of the home; and (b) the revenue and internal recoveries made by the licensee relating to the sale or provision of any food and beverage prepared in the home, including revenue and internal recoveries made from cafeteria sales and catering	Reg 79/10 s. 72(5)
Licensee shall ensure that the lighting requirements set out in the Table under s. 18 are maintained	Reg 79/10 s. 18
Licensee shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions	Reg 79/10 s. 23
Licensee shall ensure that there is safe and appropriate space in the home for the provision of therapy services and that there is a sufficient supply of therapy equipment available at all times to meet the needs of residents	Reg 79/10 s. 60
Licensee shall ensure that the home's restorative care program, including the services of social workers and social service workers, are co-ordinated by a designated lead	Reg 79/10 s. 64
Licensee shall ensure that there is a designated lead for the recreational and social activities program	Reg 79/10 s. 66(1)
Licensee shall maintain, and keep for at least one year, a record of, (a) purchases relating to the food production system, including food delivery receipts; (b) the approved menu cycle; and (c) menu substitutions	Reg 79/10 s. 72(4)

Licensee shall ensure that there is a designated lead for each of the housekeeping, laundry services and maintenance services programs, but the same person may be the designated lead for more than one program	Reg 79/10 s. 92(1)

Appendix 3: Staffing and Four Hours of Care

Note: Highlighted and bolded text flag our suggested wording changes.

Long-Term Care Homes Act Amendment

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 **and in accordance with a per home average of four hours of care (worked hours) per resident.**

O.Reg. 79/10 Amendments

NURSING AND PERSONAL SUPPORT SERVICES

Nursing and personal support services

31. (1) This section and sections 32 to 47 apply to,

(a) the organized program of nursing services required under clause 8 (1) (a) of the Act; and

(b) the organized program of personal support services required under clause 8 (1) (b) of the Act. O. Reg. 79/10, s. 31 (1).

(2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

(3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs, **available funding** and that meets the requirements set out in the Act and this Regulation;

(b) set out the organization and scheduling of staff shifts;

(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, **while recognizing that a licensee retains flexibility to staff with allied health such as nursing and personal support workers in such ratios as appropriate as long as the other requirements of the Act are met;**

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and

(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

(4) The licensee shall keep a written record relating to each evaluation under clause (3) (e) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 31 (4).

Appendix 4: Additional Amendments

Note: Highlighted and bolded text flag our suggested wording changes.

Long-Term Care Homes Act Amendment

Family Councils

Right to be a member

59(5) Subject to subsection (6), a family member of a resident or a person of importance to a resident is entitled to be a member of the Family Council of a long-term care home. 2007, c. 8, s. 59 (5).

(5.1) A Family Council may provide a term limit for a member, where the resident associated with that member has died or been discharged from a long-term care home.

Who may not be a member

(6) The following persons may not be members of the Family Council:

1. The licensee, and anyone involved in the management of the long-term care home on behalf of the licensee.
2. An officer or director of the licensee or of a corporation that manages the long-term care home on behalf of the licensee or, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129, as the case may be.
3. A person with a controlling interest in the licensee.
4. The Administrator.
5. Any other staff member.
6. A person who is employed by the Ministry or has a contractual relationship with the Minister or with the Crown regarding matters for which the Minister is responsible and who is involved as part of their responsibilities with long-term care home matters.
7. Any other person provided for in the regulations.

Long-Term Care Homes Act Amendment

Duty to Pay

RESIDENTS – INFORMATION, AGREEMENTS, ETC.

Information for residents, etc.

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

(a) a package of information that complies with this section is given to every resident and to the SDM of the resident, if any, at the time that the resident is admitted;

(b) the package of information is made available to family members of residents and persons of importance to residents;

(c) the package of information is revised as necessary;

(d) any material revisions to the package of information are provided to any person who has received the original package and who is still a resident or SDM of a resident; and

(e) the contents of the package and of the revisions are explained to the person receiving them. 2007, c. 8, s. 78 (1).

Contents

(2) The package of information shall include, at a minimum,

. . .

(i) a statement of the maximum amount that a resident can be charged under paragraph 1 or 2 of subsection 91 (1) for each type of accommodation offered in the long-term care home;

(j) a statement of the reductions, available under the regulations, in the amount that qualified residents can be charged for each type of accommodation offered in the long-term care home;

(k) information about what is paid for by funding under this Act, or the Connecting Care Act, 2019 or the payments that residents make for accommodation and for which residents do not have to pay additional charges;

(l) a list of what is available in the long-term care home for an extra charge, and the amount of the extra charge;

(m) a statement that residents are not required to purchase care, services, programs or goods from the licensee and may purchase such things from other providers, subject to any restrictions by the licensee, under the regulations, with respect to the supply of drugs;

(m.1) a statement that residents' (or if incapable, their attorneys for property) are responsible for payments authorized by this Act;

<u>O.Reg. 79/10 Amendment</u>

Waitlist for Cultural Homes

Keeping of waiting lists

165 (1) Each placement co-ordinator shall keep a waiting list for admission to each of the long-term care homes for which the placement co-ordinator is designated. O. Reg. 79/10, s. 165 (1).

(2) In addition to the waiting lists under subsection (1), the placement co-ordinator shall, if applicable, keep a separate waiting list for each unit or area within a home that is primarily engaged in serving the interests of persons **(a minimum of 75% of its residents)** of a particular religion, ethnic origin or linguistic origin as referred to in clause 173 (1) (b). O. Reg. 79/10, s. 165 (2).

(3) The waiting list shall be established to have a minimum threshold of 75% of residents

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