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Tuesday 16 January 2007

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Mardi 16 janvier 2007

**Standing committee on
social policy**

Long-Term Care
Homes Act, 2007

**Comité permanent de
la politique sociale**

Loi de 2007 sur les foyers de
soins de longue durée

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON
SOCIAL POLICYCOMITÉ PERMANENT DE
LA POLITIQUE SOCIALE

Tuesday 16 January 2007

Mardi 16 janvier 2007

The committee met at 0904 in committee room 1.

ELECTION OF ACTING CHAIR

The Clerk of the Committee (Mr. Trevor Day): Honourable members, it is my duty to call upon you to elect an Acting Chair.

Mr. Peter Fonseca (Mississauga East): I'd like to nominate Bob Delaney as the Acting Chair.

Mrs. Elizabeth Witmer (Kitchener–Waterloo): I would second that.

The Clerk of the Committee: Are there any further nominations? Seeing none, nominations are closed.

Mr. Delaney, you are the Acting Chair.

The Acting Chair (Mr. Bob Delaney): Thank you very much. Good morning, everyone. This is the standing committee on social policy. We are here this morning to begin our consideration of Bill 140, An Act respecting long-term care homes.

REPORT OF THE SUBCOMMITTEE

The Acting Chair: Our first order of business is the report of the subcommittee on committee business.

Mr. Fonseca: Thank you, Chair. I'll read in the report of the subcommittee.

Your subcommittee met on Monday, December 11, 2006, to consider a method of proceeding on Bill 140, An Act respecting long-term care homes, and recommends the following:

(1) That the committee request authorization from the House leaders to meet on January 16, 17, 22, 23, 24, 30 and 31, 2007, for the purpose of considering this bill.

(2) That, if authorized, the committee meet in Toronto on January 16 and 17, 2007, and in Kingston, Sudbury and London on January 22, 23 and 24, 2007, for the purpose of holding public hearings.

(3) That the committee clerk, with the authorization of the Chair, post information regarding public hearings for one day in the Ontario English dailies and French weeklies, once authorization has been received by the House.

(4) That the committee clerk, with the authorization of the Chair, post information regarding public hearings on a second day in the local papers of the cities in which the committee intends to travel, once authorization has been received by the House.

(5) That the committee clerk, with the authorization of the Chair, post information regarding public hearings on the OntParl channel and the Legislative Assembly website, once authorization has been received by the House.

(6) That interested parties who wish to be considered to make an oral presentation contact the committee clerk by 12 noon on Friday, January 5, 2007.

(7) That, in the event all witnesses cannot be scheduled, the committee clerk provide the members of the subcommittee with a list of requests to appear by 2 p.m. on Friday, January 5, 2007.

(8) That the members of subcommittee prioritize and return the list of requests to appear by 4 p.m. on Monday, January 8, 2007.

(9) That groups and individuals be offered 15 minutes for their presentation. This time is to include questions from the committee.

(10) That the deadline for written submissions be 12 noon on Friday, January 19, 2007.

(11) That an interim summary of presentations be prepared by the research officer by Thursday, January 25, 2007.

(12) That for administrative purposes, proposed amendments be filed with the committee clerk by 12 noon on Friday, January 26, 2007.

(13) That the committee meet for the purpose of clause-by-clause consideration on January 30 and 31, 2007.

(14) That the clerk of the committee, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee, to commence making any preliminary arrangements necessary to facilitate the committee's proceedings.

The Acting Chair: Thank you very much. Is there any discussion on the subcommittee report? Ms. Martel.

Ms. Shelley Martel (Nickel Belt): Thank you, Mr. Chair. Very briefly, I'm going to be voting against the subcommittee report. The reason is that during the meetings of the subcommittee I encouraged the other members to consider more days for public hearings. I felt there was going to be significant interest in this bill and that we would receive more requests than we could deal with as a result, and I think that has been borne out. In Toronto, we received 96 requests and are able to accommodate only 48 organizations and individuals. In London, 31 requests, 24 folks being accommodated; In

Kingston, 42 requests, and 24 individuals and organizations are accommodated. I think we could have used the extra days that I had suggested and we probably could have heard everyone who wanted to be heard. So on that basis, I'm going to vote against this subcommittee report.

The Acting Chair: Thank you. Are there any further comments on the subcommittee report? Adoption of the subcommittee report?

Ms. Martel: Recorded vote, please, Chair.

Ayes

Fonseca, Mauro, Sandals, Smith.

Nays

Martel.

The Acting Chair: I declare the report of the subcommittee to be carried.

LONG-TERM CARE HOMES ACT, 2007 LOI DE 2007 SUR LES FOYERS DE SOINS DE LONGUE DURÉE

Consideration of Bill 140, An Act respecting long-term care homes / Projet de loi 140, Loi concernant les foyers de soins de longue durée.

PSYCHIATRIC PATIENT ADVOCATE OFFICE

The Acting Chair: Our first deputation this morning is Mr. Bernard Maheu. Is Mr. Maheu here? Oh, I beg your pardon. My error. The first deputation would be the Psychiatric Patient Advocate Office, David Simpson and Lisa Romano. Unfamiliar formatting here.

Good morning and welcome. You'll have 15 minutes to do your deputation. If you leave any time remaining, it will be divided among the parties for questions. Please begin by introducing yourself for Hansard and then proceed.

0910

Ms. Lisa Romano: Good morning. My name is Lisa Romano. I'm legal counsel to the Psychiatric Patient Advocate Office. With me is David Simpson, acting director of the PPAO. We would like to thank the committee for this opportunity to share our recommendations with you in the hopes that they will be adopted to strengthen Bill 140.

Due to time constraints, we will not discuss all the topics contained in our submission, but we trust that you will consider the submission in its entirety. Today we will be primarily focusing on the issues of rights advice and restraint.

For the past 20 years, the PPAO has been providing rights advice in the mental health sector. Presently we

deliver the majority of rights advice in the province. In 2005, our rights advisers met with individuals on over 25,000 occasions, in 48 different languages.

Rights advice is a process by which patients in psychiatric facilities and persons being considered for community treatment orders and their substitute decision-makers, if any, are informed of their rights when their legal status has changed. For example, if a person is found to be treatment-incapable, then he or she is unable to make decisions about treatment and another person, the substitute decision-maker, is able to consent to treatment decisions affecting the person's bodily integrity.

The role of the rights adviser is to explain the significance of the legal situation to the affected individual and to discuss some of their options. The rights adviser will also assist the individual, if they so choose, to apply for a hearing before an administrative tribunal called the Consent and Capacity Board to challenge this change in legal status. They will also assist the person to obtain a lawyer and to apply for financial assistance. Thus, rights advice is an integral check and balance that serves to protect the rights of the individual in the system.

Now I'm going to briefly discuss admission or transfer to a secure unit in a long-term-care home, which can be found on page 7 of our submission.

Bill 140 requires the provision of rights advice to residents who are found incapable of consenting to their admission or transfer to a secure unit where substitute consent has been provided. Residents are prevented from leaving secure units. Individuals are able to challenge their admission or transfer to the board, to determine whether the substitute decision-maker has complied with the principles of giving or refusing consent.

As the admission or transfer to a secure unit is effectively an involuntary admission within a long-term-care home, the liberty interests of the individual must be protected. Therefore, the PPAO believes that every person being admitted or transferred to a secure unit should receive rights advice in order to understand the implications of being detained on a secure unit.

The PPAO believes that Bill 140 lacks a framework to protect residents who remain on a secure unit for an indeterminate amount of time. Timelines should be enacted for both the regular provision of rights advice and the review of decisions to keep residents on secure units in order to safeguard their liberty interests and maintain accountability. With this in mind, the PPAO recommends that residents detained on a secure unit be required to obtain mandatory rights advice every six months. Moreover, the Consent and Capacity Board should hold a deemed review once per year in cases of continued admission on a secure unit.

The proposed legislation also needs to provide for the written confirmation of rights advice and the creation of a regulated form similar to the current form 50 that exists for mandatory rights advice situations under the Mental Health Act. This form should provide clear information as to whether rights advice has been provided and whether the person has applied to the board.

I am going to speak now for a few minutes about expanding rights advice situations. This can be found on page 6 of our submission.

While the PPAO commends Bill 140 for requiring the provision of rights advice for transfers and admissions to secure units in long-term-care homes, we believe that enhanced rights protections should be extended in four additional scenarios. I will briefly discuss each of these situations.

First, where a health care provider finds a person incapable of consenting to admission to a long-term-care home, the person is not entitled to rights advice. The health care provider is only obliged to provide the person with rights information. We submit that rights advisers are better able to assist individuals in this regard due to their experience and impartiality. For example, some individuals may feel awkward or uncomfortable asking the person who found them incapable for additional information in order to challenge that finding. Therefore, the PPAO recommends that rights advice be provided to all incapable individuals facing admission to a long-term-care home.

The second situation occurs where an individual is a patient in a psychiatric facility and has been found incapable of managing his or her property. Prior to discharge from the psychiatric facility, a notice of continuance of inability to manage property, which is referred to as a form 24 under the Mental Health Act, must be completed by a physician. A rights adviser is then to meet promptly with the person to explain this finding to them and to explain to them their rights. If patients have not submitted an application to the board prior to discharge, they are precluded from having this decision reviewed once they're in the community. Unfortunately, individuals are often discharged after receiving the form 24 but before receiving rights advice, and some patients are discharged shortly after receiving rights advice but before they have the opportunity to apply to the board. These situations are especially true of those being admitted to long-term-care homes due to the risk of losing a bed if the admission does not take place quickly. Once individuals are at the hospital, if they wish to challenge the finding before the board, they must undergo another capacity assessment at their own expense. This kind of assessment usually costs hundreds of dollars.

To remedy this situation, the PPAO recommends that residents receive rights advice when a form 24 is issued but where rights advice did not take place prior to the admission to a long-term-care home and that the existing legislation be amended to allow the board to accept these applications. Also, rights advice should be mandatory within a long-term-care home where a capacity assessor finds a resident to be financially incapable.

Finally, under existing law, if patients of a psychiatric facility are found to be incapable of making a decision about their treatment for a mental disorder, rights advice is mandatory. However, residents of long-term-care homes are not afforded the same right, despite the fact that residents are also members of a vulnerable popu-

lation. Due to this loss of personal autonomy, the PPAO recommends that the legislation stipulate that rights advice must be provided to residents of long-term-care homes.

Mr. Simpson will now continue with the remainder of our submission.

Mr. David Simpson: Good morning. I would like to spend the next few minutes addressing the issue of restraint and the implications for individuals in the long-term-care sector, as well as some of the myths and misconceptions about the use of restraint. In our submission you'll find our comments and recommendations beginning on page 8.

In 2001, our office conducted a study on the use of seclusion and restraint in provincial psychiatric hospitals, and we made 23 best-practice recommendations on the basis of our findings. Some of the results were troubling, particularly the frequency of the use of seclusion and restraint and what was perceived by health care providers as an environment that was permissive and tolerant of the use of restraint. Consequently, we have advocated for the mental health sector to move towards becoming a hands-free, restraint-free environment. Our report has been used by many hospitals in the development of their policies, and we believe that many of the best-practice recommendations are applicable to the long-term-care sector.

Bill 140 falls short of protecting residents' rights by including restraint in the plan of care. Restraint seriously limits individual autonomy and is associated with significant physical and psychological risks. The benefits of restraint may be difficult to ascertain, while risks of morbidity and mortality are well documented.

I would now like to address some of the myths and misconceptions about the use of restraint. There are some who believe that a resident in restraints is safer and requires less supervision. On the contrary: Such residents are at an increased risk due to health complications if the restraint is inadequately monitored and supervised. Restrained residents are unable to protect themselves from aggressive co-patients. Also, if the restraint is misapplied, it can cause life-threatening injuries or even deaths. The results can be tragic. Although some staff members view restraints as safety and protective devices, they are often misused, overused and inappropriately used as a way to manage difficult clients: those who wander or who would otherwise require higher levels of supervision.

As a rights protection organization, we are concerned that this legislation fails to even define "restraint." There are many different types of restraint, including physical, chemical and environmental. Without a clear and concise definition included in the law, its usage is open to uncertainty and, potentially, abuse.

0920

The legislation also permits care providers to include restraint in the resident's plan of care. By definition, "care" includes all dimensions of treatment and intervention. Bill 140 says that restraint can be used when a resident is incapable, but it does not articulate the nature

of the incapacity: Is it referring to incapacity to consent to treatment decisions, incapacity to consent to the plan of care or incapacity to consent to the restraint itself? Thus, it is unclear in Bill 140 whether restraint is considered to be a treatment as defined in the Health Care Consent Act, because there is no definition of "treatment." If it is treatment, then there must be a determination by a health care provider of the person's capacity to give consent to restraint.

For persons found to be incapable, consent must then be given by a substitute decision-maker. If restraint is not considered treatment, but still requires consent for inclusion in the plan of care, then how and under what authority would capacity be determined? Also, under what authority would a substitute decision-maker consent to the use of restraint outside of the context of treatment? What would be the resident's right of review, if any, before the Consent and Capacity Board?

It is our position that restraint is not treatment and we would recommend that it be clearly defined from treatment. Therefore, the PPAO recommends:

- the inclusion of a clear and comprehensive definition of "restraint" for physical, chemical and environmental methods;

- the omission of restraint from the plan of care;

- that "restraint" be clearly distinguished from "treatment";

- that it be considered a means of managing emergent situation where the risk of serious bodily harm to the resident or others is imminent;

- the inclusion of crisis intervention plans in the plan of care with consent and the involvement of both the resident and their substitute decision-maker, if any; and

- the establishment of a written documentation standard within the proposed statute or its regulations, requiring a detailed account of regular, relevant occurrences, interventions and outcomes.

Documentation and reporting standards are essential if residents of long-term-care homes are to be protected from abuse. Staff in long-term-care homes should be trained and certified in crisis prevention and crisis intervention techniques.

Although we don't have time today to address all of our concerns, we would like to draw your attention to other recommendations, such as on page 11, the need to appoint an independent seniors' advocate to protect the legal and civil rights of seniors residing in long-term-care facilities; on page 14, the importance of appointing a seniors' ombudsman to report on the state of long-term care in Ontario and to receive complaints from all stakeholders, including the independent seniors' advocate; the benefit of strengthening resident and family councils by providing adequate funding and autonomy with funding and reporting relationships; and the provision of legal sanctions to hold every person who contravenes any provision of this legislation accountable for their actions.

Bill 140 will affect the quality of care and life of all residents in long-term-care homes for this and future generations to come. It's for this reason that we must get it right. Our challenge is to work together to strengthen

rights protections for Ontario seniors and address issues related to quality of care and life. Adopting our recommendations is the first step in making the system both responsible and accountable to the people it serves.

The Vice-Chair (Mr. Khalil Ramal): Thank you for your presentation. We don't have any time left. Thank you very much.

BUD MAHEU

The Vice-Chair: The second presentation will be by Bernard Maheu. Welcome, sir. You can start whenever you are ready.

Mr. Bud Maheu: Thank you, Mr. Chairman. Ladies and gentlemen, my name is Bud Maheu. I am the president of the residents' council at the Gibson Long Term Care Centre, a 202-bed class C home in North York. At retirement, I was the director of international trade programs at the Toronto Board of Trade, I was a member of various committees and I participated in submissions to the three levels of government on different issues. I also lectured to students at colleges and universities on international trade and I participated in forming the postgraduate international program at the University of Waterloo.

After my retirement, I completed projects for the Canadian federal government and for my former employer, the Toronto Board of Trade.

Shortly after my wife's passing about a year and a half ago, I had an allergic reaction to Lipitor. The resulting muscle weakness is what brought me to Gibson's.

Now, about the bill: As president of the residents' council, I applaud Bill 140 for putting pressure on all LTC centres to assure and standardize as much as possible protection and safety in all areas, such as physical, mental, diet and nutrition, religious beliefs, duties of nurses etc. for the residents. In these regards I can honestly say that Gibson's goes to great lengths to ensure that these issues are addressed appropriately.

However, Bill 140 provides two primary areas of concern. My first area of concern is licensing. I strongly believe that a licence should not be issued or renewed when there has been non-compliance of rules, false statements made and/or inability to establish the need for such a home in the area. However, I am opposed to section 101, where it states, "(5) The director is not required to provide reasons for deciding whether or not to issue a new licence." The granting or not granting of licences should be an open and transparent issue.

I am also deeply concerned with the proposed changes to the licensing period for all homes. I would base renewal on a home's structure. All homes that meet the requirements of the current act, regulations and service agreements have their licences renewed annually. However, under Bill 140, the proposed term of the licence will be determined by the structural classification of the home—A to D inclusive—with A homes being licensed for 25 years and C homes being licensed for only 10 years. As president of the residents' council, I certainly

cannot condone such action. Instead, I believe that the current one-year licensing term should be maintained for all homes.

My second area of concern is financing. I understand that under Bill 140, the government can try and force an operator to invest millions of dollars in upgrading just to get their licence renewed. I don't know who would finance such a venture when they wouldn't know how long the home would even have their licence for. From a fiscal point of view, a defined long-term period is necessary to plan the appropriate finances.

I have concerns about the homes that have three- and four-bed wards: class B and C homes. These homes were approved a few years ago but will no longer be acceptable. I understand that in all new homes, the wards consist of two beds with a shared bathroom. Gibson's has four-bed wards and is classified as a C home. I believe that three- and four-bed wards must be converted to two-bed wards within a reasonable length of time. But government funding will be required to assist the operators to perform such rebuilding. I understand that government funding was provided for homes built since 1998 and class D homes that have recently been rebuilt.

On behalf of the residents at Gibson's I ask, why is this program not available to assist us in our home? I was told that the operator of Gibson's has already invested some \$3.1 million to upgrade the building and is budgeting another \$500,000 in fiscal year 2006-07. You can see the difference this investment has made and is making with the interior appearance. Yet, despite their best efforts, they could get rid of the four-bed wards or make the bathrooms bigger so that residents like my friend Eleanor can go to the bathroom in their wheelchairs. And so, Gibson's remains a class C home. In tying a home's licence to its classification, it would be very difficult for a class C building such as Gibson's to approach a financial institution about a loan with a 25-year amortization to cover their share of the cost of reconstruction and all other expenses to upgrade to a class A home when their licence expires in only 10 years. So, if these financial issues cannot be resolved, what happens after 10 years? Do we still live with three- and four-bed wards, or does the government close these homes, effectively putting residents out on the street and laying off staff, some with many years of service?

In summary, my primary areas of concern are licensing and financing. Licences should be renewed annually, the renewal process should be open and transparent, and the licensing should not be tied to the structural classification of the home. By eliminating the connection between a home's licence and its structural classification, and government committing to the same capital program that exists now for other homes, the operators of class B, C and D homes have the opportunity to obtain suitable financing to upgrade their facilities to a class A residence.

Thank you, ladies and gentlemen, for your time.

0930

The Vice-Chair: Thank you very much, sir. We have a lot of time left, about seven minutes. We will divide it

equally between the three parties. We'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much, Mr. Maheu. I really appreciate your presentation. I think it's so meaningful when you, as a resident and someone who's representing the other people in the home, come forward and express your concerns.

You're saying you would prefer the continuation of the one-year renewal as opposed to this renewal that's based on the age of the home, and I would certainly agree with you. You feel confident that the current program in place, where the renewal is based on one year at a time and not on the structure, would give security to the residents, because the one thing we keep hearing is that this new proposal based on the age of the home is creating a lot of uncertainty for people. The fact that the government doesn't have to give any reason for pulling your licence, of course, provides further concern. Can you speak to that?

Mr. Maheu: I'll certainly try. At the moment, it's being renewed on an annual basis.

Mrs. Witmer: That's right.

Mr. Maheu: As long as you follow your Ps and Qs, there's no reason why a financial institution would not loan you money as they have before, certainly over a long-term amortization plan. However, with Bill 140, as I see it, anyway, there's a 10-year structure here. At the end of seven years they may, if they wish, come along and say, "Your licence will not be allowed to be extended after three years," which means, what do you do if you already have a 25-year-old plan, if someone is silly enough to loan it to you, that is?

The Vice-Chair: Thank you very much. Ms. Martel.

Ms. Martel: Thank you very much for being here this morning, for taking the time to make the presentation. I was interested very specifically in your concerns with respect to section 101, where the director does not have to provide reasons whether or not to issue a new licence. I agree with you that it should be a public matter, but I'm wondering if you can tell the committee why you have a concern that would lead you to that conclusion in the first place.

Mr. Maheu: Gosh, I gave that a lot of thought. I find it very difficult to answer, because I certainly believe that no government in power would ever do this and expect to get re-elected in the next term. Nevertheless, the wording is still in Bill 140, so theoretically it could happen.

Ms. Martel: So your concern is that if there is a reason that a home is not getting the licence, that should be very public. Perhaps it will act as a deterrent to other homes to get their act in order if they are out of compliance. Is that how you see it?

Mr. Maheu: That is how I see it. I can imagine what the local press would say too. If a long-term-care home did everything it should have been doing, followed all the inspections, and had no black marks against it, and then the residents were suddenly put out on the street, here in Canada where it can get cold, I'm sure the press would make big headlines on that. However, the possibility is there.

The Vice-Chair: Thank you, Ms. Martel. The parliamentary assistant.

Ms. Monique M. Smith (Nipissing): Mr. Maheu, I'd like to thank you for being involved in your resident council. It's so important that we have residents' councils in all of our homes and that we hear the voices of residents as we move forward on this legislation. So I'd like to thank you for coming today.

Your concern—I just want to pick up on what Ms. Martel was talking about: the notice and the discussion with the community around possible changes to a home. I note that in subsection 101(4) there is a duty on the director to consult with the public; it's outlined in section 104. Section 104 actually sets out when the director has to consult with the public. It's before issuing a licence for a new home, undertaking to issue a licence under section 98, deciding whether or not to issue a new licence, transferring a licence or beds, or amending. So there are provisions in the act for public consultation around the decisions of the director. Does that in any way calm your concerns around transparency? There is the ability to have public consultation—actually, a requirement, not just the ability.

Mr. Maheu: I suppose only to a degree. When I read that article on subsection (4), I felt very good about it. Then I read (5), and I thought, "Oh, my goodness, that is contradictory to what (4) says." That is why I emphasized subsection (5).

Ms. Smith: Right. Okay.

The Vice-Chair: Thank you very much.

ONTARIO LONG TERM CARE PHYSICIANS

The Vice-Chair: The next presentation will be by Ontario Long Term Care Physicians. I have two names here on the list. If you would state your name before you start, if you don't mind.

Dr. Norman Flett: Good morning, Mr. Chairman and committee members. I'm Dr. Norman Flett, medical director at St. Joseph's Villa. With me are Dr. James Edney, medical director at Castleview Wychwood Towers, and Dr. Peter Bolland, who is medical director at Sheridan Villa.

I'm very proud to be here this morning to represent the 580-some medical directors across the province of Ontario and the 2,500-plus attending physicians who look after our residents in long-term-care homes and who are expert in low tech and high touch—low-tech, high-touch medicine. Together the three of us here represent 93 years of practice in the province of Ontario as medical directors and attending physicians. Dr. Edney is going to make the presentation to the committee today. Thank you.

Dr. James Edney: Good morning. There has been a profound change in both the type of resident admitted to long-term care and the care culture over the last 30 years. In the 1970s, the average age of a resident admitted was in the late 60s. The resident had reasonable health, with one or two diagnoses. The average number of medi-

cations was less than three, and some of the residents even drove their own car and were able to vacation out of the province. The three acts that we still work under were appropriate to the population of the time. Also, the three acts were passed when the management culture was one of structure, policies, procedures; the time of QA, quality audit. It was long before the current patient—resident—safety culture.

Our assessment of the present act is that the contents of the old acts have been moved into Bill 140 without consideration of the management changes or the type of resident admitted to long-term care. We find this paradoxical, that a government that prides itself on not micro-managing systems and on being at the cutting edge of health care should limit its vision to a bill that is micromanaging par excellence and, in our opinion, is not at the cutting edge, as it does not recognize continuous quality improvement or patient safety.

We believe this act will result in the care of the institutionalized elderly being mired in a morass of inspection, reporting, blame and punishment. This will inhibit innovation and the fostering of a culture of care and safety.

We're very concerned that recruitment and retention of physicians as well as nurses, especially nurse managers, and other staff and administrators will be adversely affected by this bill. We predict that if this act passes in the present or even a mildly altered state, the recruitment of physicians for any home will be almost impossible.

The average age of physicians providing care to residents in long-term-care homes is close to 60 years. There are two implications we draw from this: (1) these physicians are very close to retirement and may indeed take that option, and (2) there are very few younger physicians willing to take on the demanding and poorly remunerated care of the elderly. The recruiting and retaining of physicians and senior long-term-care home staff are critical for the management of our institutionalized elderly.

Bill 140 emphasizes individualized care, and care to the "greatest extent" possible. Individualized care comes with a great economic cost and falls way short at the present time. Care must not endanger other residents or staff. It must allow for the institution to function effectively and must foster a living and working environment that promotes a culture of care, safety and community for residents and staff.

0940

We draw your attention to seven areas of this act that cause us major concern.

(1) The fundamental principle: We believe the fundamental principle is unrealistic. It does not address the present, let alone the future, environment of the long-term-care home. It is inaccurate because of what it leaves out. The residents admitted to a long-term-care home have deterioration in their health in the broadest sense. They are frail. They have five or more diagnoses, an average of nine medications and require assistance in a number, if not all, activities of daily living. The act fails to address the fact that the reason for admission is due to

illness/ill health which cannot be reversed. Our recommendation is to include these realities so that the future residents and their families are not deceived or lulled into thinking that admission to a long-term-care home is equivalent to or better than their own home.

(2) Residents' rights: Residents' rights are presently in regulation. We believe this is appropriate and that the residents' rights should stay in regulation. Here is an example and a reason why. The example: If you look at resident right number 14 and the first part of that, it says, "the right to communicate in confidence." We interpret this as meaning that a physician or nurse discussing symptoms or signs, medications and care with a resident must do it without anyone else hearing the exchange. First of all, what about the residents in the two- and four-bed rooms that are not up to present design standards?

Secondly, this right goes against the physiological consequences of aging that everyone in this room will experience as they get older. By the mid-80s, all persons will have a significant degree of hearing loss. This hearing loss is mainly high-tone, i.e., the female voice, but also affects lower tones. That's why you hear people complaining about female staff shouting. So if someone else—other residents, family, friends of other residents, volunteers—hears the discussion, an offence has been committed and must be reported.

Now the reason: What happens in a number of years—10, 15, 20—when this government will long have been consigned to the history books and a new resident right becomes important to the elderly? The future government will have to open the act in order to ensure that it also follows the course of inspection, monitoring, enforcement and penalties. When you consider all of the rights—all 26 of them—we believe it will be impossible not to commit frequent, daily, even hourly, offences, which of course will need to be punished because they are against the law.

(3) The plan of care, section 6: Subsection (10) outlines the documentation requirements. Physicians have documentation requirements mandated by the College of Physicians and Surgeons. This act may be in conflict with these requirements. If there is no conflict, then how does the physician fulfill the requirements of this section? How detailed must the plan of care be to meet the standard implied in section 22? For instance, documenting the plan of care for a resident with diabetes or dementia could take a number of pages if one outlined all the guidelines and possibilities. The result will be nonsense documentation, more failure and therefore more offences and punishment. Current requirements for documentation already remove staff from bedside care. This is not in the best interests of the residents. This legislation provides an unnecessary layer of inspector scrutiny for attending physicians in long-term care, which will drive physicians from the care of the elderly.

(4) Sections 22 and 23: These two sections completely ignore the continuous quality improvement culture the medical system has embraced. We expect physicians will refuse to do audits to see if care could be improved

because of the risk of exposing care that might be judged as improper or incompetent by an inspector. These sections are counterintuitive to the patient/resident safety culture that the health care system is also embracing. The present culture of safety is to encourage staff to report all misses and all near misses so that the system can be improved for the safety of residents and patients, so near misses and anticipated misses will not be reported for fear of penalty. For example, what of the phone call to the physician who is not in the home who is busy and doesn't respond immediately? Is this included in the risk of harm and therefore open to penalty?

(5) Section 74, training: The whole act is confusing in respect of whether physicians and medical directors are staff or not. We read the act as that both are staff, so all physicians will need the training prescribed in this section. This is onerous in the extreme, particularly as the physicians are trained already in a number of areas: restraints, caring for persons with dementia etc.

(6) Compliance and enforcement: This is the most ill-conceived part of the act, in our opinion. It pits the inspectors against the staff, staff against staff, residents against staff, families against staff, all setting up inevitable failure. It provides no support for the residents who have chosen the home and no support for the staff who are often working in very compromising circumstances. It does not distinguish between the spilled banana purée—a risk of a fall—and murder from an aggressive resident for whom we may have little information. We are not to use medication, restraint or locked units for fear of breaking this law.

(7) Penalties: When one considers the likelihood that offences will be committed daily, if not hourly, the penalties are clearly excessive.

Overall, we feel that this act requires diligent revision so that the principles of continuous quality improvement and patient safety are more clearly enunciated. We need to ensure that homes can be flexible in the provision of care and innovative in meeting the needs of present and future residents. In its current form, we see it as very bad for residents, neither helping them obtain good care nor allowing staff to meet their needs. We predict that it will be very difficult to persuade physicians to be medical directors or attending physicians to work in the homes. We are also concerned that our remarks on retention and recruitment will almost certainly apply to nurses and other staff.

In summary, we advise the government to:

- reword the fundamental principle to include the realities of residents of 2007 and the future;
- keep the bill of rights in regulation;
- put the documentation requirements into the regulations;
- rewrite sections 22 and 23 and the sections on inspection and enforcement using the principles of CQI and patient/resident safety;
- return the training requirements to regulation; and
- make the penalties appropriate to the issue.

Thank you for your attention. We'd be pleased to take questions.

The Vice-Chair: Thank you very much. We have a few minutes for questions. We'll start with Ms. Martel.

Ms. Martel: Thank you very much for being here today and for your presentation on behalf of yourself and your colleagues.

Number four in the summary says, "Rewrite sections 22 and 23," and it also references the "principles of CQI and resident/patient safety." When you talk about the principles of CQI and resident/patient safety, what are those principles? Are those standard principles that are used across homes? I'm sorry to display my ignorance, but I don't understand what the reference is to.

Mr. Flett: Yes, they are. These are situations that are highly individual depending on the capability or incapability of the individual resident. When we look at their strengths and weaknesses, continuous quality improvement is a way that we review those on an ongoing basis to see how we in fact can best manage that individual in the environment in which they are in.

Ms. Martel: So if you wanted to put that into the—

The Vice-Chair: Thank you, Ms. Martel. The parliamentary assistant?

Ms. Smith: Just to follow up on sections 22 and 23: Sections 22 and 23 are the duty to report neglect and abuse and improper or incompetent treatment. Are you suggesting that we should be removing that duty to report? Is it not in the best interest of our residents that we ensure that any abuse and neglect are reported?

Mr. Flett: It is in their best interest. The way that it is worded, and the penalty for that, is such that there will be a lot of justification and staying in terms of where they were at, that no neglect in fact was permitted. When we have had an error—particularly an error in dosage of medication, which could be an error in terms of the resident directly—we want those to be reported so we can look at the system.

The Vice-Chair: Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. Were you consulted at all in the drafting of this legislation?

Interjection.

Mrs. Witmer: So this is the first opportunity?

Mr. Flett: We had an opportunity to present at a committee that was looking at the white paper, and we noted that the word "physician" is in the white draft on two occasions. On those occasions, it was to be associated with the nurse practitioner taking activity away from physicians.

The Vice-Chair: Thank you very much.

Mrs. Witmer: Oh, okay.

The Vice-Chair: Sorry. We don't have enough time. Thank you very much for your presentation.

ONTARIO ASSOCIATION OF COMMUNITY CARE ACCESS CENTRES

The Vice-Chair: The next presentation will be by the Ontario Association of Community Care Access Centres.

You can start when you're ready. If you don't mind, state your and your associate's name before you start.

Ms. Georgina White: Good morning. I'm Georgina White, the director of policy and research with the Ontario Association of Community Care Access Centres. I'm here with Sheila Jaggard, who is our vice-president of member services and chief operating officer. It's a pleasure to have the opportunity to speak to you today.

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The Ontario Association of Community Care Access Centres is a voluntary organization that represents Ontario's CCACs. As the provincial voice for CCACs, the mission of the OACCAC is to represent the interests of our members, to act as a vehicle for the development of common policy and shared services, to provide leadership in shaping health care policy and to promote best practices on behalf of the people served by community care access centres.

As you may know, CCACs have been planning a major reorganization over the last year and, as of January 1 of this year, we have consolidated our 42 organizations into 14 new organizations that are aligned with the LHIN boundaries.

Each year, CCACs provide coordinated access to health and support services to approximately half a million clients in Ontario. Through our case managers and care coordinators, our information and referral processes, CCACs play a major role in promoting independent living, helping people to navigate through the health care system and providing a bridge to other health care services. Within this mandate, CCACs have the legislated responsibility to act as the placement coordinator for people seeking access to long-term-care homes on both a long-term and short-term basis.

We're responsible for assessing individuals' needs and eligibility for placement and helping individuals and families to find homes with programs and services that meet their physical, behavioural, cultural and spiritual requirements and their preferences. CCACs also determine priority for placement and manage the wait-lists for placement, and we work with long-term-care homes to coordinate the admissions process. Last year, CCACs managed over 50,000 new referrals for placement and coordinated approximately 44,000 admissions to long-term-care homes.

Before I begin my comments on the bill, I want to congratulate the government for bringing this long-anticipated bill forward and for the principles and values reflected in the legislation, specifically the recognition that a long-term-care home is a home where residents have the right to live "with dignity and in security, safety and comfort." Long-term-care homes are not like acute care hospitals where people may spend a few days or weeks. They are homes where thousands of Ontarians go to live each year, often for the final months and years of their lives.

We were grateful to have the opportunity to participate in the consultation process undertaken by Parliamentary Assistant Monique Smith. I also want to express our

special appreciation to the team in the Ministry of Health and Long-Term Care that worked on this bill for their willingness to meet with stakeholders, to answer questions and receive feedback.

With respect to the preamble and principles, one area of concern for us, I think as you've heard before us, is the absence of a commitment to supporting continuous quality improvement. Both the Commitment to the Future of Medicare Act and the Local Health System Integration Act include continuous quality improvement as a fundamental principle. Bill 140 focuses instead on compliance with and enforcement of specific standards of care and services. We would suggest that compliance with standards that may or may not be evidence-based is not the same as a fundamental commitment to quality that acknowledges and rewards innovation and the pursuit of excellence.

Part III of the act deals with the admission of residents and is most pertinent to the placement responsibilities of CCACs. Section 41 deals with the assessment requirements for eligibility and determining an appropriate placement, and section 42 deals with authorization for admission. Under subsection 42(7) the placement coordinator, the CCAC, must provide copies of an applicant's assessment to the home selected by the applicant to determine if the home is able to meet the applicant's needs. In practice, in the absence of an electronic system for transmitting an assessment and assessment results, this entails faxing a multi-page, very-small-print document to the home that is difficult to read and may not provide information in a useful form to the home.

In consultation with long-term-care homes, a summary document or personal health profile has been developed that summarizes the relevant findings of the assessment. This profile, as opposed to the raw assessment data, is sent to the home in the majority of cases. It's not clear in the current wording of this section if it would permit the continued use of this personal health profile. To clarify, we would suggest a minor amendment to that subsection that would require the assessment results or personal health profile to be provided rather than the raw assessment data to ensure that homes have access to information that is useful and specifically designed to assist in their decision-making. The full assessment could be made available at the home's request rather than as a routine requirement.

Section 43 addresses admissions to secure units and includes new requirements for individuals to receive written notice and have access to a rights adviser in situations where the consent is given by a substitute decision-maker. These provisions mirror section 30, which deals with internal transfers to secure units in the home. The designation and characteristics of rights advisers are yet to be described in regulation.

While we support the underlying principles of respecting individual autonomy, minimizing restraints and maximizing the protection of vulnerable people, we are concerned that this is one example of several areas where the act sets out operational and procedural requirements

that may be difficult to implement effectively. This could have unforeseen consequences that negatively impact the care and safety of individuals. It's not unusual for admissions to secure units to be carried in the context of a crisis for the family or the individual who requires a very rapid response. If rights advice is not available within hours, these requirements could leave vulnerable applicants or their family caregivers at risk or potentially result in inappropriate admissions to acute care hospitals. In the absence of the operational details about how a rights advice program is to be implemented and assurance that a rapid response capability will be there, we suggest that it's inappropriate at this point to include this as a requirement in the legislation. We recommend that consideration be given to moving these requirements to regulations, where they're enforceable but can more easily be adjusted if they prove unworkable or have unforeseen negative consequences for individuals and the health care system.

Section 76 sets out the requirements for information packages to be provided to residents, again with a long list of specific contents. We suggest that this is another area where the details may be better left to regulation to ensure that the information provided is responsive to residents' needs on a long-term basis. Further, much of the information in this list is standard information across the system, such as the Residents' Bill of Rights and charging policies. We recommend that a standard information package be developed by the province that could be augmented with information specific to the home to minimize the administrative burden on homes.

We recognize the government's need to be responsive to the issues and concerns raised by individuals and families through the consultation and to ensure an open and transparent process. While the legislative process provides this transparency, this is counterbalanced by the difficulty in amending legislation. The regulatory process can be less open, but it provides a greater capacity to make changes and adjustments over time.

Beyond the legislation, the anticipated regulations under the Long-Term Care Homes Act will have significant impact on CCACs, and we would encourage the government to continue to consult with our sector and other stakeholders as regulations are developed.

I have just a couple of additional comments.

Section 85 requires homes to develop emergency plans that address procedures for evacuating and relocating residents in the event of an emergency. As a matter of practice, long-term-care homes would consult with CCACs and other key stakeholders, including local health integration networks, in the development of such plans. However, we would suggest adding a requirement for consultation and for sharing a copy of the plan with CCACs to ensure that CCACs are prepared to assist as necessary.

Finally, on a somewhat lighter note, I want to wholeheartedly support the name change of the Long-Term Care Act to the Home Care and Community Services Act under section 208. This new name better reflects the

scope of this act and recognizes that not all home care and community services are provided on a long-term basis.

On behalf of CCACs and our association, we are grateful for the opportunity to share our views on this important piece of health care legislation. We'd be happy to respond to your questions.

The Vice-Chair: Thank you very much for your presentation. We'll start with the parliamentary assistant.

Ms. Smith: Your recommendation under section 76 about the information package: I know that as a CCAC you deal with a number of homes in your area. I think you would agree with me that the information that homes provide to residents is somewhat inconsistent, and we've certainly heard from residents' family members that they want more information. That would be the reason that we've put that requirement in the legislation. I just want to make sure you would agree with me that the information being provided to the residents and their families is necessary, but what you're saying is that you'd like to see the details more in the regulations than in the legislation. Is that basically your—

Ms. White: That's right; again, so that it could be evaluated over time. It may be that some pieces of information are more useful to people than others. Obviously, you have the ability to continue to add to that list as necessary.

Ms. Smith: Right, and we do. In the reg-making authority we do provide for additional information.

Ms. White: Yes. But I think ideally you'd want to have some flexibility with that list so that we're not overloading people with information that ultimately may not be useful to them.

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Ms. Smith: Right. Okay, thank you.

The Vice-Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much for your presentation. We're starting to hear a bit of a little theme here about the concern of the absence of a commitment to supporting continuous quality improvement. Maybe you could expand on that. We're hearing a lot about this bill being quite prescriptive and focusing on compliance and enforcement. What type of recommendations would you recommend for the government as they amend this bill, specifically?

Ms. White: I think our key recommendation would be that continuous quality improvement ought to be a concept that's reflected in the principles of this act, as it is in other significant pieces of health care legislation. What we've heard from the homes that we've spoken to is a concern that the heavy emphasis on compliance with standards can distract from an environment that focuses on quality improvement and innovation, that kind of approach to the provision of care.

The Vice-Chair: Ms. Martel?

Ms. Martel: I want to just focus on the profile that you refer to. Is that standard across long-term-care homes now, or has that just been developed in certain regions of the province?

Ms. White: The RAI home care tool is used right across the system now as our standard assessment tool for placement, and the personal health profile is basically a form that's developed based on the assessment results from that RAI.

Ms. Martel: In your view, though, is it full enough to give the home a significant understanding of the individual who wants to be admitted?

Ms. White: It was developed in consultation with homes, based on their specific requirements for information, and the practice at this point is to provide the actual RAI results if they are requested.

The Vice-Chair: Thank you very much for your presentation.

SERVICE EMPLOYEES INTERNATIONAL UNION, LOCAL 1.0n

The Vice-Chair: The next presentation will be by the Service Employees International Union, Local 1.0n. I believe we have with us Sharleen Stewart, the president, and, for Hansard—

Mr. John Van Beek: John Van Beek.

The Vice-Chair: Thank you very much. You may start whenever you are ready.

Ms. Sharleen Stewart: First, I'd like to thank the members of the committee for allowing the Service Employees International Union to address our concerns this morning on Bill 140. As indicated, I am Sharleen Stewart. I am president of SEIU Local 1.0n.

The Service Employees International Union has been fighting for better nursing home care standards for years. SEIU Local 1.0n. represents approximately 12,000 nursing home workers—registered practical nurses, health care aides, personal support workers, dietary and house-keeping aides, and maintenance staff—at more than 140 nursing home facilities across Ontario.

I will be jumping around this morning, so please bear with me and hopefully just sit back and listen.

Seniors in Ontario nursing homes are still not receiving the care they deserve, and Bill 140 will entrench the fact that Ontario will continue to have the lowest nursing standard for nursing homes in the western world. The Ontario government, despite promises made by Dalton McGuinty prior to the 2003 provincial election, refuses to establish a standard of quality care that nursing homes must provide each resident.

Since the McGuinty government came into office, there have been no significant increases to nursing home staffing levels, save for an increase in registered nurses. The Ontario government promised a revolution of change to Ontario's nursing home industry. What nursing home residents get is more of the same old regime. The Ontario government's lack of action in developing any standards for a minimum number of care hours nursing home operators must provide is nothing short of scandalous, and in my view it's immoral.

Prior to the last provincial election, SEIU asked the following questions. I'd like to point out these questions and Dalton McGuinty's responses.

The question was, “Will your government make public the number of care hours nursing home residents receive on a daily basis, for each Ontario nursing home?” The answer: “Ontario Liberals are committed to ensuring that nursing home residents receive more personal care each day. We will invest over \$400 million to increase the level of care in nursing homes and reinstate minimum standards.”

Next question: “Will your government establish a minimum number of care hours nursing home residents must receive on a daily basis? If so what should the number of care hours per day be?”

“Yes. Ontario Liberals are committed to reinstating the standards of care for nursing homes that were removed by the Harris government, including a minimum 2.25 hours of nursing care daily and three baths per week,” was the answer.

A year after taking government, here is what George Smitherman responded to questions at the standing committee on estimates. Ms. Martel asked, “Are you going to reinstate the 2.25” hours of care?”

“*Hon. Mr. Smitherman:* I answered the question yesterday, directly, and I’m pleased to answer it again.

“*Ms. Martel:* Okay, let me just confirm again. Are you going—

“*Hon. Mr. Smitherman:* No.

“*Ms. Martel:* So in fact you don’t have any intention of keeping the promise you made in your election document, even though you were quite critical of the former government for cancelling the 2.25 hours of nursing care.”

Moreover, the Liberal government has failed to deliver on funding by \$3,500 per resident annually to fulfill yet another 2003 election promise to increase nursing home funding to \$6,000 per resident annually.

I’d like to refer to the brief we’ve handed out, on page 6, where it says the crucial issue for this legislation must be the inclusion of a care standard. Every other jurisdiction in the western world is adopting minimum care standards. My question is, why not Ontario?

There is wide support in the literature that suggests minimum staffing levels ensure better quality care. Dr. Robyn Stone says, “Front-line workers such as nursing assistants, home care aides, and personal support workers are the centerpiece of a long-term-care system.... They are the ‘eyes and ears’ of the care system....

“Inadequate staffing levels diminish quality care....

“The consequences of inadequate staffing levels and poor training are:

“—diminished quality of care;

“—high turnover;

“—poor job quality;

“—abuse and neglect;

“—higher rates of injury to staff and clients.”

Nancy-Ann DeParle says, “Our findings to date show a strong association between staffing levels and quality care.... The findings demonstrate that there are significantly more problems in facilities with less than 12 minutes of registered nursing care, less than 45 minutes

of total licensed staff care, and less than two hours of nursing aide care per resident per day.” This is a total of 2.95 hours of care per day. In no nursing home SEIU surveyed was this standard anywhere near to being met.

DeParle contracted research firms and gathered data from 1,786 nursing homes in three states. Her recommendation for daily care came out as follows: Suggested minimum staffing is 2.95 hours per day; the preferred minimum is 3.45 hours of care per day.

A conference on nursing home staffing in April 1998 at New York University recommended that a proposed minimum total number of direct nursing care staff be 4.13 hours of care per resident per day, and that the total hours of care, including administrative and direct and indirect nursing hours, be 4.55 hours of care per day.

A United States study commissioned by the federal Centers for Medicare and Medicaid Services identified three staffing thresholds below which the quality of care was found to suffer. The threshold is 45 minutes for RNs; one hour, 18 minutes for total licensed services—RNs plus LPNs; and two hours, 48 minutes for certified nurse assistants. Any nursing home that meets these standards would provide at least four hours, six minutes of total nursing care per day. Thirty-six US states have adopted minimum standards of care. Some of those standards include: in California, 3.2 hours; Vermont, three hours; Ohio, 2.75 hours; Illinois, 2.5 hours; Florida, 3.6 hours.

I’d like to refer you to page 8 of the brief. You are already familiar with the PricewaterhouseCoopers study so eloquently cited by Liberal MPPs when they were in opposition. Again, the study points out that Ontario has the lowest standard in the western world. SEIU data shows most nursing homes are still below the 2.25 standard eliminated by the last government.

1010

Page 9 of the brief: According to Online Survey Certification and Reporting, a data network maintained by the Centers for Medicare and Medicaid Services in the United States, total staff hours per resident per day in 2004 averaged 3.6. Nova Scotia’s Department of Health has set targets when establishing approved facility staffing budgets: 3.25 hours of care for level II nursing homes.

William F. Benson, president of the National Citizens’ Coalition for Nursing Home Reform, at a White House Conference on Aging in 2004 said, “Staffing is the primary issue that determines the quality of all of long-term care ... a minimum staffing level is absolutely essential to ensuring that basic care is provided to residents.”

The Toronto Star, in an editorial in October 2006, had this to say about the new Long-Term Care Homes Act: “Without such a [minimum] standard, other efforts to improve care and curb problems will almost certainly fall short. How can neglect be stopped if nursing homes are not required to hire enough workers to ensure adequate care? How can abuse be ended if harried workers are too busy to notice?... Smitherman said this week he has not set a minimum level of care because it would encourage staff to ‘treat people like widgets.’”

Smitherman's view has done exactly that. He has treated people as commodities rather than real people with real needs.

A coroner's jury report in May 2005, in the inquest into the death of two nursing home residents in June 2001, made 85 recommendations to improve nursing home standards. The Ministry of Health and Long-Term Care responses to these recommendations in July 2006 indicated that the Ontario government will not make the changes to the care nursing home residents receive. Liberal promises for better standards remain broken.

For example, the coroner's jury recommendation 29 calls on the MOHLTC, pending an evidence-based study, to fund and set standards requiring long-term-care facilities to increase levels to, on average, no less than 0.59 RN hours per resident per day and 3.06 per resident per day overall nursing and personal care for the average Ontario case mix measure. The funding formula must be immediately adjusted to reflect this minimum staffing standard.

The ministry's response to the coroner's jury recommendation that at a minimum the care hours in Ontario nursing homes are comparable to similar jurisdictions is, as the international data shows, simply not true.

In a response to a petition presented to the Legislative Assembly of Ontario in the fall of 2006, the McGuinty government now says it believes that every resident's needs have to be assessed and that a legislated care level would not be responsive to a resident's changing needs. Does this government really believe that private nursing home operators will allow their front-line workers to make a decision on the level of care a resident will receive?

In the middle of page 6, understaffing equals poor resident care: In a membership survey conducted by SEIU last fall, 69% of nursing home workers indicated their workloads had increased over the past three years. Overall, they estimated their workload had increased by 36%. That's a result of the workload and the levels of care that these people are providing in the nursing homes as they exist today.

This government has lauded the fact that it has introduced patient lifts in every nursing home. While this is true, SEIU nursing home members report that it takes at least 10 minutes to find another staff member to help lift that patient because those lifts require two people to operate.

This government prides itself on the fact that it increased resident baths from one to two per week, ignoring its election pledge that it would institute three baths per week. Even now, our members report that residents always or sometimes—at least 30%—miss their second weekly bath.

Smaller nursing homes laid off other caregivers so they could accommodate the new 24-hour-RN regulation.

The typical situations nursing home workers experience daily show—

The Vice-Chair: You have one minute left.

Ms. Stewart: —thank you—show the urgent need for increased staffing. Local 1 members responded to a survey about patient care and staffing.

I want to touch on a couple of our many amendments for nursing homes in the remaining minute that I have.

Section 72: Amend to read, "That in order to provide a stable and consistent workforce and to improve the continuity of care to residents, every licensee of a long-term-care home shall ensure there is a staffing ratio of not less than 75% full-time and 25% part-time. No nursing home licensee shall allow the nursing staff or resident ratio to fall below 3.5 hours of care per resident per day."

Accountability: The Minister of Health and Long-Term Care has indeed established a public reporting on long-term-care homes; however, the information is dated. The data includes only information from the current reporting period, which means it will be at least six months old and could be as old as eight or nine months.

The Vice-Chair: Thank you very much for the presentation. There's no time left.

CONCERNED FRIENDS OF ONTARIO CITIZENS IN CARE FACILITIES

The Vice-Chair: The next presentation will be by Concerned Friends of Ontario Citizens in Care Facilities. Please state your names for Hansard, if you don't mind. You can start when you are ready.

Ms. Freda Hannah: Freda Hannah.

Ms. Lois Dent: Lois Dent. We're representing Concerned Friends of Ontario Citizens in Care Facilities, which is a volunteer advocacy group that has been dedicated to improving the quality of care for residents in long-term-care homes for over 25 years. The work of Concerned Friends is done by volunteers and supported by membership fees and donations.

The board of directors of Concerned Friends appreciates this opportunity to present our comments and recommendations on Bill 140 to the standing committee on social policy.

We are pleased with the spirit of this act. We find that it is resident-focused, has an expanded and strengthened bill of rights, detailed provisions on the prevention of abuse and neglect, and limits on the use of restraints. We welcome and support many provisions in the act, such as the graduated sanctions, significant financial penalties assessed against anyone convicted of an offence under the act, and the definition of a secure unit as a restraint if the resident cannot exit from the unit independently.

The section on the plan of care outlines clearly what must be included in the plan, and also details the documentation required. These provisions will help to ensure high-quality and consistent care. However, because accurate and concise documentation requires both time and skill, the Ministry of Health and Long-Term Care must ensure that homes have sufficient qualified staff to effectively carry out this essential function.

The protection of residents from abuse and neglect is strengthened through zero tolerance policies, mandatory reporting requirements and whistle-blowing protection. We hope these protections, especially the whistle-blower protection, will prove to be effective, as the fear of retaliation has long been a deterrent to the reporting of incidents of neglect and abuse.

Given the present variety of venues available for obtaining information—such as the long-term-care hotline, the Public Reporting on Long-Term Care Homes website, compliance advisers and community care access centres—we do not see a need for the establishment of an Office of the Long-Term Care Homes Resident and Family Adviser, as described in this act. We are also concerned that the duties of this office are open-ended and could be expanded to include the powers and costs of a long-term-care-homes ombudsman. If such a position is created, we believe that the ombudsman's responsibilities should encompass all aspects of elder health care, and that such an office must be independent from the Ministry of Health and Long-Term Care.

1020

The act helps to empower family councils and ensure that they will have an important role in the life of the long-term-care home. It obligates the licensee to advise families of their right to establish a family council if one does not exist. The act states that a family member of a resident, a former resident, or a person of importance to a resident or former resident may be a family council member.

It also allows a person who lives in the community where the long-term-care home is located to be a member of the family council. We do not see the benefit in having someone from the community who has no connection, past or present, with any resident as a member of the family council, and we have some concern that adding this category of membership could lead to potential difficulties for the family council. For example, the motivation of a community member may be completely at odds with the educational/informational directions and immediate concerns of family members or friends of residents. The family council would certainly be able to invite interested members of the community to attend meetings and assist in various ways, but they would not have the same rights and privileges as a family member or a friend.

The act lists 10 powers that family councils may exercise, including the power to “attempt to resolve disputes between the licensee and residents.” We believe that this responsibility is better left to the residents' councils, and that family councils should have the power to seek solutions for areas of concern between the licensee and families.

We support the section of the act requiring the licensee to prepare a package of information for every new resident and make it available to family members and persons of importance. This very comprehensive package is to include information about the family council, if any, or, if there is no family council, any infor-

mation provided in the regulations. We recommend that the regulations inform families that there are resources available to them for assistance in developing and sustaining a family council. The information on family councils should also note that the benefits of family councils include mutual support, information and education, as well as advocacy.

Limits to the use of agency and temporary staff are important and will improve the consistency and overall quality of care. The requirement that staff providing direct care to residents must receive additional training in caring for people with dementia and managing aggressive behaviours is critical to ensuring good care. We recommend that training to improve the cultural competency of staff also be included. We expect the regulations will spell out in more detail what the training must include and how it will be undertaken. We also look forward to details about the qualifications that staff will be required to have.

We recognize that the education standards for personal support workers have improved in recent years. However, as far as we are aware, it is still not a requirement that all personal support workers complete the course of study before being hired. We urge that the ministry make it mandatory for personal support workers, who provide the majority of hands-on care to residents, to complete a certified, government-approved personal support worker course before being hired to work in a long-term-care home.

The act states that there may be regulations related to the use of psychotropic drugs, including requiring that the home discuss the use of such drugs with the medical director. We believe that the role of the pharmacist should also be considered and include overseeing the safe use of these and other drugs, as well as the interactions among medications already prescribed for the resident. We also recommend that the act contain provisions to ensure that the medical director and the physicians providing care to residents in the home have previous experience in treating elderly people with complex care issues or have some training in geriatric principles.

The act includes an amendment to the Coroners Act that requires the coroner to be notified of the death of every resident in a long-term-care home. It will then be up to the coroner to decide whether or not the death should be investigated. This is an important safeguard. We recommend an added provision that prohibits coroners from being employed as physicians in long-term-care homes to avoid any potential conflict of interest.

Concerned Friends regrets that this legislation does not respond to the urgent need for specialized units in designated long-term-care homes to care for residents with serious behavioural problems. As recommended by the jury for the Casa Verde inquest, these units should include short-stay beds for assessment and development of appropriate care plans; longer-stay beds to allow for the implementation of the care plan; and, where necessary, beds allotted for the long-term stay of residents who

need to continue to be cared for in such specialized units. This is a serious omission that must be rectified.

The Ministry of Health and Long-Term Care has chosen not to include a minimum standard of care—hours of nursing and personal care per resident per day—in this act, yet adequate staffing to meet the increasingly complex care needs of residents is fundamental to the successful implementation of many of the provisions of this act.

While a minimum standard of care is one way to ensure adequate staffing, we believe there are better methods. The ministry is currently piloting the adoption of the long-term-care assessment tool—the minimum data system—resident assessment instrument, MDS—RAI—for assessment and care planning in homes across the province. We recommend that this process be speeded up and used as the basis of a new funding system. We need a responsive funding system that is based on the actual needs of residents, not an arbitrary minimum number of hours of care. As well, the public has a right to information about each home's staffing levels. We suggest that this information be added to the home profile on the public reporting website.

In conclusion, Concerned Friends is aware that a lot of hard work and careful consideration have gone into the drafting of this very comprehensive act. It has been a long time coming. Although we believe the act will benefit from some adjustments, we look forward to its implementation.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left, one minute for each party. We'll start with Ms. Witmer.

Mrs. Witmer: Thank you very much for your presentation. I found it really quite interesting. I think you've made some excellent recommendations. The point about the need for the personal support workers to receive some programming and education is, I think, an important one.

Just a question about your organization: Are you primarily Toronto-based or do you have representation across the province of Ontario?

Ms. Dent: We have some representation across the province, yes.

Mrs. Witmer: Okay. So what you've gathered here is from all of those individuals?

Ms. Dent: It comes a lot from the calls that we receive. We get calls from people from across the province. Certainly, more of them are in the GTA than, say, Thunder Bay, but it does represent our members across the province.

Mrs. Witmer: Thank you very much.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you very much for your presentation today. I notice that you said we don't need the Office of the Long-Term Care Homes Resident and Family Adviser. So you think that should be deleted from the legislation?

Ms. Dent: I think it could be, yes.

Ms. Martel: As I understand it, your organization is part of the seniors' advisory committee on long-term care.

Ms. Dent: Yes, we have a representative there.

Ms. Martel: You're signatories to a letter that went to Ministers Smitherman and Bradley in August 2005 recommending an independent ombudsman. Can you give the committee the reason why you think an independent ombudsman, or perhaps having the current Ombudsman have oversight, is an important change that should be implemented?

Ms. Dent: Yes, we were signatories to that letter. However, there was a lot of back and forth about what the ombudsman's responsibilities should be. It definitely should be independent, because how else can an ombudsman really carry out their duties? He or she should report directly to the Legislature, as the current Ombudsman does, but it should be encompassing all health, not just long-term care.

The Vice-Chair: Thank you, Ms. Martel. Parliamentary Assistant?

Ms. Smith: I just want to take this opportunity to thank both of you, Lois and Freda, for all of your help and work. As the other committee members may or may not know, these two women have come out to every advisory meeting that we've had on the legislation moving forward. So I want to thank you for the input that you've given and again for appearing today and providing us with yet a little bit more.

I just wanted to have you expand for a moment on your views around family councils and the need or lack of need for having community members. Why do you see that as a downside for the structure of family councils?

Ms. Dent: Well, as we tried to say in there, we don't see any benefit from it because the whole focus of a family council is to work with a home regarding improving the quality of care of the residents. We're not sure what a community person would add, and potentially they might—why would they be interested? Maybe they just want to help out or—I hate to say this, but they might have some other reasons for wanting to have some influence. It's just a potential concern, but I don't see any upside. I can't see any benefit from it, and I can see potentially a problem.

1030

The Vice-Chair: Thank you very much for your presentation.

ONTARIO LONG TERM CARE ASSOCIATION

The Vice-Chair: The next presentation will be by the Ontario Long Term Care Association. Can you please, before you start, state your name for the Hansard?

Ms. Karen Sullivan: Sure. I'm Karen Sullivan. I'm the executive director of the Ontario Long Term Care Association.

Mr. Bill Dillane: I'm Bill Dillane. I'm president of the Ontario Long Term Care Association.

Mr. Brent Binions: I'm Brent Binions, vice-president, financial liaison, OLTC.

Ms. Sullivan: We're here on behalf of our members, who operate 430 long-term-care homes, where 50,000 of Ontario's oldest and frailest citizens live, to ask you to remove the uncertainty that Bill 140 creates for their future, to strengthen its ability to provide the care and services that residents need and to increase long-term-care homes' ability to be a system solution.

We support the bill's strengthened provisions for resident safety, abuse prevention and whistle-blower protection. We are deeply concerned, and in some instances puzzled, that Bill 140 contains many other provisions that will create uncertainty, focus on paperwork at the expense of care, foster institutionalization, and set homes up for failure.

Committee members will know that our concerns are also shared by residents, families, staff, communities and others. We have developed 95 amendments that we believe are required to address the issues in Bill 140, and we will provide these to you by January 19. Today I want to focus on the two critical issue themes: uncertainty for existing homes and risk to care and services, both of which also impact the broader health care system.

It is disappointing that while this legislation took three years to write, it will introduce limited-term operating licences linked solely to the building's structure without a plan to reassure communities that there will be homes to meet increasing demand or that these homes can meet resident expectations for privacy and dignity. The plan is apparently an afterthought.

But without this plan, sections 100 and 180 will start the clock of uncertainty ticking for all homes the day this bill is passed. This clock will tick the loudest for 263 C class homes, many in small rural communities. Their operators, families, staff and 27,500 residents will be left wondering what day in the next seven years the ministry will decide to reveal their future. The options include: close the home, close some of the beds, rebuild—which is impossible without a capital renewal program, invest millions in upgrades and still leave three- and four-bed wards, or renew the licence with no changes, again perpetuating three- and four-bed ward accommodation.

Even if a home meets government's renewal terms, Bill 140 doesn't identify the length of a new licence term. Apparently it could be different for different operators or homes. The worst option is hearing nothing in seven years. Ministry silence means the home will close, and subsection 101(5) allows them to not explain their decision to anyone.

This is hardly reassuring for any community, particularly since many, like Kingston, Sudbury and Niagara, are struggling with shortages of long-term-care beds. It hardly reassures residents, families and staff over the future of their home, their care or their job. They also do not understand why the government does not provide capital funding so that residents can live in homes that provide the privacy and dignity that government is helping fund for residents in newer and rebuilt homes, particularly when all residents pay the same.

Operators will see their financing terms change and find it increasingly difficult to finance home maintenance and upgrades. For smaller operators, it is enough uncertainty to threaten their future in the sector.

We have developed a more workable solution that meets what we believe are the government's objectives, but replaces threat and uncertainty with predictability and stability. It will allow government to introduce limited-term licences and recognizes that these licences should not be perpetual. It also recognizes that community bed demand, operator performance and building structure should determine license renewals.

Most importantly, our solution provides the action plan for Ontario to move forward with the rest of Canada in eliminating three- and four-bed ward rooms in all homes over the initial licence term. It defines what happens after the initial term expires, which is essential for stability and financing, and it supports maintaining structural integrity on an ongoing basis.

We ask that you support this solution by amending subsection 180(3) to provide B and C homes with initial fixed-term licences of 15 years and to empower government to fund a capital renewal and retrofit program. Government must then act on its support for Elizabeth Witmer's motion by committing to work with the sector to immediately develop this program. This would enable the sector to rebuild or retrofit 2,500 beds per year, which is the approximate number of D beds that were rebuilt annually, and renew all B and C homes over those 15 years. This licence term matches the current average amortization period for these homes, thus eliminating much of the instability from the proposed 10- and 12-year terms. Homes would have to meet this deadline for their licence to be renewed. Homes would then receive a 25-year licence. In some cases, retrofitting would make more sense for eliminating three- and four-bed wards and would reduce capital program costs.

The Canadian experience, and Ontario's D bed rebuild program, demonstrate that successful structural renewal requires a plan that includes design standards, capital funding and operator deadlines. Ontario can begin building a major success story with commitments in place and details worked out over the next six months. Actual funding would not have to flow until the first rebuilt or retrofitted homes open in 2009.

To provide predictability for government, homes and communities, we ask that section 100, subsections (1) to (3), be amended to provide 10-year licence terms at the end of the 25-year term, with renewal subject to the operator demonstrating a demand for the beds, a solid compliance record and that structurally the home meets residents' needs. A commitment to work with the sector on a jointly funded asset management program would help ensure that the latter is not an issue.

I now want to focus on how Bill 140 fails to meet enhanced care and service expectations, specifically some of the sections that, if not amended, will put existing care and service levels at risk and make homes more institutional.

Bill 140 requires additional paperwork and processes that will reduce the already insufficient time available for resident care. A new doctrine of absolute compliance will force homes to comply, as inspectors will have no choice but to formally ticket homes for every compliance infraction they see, even something like a cup of tea that is spilled during lunch and wiped up a minute later. The impact will not only breed a culture of blame and shame but more paperwork and processes to track and document compliance issues, irrespective of the effectiveness of these requirements for enhancing care delivery.

For example, under paragraph 5 of subsection 28(1), any resident who cannot enter the outside door lock code will be deemed to be restrained. Ministry standards require these locks to protect the over 60% of residents affected by dementia. Now the home itself will be considered a restraint, requiring homes to implement the increased monitoring and other provisions as outlined in subsection 28(5) for some 45,000 residents. With the new public reporting requirement for the number of residents restrained, Ontario is ensuring that it will have the worst resident restraint record by far.

Further, subsection 18(3) requires that anyone entering the home to do work has a copy of the home's abuse policy first. To demonstrate compliance, homes will need processes that document that everyone from the ambulance attendant to the newspaper carrier has received the policy before they come in the door.

We ask you to amend these and other sections, as outlined in our detailed submission, to be more realistically implemented while still enabling government to effectively monitor homes.

We also ask you to amend sections 150 to 154, dealing with graduated sanctions. Although we support their principle to enhance resident care and safety, two issues need to be addressed. Firstly, it is not a truly graduated process, because inspectors can apply whatever remedy they want to any situation. Secondly, they will have unfettered authority to issue work and activity orders for everything from staffing to building renovations, without reference to ministry funding or a home's financial capacity. Bill 140 will legislate that lack of government funding is not grounds for appeal, and if a home cannot comply, government will have the authority to withhold or claw back the home's funding.

How is it appropriate that when government funds nursing care, and the home spends it all for this purpose, the government can then order them to add more staff? This absolute power will see care and accommodation standards increasingly being set by work and activity orders, and these standards will vary from region to region and home to home. Further, we fail to understand how reducing funding will benefit residents if a home is non-compliant.

1040

We urge you to amend sections 150 to 154 to provide a predictable and consistent sanctions framework, and to replace work and activity orders and financial penalties with more resident-sensitive remedies. These would in-

clude the power to impose external managers at the operator's expense.

Funding is a core issue and, admittedly, primarily a budget issue. Bill 140, however, does have significant funding implications for the ability of homes to meet its requirements. Most glaring are sections 8 and 9, which require homes to provide restorative care and recreational and social activity programs to meet individual assessed resident needs. We want to do this, but we know we will fail because it is impossible when government funds about 2.5 hours of nursing care a day and three hours or more are required, and only provides \$6.82 per resident per day for all activation, social work and therapy services.

At the same time, government is eliminating its commitment to fund what Bill 140 requires. The reference to this commitment in subsection 88(1) contains the wording "may fund." Existing legislation contains the commitment "shall fund."

I want to conclude with a comment on Bill 140's implications for system issues such as the hospital bed shortages created when hospitals cannot discharge alternative-level-of-care patients to long-term care. You likely are aware that the Kingston General Hospital may now start charging those patients \$800 per day. This is a complex issue, and the solution is larger than building more beds. It also requires measures that provide a strong, stable and effective long-term-care sector that is there to meet the needs of the community, including transferring people out of expensive hospital beds.

Instead, however, Bill 140 is creating huge uncertainty, diverting our limited staff to undertake more paperwork and making us accountable to do more, with no commitment to funding. At a time when it is becoming increasingly difficult to recruit and retain staff, we are creating a culture of blame and shame with Bill 140 that makes our sector less and less attractive to staff.

Please help us so that we are there for our hospitals, for our communities and for our seniors by making these important amendments to Bill 140 and committing to a plan for capital renewal.

Thank you for your time this morning.

The Vice-Chair: Thank you for your presentation. We have three minutes left. We can divide them equally among the three parties, with Ms. Martel first.

Ms. Martel: Thank you for your presentation today. The draft white paper asked questions about licensing. Can I ask what your association put forward at that time? Subsequently, after you did that, what kind of discussions did you have with the government with respect to proposals around licensing, if any?

Ms. Sullivan: We would have preferred to have our licences based on compliance with the legislation as it is now, a yearly licence, and we asked for a capital renewal program as well as an asset management program to set aside money so that we keep our homes up. We've now submitted an amendment to try to work within their fixed-term licence principle and still have some certainty within the sector so that we can ensure that homes are

there to meet the needs of communities, which we're very concerned about with the current—

The Vice-Chair: Thank you. The parliamentary assistant.

Ms. Smith: Karen, you will acknowledge that we do have an RFP out in Kingston and Sudbury and in a number—I think 10 in total—of communities across the province for new beds to address some of the shortages that you discussed, right?

Ms. Sullivan: You do, yes.

Ms. Smith: Also, I just wanted to ask you—on page 10, you talk about the “absolute power that will see care and accommodation standards increasingly being set by work and activity orders.” Can you expand on that and your view that this will create standards that vary from region to region?

Ms. Sullivan: We're concerned that an activity order could be, “You need to add more staff,” and if we're spending all of our nursing envelope, which is the funding that you give us, and an inspector can say—they attempt to do that now. They come to our homes and say, “We want you to add a shift in the night, because we see that you need more care,” except that we're spending all of our nursing envelope; we don't have additional money to spend. So we're concerned we're going to get those types of activity orders in the homes based on that piece of the law.

The Vice-Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much. I certainly can understand your concern, and I think the RFPs the government is talking about have just gone out now. The reality is, there's a huge problem in our acute care hospitals with people looking for alternative placements, including long-term care, and the government up until now has had absolutely no capital renewal plan. Unfortunately, this bill as currently written really does endanger even more the certainty of people who need long-term care being able to access a facility in a timely manner. I appreciate the compromise that you've put forward to the government regarding that requirement.

I guess the other issue that you're very concerned about, and we've certainly heard that as well, is the environment that's being created by some of this legislation and the impact it's going to have on staffing. We heard from the physicians this morning and I think you've indicated as well that it may become somewhat difficult to have the staff that is going to be required with some of the punitive measures and enforcement measures. Can you speak to that a little bit more?

The Vice-Chair: Sorry. Thank you very much; we don't have enough time. My apology.

ONTARIO STROKE SYSTEM

The Vice-Chair: The next presentation will be by the West Greater Toronto Area Stroke Network. Welcome. You can start whenever you're ready.

Ms. Nadia Hladin: Good morning. My name is Nadia Hladin and I am representing the Ontario Stroke System.

I'd like to express my appreciation and that of the Ontario Stroke System for the opportunity to provide input on this important legislation.

We are pleased to offer our advice and input to the Ontario government, particularly when we see that the government is moving in the right direction to improve our health care and long-term-care systems. However, our positive comments must be mixed with some cautions and constructive criticism. While we are pleased to see that the legislation attempts to clarify and protect the rights of long-term-care residents, Bill 140 does need some amendment to reach some of these goals.

Before we outline the problems we see and the solutions we suggest, let me provide some information about the Ontario Stroke System.

In 2000, following a three-year demonstration phase led by the Heart and Stroke Foundation of Ontario, the government of Ontario released Towards an Integrated Stroke Strategy. This report, prepared by a joint Ministry of Health and Long-Term Care and Heart and Stroke Foundation work group, outlined a comprehensive strategy to improve access to best possible stroke care.

There are now 11 regional steering committees developing and implementing regional plans for effective stroke care across the full continuum from prevention to long-term care. A provincial steering committee identifies and responds to province-wide issues and fosters collaboration. I am the chair of the rehabilitation and community engagement subcommittee of the provincial steering committee.

The Ontario Stroke System work with respect to long-term care includes the following:

(1) The development of best-practice guidelines. Our guidelines cover the complete care continuum.

(2) We recognized the importance of educating and supporting personal support workers in long-term-care homes. We developed the Tips and Tools resource, which we would be happy to share with you.

(3) Each region has a community and long-term-care specialist who is supporting collaborative work to address the needs of stroke survivors in their own homes, including long-term-care homes.

The Ontario Stroke System has a strong interest in health care legislation affecting the elderly because of the large role that stroke plays in that segment of the population. Stroke is the leading cause of disability in elderly people, affecting 85% of stroke survivors in their daily lives. In fact, over the age of 65, stroke is more common than heart attack, especially in women.

Despite our best efforts, this is expected to be a growing problem. The aging population and longer lifespans are making stroke more common. The residual effects of stroke can be very serious, not only limiting people physically, but affecting their ability to think, communicate, perceive, sense, and connect to others on an emotional or social level. The after-effects sometimes include depression and dementia. Not surprisingly, the caregivers of stroke victims are often deeply affected.

The good news is that a growing body of research is validating the important role played by rehabilitation of the victims of stroke. While the first 12 weeks usually see the biggest motor improvements, research is showing that patients can continue to improve as much as two years later, and those improvements can be sustained in the long term.

1050

Rehabilitative therapy is vital to improving victims' rate of recovery, their functional outcomes and the quality of life. Just as importantly, rehabilitation programs reduce morbidity and mortality rates. In short, rehab saves and improves lives.

We are very pleased to see that the patients' right to receive restorative care that promotes and maximizes their independence is written into this legislation; however, we are concerned that the term "restorative" is not defined anywhere in the legislation. As I am sure members of this committee can appreciate, failure to spell things out in legislation can lead to confusion and misinterpretation down the road. While physiotherapy is now available in many long-term-care homes, there are other types of services and therapies that could, and should, qualify as restorative. Those rehabilitation options should be spelled out in the legislation, providing a specific meaning to "restorative" in Bill 140. This list should include not only physiotherapy but occupational therapy, speech language pathology and social work. This would ensure that residents benefit from the clear intent of the bill, which specifies that a plan of care created by a licensee should cover "all aspects of care."

This brings us to what the Ontario Stroke System sees as the most important area of needed improvement in Bill 140: the need to match resources with intent. For example, it is wonderful to state, as this legislation does, that every long-term-care home should have an organized program of restorative care. It is even better to state, as Bill 140 does, that those programs must meet the assessed needs of residents and aim at promoting the greatest possible independence. However, who will make those assessments of those residents' needs? Who will decide what services or therapies will best promote their independence? Obviously, to meet the stated goals of the legislation, those decisions should be based on professional opinions, using solid evidence and best practices. Only then can we be certain that the best interests of residents are being served.

It follows that rehabilitation professionals working in or for long-term-care homes should have demonstrated knowledge and expertise to appropriately assess and treat the residents. And once the right professionals have decided upon the right care, we must make sure that residents have access to that care. There is no point in making expert assessments and designing perfect care plans if the residents are left on waiting lists or simply do not receive the services they need.

This is where the Ontario Stroke System believes that flexibility must be built into the legislation. Long-term-care facilities need flexibility to make the best use of

their limited resources, to minimize the bureaucracy and rules that might prevent giving the appropriate care. Again, we return to the principle here that residents deserve appropriate rehabilitation services that will improve their function, safety and quality of life. Let's make sure that Bill 140 does not inadvertently create barriers to care.

Long-term-care facilities should have the flexibility to offer specialized programs or services where there is sufficient demand and hope for helping residents. Pilot projects have found that these programs not only help residents but improve staff expertise and job satisfaction. For example, Castlerview Wychwood Towers in Toronto created a slow-stream rehab program for 40 residents who had survived severe strokes. At the end of the project, 16 of those residents were actually able to return home.

If a particular long-term-care facility cannot provide what, in expert opinion, is needed, then residents should have the ability to access services in the broader community. I want to quote directly from the preamble to Bill 140, where it states that the people of Ontario "strongly support collaboration amongst residents, their families and friends, service providers, caregivers, volunteers, the community and governments, to ensure that the services provided meet the needs of the resident."

The Ontario Stroke System agrees that collaboration is necessary to meet the goals. It will also be necessary to provide sufficient funding and resources so that access in real life matches the principle of the legislation.

Our evaluation report of the Ontario Stroke System, released last October, found that only 24% of acute stroke sufferers access in-patient rehab. The most severely affected stroke clients are not being treated in hospitals but are being discharged home or to long-term-care facilities.

In fact, nearly one quarter of all people suffering a stroke go directly to a long-term care facility after an acute hospital admission. What's interesting here is that in 2001, it was 8.9%. We did stats for 2005, and it was 22%. So it has gone up significantly in a four-year period of time.

Long-term-care facilities are rapidly becoming key stroke treatment centres. Our Ontario Stroke System evaluation report found that more than 19% of all long-term-care residents are stroke survivors. We need to make sure that they are getting the rehabilitative care they need, either in those homes or in the community. Yes, there is a cost to providing that level of care, but it is actually less than the cost of not providing that care. Access to appropriate rehab services early on actually decreases health care costs in long-term care.

This commonsense conclusion is backed by many studies, such as the geriatric rehab study conducted in long-term-care facilities in Alberta in 1996. It demonstrated reduced nursing costs due to reduced care needs where rehab services were optimized in a long-term-care setting.

Closer to home, a pilot study in the southwestern Ontario stroke region found that individuals with severe

stroke benefited from outpatient services. Thanks to the extra treatment, 43% more survivors of severe stroke were discharged back to their homes and 38% fewer were discharged to long-term-care facilities. Those numbers add up to real savings for the health care system and real improvements in the lives of stroke victims and their families.

Even for those residents who do go to a long-term-care home, those who have been given rehab treatments tend to need less staff intervention and support. Again, this results in both savings and better health outcomes.

The committee should consider how funding formulas could be changed to reward long-term-care homes for enhancing independence instead of encouraging dependence on staff.

I want to leave some time for questions, so let me conclude by congratulating the government on recognizing the important principle of access to restorative care and by urging the government to ensure that this principle is upheld in action and in the future by amending the bill.

Once again, I thank you for this opportunity.

The Vice-Chair: We have two minutes left. Mrs. Sandals.

Mrs. Liz Sandals (Guelph–Wellington): Thank you very much for your presentation. I have a very active stroke group in Guelph, and they've shared their concern around rehabilitation with me.

I'm intrigued by your concluding comment about considering how funding formulas could be changed to reward long-term care. You've talked about all the non-nursing supports that your stroke victims would benefit from. I'm wondering how you would see the funding formula rewarding access to those other services which I think you feel are really crucial for your folks.

Ms. Hladin: Our thoughts are that now the funding formulas are based on the amount of nursing care—the heavier the care, the more funding they receive—so it prevents people from wanting their residents to become more independent, because they will receive less funding. There should be a shift in the dollars to encourage independence and provide other programming etc. that they can participate in to offset the nursing costs.

The Vice-Chair: We don't have enough time for the other parties. Thank you very much for your presentation.

1100

ONTARIO MEDICAL ASSOCIATION

The Vice-Chair: Next is the Ontario Medical Association. You can start whenever you're ready.

Dr. David Bach: I am David Bach, president of the Ontario Medical Association and a radiologist in London, Ontario. With me on my right is Stephen Chris, the chair of the OMA working group on long-term care and a family doctor in Toronto, whose medical practice is dedicated to long-term care. On my left is Ms. Barb LeBlanc, the executive director of health policy at the Ontario Medical Association.

I would like to begin by commending the government for moving forward to consolidate the statutes that currently govern various types of long-term-care facilities. Having one act instead of four will bring much-needed clarity and consistency to the field.

Although I believe Bill 140 to be well-intentioned, it appears from the physician perspective to have two fundamental flaws. First, it does not reflect the reality of the medical condition of the average nursing home resident. Second, it seems to reflect a belief that the challenges in the nursing home sector can be resolved by the imposition of rigid rules and harsh punishments upon those who work in the field. There is now abundant evidence, drawn from many disciplines, demonstrating that this is not a successful strategy for system improvement, and we do not believe it will be successful in this environment either.

The general thread running through Bill 140 is one of mistrust of everyone who operates or works within a long-term-care home. In truth, the current problem with long-term care is primarily due to inadequate funding, as you've heard earlier. Despite this, quality health care services are delivered to long-term-care residents owing to the care and dedication of long-term-care staff. We will not discuss the funding issues further this morning, but it remains a significant problem.

A paternalistic and suspicious attitude manifests itself in numerous ways throughout the legislation, but is seen most vividly in the proposed mandatory reporting requirements. The act would impose a duty upon all persons coming into the home to report any perceived abuse, neglect, improper or incompetent care, or even a suspicion of any of these things, to a government civil servant. The implication here is that the staff in the long-term-care homes are non-caring, incompetent or ruthless, and therefore in need of intense monitoring. This flies in the face of the entire patient safety movement and its shift away from "naming, blaming and shaming" towards looking at means to improve processes and systems. Given this government's stated commitment to patient safety, it is discouraging to see a potentially promising opportunity to embed these values into our long-term-care system lost.

We believe that Bill 140 should be amended to better reflect and utilize the current state of knowledge with regard to quality management and to reflect the government's stated commitment to advancing this philosophy. This would require a clear commitment in the legislation towards advancing continuing quality improvement within nursing homes.

Moving from the philosophical to the practical for a moment, we also worry that the proposed reporting system may result in overzealous reporting in light of the threat of \$25,000 or \$50,000 fines or even imprisonment. The OMA would rather see clear and focused reporting criteria that deal with sentinel events, coupled with a well-resourced government body to investigate and deal expeditiously with real problems.

We know that patient safety principles and individual accountability are not mutually exclusive. The patient

safety paradigm clearly supports action against individuals where there is malfeasance, abuse or genuine neglect. It recognizes, however, that most errors and omissions in complex systems, be they commercial air travel, nuclear power or health care systems, are the result of system failures, even when they manifest themselves in the action or inaction of a particular individual. The government's current compliance and inspection system is in no way prepared, either by philosophy or expertise, to deal with problems using patient safety tools, and indeed, as government agents, they are not the appropriate body to do so. The OMA recommends that the current government program remain in place to deal with serious events and allegations of abuse or neglect, but that other matters be addressed through a strengthened focus upon quality assurance within long-term-care homes.

I would now like to turn the microphone over to my colleague Dr. Stephen Chris to talk about the OMA's concerns about Bill 140's impact upon health care for residents of long-term-care homes.

Dr. Stephen Chris: Quality of life for the frail and vulnerable segment of our population living in long-term-care facilities is directly related to health, and it is essential that attention be given to issues around the care and treatment of nursing home residents, virtually all of whom have multiple health problems. The Ontario Medical Association calls upon government to commit to the health of our seniors by acknowledging, as a fundamental principle, that residents' health care needs will dictate the care and treatment they receive, including their placement within the home, as well as movement in and out of the home as their health status changes.

It is evident from the introductory paragraphs that Bill 140 has not been written with a view to improving the care provided to residents of long-term-care facilities, and the OMA finds this omission disturbing.

A commitment to care includes fundamental issues like safety for both individual residents and the residents as a whole. Preventing a home from moving a resident to a secure unit even with family consent, until such time as they have met with a rights adviser and, where requested, had a hearing before the Consent and Capacity Board, puts the safety of the individual at risk. Depending on the circumstances, the safety and security of other residents, as well as visitors and staff within the home, may also be placed at risk. While the OMA agrees that greater attention needs to be given to the utilization of restraints and secure units, we believe that the real problems in this area would be better addressed by means of expanded geriatric assessment services and better access to specialized geriatric behavioural treatment facilities.

The act does attempt to deal with the care of residents in the section relating to plans of care, but again, instead of creating an enabling environment to promote and enhance interprofessional care, the bill is prescriptive and bureaucratic. The OMA recommends that Bill 140 be amended to promote interprofessional care by means of shared input into each resident's overall care plan. Such

plans would be reviewed annually, or more often if required. There needs to be a distinction, however, between this broad plan and all of the detailed program- or discipline-specific plans that would fall under it. The treatment plan is one such subset, and although there are clearly some issues relating to a resident's medical status that are of general interest across programs within the facility, such as the onset of type 2 diabetes, there are other health matters that should not be widely shared, and the OMA strongly supports patients' rights to privacy as outlined by this government in the Personal Health Information Protection Act, 2004. We believe that the proposed plan-of-care provisions in Bill 140 need to be amended to support its practical application and to protect residents' rights.

Before turning the microphone back to Dr. Bach, I would like to conclude on a personal note. As a medical director at four homes in Toronto, I am responsible for the quality of medical care in these homes, and I have to say that I felt very discouraged reading this legislation. I am left with the feeling that the services of physicians are not valued, and I worry that others will have the same feeling. Why would I want to subject myself to a demeaning work environment where I am constantly worried about the possibility of being the subject of a frivolous or vexatious complaint? Why would my colleagues feel any differently? I am genuinely worried about the message that this legislation sends to physicians, and I hope that you will listen very carefully to our concerns. Thank you.

Dr. Bach: In our view, this bill, if unchanged, will represent as significant a failure of public policy as the decision to shrink medical school admissions over 10 years ago; that is, the consequences are not immediate but will be dramatic and will be difficult to reverse once recognized.

I will close by saying that the OMA believes that Bill 140 would benefit from a review that places residents' health care needs on an equal footing with the various rights that are outlined in the act. From our perspective, the right to enjoy the best possible health is a fundamental human right and should be supported, not undermined, by government legislation.

In addition to our verbal comments today, the OMA has prepared a written submission which outlines a number of concrete areas for change. Although it is difficult to amend the tone of the legislation, we urge this committee to make amendments in key areas to make the bill less mean-spirited towards the dedicated people who work in an increasingly complex and difficult environment.

Thank you for your attention. We are pleased to take questions.

1110

The Vice-Chair: Thank you, Dr. Bach and Dr. Chris, for your presentation. Now we will open the questioning. You have about four minutes. We'll divide it between the two parties.

Mrs. Witmer: Thank you very much, Dr. Bach, for your presentation. Actually, it's quite concerning to see

the statements that you've made, particularly when you say this is going to be as significant a failure of public policy as the decision to shrink the medical school admission 10 years ago, and I think we are hearing this morning that the bill is mean-spirited and is naming, blaming and shaming the dedicated people who are working in the environment. That is of personal concern to me, and obviously other people. How can the government make specific amendments that would change that tone, and do they need to rewrite other parts of the bill in order that it reflects the need to move forward in a different manner?

Dr. Chris: Our written presentation goes over some of the specific sections that we think should be amended, but I agree that it is very difficult when the underlying tenor of the bill from beginning to end will create problems for staffing in homes. I would personally prefer to see the bill reviewed again with the input of all of those of us who will be affected in our day-to-day work.

Mrs. Witmer: Did you have input into this legislation already?

Dr. Chris: I don't believe we had input in the drafting process.

Interjection: Did you want to respond to that?

The Vice-Chair: Thank you very much.

Interjection: If we could—

Ms. Martel: If you just want to respond, and then I'll ask you my questions.

Ms. Barb LeBlanc: We were involved in the earlier consultation phases, but unfortunately, as we volunteered to have meetings with the government as they were drafting and pre-drafting, they did not choose to meet with us.

Ms. Martel: Thank you for your presentation today. You've mentioned amendments in two areas, and we don't have the written submission—at least I don't; maybe the others do—so maybe off the top you can tell us: One was an amendment to better reflect and utilize the current state of knowledge with regard to quality improvement, and the second area had to do with protecting residents' privacy rights. I wonder if you can just give us a flavour of the proposed changes.

Dr. Chris: The whole modern area of quality improvement in complex systems is a rapidly advancing area of knowledge. This bill uses the old-fashioned, almost mid-20th-century attitude of punishing people for errors, rather than looking at how errors can be used to improve the systems themselves. I think the OMA is proposing that there be quality improvement measures written into the bill.

The Vice-Chair: Thank you very much, Dr. Bach and Dr. Chris.

ASSOCIATION OF MUNICIPALITIES OF ONTARIO

The Vice-Chair: The next presentation is the Association of Municipalities of Ontario. Mr. President, welcome.

Mr. Doug Reycraft: Thanks, Mr. Chairman. It's good to see you again. My name is Doug Reycraft. I'm mayor of the municipality of Southwest Middlesex, a county councillor in Middlesex and president of the Association of Municipalities of Ontario. With me this morning is Petra Wolfbeiss, who is a policy adviser with the ministry.

I want to begin by saying how much AMO appreciates the fact that these hearings were delayed until after the Christmas break. I know that at one time it was contemplated that they'd be dealt with before Christmas, and between the new Municipal Act and some other things, we had our hands more than full at that time. We appreciate the fact that we've had time to prepare for the hearings on this bill.

I want to make a few observations that AMO believes are very important.

First, I believe we all recognize that the quality of life, safety and well-being of residents in Ontario's long-term-care facilities is a top priority for the province, for our communities and for the people of Ontario.

Second, I know we agree that individuals, private and not-for-profit agencies, and governments providing services to vulnerable populations must be truly accountable for the quality of care they provide.

Third, I think it is widely recognized that municipally operated homes for the aged do an excellent job, under the current legislative framework, of providing the highest quality services that routinely exceed provincial standards.

Fourth, and perhaps less widely recognized, Ontario's municipal governments go far beyond what they are required to do in law by investing a net \$270 million a year of municipal resources in the provincial long-term-care system through the funding and operation of homes for the aged. They do so because they recognize the need for services in their communities and because provincial funding for the provincial long-term-care system is woefully inadequate. In Middlesex county, the municipal subsidy to this provincial program will be over \$825,000 in 2007 for 160 beds in a brand new facility in Strathroy. That's over \$5,000 per bed per year, and that's much lower than, perhaps less than a third of, the average experienced by counties and regions across this province.

My final observation is that, given what I have just said, it is surely not the intent of this bill to encourage municipal governments to vacate the industry to the greatest extent possible, yet that is the concern that is being expressed among municipal governments today.

While we believe the government's intentions are laudable, our assessment of the bill itself is that it is excessively heavy-handed when it comes to regulating the operation of homes for the aged, with many of the measures having nothing whatsoever to do with the quality of life, safety or well-being of our residents.

In the case of municipally operated homes for the aged, to put it quite simply, this bill sets out to fix something that is not broken. The result is a level of liability exposure for municipal councillors and property tax-

payers that is unprecedented in Ontario's legislative history. As the bill reads currently, municipalities would be well advised to reduce services and investment in Ontario's long-term-care system and provide only the minimum mandated level of service to their communities.

And there is another result. By compounding the current administrative responsibilities of those operating homes for the aged without increasing provincial funding in the system, the bill will require administrators to reallocate resources away from patient care to administration, with a consequence of reduced services. Surely it is not anyone's intention to reduce the number of beds in our communities by taking a heavy-handed approach to addressing a problem that does not seem to exist in the municipal operation of provincial long-term-care services.

Before I address a number of specific concerns, I would like to provide the committee with some contextual information.

Municipal governments operate over 16,500 beds in long-term-care homes in Ontario. That is nearly a quarter of the total beds in this province. In any given year, that is over six million days of care. As I mentioned earlier, municipalities also invest a net \$270 million of property tax revenues per year into the operation and capital development of their long-term-care homes. That averages over \$16,000 per bed per year.

As the most accountable of the three orders of government, municipalities operate under significant scrutiny. As a mayor and municipal councillor, I can tell you that poor service or poor standards in a municipal facility would not escape this scrutiny.

As the minister has acknowledged, municipalities are not only leaders in long-term care but committed to the provision of quality long-term-care services. Yet, over the years, municipalities have seen the increased cost of new standards without corresponding provincial funding support.

And finally, by way of context, the government's commitment to increase operating funding to \$6,000 per resident per year, as expressed in its 2003 election campaign, has not been achieved.

The bill places great emphasis on the enforcement of standards. AMO agrees that administrators of homes for the aged must be accountable. But the bill will require administrators to spend a great deal more of their time and resources on compliance and documentation, and unless the government provides additional funding, homes will be forced to apply even more of their limited resources to meeting all the new administrative requirements.

Without provision for additional funding from the province, the act will lead to existing staff resources being reallocated to administrative and other non-resident care activity. That means less money will be getting to the care of residents.

1120

Bill 140 would create unprecedented liability for municipal councillors, municipal governments and their

property taxpayers through its heavy-handed approach to the issue of duty of care.

Section 67 is a remarkably blunt instrument. It would set out a requirement that a committee of management or board of management for a municipal home for the aged will "take all reasonable care to ensure" that the operation of the home for the aged "complies with"—and emphasized—"all requirements under this act." Every person who fails to do so would be "guilty of an offence." That means, without any exaggeration, that if a municipal councillor or a member of a board of management cannot demonstrate "reasonable care" to ensure that the administration of the home meets even the most minuscule administrative requirement of a regulation that we've not yet seen, the councillor or board member is guilty of an offence.

This section is not about offences related to the specific wrongdoing, such as failing to report an incident of abuse; those serious matters are dealt with directly in the bill. In fact, this section is not about safeguarding the rights or interests of long-term-care residents. This section is a catch-all of liability that would make anyone think twice about operating a home for the aged or running for a seat on municipal council.

The penalty set out in the bill includes a fine of up to \$25,000 or imprisonment of up to 12 months for a first offence. Furthermore, this section will likely be a significant barrier to recruiting and retaining directors. Interestingly, the penalties far exceed similar accountability sanctions for members of hospital boards under the Public Hospitals Act, imposing harsher offence provisions on the board members of homes than on those serving on hospital boards. If this is the road the province is choosing to travel, it would seem reasonable to align the offence provision under Bill 140 with the Public Hospitals Act.

I want to turn for a moment to issues of standards and licensing. AMO appreciates the need for the ongoing upgrading of homes, but the fact of the matter is that there is no evidence that there is any problem with the maintenance or upkeep of facilities in the municipally operated homes sector. This begs the question of why Bill 140, in sections 150, 151 and 156, would provide ministry officials with the authority to order municipalities to undertake upgrading and other work as a condition of licensing. This authority could be used by the ministry to require municipal governments to make any number of unbudgeted and perhaps unnecessary expenditures without recourse. If this committee agrees that municipal governments are accountable and responsible, then surely giving such sweeping authority to the ministry is unnecessary.

These provisions that I've raised act as disincentives to the expansion of long-term-care services and fail to recognize that it is municipalities and municipal revenues, not provincial standards, that are what is holding the provincial long-term-care system together and filling a quarter-of-a-billion-dollar gap in provincial health care funding.

The future is quite clear regarding long-term care in Ontario. For the municipal role in the province's long-term-care system, Bill 140 appears to be moving the sector towards fewer beds, reduced funding for care, greater risk and greater costs. AMO and many others in the sector foresee an overall erosion of quality, resident-focused long-term care in the province.

What is clearly missing in Bill 140 is a statement that commits the province to preserving and promoting long-term care through adequate and sustainable funding. The government must consider that any new or enhanced standards must be accompanied by appropriate operating funding and must consider the added financial burden that will be placed on homes for the aged and municipalities as a result of the new requirements. The government must, at a minimum, increase operating funding by that amount.

AMO's position on which order of government should be funding provincial health care services is, I think, well known. Until we have achieved our goal of good public policy and good fiscal policy in Ontario, please do not undermine our ability to deliver provincial services effectively. Implementation of Bill 140 without appropriate and sustained provincial funding bodes poorly for the future of long-term care in Ontario.

Finally, let us not undo the good and productive work between AMO, municipalities and the province as a result of legislation that, on the face of it, is designed to fix a problem that doesn't exist, legislation that fails to recognize the municipal contribution to the long-term-care system in Ontario.

We look forward to building on our successes to ensure that long-term-care legislation meets the needs of our vulnerable residents in a sustainable and realistic manner. We urge the committee to consider the important matters that we have raised today.

The Vice-Chair: Thank you, Mr. President. We have three minutes left. We'll start with Ms. Martel.

Ms. Martel: Thank you for being here this morning and for the presentation. I must say that the presentation is pretty blunt in its concern with respect to the municipal sector's view of where the government might be heading in terms of actually losing spaces. So let me ask you, what would be the three things—I'm not trying to provide a trick here—the top three things that the government could and should be doing with respect to the legislation which would remove both that perception among municipalities and also that potential among municipalities?

Mr. Reycraft: Certainly recognizing in the bill the contribution that municipalities and their taxpayers make to long-term care in the province would be important. But the additional administrative requirements, if they can't be reduced, need to be recognized in the form of funding to municipalities so we don't have to further burden their property taxpayers paying for health care service, which we believe should be properly funded through income and sales tax revenues that the province has available to it.

Secondly, we believe that the penalties that are described in the bill are draconian and need to be more realistic and, we've suggested in our presentation, consistent with those that apply to board members of public hospitals.

The Vice-Chair: Thank you. Parliamentary assistant.

Ms. Smith: We have heard your concerns on that point. I would note that in the previous legislation, municipalities managed their homes under approvals, and it was AMO's point of view or the municipal homes' perspective that they wanted to continue under that regime, and we have in fact continued under that regime. That does not give us any kind of renewal period or period of time when a home's licence would expire and we would have an opportunity to discuss with them what needed to be done with the home. That's why, in fact, we've introduced the concept of orders around needing to do upgrading in the homes. What other suggestion could you make that would allow us the flexibility to have that discussion around upgrades where you're not looking at a licence term or any kind of fixed period of time?

Mr. Reycraft: It's my understanding from the legislation that there is no recourse to appeal for any of those orders that might be extended, and I think including that in the bill might be something that would be helpful to municipalities where they disagree with orders that are made on them by provincial inspectors. I understand the problem in the past with respect to the agreements that have been entered into between the ministry and the municipalities. Our experience in Middlesex is usually that we sign those agreements about six months after the year in which they apply. But I would go back to my basic point, which is that there isn't evidence of neglect or wrong-doing or inadequacy within the municipal long-term-care sector. I think municipal governments across the province do a superb job in delivering those services.

The Vice-Chair: Thank you. Mrs. Witmer.

Mrs. Witmer: Thank you very much, Mr. Reycraft. That's an excellent presentation. I know in my own community of Waterloo our municipality does an excellent job of looking after the needs of citizens who live in the home that they manage. I find it interesting—you say here that the bill, the legislation "is designed to fix a problem that does not exist." You refer to the bill as being heavy-handed. One of the things you've stressed is that if some of this is to be implemented, obviously there's a need for adequate and sustainable funding. Does the government need to look at dealing with the not-for-profit municipal homes differently than the other homes? Are you suggesting this in some respects? You're saying that the stock could shrink; people aren't going to want to move forward.

Mr. Reycraft: The additional administrative responsibilities that are going to be required as a result of the bill are going to have the consequence of either increasing costs or reducing care that's available to residents or—what we would hope for—increased provincial funding to cover the additional costs that municipalities are going to incur. The numbers I provided underlying

financial support for homes for the aged I think suggest that municipal homes for the aged are a different category of health care than the private homes and I don't believe should be subjected to the same kind of legislation and regulation.

Mrs. Witmer: Okay, that's what I thought I heard you suggest.

The Vice-Chair: Thank you very much for your presentation.

1130

SENIORS' HEALTH CENTRE,
NORTH YORK GENERAL HOSPITAL

The Vice-Chair: The next presentation will be by the Seniors' Health Centre, North York General Hospital. You can start whenever you're ready.

Ms. Helen Ferley: Good morning, everybody. My name is Helen Ferley and I thank you for the opportunity to meet with you today. I'm administrator at Seniors' Health Centre, which is a 192-bed long-term-care home run by North York General Hospital. One board operates the total hospital, and we do have charitable status. I am an RN by profession and I'm also a surveyor with the Canadian Council on Health Services. Due to my clinical experience, I survey across Canada and I survey both, on the acute side, the rehab complex continuing care and long-term care.

I do want to recognize the work that's been done so far to Bill 140, but in the absence of time, I'm not going to comment on the strengths of the bill; I'm going to keep my comments to areas that may need—

Mr. Bill Mauro (Thunder Bay–Atikokan): Motion for extra time.

Ms. Ferley: The first area I would like to comment on is resident/patient flow. We all know that flow is not related to one area of the health care system and that it has a domino effect. If something happens, it can slow down the whole system. The implications of Bill 140 around admission to a secure unit may well have implications on patient/resident flow across the system. There probably will be a time delay, there probably will be an increase in ALC bed times on the acute side and there may well be an increase in the vacancy rates in the secure unit while the paperwork is being done.

Interestingly enough to note, in Bill 140 there are a lot of details around admission to a secure unit, but there's no reference to what happens if the POA refuses the admission on behalf of the incompetent person.

Very quickly, I'd just like to talk about the assessments of applications. Notice that Bill 140 does now require assessments to be current within three months. It also requires a written notice that a reassessment has been reviewed; behavioural history for the last year has to be included, and the mental health history requirements have to be included as well. I just have a concern with how, realistically, all this can be given, given the system at the moment. If this does stay in, obviously there will be an impact on time and workload.

Very briefly, I'll talk about licensing—you've heard a lot about it this morning. But from a charitable organization, licensing may have some impact on the ability of the facility to fundraise, because many donors will give an endowment, where the money comes in on a regular basis over an extended length of time. If there is inconsistency and uncertainty, it may impact on the ability of the charitable organizations to fundraise.

I'd now like to spend some time talking about quality outcomes. I think there is a real commitment by many of us who really enjoy working in long-term care to the safety of our residents and the quality care we can provide. When I read the Bill of Rights, number 12—that restorative care is there “to promote and maximize independence to the greatest extent possible”—my comment, based on what was said earlier this morning, is that that “restorative care” is broader than “rehabilitation.” Restorative care is a concept in long-term care, not a particular program. It's a concept that's intertwined, interlaced across all the disciplines and across all the programs.

I'll just tell you very briefly a short history of a research study that was done on restorative care. A nurse practitioner did research on a small number of residents, asking them what meant a good day to them and what meant a poor day to them. The findings of that small survey were absolutely startling to us. What they said was that they wanted the freedom of choice so that they could use their limited energy to do what was of interest to them. One resident, for example, did not want to be kept with the one person and transferred on and off the toilet; she wanted to be mechanically lifted. The reason for that was she wanted her energy so that she could lift the phone and speak to her daughter. Another resident who was very complex did not want to wash herself in the morning, and the reason was she needed her energy, which was limited, to read her book for extended periods during the day. So given the fact that we probably lose 20% to 40% of our residents in a year, restorative care differs in very many levels across the whole concept of care.

If we're looking at restorative, long-term care is now looking at chronic disease management, with health promotion within chronic disease management, rather than actually going through rehabilitation-restorative.

Just briefly on the quality reviews, it's in Bill 140 that inspectors now will have access to all information. All long-term-care facilities, mine included, really want to develop a culture of openness and transparency, where near misses, mistakes and that are openly discussed and brought forward. We need to be able to support our values. My values are listening, learning, leading and serving. I have to have the ability to support those values through an open culture, so I'm suggesting that long-term care be allowed to continue under the Quality of Care Information Protection Act.

I support satisfaction questionnaires 100%, but if they continue to be done in a decentralized fashion as they are at the moment, with each home doing their own, I think we lose the strength of the results of the satisfaction

questionnaire. So I strongly promote that a satisfaction questionnaire is done province-wide through a centralized approach.

Funding: You've heard a lot about it, and I'm just about to say that this legislation must be backed with adequate funding and resources.

On governance, I was pleased to hear the presentation before talk about the responsibilities and liabilities for board members, and just encourage this committee and government to look at having consistency across the acts, such as the Public Health Act and the Nursing Homes Act.

I'd like to spend a few moments talking about rights and responsibilities. As I read through the act a couple of times, I noticed quite markedly that there was variance, and not a balance between rights and responsibilities. I think the rights and responsibilities have to not only support our residents, they have to also support the professional staff in the home so that they can definitely use the full scope of their professional abilities. Also, they have to support what the crown expects.

For example, residents have extensive rights. They can enforce a bill of rights against the licensee in subsection 3(3). The licensee has extensive responsibilities. For example, they do not have the right to relocate a resident even if he or she acts maliciously; subsection 24(3). The inspectors, as has already been mentioned, have extensive rights. They can give an order to do or refrain from doing anything, and they can also direct the licensee to perform any work or activity that is necessary in the opinion of the person making the order. So our concern is around responsibilities and rights, that there has to be a balance, and the subjectivity around some of the way this is written should be reduced.

From a closing comment point of view, I do recognize the work that has been done. We recognize that there are very strong points in this act. I think all of us who work in long-term care and really enjoy it really want a strong process there so that we can give good care and so that we can feel proud of working in the environment we do. But when I look at the act as it is written at the moment, a lot of policy is moved into legislation. It's quite descriptive, and it's quite directive. My question is, how can descriptive, directive legislation be adaptive in the future, when in this world changes come very quickly and changes probably will continue to come within the health care system?

When I ask myself what one measure would be necessary to make this act truly realistic out there, so that the act could be a cornerstone for long-term care, so the act would respect the residents' rights, would make a difference and would build community confidence, I am in total agreement with everything that has been said before me by the other presentations. There will need to be a lot of funding and resources put in to support what this act is expecting.

Thank you. I know I've rushed through that.

The Vice-Chair: Thank you very much for your presentation. We have six minutes left. We can divide

them equally among the three parties. We'll start with the parliamentary assistant.

Ms. Smith: You commented on the consistency of governance when you were talking about the governance issue. Can you just expand on what you meant by "consistency of governance"?

Ms. Ferley: The governance when it was relating to liability and responsibility for the board members? The Public Health Act has a different expectation than Bill 140 has. Because an organization such as our own has one board for both the long-term care and for the hospital, and there are other organizations which are in a very similar position to ours, I would suggest there was a consistency there between the two.

Ms. Smith: Okay. I missed a little bit of your presentation on restorative care, but you were talking about the choice and the need for choice for the residents. I'd just point you to the plan-of-care provisions in the legislation, where we've actually mandated that there be resident involvement—as well as their substitute decision-maker or their family member—in the development of the plan of care and that it also be collaborative between all of the professionals and front-line workers who are involved in the actual activation of the plan of care, so to speak. Is that the kind of thing that you would support?

1140

Ms. Ferley: I would definitely support it. It's just the wording of that bill of rights, number 12, that restorative care is "to promote and maximize independence to the greatest extent possible." When I use it on a personal basis, if I went to a trainer today and they said, "I'm going to maximize your potential, and you're going to be back and run 20K"—I don't want to run 20K. So I'm just concerned about the wording here, that it's to "maximize independence to the greatest extent possible." I think it needs to be qualified based on the resident's wishes or something.

Ms. Smith: The bill of rights is actually there to ensure or entrench the rights of the resident, so it would be up to the resident to use that to enforce it. So if they feel that their restorative needs are being maximized, in whatever way that is, then that's meeting that—

Ms. Ferley: Also, restorative care is a concept rather than a program.

Mrs. Witmer: Thank you very much for your presentation. I appreciate the experience that you bring to the table.

You talked about the need for the bill to be more flexible; maybe you could expand on that. You also talked about the need for better balance between the rights and responsibilities for residents, staff and inspectors. Can you expand on that? What is your perception of the role of the inspectors in this legislation?

Ms. Ferley: When I read about the role of the inspectors in this legislation, it appears to be an inspector type of role rather than a supportive one. I think the health system, in a broader context, has moved to safety of people and to supporting and more open encourage-

ment. To me, the conflict is that within the home, we're trying to have an open, home-like environment, where there is openness, where there is encouragement to bring forward near misses, where there is encouragement to discuss issues, and then on top of that, outside it, we've got this more directive, prescriptive approach. There is a conflict between the two. Go into different organizations; you don't hear legislation mentioned in complex continuing care when you're out there. You don't hear legislation mentioned that much on the acute side. But if you walk into a long-term-care home, within the first hour there will be some comment around the strictness of legislation. That is where I would like to see balance: where there is the ability for the home to still have the broad guidelines, that they do a really good job in line with residents' rights and in line with residents' wishes, but at the same time have a more supportive environment to do it in rather than a punitive one.

Ms. Martel: Thank you for your presentation here this morning. I want to focus on the funding, because you said several times—and in fact at the end you summed it up by saying what measure would make this realistic, and that is that there be the funding in place to back up what the government is requiring. In your own organization, have you tried to sort that out or cost that?

Ms. Ferley: Because we're not-for-profit, my nursing envelope is always over budget by a couple of hundred thousand dollars a year, which is supported through the accommodation envelope. Even with that support, the RN hours in my organization are 14 minutes per resident per day, and an RPN is 21 minutes per resident per day. Their job includes all of the non-professional duties within that time frame. From professional staff, the amount of time per resident per day is absolutely minimum. My health care aides are working one to 10 on days, one to 13 on evenings, and one to 20 on nights, for complex continuing care, where we're getting many people from the complex side who are not now meeting the MDS requirements in the complex organizations, who are now coming in to long-term care. The care at the bedside level is not adequate to support either the professional side or the non-professional staff.

Ms. Martel: So if you have to take money from somewhere to deal with administration, you're already supplementing that personal care envelope.

Ms. Ferley: We're supplementing the personal care envelope. Last year it was over \$300,000, and this year I'm still in the same bracket. That all comes from—as a not-for-profit, I can put that into it. I don't buy any equipment from that either. It is pure salaries and supplies for care.

The Vice-Chair: Thank you very much for your presentation.

NATIONAL PENSIONERS AND SENIOR CITIZENS FEDERATION

The Vice-Chair: The last presentation is the National Pensioners and Senior Citizens Federation. Sir, you can start whenever you're ready.

Mr. Art Field: Thank you for letting us come here. I want to explain that I had a handout for you that was prepared by a friend of mine.

Our organization is a national organization. It's a voluntary group. It comes from across Canada. In the bio that I gave you, or the brief, as it's called, is a list of our executive. The secretary is in Saskatchewan. There are two people in Newfoundland, and the second vice is in Nova Scotia. The treasurer and myself, the president, are from Ontario.

When I go to conventions, I seem to draw the time to speak at 11:45. When you're at a seniors' convention, you don't want to go over your 15 minutes because they're ready for lunch, and I'm sure you guys are too, so I'm not going to be long.

I'll just give a bit of background. I live in Little Britain, Ontario, which is near Lindsay. Now it's called the city of Kawartha Lakes. It has a high density of seniors; some are very affluent and some are not. There are quite a few nursing homes there. This is why I am interested. But I'm also interested because, at our convention that we have every year, we have a lot of resolutions on health care, on nursing homes, and they're from all across Canada, obviously. There seem to be lots of problems. The problems are the same; it's just that they're in different parts of the country. So we're just trying to help the committee here to establish better care.

It's amazing that Ontario doesn't have any time limit for care but Alberta, Saskatchewan, Nova Scotia and all of those have some time. I hope that you can put it in. Hearing the two people before me, I guess it's money. We now have more people in nursing homes than we've ever had before, so obviously we need more money. They need to be looked after better because of the situation.

My father was in Victoria Manor, which was in Lindsay. The care was good, it was acceptable, but I saw days there when I would go in to visit—in the end I was in feeding him—and the floor would be extra dirty or not cleaned because of the shortage of staff. That's also part of care, of looking after—the place has to be clean. I realize that if there's a shortage of staff, they have to prioritize what they do. That's what I think the bill has to do to look after things. As I said, our organization is from across Canada.

The other thing: I see in the paper the food costs. If you live in a jail, you get more money for food than you do if you live in a nursing home. There's something wrong here and I hope the committee can change that.

Other than that, you have my short brief. I'll answer any questions if I can and we'll let you go to lunch early.

The Vice-Chair: Thank you very much for your presentation. We have a lot of time for questions. We'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for coming forward, Art, to make this presentation. You've indicated here that, regrettably, this bill is going to create a huge amount of paperwork for the staff and, at the same time, it's not going to do that much to increase the level of care

or of programming for the residents. What suggestions would you have for the government to make changes? What would you suggest they do to kind of tilt the balance the other way?

1150

Mr. Field: In this society now, we seem to have less workers, less people and more technology. It seems to make it longer and harder to go through it or get done. If the government is demanding, as the lady before me said, more administration work, then obviously they should have more money there and hire more people. As a society, if we are all not working, then nothing is going to work. I guess I didn't tell you my background. I was an auto worker in Oshawa for 35 years, involved there in the political process, involved with the union. All they're doing nowadays is cut, cut, cut, cut. They're doing it, and some of our administration buildings are doing it, and the government. We've got to stop somewhere.

On my side are my grandchildren and your grandchildren, and for some of you people it's your own children. If there are no jobs for them, we're not going to survive, never mind being able to supply support to our seniors who need it.

Mrs. Witmer: Thank you very much for coming forward.

The Vice-Chair: Ms. Martel?

Ms. Martel: Thank you for driving here today to make the presentation.

Mr. Field: Today's better than yesterday.

Ms. Martel: You've got that right, Art.

You mentioned at the start that Ontario doesn't have any rules or standards in place with respect to how many hours of care would be provided to a resident and that other jurisdictions do. Of course, the Liberals promised to do that in the last election, and now they're not living up to that promise. From your perspective, why is it important that there be some rule, some standard, around even the minimum level of care that a resident should be expected to receive?

Mr. Field: It's like everything else, I guess. It's a shame that you have to put these rules there, but if they are not there and there aren't criteria for the management or the worker to follow and you're short-staffed, especially in the private ones, then—because the bottom line is profit. So if they can get away with it, they will. Obviously, that's why there are rules. Other provinces have put in rules so that they have to supply a certain amount of staff care per day, which is sad, but we have to look after—if we're supplying, as a government or as a taxpayer, places for people to live, they've got to live in dignity, regardless of their financial background or whatever.

Ms. Martel: And of course “minimum standard” means just that, only a minimum standard to ensure some level of care. For those people who need more, you would expect, of course, that they would get more and that by having a minimum standard, you're not taking away from those people who might clearly need more care as well.

Mr. Field: No, I would hope not. But it's sad that we have to put in a minimum standard because the system is not allowing the worker, the caregiver, to perform her or his duties to the standard that they want.

Ms. Martel: Because there's not enough staff?

Mr. Field: Because there's not enough staff.

The Vice-Chair: The parliamentary assistant?

Ms. Smith: Just a follow-up on your discussion about minimum standards: Don't we run the risk, if we have a minimum standard, that we'll have people working just to that minimum, and those who actually need more care may not be getting that level of care?

Mr. Field: I suppose you could call it management's prerogative to make sure that the caregiver or worker does the job that has to be done. So some people maybe only need minimum and some need more. I guess if you're making it a law, then it means that it should be done and there's a background for somebody—the family—to make sure of getting their parents looked after properly.

Ms. Smith: Right. In the province over the last three years, the government has made some substantial investments into long-term care. I know you mentioned that there are a number of homes in and around your area. We've actually hired about 4,900 new front-line workers, including about 1,100 nursing staff. In your visits to the homes in your area, have you seen any improvement in those areas?

Mr. Field: To be truthful, my father passed away in the home he was in, and it's sad to say that I haven't been into the homes since then. I'm just going on the bit of information on friends who have gone—I have friends who work in the homes also, but I'm not going around and being Art the cop to see what's going on, because I don't have the time. I wouldn't mind doing that, but I don't have the time because of the other things that I have to do.

Ms. Smith: Absolutely. I appreciate that.

I wanted to talk for a minute about your comparison on the food costs and just put to rest that myth that keeps getting out there about the level of expenditures in prisons versus long-term care. The numbers that have been put out there were actually apples and oranges. Just for your information, in prisons the \$11.43 per day per inmate is actually the cost that includes raw food and preparation and service; a comparable number in long-term care, using comparable inputs, is about \$18.10, so in fact we spend more on our long-term-care residents than we do on our inmates, just to be clear.

I want to thank you for coming in today, and actually I want to thank you for explaining where Little Britain is, because I saw that on the agenda and I wondered where it was. So thank you so much for your interest.

Mr. Field: Just to comment on the food cost, I agree with you, but something like that gets out and the first thing the senior sees, or your neighbours who aren't seniors—it's, “Look at this. The government is doing” whatever. It's a hidden thing, but that's part of what goes on. It's called image, I guess, or press releases or

promoting what we do. That was promoted for some reason, and then obviously you know how that goes.

Ms. Smith: Absolutely. Thank you.

The Vice-Chair: Thank you very much for your presentation. Now we will recess until 1 o'clock sharp.

The committee recessed from 1156 to 1306.

ONTARIO COUNCIL OF HOSPITAL UNIONS

The Vice-Chair: Good afternoon, ladies and gentlemen. We'll start with the afternoon session. We have with us many of the presenters; first, the Ontario Council of Hospital Unions. You know the procedure. You have 15 minutes. You can use them all or you can leave some for questions. You can start whenever you are ready.

Ms. Candace Rennick: Hello. My name is Candace Rennick and I am the president of CUPE Local 2280, representing workers at a not-for-profit charitable home for the aged in Peterborough. I have the pleasure to present today on behalf of the Ontario Council of Hospital Unions, who rightfully are very concerned about the downloading of acute and mental health patients from hospitals into long-term-care facilities.

I have worked at the home in Peterborough for 12 years in different capacities, but mainly in ancillary services. I wanted to start by thanking you for the opportunity to present to you today, but I must acknowledge the dozens of citizens and organizations who actually won't be getting this opportunity. I would be remiss if I did not express my extreme disappointment with the limited amount of public hearings. This appears to be an attempt to fast-track a bill that deserves broader and wider public consultations. I would think that you should all be concerned about hearing from as many people as possible on this proposed legislation.

I know of several people personally who were denied. Further requests from several residents of Peterborough to bring a hearing to that community have been unanswered. Peterborough has one of the most aging populations in the entire province. We have more homes there than Tim Hortons by far, and the vast majority of them are privately owned and operated for profit.

I'd just like to put a couple of questions to you. I'd like to ask you, could you imagine sitting in your feces or urine for hours on end because there is not enough staff to assist you immediately, or could you imagine being rushed through your care and being up, cleaned, dressed and ready for the day within 10 minutes from the time you open your eyes? Could you imagine sitting up for hours on end, waiting to lie down for a nap, but having no staff available to assist you? Could you imagine health care workers endangering themselves and you by using a two-person lift alone, just to be able to provide you some comfort, because there is no staff to help? Imagine sitting alone day after day, no visitors, no family; friends are gone. A chat about the weather or current events has become a long-lost luxury. Can you imagine that after long, hard work, you live your last years in such inadequate conditions in one of the richest provinces and

one of the wealthiest, most privileged countries in the entire world, thanks to many of the people who call long-term-care facilities in Ontario their home? Can you really imagine that?

Well, folks, I see those conditions each and every day. They are not exaggerated; they are reality. That is why minimum staffing standards required by law are so important. They will guarantee additional resources for front-line care and enhance the quality of living and working conditions for residents and workers in long-term-care facilities.

Long-term-care workers do the very best they can with the resources that they have, but it is not enough. And all too often, caregivers are leaving their shifts feeling guilty that they didn't have the resources to do more.

Injury rates continue to be among the highest of any industry, and burnout, stress and low morale have bottomed out for the past several years.

Violence continues to be on the rise in facilities as a great many mental health patients and mentally challenged and disabled individuals are downloaded onto an already strained system. Caregivers are often not trained to deal with these types of special behaviours, and there is no stimulation in long-term-care facilities for these types of residents.

I have personally witnessed many young people with disabilities in these long-term-care facilities go downhill at a rapid rate. People who walked in and spoke to you when they came in now don't speak and spend all of their time in geriatric chairs. People with mental difficulties and disabilities should not be downloaded onto the long-term-care system. They should be placed in institutions or homes that will truly meet their needs.

In facility after facility, providers are making decisions to not replace workers who are off sick and who are on vacation. All of the examples that I just cited at the beginning are examples of a fully staffed facility, so just imagine being told that four of your co-workers aren't coming to work today and that you have to pick up the slack of their 40 residents. Obviously, residents become widgets.

Who holds providers to account for decisions like this? They develop staffing models to meet the needs of residents in good faith, often not adequate in the first place, and then they make decisions strictly based on financial reasons to not work with a full complement of staff. Conditions on those days for workers and residents are not just inadequate, they are horrible. We call the compliance hotline. We're told that compliance can't talk to our providers about how they spend their money. So who does?

As I mentioned, I come from a not-for-profit organization in Peterborough. My employer is not seeking to siphon profit from the accommodation envelope; instead, they transfer up to \$100,000 a year into the nursing and personal care envelope to make up for the obvious shortfalls. I would offer that the conditions, even with this top-up, are not adequate—and like I said, in a charitable, not-for-profit home. So it does beg the question, what is happening in the for-profit-operated homes? Their goal is

to earn profit. This is a booming industry in Ontario, and why is it booming? Because there is money to be made, and there is no protection from the government, and no plans to limit the expansion of the for-profit sector.

Minimum staffing standards would mean that service providers would not be able to make decisions that are harmful to staff and residents based on funding problems. They would be required and held accountable to provide the 3.5 hours of care per resident per day. It would be a guarantee to seniors about the care that they can expect to enjoy.

How do the minimum staffing standards work? A facility with the average case mix would receive resources for 3.5 hours. Facilities with lower acuity levels would receive less, and those with higher acuity levels would receive more, just like when the standards did exist under the 2.25 hours.

This may be the only piece of long-term-care legislation we see for several years. It needs to protect in a real and meaningful way the seniors of this province. CUPE, the Ontario Council of Hospital Unions and our allies will not accept a bill that does not include minimum staffing standards.

I am pleased to see the whistle-blowing protection in the legislation. A worker in my facility spoke out about the conditions in our home, and she was suspended for five days without pay. Five days without pay: That's close to \$600.

I have to offer that I think the whistle-blowing protection is a bit weak. I don't think it fully protects whistle-blowers when they blow the whistle on conditions they've witnessed. You still have to go before a labour board or an arbitration board, and ultimately, at the end of that process, you do still risk losing your job. So I'm not sure how that is protection; I fail to see that. But I am happy that it's there and that we're moving in that direction.

Surprise inspections: I applaud the government for implementing surprise inspections of long-term-care facilities, but compliance officers must also be obligated to speak with and record staff comments and concerns. They need to ensure that staff feel comfortable and that that's an environment where they can come forward and talk about those things.

I also understand that some compliance officers allow facilities to produce what charts will be inspected. Like the visits to the home, viewing of documentation should also be random and selected by the compliance officer.

I by no means claim to be an expert on the legislation. I would refer you to the CUPE Ontario brief for the things that I've not touched on in my conversation today, but I do want to thank you for the opportunity. I would encourage you during your clause-by-clause review to pay serious attention to creating minimum staffing standards, because it will be real protection and accountability for residents living in long-term-care facilities. The Liberal government, as many of you around this table will know, promised to reinstate those standards in the last provincial election, and on the eve of another provincial election, it cannot be another broken promise.

If you have any questions, I'll do my best to answer them.

The Acting Chair (Mr. Bob Delaney): Thank you very much. We should have enough time for one brief question from each caucus, beginning with Ms. Martel.

Ms. Martel: In your view, why is it so important to have a minimum staffing standard? It would probably have to be higher than the 2.25 that was in place, because that was over 10 years ago.

Ms. Rennick: I think that the residents deserve a level of protection. They need to know that there's going to be a guarantee of staffing standards, that they're going to receive a level of care. I think that it's also going to hold service providers to account for their constant non-replacing of workers, allowing facilities to work short. They would have to meet that threshold. I think that the standard should be implemented.

The Acting Chair: Ms. Smith?

Ms. Smith: Two quick ones: Are you the same Candace Rennick who was on CBC saying that you weren't appearing before the committee this morning?

Ms. Rennick: Yes. I said that I was actually denied the opportunity to present on behalf of what—I had applied and was denied, and I was lucky enough to be offered the Ontario Council of Hospital Unions' presentation spot this morning.

Ms. Smith: Your view on whistle-blowing protection: You think that it doesn't fully protect workers. What is it about the whistle-blowing protection that you don't think is adequate?

Ms. Rennick: I guess I just don't understand why, if there is protection for workers, they would still have to fight it out at an arbitration board and risk losing their job at the end of that. I don't even really understand why the arbitration hearing would have to come into the process. If there was real protection for workers, it would be real protection for workers, and they ultimately wouldn't have to fight for their jobs at the labour board or an arbitration hearing.

The Acting Chair: Mr. Arnott?

Mr. Ted Arnott (Waterloo-Wellington): Ms. Rennick, thank you very much for your presentation. I'm pleased that you've had the opportunity to express your views and the views of your membership. I think you've done a very passionate and eloquent job of talking about the important care and services that your membership provides for people. I believe in standards too, but I think, perhaps more importantly, that the care of seniors depends on the compassion and dedication of your members, and we express our appreciation for that.

The Acting Chair: Thank you very much for having taken the time to come in and make your presentation this afternoon.

JANET HOLTRUST

DAPHEN STANTON

The Acting Chair: Janet Holtrust, please. Good afternoon. Welcome. I see two of you, so please begin by

introducing yourselves for Hansard. You'll have 15 minutes to do your deputation this afternoon, and if you leave any time, it'll be divided among the parties for questions. Please proceed.

Ms. Janet Holtrust: Thank you, Mr. Chair and members of this committee, for allowing us to make a presentation to you today. My name is Janet Holtrust. With me is one of my co-workers, Daphen Stainton. We are both personal support workers, with many years of experience between us. We work in a for-profit nursing home owned and operated by Central Care Corp.

We are here today to make a request for a minimum standard of care hours for long-term-care facilities. We were told by Mr. Smitherman that there would be a "revolution in long-term care." He stated that he would fix the problems that were facing troubled nursing homes. It is with great disappointment and regret that we inform you today that in fact there have been no real changes or improvements to the amount of care or the quality of care seniors receive today.

The hours of care in our facility is 2.23 hours per resident per day. This is at an optimal level. We often don't get to 2.23 hours. Yesterday we worked two short, the day before that we worked one short, and the same for the day prior to that. This is just for the day shift. It needs to be made clear that the expectations from the employer are the same regardless of what our staffing levels are. Only yesterday the administrator called all the PSWs together to inform us of our obligation to complete our baths regardless of staffing. "Other homes get it done," she said. "We should be able to too."

On a regular basis we work with a complement of staff less than required and scheduled. This reduces the time we are able to spend with each individual resident. When staffing levels are met, the average PSW is responsible for the care of approximately 11 people. When we work short, each PSW becomes responsible for up to 13 or 14 residents.

1320

The ministry has also imposed a two-baths-per-week mandate. This is great for the residents, but again it's more work with no additional staff. When we work short, the time spent bathing a resident takes away from the care we need to provide for other residents. It also leaves us unavailable to assist our partner with transfers and to monitor high-risk residents.

There are many reasons we work short, including illness, WSIB injuries and stress leave. We also struggle to maintain staff, including administrators and managers. Quite often new employees quit because they are unable to keep up with the workload. It becomes so overwhelming that they leave and never come back. We are unable, much of the time, to recruit new staff due to our rural location. In fact, at this time we are laying off nursing staff. So much overtime has been paid in the nursing department that we in fact exceeded our budget. We now fear more layoffs will come. It's cheaper to pay straight time; it's less stress on the staff, much more cost-effective and ultimately better for the residents. Nursing

staff often work 16-hour shifts, then return again in eight hours to work another full shift. There have been situations where staff have had to work a 24-hour shift. Weekends have been a nightmare for the staff and residents alike. Employees just don't want to work every weekend and should not be expected to do so. Vacation time poses the same ongoing problem. Staff are even called while on vacation to work.

So you see, without a standard of hours that employers are required to meet, things simply are not going to improve. The government provided funding for new equipment and new builds, but until there are more staff provided to operate that equipment and work in the new builds, we are really just wasting taxpayers' money. We have sufficient mechanical lifts in our facility, but we often wait up to 10 minutes to get help in using them.

Truly, this gives a false sense of security to the public. This bill is not going to make lives better for the seniors who currently live in long-term-care facilities in this province. What they really need the most is more staff.

Ms. Daphen Stainton: Just throwing numbers out there doesn't give a clear picture of the truly sad situation in nursing homes. For this reason, I would like to share with you a typical day for us and for the residents.

At 6:30 a.m. we start our shift and receive report. Shortly thereafter we do a quick check of our residents to make sure they are safe and accounted for. We then stock up on linen and other nursing supplies. Quite often we are searching in vain, as there are insufficient supplies available.

Now it is almost 7 a.m. We start morning care for our assigned residents. On a day when we are fully staffed, we have approximately 11 people to care for. Each resident should be provided about 15 minutes for care.

At 8:15 we are to stop care and take residents to breakfast. So 15 minutes per resident times 11 residents is 165 minutes. There are only 80 minutes available to meet the needs of these individual patients prior to breakfast.

Please consider also that during this time we have a partner that will require assistance to transfer his or her residents. The buzzers will ring and we must stop what we are doing to answer them immediately for safety reasons. Oftentimes we have to stop everything to address medical emergencies, residents who become aggressive and/or agitated. If this happens, we are likely going to be late for meal service. Not all residents have to come to breakfast dressed for the day. We are allowed to send them in in nightclothes, but they still need time spent with them to prepare them for leaving their room, regardless of if they are dressed or not. So simple math will show that 15 minutes per resident is not possible.

At 8:30 we start serving breakfast. Increasingly, there are more residents to feed and to assist than there is staff. We cannot rely on other departments, as often there is no one to assist. We struggle though a very busy meal and then porter all residents to another area of the home.

It is now about 9:15. We have documentation to complete, breaks to take, bathroom requests from

residents to meet and residents who require being put back to bed.

At 10:30 all staff converge to do the nourishment cart. This takes about 30 minutes, and then we move on. The beds need to be changed, laundry needs to be taken down and documentation needs to be done. During this time, we continue to answer buzzers and assist any residents with other needs.

Usually by now it is 11:30. We start getting the residents up from their nap and porter all residents to the dining room for lunch. This does take up to about 30 minutes to complete. We go through another busy meal and then follow the same routine again. By now there are many more residents who go to bed for a nap and others who again need a trip to the bathroom.

It is now 1:30 p.m. We take our lunch break, complete documentation and do our report for the next shift. We take down more laundry and check our residents again. The shift is now over. It's 2:30 p.m.

Ms. Holtrust: This day has been laid out to you with no exceptions. Further to basic care needs, we feel there has been an increase in resident falls in our home. We would not be surprised to find that we are above the provincial average. Many of our residents require constant monitoring to reduce the risk of falling. New alarms have been made available, but again, you can have the equipment, but if there is no staff to respond quickly enough to those alarms, then they are ineffective. We also have to assist residents with all appointments they may have to attend that day.

Twenty years ago, when I started nursing in this facility, we had the same amount of staff for the same amount of residents. At that time, almost all our residents were ambulatory; now almost all are in wheelchairs. Then, most people were continent, and now most are incontinent or require assistance with toileting. Back then, they were able to feed themselves, and now almost half require feeding or some level of assistance with feeding. You could also leave a resident alone in their room to eat a meal; now you must stay with them. The level of care has tripled, but I can say our staffing has not increased to meet the demands. The ministry standards were much different 20 years ago. Now they are quite strict and require three times the amount of documentation. The time spent on charting takes away from hands-on care.

This inability to provide the level of care we should be giving to our elders is emotionally trying and frustrating to health care workers. We are trained to provide holistic care, yet always we are looking for ways to cut corners to keep up with the workload. Their needs far exceed the basic activities of daily living that we struggle to meet each day. These people have the right to not be rushed and treated like a number. They should also have the right to have staff be able to make time for them when they need to cry on our shoulder or if they just need to talk.

A typical day for a senior is much different from ours. They will wait until someone has time to provide them

with their morning care. They will see us for a few minutes only. We will come back to get them for breakfast and spend another minute or so talking to them on the way to breakfast. If they are classified as a total assist or a feeding resident, then a nurse will sit with them during that meal; otherwise, they will be served their meal and left to eat with their tablemates. After breakfast, we will porter them to another area of the home. If they require assistance with any nursing needs, we will provide it at this time. This may take up to 10 minutes, depending on the needs of the resident.

Now they will sit and wait for any activities that may be scheduled. The ministry mandates 1.5 activity aides per 100 residents. It is impossible for all residents to attend an activity program on a daily basis. If there are no programs, they will now sit, likely in front of a TV, sleeping, and wait for us to come and get them for lunch. They wait and they wait and they wait. We will come at some point and get them for their meal and they will go through the same process again. After lunch, they will have their nap and wait for dinner.

You can quickly add up the amount of time residents have had contact with staff. These people are dying of loneliness and boredom. For this reason, they become more dependent on their PSW to be available for all aspects of their needs. These needs, many times, cannot be met.

These people are human beings with the right to be treated as such. We are not factory workers and they are not machines, but this is how both parties feel. These people are the individuals who built this country. They are my parents and grandparents and your parents and grandparents. They are also our war vets that we owe so much to. These people have already endured enough hardship in their lifetime. They have the right to live out their golden years in a safe and comfortable environment. They have the right to dignity and respect. Their needs are few, and yet we continue to fail to meet them. We all know this is not what we want for our seniors, and we all know that what is happening in long-term-care facilities can be changed. It is time that Ontario got with the rest of the world in setting minimum standards of care.

So in conclusion, we plead with you to consider a minimum care hour of 3.5 in Bill 140. It's time to move forward in the direction that will evoke the revolution that Mr. Smitherman promised all of us. Thank you.

The Vice-Chair: Thank you very much for your presentation. There is no time left.

1330

ONTARIO HOSPITAL ASSOCIATION

The Vice-Chair (Mr. Khalil Ramal): Now we'll move on to our next presentation, the Ontario Hospital Association.

Mrs. Witmer: On a point of order, Mr. Chair: I just wonder if the committee would consider changing the location for the hearings tomorrow to the Amethyst Room, since that room is available. I think, based on the

public interest we're seeing in the legislation today, it would be an opportunity for people throughout the province of Ontario to learn more about this piece of legislation and be better informed. So I would ask you to consider whether or not that would be possible for tomorrow's hearings.

The Vice-Chair: The room is free tomorrow. It's up to the committee to decide if it's going to move to it tomorrow or not. If there are no objections, it's still free. It's up to the committee. Is it okay? Are there any objections?

Ms. Martel: I agree with that request, Mr. Chair.

The Vice-Chair: No objections? Okay. Then tomorrow would be in room 151. Probably the schedule will remain the same; just our location will be changed. Thank you, Mrs. Witmer.

Now we'll go back to the Ontario Hospital Association. We'll give back your time.

Ms. Hilary Short: Good afternoon. My name is Hilary Short and I am president and CEO of the Ontario Hospital Association. Joining me today is Jean Bartkowiak, president and CEO of the SCO Health Service in Ottawa. In addition to serving as president and CEO of a continuing care academic health science centre that operates two long-term-care homes, Mr. Bartkowiak has significant experience in similar roles outside of Ontario.

We are pleased to have this opportunity to comment on Bill 140, the Long-Term Care Homes Act, 2007. The OHA is, of course, supportive of efforts to improve and modernize the legislative framework for long-term care in Ontario.

While a single piece of overarching legislation is an important step towards the ultimate goal, we strongly believe that some changes are needed to improve and strengthen Bill 140 to benefit those who are cared for by and work in Ontario's long-term-care sector.

Bill 140 has important implications for Ontario's hospitals. A number of hospitals in this province own, operate and govern long-term-care homes as well as EldCap long-term-care beds. In addition, long-term-care homes are often a common destination for patients who require post-acute care following discharge from hospital.

While our recommendations are set out in detail in our written submission, I'm going to ask Jean to speak to some of the more important aspects of our submission, and then we'd be pleased to answer questions.

Mr. Jean Bartkowiak: Thank you, Hilary. While we have noted a number of suggested amendments in our written submission, I would like to take a few minutes to focus on a number of important areas in which the legislation could be strengthened.

Ontario's long-term-care homes strive to provide safe, high-quality care to their residents. While we are supportive of the intent of Bill 140 to further this objective, we are concerned that a number of the provisions set out in the bill will make it difficult for homes to carry it out.

Many of the provisions currently set out in the regulations to the three existing acts appear in Bill 140. We are concerned that the inclusion of many provisions in the legislation which were previously set out in regulation moves away from a positive culture built on the quality of care and toward a negative culture of enforcement.

We are similarly concerned that the legislation is silent on the value of teaching and research in the long-term-care sector. As fundamental building blocks to innovation and to ensuring the availability of health human resources, we believe that these important values should be clearly articulated in the legislation.

Some specific concerns: We have identified a number of ways in which the bill could be significantly improved, and, with input from our members, have developed some recommendations in this regard. I'll now review some of these recommendations.

Director and officer liability: First, I would like to speak to the personal liability that Bill 140 would impose on officers and directors of corporations operating long-term-care homes. Bill 140 would create an onerous standard of personal liability that does not currently exist in long-term-care legislation or other health-related legislation. This has sparked specific concerns among hospitals and not-for-profit long-term-care homes.

We are concerned that the legislation, as currently drafted, would present serious difficulties for not-for-profit boards in recruiting and retaining board members. Ontario hospital boards and boards of not-for-profit long-term-care homes are composed of community volunteers. In some cases, boards govern both a hospital and a long-term-care facility.

As you know, recruiting and retaining qualified, expert and skilled directors who give of their time without remuneration is critical to the sustainability of the not-for-profit sector. As currently drafted, Bill 140 may become a significant barrier to achieving this. Officer and director liability needs to be consistent across the health care sector and aligned with best governance practices. We believe that amendments to the bill are necessary to ensure that this consistency is achieved.

Transfer to a secure unit: Placement of individuals requiring long-term care is an ongoing challenge for hospitals. We support the notion of due process for the transfer of individuals to a secure unit. However, we are concerned that the detailed requirements for transfer set out in the legislation may have significant implications for hospitals that have alternative level of care patients awaiting long-term-care placement.

Bill 140 sets out specific conditions that must be met before an individual can be admitted to a secure unit, such as the requirement to notify a rights adviser in certain instances. Hospitals are concerned that these detailed requirements may further delay the placement process for ALC patients awaiting transfer from a hospital to a long-term-care home. To expedite the process and timeline by which these transfers are made, we suggest that specific timelines, such as the time within

which a rights adviser must provide advice, be set out explicitly in the legislation.

Regulation-making process: Another important issue for the OHA and its members with respect to Bill 140 is the need for due process in the making of regulations. As currently drafted, Bill 140 provides the Lieutenant Governor in Council with significant, broad regulation-making powers. These powers can be exercised without having first provided affected residents, providers and their communities the opportunity to be heard on the merits of the proposed regulation.

Public consultation in the regulation-making process is something that is codified in a number of pieces of health care legislation, including the Commitment to the Future of Medicare Act and the Local Health System Integration Act. Given that regulations developed under Bill 140 will have a significant impact on how the detailed provisions of the bill are implemented, we believe that those most affected should have an opportunity to be apprised of and provide input on proposed regulations. We therefore request that Bill 140 be amended to provide for a public consultation process during the development of regulations that is consistent with other health care legislation.

These are a few of the suggestions that we believe will improve and strengthen Bill 140. Further details and additional recommendations are set out in our written submission.

I'll now turn to Hilary for some concluding remarks.

Ms. Short: The OHA and Ontario's hospitals support the government's plan to build a stronger and safer long-term-care home system in the province. As I indicated earlier, Bill 140 is a much-needed piece of legislation, so our recommendations are offered in the spirit of ensuring that the goal of creating a resident-centred system that meets the needs and preferences of residents, their families, providers and the system as a whole is achieved. We have really tried to provide constructive advice and recommendations with a view to ensuring that this goal is ultimately successful.

Once again, thank you for the opportunity to appear before you today. We'd be pleased to answer any questions you may have.

The Vice-Chair: Thank you very much for your presentation. We have five minutes left. We can divide it equally among the three parties. We'll start with the parliamentary assistant.

Ms. Smith: I appreciate your comments. I did have one question on your—I appreciate your concern around the timing of rights advice when transferring into a secure unit. I find it somewhat ironic that you find provisions in the legislation to be too prescriptive, and then, in this case, you're asking that it be set out in the legislation what the timelines are. Maybe you can address that and how you see we could be doing that amendment.

1340

Mr. Bartkowiak: You're right, and the reason it's there is because there are other timelines already set out in the legislation. If we're taking up timelines, then they

could be included in the regulations. Our point is that we want the legislators to appreciate that we're facing very critical situations sometimes where the transfer of patients requiring secure environments could be delayed, which will, in turn, impact on admissions of other critical cases in the acute care setting. So both the ER patients and the long-term-care patients are facing issues and problems in that respect.

You have similar situations in psychiatric facilities, for instance, or psychiatric transfers, where the admitting physician signs an order and then there are specific timelines provided for a review of those orders. Maybe this is an area where this legislation could borrow from other existing practices in health care.

Mrs. Witmer: Thank you very much for your presentation. You didn't mention this, but you have indicated that you have a concern around the fixed-term licences. Could you explain the concern you have and perhaps the amendment that could be made?

Mr. Bartkowiak: My concern has two aspects; one is related to labour relations in that some of our labour contracts could provide for longer terms than the actual licence that would be awarded. What happens, then, with that employer-employee obligation? That has to be addressed. The other impact is mostly for not-for-profit organizations that have loans with banks or other financial institutions where the terms of those loans extend over and above the terms of the licence. The legislation or its regulation should address those specific situations.

Mrs. Witmer: Thank you very much.

Ms. Martel: Thank you for the presentation today. You noted section 88 of the bill, which says, "The minister may provide funding for a long-term-care home." We heard a similar presentation this morning that suggested that should become "shall" to ensure that there is adequate funding. I don't know if you have a thought on that, one way or the other.

Mr. Bartkowiak: "May" is not necessarily as definitive if you put it against all the obligations that are set out in that bill. It seems, from the operators or the licensee, that there should be an equal kind of obligation from the ministry. If we are to comply to provide quality, innovative care to our residents, we have to have some kind of assurance from the payer that he will support and meet financial obligations that flow from providing quality care to our residents.

Ms. Martel: My second question is, has the hospital association been able to do or thought about doing a costing of what those additional costs would be from the new requirements in the bill?

Ms. Short: We have not done that yet. We could certainly try.

Ms. Martel: I'd be interested to see what that turns out to be, because you are not the only group that has expressed a concern about more requirements and the need to have government fund that.

Ms. Short: We can certainly do our best to get that for you, for the committee.

The Vice-Chair: Thank you very much for your presentation.

The next presentation will be the Ontario Health Coalition.

Ms. Martel: On a point of order, Mr. Chair: I'd like to make a request for the clerk to give all of us a list of those organizations and/or individuals who were not able to get standing at the committee hearings and if that can be provided to everybody.

The Vice-Chair: To my knowledge, two weeks ago the clerk provided all the members of the subcommittee the information. It's not secret information, is it?

Ms. Martel: No. The information that we have is a list of everybody. What I'm asking for is the final list, because I gather there were some duplications in those lists in terms of people putting their names on twice. So if we can just have the final list of who was off, that would be great.

The Vice-Chair: Okay. Ms. Martel has put a question to the committee. She wants the information. Are there any comments?

Ms. Smith: As long as the list clearly delineates those who chose not to attend even though they were offered a spot, because there were some who deferred.

Ms. Martel: If it can show who deferred, and otherwise, if they took somebody else's spot—I don't know if you can do that as well, Trevor.

The Vice-Chair: That's okay?

Interjection.

The Vice-Chair: No problem. Thank you very much.

ONTARIO HEALTH COALITION

The Vice-Chair: The next presenter: You can start whenever you're ready.

Ms. Natalie Mehra: Thank you for allowing us this opportunity to speak today. The Ontario Health Coalition is Ontario's broadest public interest group regarding the public health care system. Our positions regarding this legislation have been come to by consulting with our members across the province, including residents' groups, patients' rights groups, seniors' organizations, unions that represent workers in long-term care, the nurses, health professionals' organizations—so the whole range of our membership.

We approve of some significant changes in this act, and I want to mention them, because I understand that there is a push from some of the provider organizations for fewer standards and less regulation. Actually, we definitely approve of the direction towards more regulation within the act. Specifically, we support the increased ability of residents to promote their rights contained in the bill of rights. We promote written sign-off of facility operators to confirm their review of admission documents. We support the proposed intent to limit casual and agency staff, although we'd like to see it stronger. We support the inclusion of an RN on-site 24/7, the increased powers of inspectors and the continuation of regular, unannounced inspections, which has been a

big improvement over the years of lack of inspections and orders in compliance.

In addition, we approve in principle of the idea of whistle-blower protection, but we are concerned, along with the unions and the seniors' groups, that the protections are insufficient, because a whistle-blower can still be fired for whistle-blowing. They'll have to grieve, if they have a union, or go to the labour board themselves, if they don't have a union, to get their jobs back. While there's no magic solution for this, it is a real financial barrier to whistle-blowing, and we'd like to see if there's some way to mitigate that somehow.

We also believe that the bill should be clear that gag orders and such clauses in employment contracts be unlawful, and that that be enforceable.

We'd also like to see that neglect should be defined so that facility operators and the government, who bear the majority of the decision-making power when it comes to things related to neglect—including assessment, spending decisions etc., which are critical to preventing neglect—actually have some way of being held accountable for those decisions.

For us, though, the really key issue that we're hearing about from everybody across the province regarding this legislation is that there just isn't enough time to provide care. From the families, we're hearing that they're hiring caregivers, if they can afford them, to provide additional care for their family members; for those who can't afford them, they're going without. The caregivers themselves are saying, as you've heard in great detail, that there just is not enough time to provide the care.

The types of care that people are going without are more than just superficial things. We're talking about feeding, in some cases, that there's not enough time to feed. That's a common complaint. There's not enough time to reposition. These are critical, preventive measures done by personal support workers, RPNs, the work that will stop dehydration, that will help to prevent bedsores and deterioration, and there isn't enough time to provide that care.

We believe that the key thing this act needs to deliver on is an assessment of what the needs are, what the population need is, some way to provide care to meet that assessed need, a minimum care standard, and funding that's aligned with meeting the assessed need of people in the facilities. If you look through the act, that piece isn't actually there. So while there are improvements in all kinds of different types of standards and regulations and enforcement and so on, that critical, core piece of measuring and trying to meet population need isn't actually there.

1350

We're not hearing this in specific localities around the province. I travel around the province about five times a year, to virtually every community, every 100,000-person town, and we're hearing it from absolutely everywhere in the province. So we believe that this is not a localized issue, that this is a systemic issue.

We also wish to note that this legislation isn't being written just for the term of this government, that it's being written for future governments, and that there is lots of concrete evidence of abuse in the past that needs to be addressed in the legislation.

We know, for example, that facility operators have practised removing elements from the accommodation envelope, which is the envelope from which the for-profits can take profit, moving them into the personal care envelope so that there's more room for profit-taking from the accommodation envelope. Those would be incontinence supplies, security, those sorts of things. We know that there was an announced direction to actually move those things back into the accommodation envelope, at least incontinence supplies, but we are now hearing that that hasn't actually happened.

We know that there have been chain-wide bankruptcies—all kinds of creditors left, the homes left.

We know that there have been awards of beds to for-profit operators that have been convicted of fraud and neglect in other jurisdictions.

We know that record profits are being reported at the same time as Natalie Babineau's story was being told in the Toronto Star, of a really horrific death due to a bedsores.

We know that there were years of inadequate numbers of inspections, few orders, unenforced orders etc.—a litany of these in media exposés. And we know that there has been tipping off of inspectors and tipping off of facilities, staffing-up before inspections and so on.

We believe that the act needs to at least protect against that type of abuse that has already happened or has happened over the last 15 years in the facilities. In order to address those situations, we have made a variety of recommendations in our brief, which I will go through as quickly as I can.

In addition to the minimum staffing standard, we're calling for 3.5 hours tied to the average—so a CMI of 100 would get 3.5 hours, increased for increased acuity, lowered for lower acuity. We're asking for the amendment in the legislation to be that cabinet is required to make a regulation introducing a minimum staffing standard, that the staffing standard actually be in the regulation.

We're asking also for an immediate update to the type of information that was in the PricewaterhouseCoopers report, so an assessment of comparative jurisdictions, the actual acuity, the actual staffing care levels currently.

We're asking for a review of the funding model to provide adequate resources to meet the assessed level of need.

We're also asking for support for public and non-profit care. In this month's Canadian Medical Association Journal commentary, they published new evidence from Canadian jurisdictions about the difference in spending decisions between non-profits and for-profits; it's in our brief. The basic gist of it is that the not-for-profits and public facilities provided more hours of direct care and made spending decisions more in line with the

public interest. So we believe the bill should be amended to require that the government increase the proportion of public and non-profit homes, that all new homes should be built in the public and non-profit sector, and that transfers from non-profits to for-profits should be disallowed.

We'd also like to promote accessibility. We'd like the reinstatement of the fundamental principle from the former acts, including that the physical, psychological, spiritual, cultural and social needs of the residents be adequately met.

Again, we believe that the funding must be assessed to meet assessed need and that the ratio of 60% basic accommodation should be reinstated.

We'd also like some protection in the act that charges for residents for basic accommodation not exceed CPP increases, to ensure that they stay affordable.

We are supporting the calls of the seniors' organizations for an ombudsperson's office, as opposed to the office of the long-term-care adviser.

We are supporting calls for a requirement for the director to pursue sanctions in sections 150 to 154. We think that the evidence of the years of non-pursual of sanctions is sufficient that the language should be stronger than "may" and should be "shall" in that section.

We believe that there needs to be a new section on democratic accountability and access to information and that that should include that nursing home operators should not be allowed to fund political parties and politicians nor give gifts to them. We note that with the homes for the aged, under the current salary disclosure legislation, they are required to disclose salaries; we think the for-profits should be as well.

There should be a sunset clause included in the legislation aimed at preventing the revolving door between the ministry, LHINs or any body that is created to form recommendations for health restructuring related to long-term care on the one hand and the nursing home industry on the other hand. We think there is sufficient evidence that that has happened. That should stop.

The ministry should be required to make public any past criminal or civil offences for fraud, neglect and abuse by nursing home operators applying to be awarded beds in Ontario. The requirement for public consultation on licensing must be accompanied by disclosure and access for the public to information regarding the proposal and the proponent. The public must have adequate access to documents in those licensing hearings.

The government must provide access to the information it collects regarding actual staffing and care levels. It's inexcusable that people have to pursue freedom-of-information requests to get that information, as has recently happened. It must make public the funding formula. The public must be given access to clear information delineating how much money each facility gets in each funding envelope and how much is spent in those funding envelopes.

We would like to see, in addition, a consultation process on the regulations. That's it.

The Vice-Chair: Thank you for your presentation. We have three minutes left. We can divide it equally among the three parties. We'll start with the Conservatives.

Mr. Arnott: Thank you very much for your presentation. I'm sorry I missed the first part. I had to go out to make a telephone call.

Your concluding comment that there needs to be greater consultation on the regulations is a very pertinent one. I would hope that the government will hear that request and respond with an appropriate process, assuming that this bill moves forward.

You brought forward a number of very important concerns. On behalf of our caucus, we express thanks for your presentation.

The Vice-Chair: Ms. Martel.

Ms. Martel: Thank you for your presentation today. I want to focus on minimum staffing standards. The recommendations you gave to the committee closely follow the recommendations that were made in the Casa Verde inquest: firstly, to update the PricewaterhouseCoopers study; secondly, in the interim, to at least have a minimum staffing standard of 3.06 hours per resident per day; and then recommendation 30, that once the new study is done, the minimum staffing be changed so that it reflects the real needs and also is comparable to other jurisdictions.

Why is it so important to have minimum staffing standards, some staffing standards, with respect to hours of care per day per resident in this bill?

Ms. Mehra: We think it's critical because although right now there's increasing funding each year for long-term care and although it appears that the staffing is starting to go up—and that's important—this legislation is going to outlast any particular government. It's supposed to be for any government that comes in. The experience over the last 10 years has been that the staffing levels have fallen periodically to points that are simply critical and in fact dangerous for care. Moreover, the people who are responsible for the state of nursing homes in this province are not just the operators, are not just the caregivers in those facilities; it's also the government. We believe that the government should be held to account to provide enough resources to provide a reasonable level of care based on the evidence and based on the assessed need of the residents in the facilities.

The Vice-Chair: The parliamentary assistant.

Ms. Smith: Thanks. I note that you would like to see the fundamental principle changed. I would like to ask you to adopt the fundamental principle and start calling them homes instead of facilities.

Following up on what Ms. Martel had to say about the PricewaterhouseCoopers study, I just note that in the auditor's report of 2002, he noted that the report considered only the amount of care provided, not the quality of care, when looking at minimum standards. He also noted, "According to the consultants, the study's limitations included the facts that data for many of the comparative jurisdictions were gathered from three to five years earlier than the Ontario data and that 'several of the

jurisdictions were required to submit the data for funding purposes, which may influence data quality.'"

1400

The auditor had real skepticism with respect to the PricewaterhouseCoopers report, and I share his skepticism. I just wanted to put that on the record because you do reference it in your submission, and of course Ms. Martel has referenced it as well.

You had a concern around basic and preferred accommodation. Was that an amendment that you wanted to see in the legislation?

Ms. Mehra: Yes. It's in the brief.

Just to respond to the amounts of care, not the quality—the PricewaterhouseCoopers study. That was in 2001. If the government doesn't actually accept the comparability of the jurisdictions, we'd be happy to see the updated report with comparable jurisdictions that you think are actually comparable. It's now 2007. That hasn't been done, so there's a question about that. Also, it's pretty much accepted practice across North America now to go for care standards.

The Vice-Chair: Thank you very much for your presentation.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Vice-Chair: The next presentation will be by the Registered Nurses' Association of Ontario. You can start whenever you are ready. Please state your name for Hansard.

Ms. Joan Lesmond: Good afternoon. Thank you for the opportunity to address the committee on this very important piece of legislation. My name is Joan Lesmond, and I am the immediate past president of the Registered Nurses' Association of Ontario. With me is Sheila Block, who is our director of health and medicine policy. While I will provide you with an overview of our position, I invite you to read our submission, which includes more detailed recommendations.

First, let me state that RNAO supports this bill and its principle that long-term-care facilities are residents' homes and should provide them with dignity, security and comfort. The association hopes this submission will help ensure the legislation does just that. We believe that long-term-care reform must occur with an overall seniors' strategy that focuses on health promotion and quality of life. This legislation should be guided by the values of healthy aging, aging in place and choice for older persons. In long-term care, that means having a resident-centred philosophy. To be truly so, long-term-care facilities need enough staff with the right training to provide effective, safe and culturally competent care.

One of the core values that drives RNAO's work is our support for not-for-profit health care delivery. This government has shown its commitment to medicare in many ways. However, in the long-term-care sector, there has been a trend towards increasing for-profit delivery. Since 2000, more than 65% of new beds in Ontario have

gone to for-profit facilities. The share of for-profit beds in this province now stands at 52%. This causes concern because there is considerable evidence that shows that not-for-profit homes provide better quality of care.

Therefore, we recommend three changes to the bill to strengthen its support of not-for-profit delivery:

(1) Include a commitment to uphold the Canada Health Act, and to promote and support not-for-profit long-term care in the preamble.

(2) Incorporate a governing principle to support not-for-profit ownership in the licensing section.

(3) Include a right of first refusal for not-for-profit homes when new beds are allocated.

There is no question that residents of long-term care are vulnerable and better protection and oversight are needed. That's why RNAO welcomes provisions in the bill that protect whistle-blowers, that protect residents' safety and security, and allow for creating the position of a resident and family adviser. But RNAO recommends that the bill go further and create an independent elder health ombudsperson office. This office could receive complaints from all seniors, not just those in long-term care.

While we support the proposed residents' bill of rights, we also recommend protecting both collective rights and individual rights, because one person's rights may conflict with the safety and well-being of others. We must also make sure those rights are not being violated. Bill 140 does require each facility to create a residents' council and, when requested, a family council. While RNAO supports these councils, we recommend the three following: first, funding them through a third party such as an elder health ombudsperson to make sure the councils are independent; second, allowing the councils to meet privately; and third, allowing the councils to speak with inspectors and have access to board minutes and copies of regulated standards.

The evidence clearly shows that the use of restraints has negative impacts, including loss of bone mass, muscle atrophy and emotional distress. As a result, we welcome measures in the bill that limit the use of restraints. However, we are concerned that the use of chemical restraint is not similarly limited, and we are concerned about the language of the bill on perimeter restrictions. As a result, we recommend that the requirement for a written restraint minimization policy include chemical restraints and we recommend that perimeter barriers be considered safety measures and suggest that the phrase, "unless the resident is prevented from leaving" be deleted from subsection 28(5).

The act clearly outlines these and a number of other measures to protect residents and improve care. We urge the government to work with home operators and consider their concerns to make sure the new requirements do not have any unintended impacts on resident care. We also recommend that the bill require full public consultations when making associated regulations. Any increased obligations resulting from Bill 140 must efficiently and effectively increase residents' quality of life.

We must also point out one glaring omission from the bill which is essential to improving residents' quality of life: a minimum standard of care. Until 1996, there was a minimum standard of 2.25 hours of care every day. It's time to bring back that standard and to improve on it. We strongly urge the government to set a minimum standard of care at 3.5 hours of care per resident per day.

Finally, nothing outlined in Bill 140 will improve quality of care without a strong commitment to provide adequate funding. There's a general consensus that this section is underfunded. Increasing demands on this sector without also increasing funding will have a negative impact on quality of care. If funds to meet new requirements for training, reporting and documentation are redirected from patient care, this bill will not live up to its promise. RNAO recommends that funding must be enhanced to cover costs of additional requirements imposed under Bill 140. Furthermore, we expect the government to keep its promise to increase spending by \$6,000 per resident per year.

I thank the committee for your attention. We look forward to working with you to ensure that the legislation provides Ontario's seniors with the best possible care. Thank you.

The Vice-Chair: Thank you very much for your presentation. We have six minutes left. We can divide it equally among the three parties. We'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation, specifically the recommendation about reinstating a minimum standard of care and that it be realistically set at 3.5 hours. Let me also ask about proposal number 9 to create an independent elder health ombudsman office. The government, instead of proposing an ombudsman, has talked about a resident adviser. I don't know if you want to make any comments about a resident adviser, but I wonder in this section, if it is not an independent health ombudsman office, would you also accept the proposal that the current ombudsman have oversight mandate both for long-term care and acute care hospitals? So if you can comment on the government's proposal for a resident adviser, which seems to take the place of an ombudsman, and why you think the ombudsman position would be more appropriate.

1410

Ms. Lesmond: I think the ombudsman position is much stronger to be able to effectively represent a long-term-care person in the environment. I think we really need to put what works as opposed to what looks like it's going to work, and we feel that would really create the level of accountability for the elder person.

Ms. Martel: So is it the independence from essentially the bureaucracy, the opportunity for that person to have independence, that's most important to you?

Ms. Lesmond: You've got that.

Ms. Martel: And you don't see that with the residents' adviser?

Ms. Lesmond: It depends if some of the same criteria for the ombudsman are expected in the residents' adviser, but I think the ombudsman is a stronger position because

of the independence and I think it also lets people be more comfortable to explicitly state what is happening with them. I don't know if you want to add anything to that, Sheila.

Ms. Martel: So people would be more forthcoming?

Ms. Lesmond: You've got it, yes.

The Vice-Chair: Thank you, Ms. Martel. Parliamentary assistant?

Ms. Smith: Yes. I was interested in some of your—sorry. Thank you for being here. I'm missing out on the niceties, I'm so entrenched in all of this.

I wanted to just follow up on some of your recommendations around resident and family councils. You set out a requirement that they meet in private. I believe that is already addressed in the legislation. We also restrict who is able to participate in family councils and residents' councils and exclude any staff except an assistant who is assigned to the resident council and who is—how do we put it?—acceptable to the council. So I believe those requirements that are already in sections 54 through 60 of the legislation address some of your concerns.

Were there more concerns around meeting privately? We also provide for the inspector to meet with the family council to discuss the report of the annual inspection, which I believe was your recommendation 12. Was there more to 10, 11 and 12 than those?

Ms. Sheila Block: I guess one of the things we're talking about is the independent flowing of funding in there, which you haven't necessarily addressed. Although you indicate that the assistant should be acceptable to the council, I think we want the opportunity for the councils to actually meet without that assistant, as might be needed.

Sorry, I think you had a third question but I can't recall what it was.

Ms. Smith: The act does provide for them to meet without any staff.

Ms. Block: Okay.

Ms. Smith: The other, with respect to the flowing of funds: The family councils project was funded independently and it's an organization outside of the Ministry of Health or outside of any long-term-care association. They receive funding from the province to run that. As far as family councils and residents' councils in homes are concerned, they are not funded by the ministry or the home; they are independent entities. That's the intention.

Ms. Block: Okay. Let me try and clarify, then. I guess we're saying that for them to function more independently and to function with strength, they need some funding, and that funding should be flowed through some independent body like that.

The Vice-Chair: Mrs. Witmer?

Mrs. Witmer: Thank you very much for your presentation. As always, it's well done. One of your recommendations speaks to the need to include both physical and chemical restraints in the requirement. I wonder if you want to explain the chemical and why you believe this is necessary.

Ms. Lesmond: I think chemical really is drugs, so sometimes the drugs can really have much more of a

negative effect. I think being conservative in both is what is really recommended.

Mrs. Witmer: Would you see that policy and procedure being very similar to the physical or is there a different process?

Ms. Block: Part of our concern comes from the specific exclusion of chemical restraints in the legislation, so I guess we have a concern that what could happen is, given that there isn't the constraint on the chemical restraints and there is one on physical restraints and the fact that chemical restraints can be less visible, there would be a bias in the legislation toward operators potentially using them. So in particular, we would want similar protections and we would also want a kind of joint decision-making process with the resident's substitute decision-maker or family in terms of an ongoing review of the use of those chemical restraints.

Mrs. Witmer: I guess the other question I would ask you is, we've heard from some people who work within the long-term-care environment that some of the enforcement requirements—the fact that people could be named and blamed etc.—would make that environment a less likely one where they might seek employment or others might go for employment. Would nurses be impacted by some of this legislation? Would there be less of a desire to work within this environment because of what is perceived to be a very punitive bill that focuses on punishment as opposed to continuous quality improvement?

Ms. Block: We have some suggestions. We think the strong enforcement in this bill is important and we support it. We have a couple of caveats on that, one of which is increased funding flow to be able to let people actually meet those requirements. We do have some concerns about not-for-profit board members in terms of some of the criminal and sizes of fines.

In terms of RNs or nurses, I think nurses want to work in high-quality environments where the quality of care is paramount. To the extent that this bill moves that forward, I think they'd be very supportive of it. We know that providers have some concerns and we believe that those concerns should be discussed and moved into regulation, making sure that any oversight is most efficient, most effective and targeted towards resident care. We think that a combination of government and home operators can try to work those through and make sure, but we do believe that the oversight in regulation is appropriate.

The Vice-Chair: Thank you very much for your presentation.

ONTARIO ASSOCIATION OF RESIDENTS' COUNCILS

The Vice-Chair: We move on. The next presentation will be by the Ontario Association of Residents' Councils. You can start whenever you are ready. The floor is yours.

Ms. Patricia Prentice: Thank you, Mr. Chairman. My name is Pat Prentice. I'm the executive director of the Ontario Association of Residents' Councils. I work for a board made up entirely of residents of long-term-care facilities across Ontario. The executive of the board met and spent the whole day reviewing the provisions of Bill 140 and have directed me to bring to you their thoughts and comments. They also wish to have me express to you their overall pleasure with what they have seen and their great pride in having an important part in the process. They were particularly pleased with the rights of residents being used as the framework and the attention to issues about which they had previously commented. In short they liked, for the most part, what they saw and they have very few suggestions, which could probably be regarded as tweaking.

In part II, regarding residents' rights, their comments on this section had to do with the emphasis on individual rights of residents. They believe that, at times, given the communal nature of homes, individual rights must bow to the rights of the group as a whole. They also were recalling with pride that nearly 25 years ago a previous board had written the very first publication of OARC and it was entitled Residents' Rights and Responsibilities. They believed then, and they do now, that rights also involve responsibilities to others, not just to their fellow residents but to staff and the administration of the home.

I'll deal with part IV, regarding councils. The executive, as you might imagine, spent a good deal of time on this section, pleased with its provisions and powers, save the requirement for residents' councils in each home. Much of this was carried over from previous legislation passed in the late 1980s. One provision that was carried over from that act is one that they would very much like to see removed from this act. It is subsection 54(2). It was, in their discussion, their strongest recommendation.

There has been provision since the previous act for membership in residents' councils, in addition to all residents, for substitute decision-makers for residents judged incompetent. Given the passage of years, and our experience with this provision, we believe that it is time to remove it. The provision has often been misinterpreted to mean any family member may be a member of residents' councils, including even holding office. In the 15 years that I have been associated with OARC, I have several times seen residents' councils literally destroyed because of an overzealous family member, no doubt meaning well but tending to take over from residents, many of whom did not wish to be told what to do by someone who did not share their lives and wishes. To be truthful, they resented them.

1420

Yes, this provision has been misunderstood at times and at other times has harmed residents' councils, but our major reason for asking for it to be removed is the wonderful growth and activity of family councils, a vehicle for interested family and friends of residents to make a real difference without infringing on the wishes and independence of residents. Our recommendation is in

fact a vote of confidence in family councils and how they can work for the benefit of everyone.

Under section 58, dealing with the powers of family councils, we ask that clause 58(1)4, the provision for family councils having the power to "attempt to resolve disputes between the licensee and residents," be removed. Board members see this as an unnecessary addition and, frankly, somewhat patronizing.

Both sections dealing with residents' councils and family councils include in their powers, with an added reference to section 146, the right to receive a copy of the reports of compliance advisers. That's lovely, and it's appreciated, but what would be even lovelier still, in the opinion of my board, would be to include a requirement for the compliance adviser, as part of the inspection, to meet with both the residents' council and the family council, if one is in place. What better way to gather information than to ask the people who are in the best position to comment? In this regard, we would also urge that the standards currently in place for residents' councils be a priority for review and updating so that they better match the provisions of this act and so that they would better bring a common understanding of what was required to all compliance advisers.

In other comments, they looked at part II, section 18, regarding the prevention of abuse, and immunity in reporting: They felt that staff who had been terminated for abuse, and the abuse shown to have occurred, should not be reinstated by any arbitration through the labour act but should, as they so simply put it, be "gone."

The provision for excepting residents who report abuse knowing the report to be false: They believe strongly that no such immunity for residents should be included. A false report by someone knowing it to be false is wrong, resident or anyone else.

Part II, subsection 28(5), regarding external barriers being a possible restraint: I visit a lot of homes, and most homes have some sort of coded entry and exit system. According to the wording of this provision, it could be considered a restraint if residents are prevented from leaving the home. This needs rewording to clarify what is meant.

Part V, section 72, made them smile. They couldn't count the number of board meetings over the years where they have repeatedly voiced concern about the overuse of agency and temporary staff, people who do not know the home nor do they know the residents. The practice can often lead to errors in care, mistaken identity errors, and a feeling by residents that they can't possibly get to know their caregivers as they wish to do.

Part IX, subsection 141(2) and section 142, regarding the possibility of less frequent inspections of some homes: The board members welcomed the change to unannounced annual inspections and would not like to see that policy changed in any way. They believe that it "keeps them on their toes." They would, as previously mentioned, welcome a provision for the inspection process to include a mandatory consultation with residents' councils, and updated and extended standards

for councils to assist compliance advisers. My own observation, after visits to many homes, is that I rarely hear that residents have had the opportunity to speak with their compliance adviser. In some cases, in fact they have met, but they have met with the administrator and senior staff in attendance to hear what the residents had to say. I can only guess how open the discussion might have been.

Part V, section 76: We are very pleased to see the provision for a comprehensive admission information package, including material not just about the home's residents' council, but why not material that the residents themselves have prepared for it to be involved? They know best the things they would like to have known when they came in. They would like to be involved in this in their individual homes.

Thank you for the opportunity to come and tell you about the things they would like to see changed, the things they welcome staying as they are, and their thoughts on the many things you have added to improve the quality of life for residents in our homes. It has made residents very proud to be a part of it all, having a voice throughout the process. We know that many people have spent many long hours of thought in drafting the proposed legislation and the lengthy and much-welcomed consultations that preceded it becoming words on paper. To the residents, they are welcome words.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left. We'll start with the parliamentary assistant.

Ms. Smith: Thank you, Pat, for taking the time and for all the work that you've done leading up to this. I was interested in a couple of things. I wanted to also put on the record the great work that your organization has done on a manual for residents' councils that you're providing to all of our homes across the province, so thank you for that, and what a great accomplishment that is. I know a lot of hours went into that.

You didn't comment on minimum standards or standards of staffing, as we've heard about from a lot of the other organizations that have come today. What would your organization's view be on minimum standards?

Ms. Prentice: They talked about them. They're looking at their own experiences in homes right across the province, and they're tending to look at this through their own eyes, which is fine. I might not have the same thoughts, since I don't live in one of the homes. But they feel that when you set minimum standards of hours of care and things like that, that number would fluctuate too much. You can't say that 3.5 hours is what I need this Tuesday and expect it to be the same as what I need next Tuesday, when I'm feeling a lot better, or when I'm feeling a lot worse because I've just found out my son is very ill. They would like to see the skilled judgment of staff, other than the barest of keeping of standards, to know when it's not enough and when it is.

The Vice-Chair: Thank you very much. Mrs. Witmer?

Mrs. Witmer: Thank you very much for your presentation. I appreciate the summary of recommendations

and certainly agree that some of them are just pure common sense. I hope the government will take a look at 54, 55, 58 etc. But I want to ask you about section 18. You've indicated here that staff terminated for abuse, with abuse proven to have occurred, should not be reinstated by arbitration under the labour act. Can you expand on that? Why do you feel that's important? And I don't disagree, by the way.

Ms. Prentice: I think it arose because I have had, in the last year and a half, two people on my board who have been residents of a home where a situation occurred, shall we say. I didn't ask for a whole lot of details; I trusted their recounting that something happened, okay? They believed very strongly that once the abuse has been proven to have occurred, reinstating that staff person or that volunteer or whatever is not even possible given the residents' feeling that if there's smoke, there's fire, or that they would have difficulty working with other staff. In fact, I was quoting them directly when I said they believed they should be not reinstated, but gone.

The Vice-Chair: Thank you. Ms. Martel?

Ms. Martel: Thank you for your presentation. I followed it word for word. There was one paragraph that wasn't read into the record, and I wondered if there had been a change in the view of the members who sat to talk about this. It's on page 2. It says, on the middle of the page, "Towards the end of part II there is mention of the possibility of an 'Office of the Long-Term Care Homes Resident and Family Adviser,'" and that this would be a duplication and is unnecessary. Is that still the view, or has that view changed?

Ms. Prentice: Thank you for pointing it out. It's probably because I was quite nervous and left it out. They did look at this and entertained the idea, because I have a pretty smart board and they're all acquainted with the job of the Ombudsman. They felt that although the legislation is worded so that it may happen, it was completely unnecessary. They thought that in order to get expert advice you'd have to have a whole building full of experts. They believed that they already had access to expert advice to know what to do in a given circumstance, and that it would be a very costly duplication of what they already knew was available to them for the asking. Their summary comment on all that was, "Take the money and put it into resident care."

Ms. Martel: So they were—

The Vice-Chair: Thank you very much. There's no more time.

1430

ONTARIO DENTAL ASSOCIATION

The Vice-Chair: The next presentation will be by the Ontario Dental Association. You can start when you are ready. Please state your name for Hansard.

Ms. Linda Samek: I'm Linda Samek, director of professional affairs with the Ontario Dental Association.

With me today is Mr. Frank Bevilacqua, director of government relations.

The ODA has a long tradition of promoting access to oral health care for Ontarians. Of particular concern to the association and its members is the promotion and delivery of oral health care for the segment of the population that resides in long-term-care homes defined in Bill 140. The ODA observes that the initiatives behind Bill 140 include ensuring the best possible level of care for residents who live in Ontario's 618 long-term-care homes. However, Bill 140 has failed to ensure that residents will be provided with the appropriate mechanisms to access oral health care.

Research indicates that residents in long-term-care homes have significant oral health needs. To ensure that residents remain, to the extent possible, pain free, comfortable and are able to eat and interact with others, there is a need to take a comprehensive approach to the overall health and daily living needs of those residing within the long-term-care system. Such an approach relies on the use of multi-disciplinary teams and regular visits from outside or community-based health providers, such as the dentist and dental hygienist team, to augment existing facility services.

The ODA agrees that a long-term-care home should be deemed to be the home of its residents and that all long-term-care residents should live with dignity and in security, safety and comfort within their home. It is in this context that the ODA suggests that this principle also must embrace the concept of informed choice for all residents. This choice should include the ability of individual residents to access oral health care.

Given the significance of oral health care to overall health and the comfort and daily functioning of each individual, the ODA is surprised and concerned that the bill does not include any reference to dental care within the context of the residents' overall plan of care. The ODA believes that it is crucial for residents who are admitted to long-term-care homes to have a comprehensive oral health examination by a dentist to ensure that an oral health maintenance and/or treatment plan is available to the individual and that the resident has access to necessary oral health care as long as they reside within the home.

Residents should know of their right to be fully informed about their overall health status, including their oral health status. Even if the home is not directly involved in the provision of dental services, residents should know that it is their right to access oral health care from qualified dental professionals, including those community and/or family dentists. For those residents who do not have a regular dentist, the ODA encourages the promotion of access to information about dental care providers in the local community.

Given that many residents are frail, with multiple chronic health conditions, and on several medications a day, the ODA recommends that the act include an express requirement that at least one member of the Royal College of Dental Surgeons of Ontario be affili-

ated with each long-term-care home to ensure that residents are accessing appropriate dental care services.

Long-term care homes should:

- be required to include participation by dentists in the integrated health care planning and coordination for residents;

- be required to offer, and residents be strongly encouraged to have, a complete oral health examination, evaluation, diagnosis and treatment on entry to the residence and on a regular basis as appropriate and, as a minimum, yearly thereafter;

- be required to have available a room in which basic professional oral health care can be provided;

- be required to have ongoing in-service training for staff on preventive oral health care; and

- be required to include, as a minimum, a dentist as part of the resident's health care team.

The ODA is concerned about another aspect of the bill, and that is the application of the mandatory reporting requirements outlined under section 22. First, there is wide variation in professional misconduct regulations among the many regulated professions. Second, even within multi-disciplinary working relationships, individual providers may not have the expertise to be familiar with the competency requirements of a member of another profession. Third, it is not clear what burden of proof an individual must have to determine that "improper or incompetent treatment resulted in harm or a risk of harm." Fourth, the investigative procedures to be conducted under the legislative framework would be separate from any disciplinary proceedings required under the Regulated Health Professions Act, thereby duplicating, perhaps, the disciplinary process. Further, it is not clear that the proposed investigative process will include provisions for privacy, due process and other applicable safeguards currently entrenched in the RHPA. Finally, we question whether the director has the appropriate expertise to address concerns around competence of professionals.

For all of the reasons outlined, the ODA recommends that any such complaints should be directed to the applicable regulatory college.

With respect to prescribing and using physical restraints, the ODA recommends that dentists be included as persons who may order or approve restraining of a resident for the purpose of assessing and providing oral health care services.

Section 70 relates to the requirement for the medical director to consult with health professionals working within the home. This provision should be expanded to include health professionals working outside of the home—that is, within the community—on behalf of the resident. This reflects the fact that community providers, such as dentists, currently provide direct care to residents within a long-term-care home or outside the home at a private dental office, and this care should be recognized within the legislative framework and facilitated through regular interaction with the director of the home.

To summarize, while the ODA supports the spirit of the legislation, it is of the view that the bill would be

strengthened if greater protections were included for the purpose of ensuring improved access to oral health care for residents in long-term-care homes. ODA's survey of its members indicates that a significant number of dentists currently provide outreach services to those within the long-term-care home. Nonetheless, the complex needs of this patient group are underserved with respect to oral health care needs. Indeed, there are examples of dentists donating equipment to a health care room within a long-term-care home, providing oral health care services for an extended period of time, only to be asked to remove the equipment when there is an administrative change. These experiences indicate that legislative provisions are needed to reduce barriers to oral health.

The Ontario Dental Association and the Ontario Dental Hygienists' Association worked closely together over a significant portion of last year examining how dentists and dental hygienists might work better. This led to a May 2006 memorandum of understanding between the ODA and the ODHA, concluding, in part, that long-term-care residences require priority attention and that both the ODA and the ODHA are prepared to work with the Ontario government to advocate for appropriate legislation in this area, including the establishment of health care rooms that can be used to examine the oral health status of the patient and to deliver oral health services within an appropriate environment.

We would suggest that the timing for such legislative reform is here. Bill 140 is an appropriate avenue to facilitate the inclusion of these health rooms within the long-term-care home and to facilitate the delivery of needed oral health care through the multidisciplinary, collaborative team of dentists and dental hygienists working in these residences.

The ODA is grateful for this opportunity to present this submission, and if there are any questions, we'd be pleased to answer.

The Vice-Chair: Thank you very much for your presentation. We have five minutes left. We can divide them equally between the three parties. We'll start with Mrs. Witmer.

Mrs. Witmer: Thank you very much for your presentation. You are suggesting, then, that at a minimum, in each one of the long-term-care homes there would be one dentist who would be providing the oral health care?

1440

Ms. Samek: We believe this can be facilitated in many ways, but there needs to be an outreach with a dentist in the community so that they can coordinate that care, whether it's ad hoc, as an individual resident needs it, or it's on a regular basis within the home. But we want to ensure that there is that contact with a dentist in the community. These dentists are already, in many instances, trying to provide that care, but it is very difficult to facilitate.

Mrs. Witmer: Right, and you've indicated that you've worked with hygienists on this issue as well.

Ms. Samek: We have.

Mrs. Witmer: Perhaps you could just enlighten us—I think sometimes people forget that people of all ages probably have the same need for good oral health care. What issues could occur, what health problems might occur, if these residents don't have the oral health needs addressed?

Ms. Samek: I think a lot of this is daily functioning as well. We all know about pain, but then there is this daily living thing, about eating, that your oral health actually helps you, and your social interaction with others. So it's sometimes the way you look—you're embarrassed; it is sometimes because of the pain, which could cause you not only pain and discomfort, but some difficulty with actual eating and functioning.

The Vice-Chair: Thank you very much. Ms. Martel.

Ms. Martel: I apologize for being out of the room for part of the presentation, so I hope that I've picked most of it up. You express the concern that in a particular situation, or several situations, dentists had donated equipment to a health care room and then had been asked to remove it when there was an administrative change. So I understand that you want some kind of provision to protect against that. But in terms of the suggestion that there be health rooms within each long-term-care home, are you anticipating that the home would cover that cost, including the equipment? What's your suggestion in terms of how this will work?

Ms. Samek: I think there needs to be discussion about what would be seen to be a minimum, but the reality is there are other health care providers that often go into homes as well. I think of optometrists and others. What we're looking at is appropriate lighting, appropriate access to water, the need to ensure disinfection, sterilization, all of those kinds of things, and while you can do some things at bedside, you want to ensure that you have in fact a more optimum opportunity to do this. We're not asking the long-term-care home to put in dental equipment, because much of that is portable, but a place where the resident can be facilitated in terms of that care within the right type of environment.

Ms. Martel: So for them to have special consideration of an appropriate room and, within that room, appropriate access, whatever that may be—if you're in a wheelchair—that would allow services to still be provided. I don't have an idea of what the cost might be to do that, but I'm assuming that is not a high-budget item in terms of facilitating that, making it happen.

Ms. Samek: As you noted originally, we have many dentists who go in from the community and try to accommodate this on an ongoing basis, and because it's not a requirement, you can have—and it is a bit of a burden for the home to be able to ensure that patients are available, that you have the administration there, that you're looking at health care records, because they need all of that information. Those things become something that can say, "This is a barrier. We don't have to do it, so we're going to turn this room into something else," for that facility.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: I understand from my dentist at home that there was a time in the late 1980s or early 1990s when equipment was donated and then rooms were converted later on. One of the concerns that I know I've heard in my community is about the availability of dentists to go into long-term-care homes, or their willingness to go in, from both the home perspective and from the dentists, who are very busy, and it is an extra burden on them to actually leave their place of practice to go into a home. I'd just like to hear your comments on that. It's one thing to put these kinds of requirements into legislation, but if we're not able to deliver on it, then it's a bit redundant.

Ms. Samek: In 2003, we actually surveyed our members to ask about their treatment for people with special needs, and that included the long-term-care population. In fact, we did put together a resource document to help facilitate them to go and do this work. We found that four in 10 of our members expressed that they were doing this or they had a strong interest in doing this. When you consider the small but significant and growing population of those in these facilities, we think it is something that's quite doable. In fact, when we've asked people to go out and find out what's happening in their community, in one area—I'm thinking off the top of my head it was Burlington—when they went out and made contact with each of the homes, they were in fact told that there is some type of arrangement with a dentist or a number of dentists to come in and care for their residents, so we know it's happening.

The Vice-Chair: Thank you very much for your presentation.

CANADIAN UNION OF PUBLIC EMPLOYEES, LOCAL 79

The Vice-Chair: The next presentation will be by the Canadian Union of Public Employees, Local 79. Welcome. Please state your name before you start.

Mr. Tim Maguire: Tim Maguire. I'm the first vice-president of CUPE 79.

Ms. Ann Dembinski: Ann Dembinski, president of CUPE Local 79.

The Vice-Chair: You can start whenever you're ready.

Ms. Dembinski: On behalf of the executive of Local 79 and members of CUPE Local 79, we wish to thank the committee for the opportunity to speak to you today and to share Local 79's views with you on the proposed legislation referred to as Bill 140, the Long-Term Care Homes Act, 2007.

I just wanted to tell you a little bit about CUPE Local 79. We are the largest municipal local in Canada. We represent more than 18,000 full- and part-time employees. Our members work at the city of Toronto, Bridgepoint Hospital and the Toronto Community Housing Corp. They work in many locations, and part of where they work is in 10 of the city of Toronto homes for the aged.

We're here today because we recall the promise that Premier McGuinty made during the 2003 election campaign to reinstate a minimum standard of care and three baths per week for seniors living in long-term-care homes. CUPE Local 79 shares the concerns of our members working in the homes for the aged that this proposed new legislation does not deliver on that promise.

While supporting the intention of the bill to improve the long-term-care system, our members have expressed a variety of concerns, including diminishing funding for resident care. It is a fundamental principle set out in the proposed act, and the act states, that "a long-term care home is 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."

Local 79 could not agree more with those sentiments, yet this proposed legislation fails to set minimum staffing standards for long-term-care homes. Where, then, is this promised dignity, security, safety and comfort for our seniors? This proposed legislation, as it is currently written, will not enhance the lives of the frail and elderly who live in our long-term-care homes.

This proposed legislation fails to guarantee Premier McGuinty's promise from his first election that his government would invest an additional \$6,000 in care for every resident receiving nursing home care. The Ontario Association of Non-Profit Homes and Services for Seniors have done the research; this government has only raised the resident care amount by \$2,000. Improving resident care and services must be the first priority. Residents' needs come first. Despite the funding announcements by this government, the level of care being provided to residents is still not what it needs to be. The promise was for an additional \$6,000 for care, which means primarily nursing and personal care, but also programming and support services and food. That's where the need was and continues to be the greatest. Most of any increased funding has not been allocated to direct care and services. Only about a third of the total amount can be legitimately described as enhancing care. The provincial government has not provided adequate funding for required front-line staffing. Resident care suffers because there is not enough staff in many homes and the number of hours allocated to care is simply not enough. Heavy workloads mean that there is insufficient time for baths, foot care, appropriate food, recreation and exercise.

1450

This government has never addressed the findings of the 2001 PricewaterhouseCoopers report that found Ontario lagging behind all other similar jurisdictions in care levels and therapies while having significantly older residents with complex care needs, including depression, cognitive impairment and behavioural problems.

Last spring, an Ontario coroner's jury made recommendations supporting a regulated standard of 3.06 hours of care per day per resident. Labour organizations, seniors' advocacy groups and the Ontario Health Coalition all agree that a minimum standard of 3.5 hours of

care per day per resident will ensure that a humane standard of living can be provided at all times to our seniors living in long-term-care facilities. Residents need hands-on care and they need a minimum standard of care. These seniors deserve nothing less.

Long-term care is already chronically underfunded. Bill 140 proposes a significant increase in directives. Long-term-care homes will be required to spend a great deal more of their limited resources on compliance and administration, with no additional funding. Establishing new requirements and standards without providing the appropriate funding does not appear to be a recipe for success.

Additionally, we're concerned that more than half of Ontario's publicly supported long-term-care beds are in for-profit homes. This gives Ontario the dubious distinction of supporting the highest number of for-profit beds in Canada using public funds—this despite the fact that for-profit homes have an interest in increasing fees for seniors and in shifting costs out of the accommodation envelope, even if it lowers care staff levels, because it fits their requirement to maximize rates of return for their investors. Thus the profit and growth requirements of the for-profit nursing homes industry are in direct conflict with the public interest in accessible and affordable care. Bill 140 does nothing to change this.

In 1996, the Conservative government withdrew the regulation that provided for a minimum standard of 2.25 hours of care. Since then, Ontario has had no care standard. This government must reinstate a care standard to improve quality of life in long-term-care homes. With the downloading of heavier-care patients from hospitals and mental health facilities and with the aging of residents, the standard must be modernized to meet today's care needs.

Based on research of standards in other jurisdictions across Canada and the US, 3.5 hours of care would be the minimum required in order that our seniors are properly cared for and are able to enjoy a well-deserved high quality of life. CUPE Local 79 strongly urges you to amend Bill 140 and introduce a minimum staffing standard of more than three hours of care per day per resident.

Part of Bill 140 must spell out a provincial funding model to ensure uniform provincial standards and accountability for public money in all homes—those run by non-profit and for-profit providers—that will assure Ontarians that their tax dollars are funding front-line care for seniors, not increasing profits. Bill 140 should reflect the government's unequivocal support for public health care, and amendments must be made to this legislation to ensure that public funds in Ontario do not continue to support the highest number of for-profit beds in Canada.

CUPE Local 79 believes that publicly funded long-term health care is best delivered in the public, not the private, sector. Superior health outcomes are the result when people, not profits, are the bottom line. The funding model must address the shortfall of approximately \$4,000 per resident, from the original promise of \$6,000 per resident.

CUPE Local 79 members working in the city of Toronto's homes for the aged are, we believe, among the best municipal workers in Canada. They are dedicated, hard-working, concerned individuals who truly care about the seniors whom they work with in these homes. Our workers and our seniors both need a Long-Term Care Homes Act that will ensure that, in the words of the act, "A long-term care home is 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."

Our seniors deserve nothing less. Do not fail them.

The Vice-Chair: Thank you for your presentation. We have about two minutes left. We'll start with Ms. Martel.

Ms. Martel: Thank you for your presentation today. I want to focus on minimum standards. There was an earlier suggestion that you shouldn't have minimum standards and it should be the staff in homes who are in the best position to determine what care is required for residents. I have no doubt that front-line staff are probably in the best position, but they certainly aren't in any position to allocate funds to have more staff to provide more care, and therein lies the dilemma. The government made a promise of \$6,000; they've funded about \$2,000 to date. The government made a promise to have minimum standards, and there are no standards. I think that the government should live up to both of those promises.

In your opinion, why do you need a minimum standard, and what is the result if you leave it up to workers to determine what kind of care is required without giving them the resultant money or authority to actually staff up to those needs?

Ms. Dembinski: Certainly, as president of Local 79, I'm in regular contact with our members in the homes for the aged. Many of our members—and I'm sure you know this—work in more than one facility. That's common knowledge. When I've been out and speaking to the members, I hear two different things. I hear about the difference that exists between municipally run homes for the aged—and I will say the city of Toronto—and the other homes they work in. Often our members in the homes—not the Toronto-run homes—are pressured to take shortcuts if they are required and, if it is left up to the staff, to decide how to do it.

The Vice-Chair: Thank you.

Ms. Dembinski: I—

The Vice-Chair: Sorry. The parliamentary assistant.

Ms. Smith: He's a taskmaster. Sorry about that. If you want to finish your answer, go ahead.

Ms. Dembinski: That's okay.

Ms. Smith: I appreciate your presentation today. I'm certainly familiar with the Metro homes, and I've visited a number of them.

Ms. Dembinski: It's the city of Toronto now.

Ms. Smith: Sorry.

Ms. Dembinski: They amalgamated.

Ms. Smith: Exactly. I get that in the ministry as well.

I appreciate your acknowledging the system improvements and some of the programs that we've introduced through our nursing strategy, our public reporting website, our complaints hotline, our assessment tools. We've also—and I don't know that it's acknowledged here—made some major investments in front-line workers, including 1,100 new nurses and about 3,800 other front-line workers.

I just wondered, regarding the assessment tool, if you were familiar with MDS—I think some of the city of Toronto homes have been early adopters—and whether or not you have any input from your membership on whether or not they feel that's going to be an improvement in the system.

Ms. Dembinski: In terms of the members, I can't say that our members are intimately familiar with it. I know the tool because I'm the president of the local. I think it hasn't got down to the level of front-line staff.

I would say that the local is hopeful that it will allow you to more correctly reflect the level of staffing that is needed. I'll speak for the homes for the aged, that in fact the level of care now is much, much heavier than when I first started dealing with the homes. I see people who have G tubes, who were never in the homes before. So it's very important that it's recognized that individuals who are extremely heavy, heavy care who are in the homes for the aged should in fact have additional funding.

1500

The Acting Chair (Mr. Bob Delaney): Thank you. That does pretty much conclude the time on that one. Mrs. Witmer?

Mrs. Witmer: Do you want to continue with your response to Ms. Martel?

Ms. Dembinski: Your question was front-line staff. Obviously, they are the ones who deliver the care. I will say, if you were to go and ask one of our members, "Do you think that this individual needs more care?"—our members want to give the best care possible to these seniors—the answer should be yes. But then, often they are faced with other pressures that come from administrators.

The Acting Chair: Thank you. I'm sorry, we have to conclude your presentation there.

DON MILLS FOUNDATION FOR SENIORS

The Acting Chair: The next presenter will be the Don Mills Foundation for Seniors, Mr. William Krever. Please be seated. Make yourself comfortable. Kindly begin by introducing yourselves for the purpose of Hansard. You'll have 15 minutes for your deputation. If you've been here for a little while, you generally pick up the protocol. Any time you leave remaining will be divided among the parties for questions. Proceed at your leisure.

Mr. William Krever: Thank you very much. My name is Bill Krever. I'm the president and chief executive officer of the Don Mills foundation. With me today

are Dorothy Pestell, the volunteer chair of the board of directors, and Bernita Borgh, vice-president of resident services and the administrator of Thompson House Home for the Aged.

First of all, thank you very much, on behalf of the foundation, for the opportunity to address the standing committee on social policy today. We're certainly very pleased to give our thoughts on Bill 140. First, I'd like to give you a very quick overview of the Don Mills foundation and some overall comments on Bill 140, and then turn things over to Dorothy Pestell, the chair of our board.

The Don Mills Foundation for Seniors provides a continuum of services for seniors in the Don Mills and surrounding area. This continuum includes Thompson House Home for the Aged, which is a 136-bed long-term-care home, E.P. Taylor Place Community Services and E.P. Taylor Place Senior Adult Centre. Thompson House opened in 1969 and has developed a strong reputation in the community for providing quality care to its residents and their families.

The Don Mills foundation is a not-for-profit charitable organization with a volunteer board of directors and a strong core group of more than 550 volunteers.

The Don Mills Foundation for Seniors has enjoyed a long and healthy partnership with the government of Ontario and the Ministry of Health over the past 38 years. Our board of directors fully endorses many of the principles contained in Bill 140 and we have always strived to maintain the quality of care for our residents that Bill 140 is trying to ensure.

Our association, the Ontario Association of Non-Profit Homes and Services for Seniors, will be providing a comprehensive critique of Bill 140 and they will be providing detailed recommendations for specific changes to the legislation. The Don Mills foundation is fully supportive of these recommendations put forward by OANHSS.

While the Don Mills foundation is supportive of the spirit of Bill 140, it is the application of the legislation that we are concerned about. In particular, we are concerned with the continued erosion of the not-for-profit sector in Ontario. From the dominance of the for-profit sector in the awarding of new beds in Ontario to the strict governance and accountability parameters contained in this legislation, the future of the not-for-profit sector is being seriously challenged.

At this point, I'll turn things over to Dorothy Pestell.

Ms. Dorothy Pestell: My name is Dorothy Pestell and I am the chair of the board of the Don Mills Foundation for Seniors. I would like to take a moment and share with you three important concerns that I have with regard to my position as chair of the board.

First of all, I am extremely concerned about the harsh penalties under Bill 140 that can be imposed on volunteer board members. When recruiting qualified professional members of the community to serve as board members, I am obligated to fully disclose all aspects of governance, and this, of course, includes any risk factors to new mem-

bers. A \$25,000 first-offence fine and possible imprisonment under this new legislation will certainly deter any prospective volunteer when the personal risk is so onerous. Canadian law does not allow insurance policies to cover these fines.

We don't live in Camelot. Our society and the people in it are not perfect. In spite of the best efforts and screening mechanisms of administrative staff, there is always the odd bad apple in the bunch. It happens in law enforcement, in the teaching profession and in other professions. You do your best. Mistakes, intentional or unintentional, are bound to happen, even in the tightest-run facility. Without the volunteers to form the board of directors, I'm not sure how our facility could operate.

Secondly, I'm concerned about the extra time required of our nurses and other health care workers. According to Bill 140, our nursing staff will be required to help residents in obtaining goods and services not provided by the home; number two, to monitor the lengthy periods of time residents who should be restrained for their own safety, as well as that of others, would require before being put into a safe, secure environment; and to develop and administer annually a satisfaction survey. These are just some of the extra items that are going to be required of the staff at Thompson House. At present, the nursing staff spends an inordinate amount of time on paperwork instead of being able to look after the people they're supposed to help.

Just projecting down in 10 years' time, 10 years from now a much greater percentage of our population will be over the age of 80. In addition to that, there will be fewer citizens in the workforce to support this substantial percentage increase. In 10 years' time, because there will likely be little or no funding to support the requirements of Bill 140, some long-term-care facilities will close, and they'll be forced to close. As well as existing residents, there will be substantially more over 80 who will need care. We're not sure where they will go.

The Don Mills foundation is very supportive of the implementation of a licensing program for the not-for-profit sector. However, fixed-term licensing tied to structural compliance will make it much more difficult to obtain financing for long-term improvements and will not solve financing issues for the not-for-profit sector. This issue is further compounded by the fact that not-for-profit organizations will only be able to sell or transfer beds to other not-for-profit organizations. There is no such restriction in place for for-profit operators. While this provision may appear to protect the balance of not-for-profit beds, it will erode the financial strength of the not-for-profit sector.

I'm going to turn it back to Bill now for a few moments.

Mr. Krever: Just a couple of comments from our perspective on the increased accountability: The Don Mills foundation fully supports accountability within the long-term-care sector, and we have a proven track record of meeting and, we think, exceeding the standards as set by the province of Ontario. However, Bill 140 proposes a

regulatory environment that will be much more prescriptive and micromanaged by the Ministry of Health. It is certainly necessary to address the small percentage of long-term-care homes that are not meeting the standards of care as set out by the Ministry of Health. However, we feel it is equally important to provide incentives for those organizations that have consistently exceeded these standards.

It should be further noted that the proposed accountability framework through Bill 140 is adding a heavy burden on long-term-care homes in terms of staff resources. Current funding levels have not been increased to cover the resources needed for this increased accountability. This burden is ultimately taking resources away from direct resident care.

At this point, I'll turn it over to Dorothy for our closing comments.

Ms. Pestell: As a volunteer leader actively involved in the not-for-profit long-term-care facility, I support many of the concepts of Bill 140. However, I am disheartened that this legislation fails to provide adequate recognition of the dedicated work that volunteers are doing throughout the province in caring for seniors in our community.

More importantly, I'm gravely concerned that not only does Bill 140 do nothing to ensure the future of not-for-profit long-term care in Ontario; it also creates new barriers with which we must deal.

1510

In closing, I would ask the standing committee to take a close look at the impact that you're having on the not-for-profit sector through this legislation. Our association, the Ontario Association of Non-Profit Homes and Services for Seniors, has provided specific recommendations that should be carefully considered by this committee.

Finally, I would ask the standing committee to also consider the opportunity that lies before you to truly send a message on the value of the voluntary sector in Ontario. This is your opportunity to demonstrate your commitment to volunteer leaders in communities throughout Ontario.

Thank you for allowing us this opportunity to present our concerns.

The Acting Chair: Thank you very much. We should have time for about one minute from each caucus for a brief question, beginning with Ms. Smith.

Ms. Smith: Thank you for being here and for your work in this sector. In your presentation, you talked about the not-for-profit sector being largely ignored in the awarding of new long-term-care beds in the recent re-development. Why do you think that was, if you want to comment further on that?

Mr. Krever: I believe the balance was about 65% to the for-profit sector and 35% for the not-for-profit sector. So again, this is eroding the balance that had existed previously.

Ms. Bernita Borgh: I think too, being a charity, we actually did put in for beds, so we had to do proposals on our own. I know that the large chains have head offices with large groups of people who can help them with

these types of proposals. In our instance, we wrote it ourselves and we weren't awarded the beds. I think that the charitable homes have put in proposals, but we're at that disadvantage.

The Acting Chair: Thank you. Ms. Witmer.

Mrs. Witmer: I had a question in here about the not-for-profits. You indicated, and as we know, that you're only able to sell or transfer your beds to other not-for-profits. Then you indicate that there's no restriction, of course, for the for-profit. You say, "While this provision may appear to protect the balance of not-for-profit beds, it will erode the financial strength of the sector." Could you explain that for me? I suspect the government thought that they were protecting the not-for-profit sector, but you're saying it will erode the financial strength.

Mr. Krever: Certainly. I think one of the concerns would be, as a not-for-profit provider, that if you're only able to sell your beds to another not-for-profit organization, the market is very limited in terms of who could buy those beds, whereas if you can sell to the whole market, the value is much greater. So that in itself, I think, would devalue the for-profit beds. I also think it could have an impact in terms of the ability of homes to get financing based on those licences to rebuild, because of the devaluing.

Mrs. Witmer: From the financial institutions, you're talking about?

Mr. Krever: Yes, that's correct.

Ms. Martel: Thank you for your presentation. You have a 136-bed home and you said you're a C home. You have three- and four-bed wards now?

Ms. Borgh: All two-bed rooms—we have two four-bed rooms in the entire building.

Ms. Martel: And those would have to be upgraded and modified. Have you had a costing for those?

Ms. Borgh: Actually, the whole building would have to be, because we're a C facility, and because it's not just the rooms that are considered in a C; there are common areas. We have residents who have to go down to a main dining room in the lower level, so it's transporting them on elevators when they're a higher level of care than when they first came in. Normally, there were 70-year-olds who were coming in 1969, and now we're getting 90-year-olds. So it's more than just the rooms. We only have two rooms that are four beds, but also our two-bed rooms are the square footage that the new standard is requiring for a single. So basically, in all of our rooms, we would have half the population. We have had different proposals, architects look at it, and we could actually facilitate 52 seniors in our building instead of 136 if we applied the new standards to them.

Ms. Martel: So for you to do a conversion, have you done an estimate on the cost?

Ms. Borgh: We'd have to do a whole rebuild. We're at the \$22-million mark. That would cost—

Ms. Martel: So you're not really in a position to do that all on your own out in the market.

Ms. Borgh: Exactly.

The Acting Chair: Thank you very much for having come in today and for making your presentation before us.

VON ONTARIO

The Acting Chair: I'm advised by the clerk that the deputation originally scheduled at 3:15 has been cancelled. I now ask VON Ontario, Mr. Paul Ting, to come forward. Good afternoon and welcome. You'll have 15 minutes to make your deputation before us. If you leave any time remaining, it will be divided among the three parties for questions. Please begin by stating your name for Hansard and then proceed.

Mr. Paul Ting: Good afternoon, ladies and gentlemen. My name is Paul Ting. I'm vice-president of operations for VON in Ontario. Thank you for the opportunity to speak with you today about VON's concerns and recommendations respecting the draft legislation on long-term-care homes in Ontario. The standing committee on social policy is to be commended for bringing forward recommendations that will ensure the appropriateness and adequacy of care provided in long-term-care facilities.

VON has been providing home and community care in Ontario for more than 108 years. We have a very distinguished record through various well-known and respected services, such as home nursing and support, health promotion, and the delivery of charitable programs like Meals on Wheels, volunteer transportation and exercise for seniors. We have 22 branches delivering care and support in Ontario.

The high-quality services we provide are intended to keep people living independently in their homes and communities and out of long-term-care facilities and hospitals for as long as possible. We know that Ontarians prefer to receive care in the comfort of their own homes, surrounded by their family, friends and neighbours. With that perspective, we offer the following comments and recommendations.

(1) Home and community care: Some people would say that the health care system in Ontario is in distress, with a shortage of hospital beds, a shortage of long-term-care beds, emergency departments that are overflowing and a shortage of family physicians. These issues must be addressed, but VON struggles to understand why more focus, energy and funding have not gone into the home and community sector, where, according to Roy Romanow's final report, "growing evidence [suggests] that investing in home care can save money while improving care and the quality of life for people who would otherwise be hospitalized or institutionalized in long-term-care facilities."

We raise two issues here. First, the standing committee on social policy should take the responsibility to regroup, following implementation of this legislation, to discuss and draft new legislation that would address the need for more resources in the home and community sector, where more and more Ontarians wish to receive

care and where it is more cost effective. Second, the current draft legislation should ensure that Ontarians are aware of their home and community care options prior to applying to long-term-care facilities and during the assessment to determine eligibility to a long-term-care facility. Therefore, VON's recommendations are as follows:

VON recommends that a clause be added to part II, subsection 41(4), to allow a comprehensive and thorough discussion of the home and community support options prior to considering a long-term-care facility.

VON recommends that follow-up legislation to Bill 140 be drafted to include appropriate and adequate financial and human resources in the home and community sector to support people safely in their own homes and communities.

(2) Caregivers: Caregivers are individuals who provide care and assistance for their family members and friends who are in need of support because of fiscal, cognitive or mental health conditions. VON has been championing recognition and support on behalf of almost three million caregivers in Canada, because these individuals play a crucial role in our health care system. Caregivers are not paid and often incur their own stresses, both financial and emotional. They provide more than two billion hours of caregiving each year, saving the Canadian health care system approximately \$5 billion a year. Caregivers keep their family members, friends and neighbours in the community and home—where they want to be—and out of institutions as long as possible. Caregivers need to be recognized as valuable contributors to the health system, and so we have the following recommendation.

1520

VON recommends that Bill 140 recognize and define the term "caregiver" under "Interpretation" and the valuable role they play and include the term, where appropriate, within the draft legislation. We have the full description within our written submission.

Finally, third, not-for-profits: The value of not-for-profit organizations should not be understated. As a not-for-profit charitable organization, VON knows the value added for communities, across Canada, across Ontario. When VON is in your community, you not only benefit from the program and services for which we are contracted to deliver, but we also assess the local health and social needs and work with community partners to fulfill these needs.

VON supports the thousands of volunteers who make things happen in local communities, and we support the important role of not-for-profit long-term-care homes. VON recommends that the standing committee on social policy include a stronger commitment to preserve and promote not-for-profit delivery of long-term care for the benefit of Ontarians.

Thank you very much for giving VON Ontario time to speak today.

The Acting Chair: Thank you very much. Your very concise brief has actually left some meaningful time for

exploratory questions, beginning with Ms. Witmer and Mr. Arnott.

Mrs. Witmer: Thank you very much for your presentation. I do appreciate particularly your first recommendation. I agree with you very strongly that we need to take a look at what options are available to people prior to going to a long-term-care facility. I do believe that if we were to provide the additional financial and human resources, many of those individuals could stay in their own homes, which is obviously the preference of most individuals. I guess, as well, we could be keeping many more people out of the hospital, again, if we were to look at the community care services that would be available to people, and we wouldn't have some of the problems we're experiencing today in the hospitals with the emergency room crisis.

I think that's an excellent recommendation, and I think it's part of an overall strategy that the government needs to look at as to how we can best ensure that people are accommodated most appropriately. So I thank you for bringing that forward.

I guess you've also recognized that in order to do this, we do need more finances and we do need more human resources to keep people safe in their homes.

I'm curious, and I'm going to ask you—I see this push towards the not-for-profit. I guess right now we've got a degree of balance within the system. I think sometimes that push and pull is kind of healthy; it keeps everybody honest, hopefully, and on their toes in providing the best services to people. Why do you feel so strongly about this, Mr. Ting?

Mr. Ting: I feel so strongly because of the nature of not-for-profit organizations. Their mission and their value are to provide services. If there is any surplus at the end of the day, we invest it in the organization to further enhance the services. The nature of that mission and the mandate and the way they organize themselves to do that, I believe, preserve the integrity of what the funding is intended to do to benefit Ontarians to the fullest extent. I believe the not-for-profit organizations leverage significantly one of the three recommendations I made, about volunteers, in terms of the role the volunteers play within the not-for-profit system. I think not-for-profit organizations do embrace that and work towards the best value for Ontarians using the volunteer sector, using the dollar invested by government and then stretching them to the fullest extent.

The Vice-Chair (Mr. Khalil Ramal): Ms. Martel.

Ms. Martel: Thank you for your presentation. Let me add that the other reason you want to see it in the hands of not-for-profits is because some of the money that could go to patient care in a for-profit setting ends up going into the profit line instead of patient care. So that's the other reason why you want to see it in the hands of the not-for-profit.

Mr. Ting: Absolutely.

Ms. Martel: We did have a significant VON presence in our community—I'm from Sudbury—until, under the cutthroat bidding process in home care, the VON lost the nursing contract to a for-profit, private company that

didn't even have an office in our community. This whole issue of for-profit versus not-for-profit is a significant one, not just in home care but also in long-term care, so I am very supportive of the philosophy that you've brought forward—and RNAO and others have today as well—that we should be indicating in this legislation a much more significant support for the not-for-profit sector if we believe in it and if we want to see it continue, not just next year but in the years to come.

I think it will be interesting to see, on the RFPs that are out now for long-term-care beds, who's going to get those. We will all be looking with great interest to see who is awarded those beds.

One question that I wanted to ask you with respect to, on your first page, when you talked about the discussion that should be had with clients etc. about appropriate supports and services, is, is it your view that in most communities the community supports would be in place to actually allow that option to be a real one? That would certainly be a concern that I would have, that you could have that discussion, but in fact the community supports aren't actually in place to allow that to be a viable option for those who are needing additional services.

Mr. Ting: Obviously by that recommendation I have the underlying assumption that the government places the value of home care as a critical part of the health care system and that that will be funded and structured effectively to provide that option in terms of the family who prefers to be cared for at home rather than in the long-term-care institution. You're right: Depending on different parts of Ontario, the funding level is different. We would hope that in time we will have adequate support for the options chosen by the family, maybe home care, long-term care or otherwise.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: Thank you for being here. I appreciate hearing your report today. I heard a lot about aging in place and aging at home when I did my initial review of long-term care just after being elected, so late December 2003 into 2004. Certainly a number of the groups that we spoke to talked about the need for aging in place and the benefits that had for the senior and the family and everyone concerned. I also heard first hand about the cuts of the previous government when I was knocking on doors in 2003, and what impact that had on seniors who were forced to go into long-term care before they really needed to because there was that little bit of support lacking in their life. We have tried to address that as a government through an increase of about \$340 million in home care over the last couple of years. We continue to make those investments, and we do recognize the importance of aging in place. I just want to acknowledge that.

I did want to ask you about your caregiver requirement and including the caregiver in the definition of family council members; at least I think that's what you were getting at. In the family council section as it's now written, we allow as a right a member to be a family member of a resident or a former resident or a person of importance to a resident or former resident. I just wondered if the "person of importance to a resident"

wouldn't capture the caregiver, wouldn't satisfy what I believe is your request to have caregivers included in family councils.

Mr. Ting: I think that recommendation is really in the context of the first recommendation that I made in terms of the options made available to those who choose to receive care at home. The caregivers in fact play a large role in that respect. Even if someone is a resident in the long-term-care facility, the family members or friends do play a role in terms of providing that peace of mind to the residents in terms of checking in, in terms of visitation and so forth. That aspect is still very significant in terms of that connectedness, even though that individual is placed in a home, still being connected to the broader network of friends and family.

I'm not expert in the legislation drafted in terms of which section in that context is best to be incorporated. I'll leave it to the experts to do that, but I just wanted to put forward the notion that caregiver is an important role in the health care system, even in this context.

The Vice-Chair: Thank you very much for your presentation.

1530

ONTARIO SOCIETY (COALITION) OF SENIOR CITIZENS' ORGANIZATIONS

The Vice-Chair: The last presentation will be from the Ontario Society (Coalition) of Senior Citizens' Organizations. Welcome. You can start whenever you're ready.

Ms. Judith Jordan-Austin: Thank you for sticking it out for this time of day. We're happy to be able to be here with you.

I'm Judith Jordan-Austin. This is Ethel Meade. We are representing both Care Watch and the Ontario Society (Coalition) of Senior Citizens' Organizations. For those of you who may not be familiar with Care Watch, it is a volunteer organization primarily concerned with quality care in the home or in the community for frail senior elders. I hope that is enough of an introduction.

OCSCO represents 150 organizational affiliates representing more than half a million Ontario seniors. We thank you and commend you on Bill 140 and the measures taken to improve Ontario's long-term-care system.

Ethel, do you want to continue?

Ms. Ethel Meade: Yes. We certainly have a very positive attitude toward this bill. We think it expresses a great deal of very good intentions in the long-term-care field. We do have some questions and I have to tell you that the very first one is, since the bill itself is in general terms, the nitty-gritty, the way that things are going to be done, the whole process of making these changes come about is going to be in regulations. We're very concerned that there will be public consultation on the regulations, at least 60 days, and as wide an opportunity as possible to make submissions.

Ms. Jordan-Austin: May I just add at this point that I would emphasize the fact that we are representing consumers, people who actually will need this kind of care.

Ms. Meade: It could happen to any of us any day.

We are also concerned with the bill of rights, which is an excellent list of rights but it's missing one thing that we consider very important, and that is the right to receive the care that you actually need. We know that we don't have that kind of right under the Canada Health Act; we only have the right to a fair share of what's going. But we think for our seniors, in their very last years, we owe it to them that they do receive the care that they've been assessed to need. That is one of our first questions and, along with it, will there be enough funding to actually bring about the changes that we need to get to this right of care?

We and other organizations have thought about and talked about, many times, staffing ratios for long-term-care homes. Staffing ratios are the surest way, as far as we can see, to make sure there is enough staff to provide the care that's needed. Understaffing in long-term-care homes has a long history. It goes back as far as I can remember and it's not mainly because long-term-care homes are laying off their staff; it's because the people who are in long-term-care homes are older and more frail than they were a decade ago, so the acuity level has gone up in all homes across the province.

When we did have this kind of ratio, it was 2.25 hours of care, on average, for each resident. At that time, 2.25 hours of care may have been sufficient, but it is not sufficient today with the sicker and older people we have. Front-line workers tell us that 3.5 hours would just barely avert disaster. We really need more than 3.5, but 3.5 would be an improvement on what we have now.

We're very happy that a couple of important things have already been put into effect, like the unannounced inspections and the requirement for a full-time regular nurse to be on duty 24/7. We do want to ask whether the RN on duty will be considered to be fulfilling this if she has another obligation as well. If she is director of care or administrator and has any other obligations or responsibilities, we don't think that she can be counted as the RN on duty. The RN on duty should be completely available to patients, to people there, for interventions, for treatments and, above all, for looking at them to see how they're doing. The nurse should be available every hour of the day for any of the needs of the residents of the home. So we hope that they would not accept somebody just having RN qualifications as having an RN on duty.

We also want to ask about people who do the annual assessing of patients' acuity and the unannounced inspections. We would like to see both the inspectors and the assessors be mandated to speak to at least a random sample of the residents and their families and the front-line staff. That way, the inspections will be more real; we'll know more about what's really going on. Just looking at charts has never been enough. We hope that these people will be not only permitted but mandated to talk to people there, not just talk to the office and get the charts.

The other big thing we're worried about is the complaints procedure. I have to say that my experience with Queen's Park is that it still underestimates the fear that

people have of complaining. If you are dependent on somebody else for anything important, you will be afraid to complain about that person. You may be more afraid, you may be less afraid, probably in proportion to how much you depend on the service, but seniors of the age and fragility that we know are now in these homes are much more afraid than anybody seems to realize. And I think that applies also to the staff. It's very nice to have whistle-blower protection, but the staff has its own reasons for being afraid to report, and especially because the bill says any retaliation problems have to go to the Ontario Labour Relations Board. That too doesn't give very much confidence that they are really safe to make a complaint. I will repeat what we've been saying for years and years: We need an arm's-length commission that is not set up by the ministry, that is completely independent and reports to the Legislature, and we need really heavy advertising to let people know that this venue is available.

1540

It's shocking how much people don't know about what governments are doing. I would say, if you walked down the street and asked 10 people, "Do you know what a CCAC is?" or even if you said "community care access centre," very few of them would know. With all of the push there's been to try to get people to know that's available, the vast majority of people don't know. The same will apply to any commission that you set up to receive complaints. Unless there is really unprecedented heavy advertising, dramatic advertising—TV, radio, everything you can think of—then neither the independent commission we're asking for nor the info hotline that has been established is going to get the calls they should be getting. It has to be proved to people, and it has to be very, very public, that this is something that really is safe to do.

The next thing I just want to highlight is the question of what happens to the new long-term-care beds that were built with public money. Two thirds of that public money went to for-profit owners. We think that for-profit owners who have had the benefit of construction charges from the public should not be allowed to sell those beds to another for-profit operator. They should either return to the public or to a non-profit organization. We do feel very strongly about that. We never liked the idea that the public money was building private facilities in the first place, but we certainly don't want to see any extension of that.

I think I'll stop there. Do you want to add anything?

Ms. Jordan-Austin: We would prefer that the proportion of basic to preferred accommodation beds be set at 60% to 40% preferred, or at the very least a ratio of half and half. One rather interesting thing that we're suggesting is that the posting of information addressed to residents be mandated to appear in the 16-point sans font, like this one.

We are very concerned about the quality of care, of course. Perhaps you have some questions of us.

The Vice-Chair: Thank you very much for your presentation. We have three minutes left. We can divide

them equally between the three parties. We'll start with Ms. Martel.

Ms. Martel: Thanks to both of you for your presentation. It's good to see you out again. I just want to focus on the section about an Ombudsman-like office for senior care, which you have highlighted. Do you have a preference for a separate office, independent of government, for senior care? Or could your concerns also be met by having the current Ombudsman have oversight? Because he now reports directly to the assembly as well. What are your thoughts on that matter?

Ms. Jordan-Austin: I think we would prefer a totally separate arm's-length relationship, not using the Ombudsman who is presently in place but another one strictly for health and complaints of abuse and neglect and so on.

Ms. Martel: Would that include care in long-term-care homes and the acute care sector?

Ms. Meade: We would hope that it would deal with all senior care, including community-based care as well as institutional care.

Ms. Martel: I understand your distinction. I appreciate that.

The Vice-Chair: Parliamentary assistant?

Ms. Smith: I have a couple of answers to some of your questions, but I wanted to just follow up on that question quickly. Would you foresee that this role would be one of advocacy or more one of investigation after a complaint or an issue has arisen? The way the long-term-care adviser is structured now, they would be providing assistance and advocacy for residents and their family members, but an ombudsperson has more of an investigative role that would look at issues after they've happened. I just wonder if that's what you're looking for.

Ms. Meade: We really would like to see those functions combined.

Ms. Jordan-Austin: They're not mutually exclusive. There's no reason why it couldn't be both.

Ms. Smith: Some would argue that they are mutually exclusive, but okay, we can debate that. I just wanted to let you know that your concern around the RN in the home having dual roles is addressed in subsection 7(4), where the same person who is acting as the RN cannot also be the administrator or director of nursing, so that role is separate. You asked about public consultation on proposed regulations, and that will be undertaken.

I'm running out of time, aren't I, Mr. Chair? Sorry, there were a couple of other issues that you addressed that I'll try to get you some responses to as well. Thank you for being here. Thanks for all your help leading up to today as well.

The Vice-Chair: Thank you very much. Mrs. Witmer?

Mrs. Witmer: I'd like to thank you for your very thoughtful presentation. What you've done here is to go through the bill from the perspective of those who are going to be impacted and I think very thoughtfully raised some questions and provided some suggestions. I hope that as we take a look at introducing amendments, we can take this into consideration.

You spoke about the resident bill of rights, and then you indicated that there should be the right to receive care that meets the assessed needs of each resident; you believe that should be a fundamental right. Whom do you see doing the assessment and how do you see those needs being addressed totally—obviously, it's going to require additional financial and human resources to do this—and how would it be enforced, too?

Ms. Meade: I've lost it.

Mrs. Witmer: Okay. The whole issue of the fact that the right to receive care that meets the assessed needs is a fundamental right: Who would do the assessment, how would the needs be provided for and how would it be enforced?

Ms. Meade: The first assessment is obviously done by the placement coordinator where the vet's going to be. The bill doesn't say if it's going to be the community care access centres or not. It used to be an independent function. I wouldn't at all mind seeing it go back to that. The second assessment surely is made when the person has entered the home. The home would want to make sure they know exactly what they have to deal with, and as we understand it, there are annual assessments of the acuity levels in every home. With the good intentions of this bill, we hope that assessors are not going to try to play down the acuity of the case but will instead be very open and honest about it, and the public will have access to those assessments.

We don't have a situation like we had 10 years ago or so when there was standard staffing for 2.25 hours. There was a big study done by Coopers and Lybrand—Pricewaterhouse—that came up with the fact that even with the 2.25 hours of required staffing, patients were getting less than that; they were getting 2.03 hours, on average. The question of enough staff to do what needs to be done is extremely important.

Mrs. Witmer: Thank you.

The Vice-Chair: Thank you very much for your presentation.

I want to thank everyone for a wonderful day and I everyone that tomorrow our meeting will be in room 151. Now we adjourn until tomorrow at 9 o'clock. Thank you.

The committee adjourned at 1549.

Continued from overleaf

| | |
|---|---------|
| Ontario Association of Residents' Councils..... | SP-1488 |
| Ms. Patricia Prentice | |
| Ontario Dental Association | SP-1490 |
| Ms. Linda Samek | |
| Canadian Union of Public Employees, Local 79 | SP-1493 |
| Mr. Tim Maguire | |
| Ms. Ann Dembinski | |
| Don Mills Foundation for Seniors | SP-1495 |
| Mr. William Krever | |
| Ms. Dorothy Pestell | |
| Ms. Bernita Borgh | |
| VON Ontario..... | SP-1497 |
| Mr. Paul Ting | |
| Ontario Society (Coalition) of Senior Citizens' Organizations | SP-1499 |
| Ms. Judith Jordan-Austin | |
| Ms. Ethel Meade | |

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Ms. Elaine Campbell, Ms. Lorraine Luski, research officers,
Research and Information Services

CONTENTS

Tuesday 16 January 2007

| | |
|--|----------------|
| Long-Term Care Homes Act, 2007, Bill 140, Mr. Smitherman / Loi de 2007 sur les foyers de soins de longue durée, projet de loi 140, M. Smitherman..... | SP-1451 |
| Psychiatric Patient Advocate Office | SP-1452 |
| Mr. David Simpson | |
| Ms. Lisa Romano | |
| Mr. Bud Maheu | SP-1454 |
| Ontario Long Term Care Physicians | SP-1456 |
| Dr. Norman Flett | |
| Dr. James Edney | |
| Ontario Association of Community Care Access Centres | SP-1458 |
| Ms. Georgina White | |
| Service Employees International Union, Local 1.on..... | SP-1460 |
| Mr. John Van Beek | |
| Ms. Sharleen Stewart | |
| Concerned Friends of Ontario Citizens in Care Facilities | SP-1462 |
| Ms. Freda Hannah | |
| Ms. Lois Dent | |
| Ontario Long Term Care Association | SP-1464 |
| Ms. Karen Sullivan | |
| Mr. Bill Dillane | |
| Mr. Brent Binions | |
| Ontario Stroke System | SP-1467 |
| Ms. Nadia Hladin | |
| Ontario Medical Association | SP-1469 |
| Dr. David Bach | |
| Dr. Stephen Chris | |
| Ms. Barb LeBlanc | |
| Association of Municipalities of Ontario..... | SP-1471 |
| Mr. Doug Reycraft | |
| Seniors' Health Centre, North York General Hospital | SP-1474 |
| Ms. Helen Ferley | |
| National Pensioners and Senior Citizens Federation | SP-1476 |
| Mr. Art Field | |
| Ontario Council of Hospital Unions | SP-1478 |
| Ms. Candace Rennick | |
| Ms. Janet Holtrust; Ms. Daphen Stainton | SP-1479 |
| Ontario Hospital Association..... | SP-1481 |
| Ms. Hilary Short | |
| Mr. Jean Bartkowiak | |
| Ontario Health Coalition | SP-1484 |
| Ms. Natalie Mehra | |
| Registered Nurses' Association of Ontario | SP-1486 |
| Ms. Joan Lesmond | |
| Ms. Sheila Block | |

Continued overleaf